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LAW ALERT

Medicare Secondary Payer Statute (MSP) Compliance:

Primary Payers Current Obligations & Potential Future Obligations in Settling Large Liability Claims.

Beginning on January 1, 2010, SB 2499 requires insurers and self-insured entities (referred to in the legislation as Responsible Reporting Entities or "RRE's") to report certain settlements to the Centers for Medicare and Medicaid Services ("CMS") when the Plaintiff is either a current Medicare beneficiary or just Medicare eligible. Failure to comply with the reporting requirements can result in a \$1,000 daily fine, plus "double damages".¹ While these provisions take effect on January 1, 2010, RRE's must report retroactively to July 1, 2009 as CMS has delayed the original implementation of the MSP until January 1, 2010. CMS agreed to this delay due to the great confusion surrounding the implementation of this complex process.

In addition to the new reporting requirements, as of July 1, 2009, Primary Payers now also need to consider the need for a Medicare Set Aside ("MSA") in most cases where they are considering settlement or they will risk severe penalties and a civil suit by Medicare for the amount that would have been payable under the MSA. A Primary Payer is defined by Medicare as any entity responsible for paying money to an injured person that is currently receiving Medicare benefits or who may be eligible to receive Medicare within the following 30 months. As Congress has authorized \$35 million in appropriations to enforce this legislation between 2008 and 2010, CMS will likely be very aggressive in their efforts to enforce this legislation.

¹ Law went into effect July 1, 2009. However, CMS provided guidance on May 11, 2009 that it goes into effect on January 1, 2010.

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Therefore, both RRE's and Primary Payers are well advised to take a proactive approach in order to minimize their potential liability for non-compliance.

The following Law Alert outlines the current obligations and potential future obligations that Primary Payers and RRE's should be aware of when settling large Liability cases. This article also provides recommendations regarding the use of Medicare Set Aside Allocations (MSA's) in large Liability Settlements.

What is the Medicare Secondary Payer Statute?

Congress has enacted the Medicare Secondary Payer Statute, 42 U.S.C. § 1395(y) 2008, to require stringent reporting duties to Primary Payers such as liability insurance plans, private self-insured entities, group health plans, and no fault insurance plans. Medicare had previously required Primary Payers to protect Medicare's interests only in the context of a Workers' Compensation settlement. On its face, the Medicare Secondary Payer Statute (MSP) lays the foundation for providing Medicare a much greater role in the settlement of liability cases, especially pertaining to Medicare Set-Aside Arrangement (MSA) cases. RRE's, which are broadly defined as all the parties to a suit, are now required to report a settlement to CMS if the case involves a current Medicare beneficiary or someone who may be eligible for Medicare benefits within the following 30 months. This last requirement means that anyone who has applied for, but not yet received Medicare entitlement, is also required to report the settlement.

In addition to the reporting requirements, the MSP also requires that the Primary Payer ensure that Medicare's interests are considered with regards to the provision of future medical care. The parties to a case cannot seek to shift the burden of future medical care of an injury onto Medicare by merely settling the claim.

When Should an RRE Notify Medicare of a Settlement?

Under the MSP, all the RRE's in a case have an affirmative obligation to notify Medicare upon the resolution, (i.e. settlement, judgment, etc.) of a

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claim which involves a payment to an eligible Medicare recipient. It is the obligation of the RRE's to determine whether the recipient of the payment is entitled to Medicare benefits and whether Medicare must be placed on notice of the settlement. However, CMS is currently only requiring the reporting of a total settlement in excess of \$5,000. This threshold will be lowered over time to only \$600. Should the RRE's fail to place Medicare on notice for any payments rendered to a Medicare recipient, the **non-compliance penalty is \$1,000 per day, per claim.** Additionally, if CMS has to pursue recovery of any funds owed to Medicare, it appears that the **Plaintiff's Attorney and/or the Defendant can be held responsible for twice the amount owed to the agency.** Accordingly, any settlement that falls within the reporting requirements of the MSP should be accompanied with a notice to CMS. An explanation of how to determine a party's potential eligibility to Medicare Benefits follows.

What are a Primary Payer's obligations under the MSP?

Medicare requires primary payers to fulfill several obligations in a liability context. They include (I) ensuring the reimbursement of Medicare for any Conditional Payments; and (II) considering Medicare's interests with regards to expenses for future medical treatment.

What Are Conditional Payments?

Under the Medicare Secondary Payer Statute (MSP), Primary Payers are required to ensure that Medicare is reimbursed for conditional payments made by Medicare. Conditional payments are broadly defined as any payment made by Medicare for services for which another payer is responsible. An example of a Conditional Payment would be the payment of a medical bill by Medicare for injuries that were sustained by a Plaintiff as the result of a car accident. The determination of whether a payment was a Conditional Payment can be evidenced by the settlement alone and the obligations under the MSP make no distinction between whether a defendant admits liability or not. The obligation of the Primary Payer is therefore to ensure that the settlement proceeds will be used to reimburse Medicare for any Conditional Payments. This can be achieved either through direct payment to Medicare by the Primary Payer or through specific language in

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the release that requires the reimbursement of Medicare.

How does the Primary Payer protect Medicare's "Future Interest"?

In 2001, Medicare mandated that any Primary Payer in a Workers' Compensation Claim who was liable (or potentially liable) for providing medical care for plaintiff/claimant's lifetime was required to consider and protect future Medicare's interests as a part of the settlement. This obligation has now been extended to liability claims as well.

In WC cases this obligation to consider Medicare's future interest has been met by the use of a Medicare Set Aside Arrangement (MSA). In the WC context, there are certain monetary thresholds that require the MSA to be approved by CMS. While there is no current requirement to prepare an MSA in a liability settlement, it is important to understand the obligations under a WC case. MSP was modeled after WC cases. Therefore it is very likely that similar requirements for liability settlements will be forthcoming in the near future. Primary Payers in a liability matter would be well advised to require an MSA as a part of a settlement so as to properly protect Medicare's interests and avoid any future potential litigation with Medicare over the settlement. Recall that both the Plaintiff's Attorney and the Defendant can be liable for twice the amount owed to Medicare if the future interests are not protected.

What is a Medicare Set-Aside Arrangement?

In its simplest terms, an MSA is a structured payment plan that is meant to provide payment for future medical benefits. As part of an MSA, a detailed evaluation of a recipient's anticipated future medical expenses must be performed by a professional Certified to perform an MSA. Various factors such as the recipient's life expectancy, the future costs of prescription medications, future surgeries, therapy, durable medical goods, etc. are all considered and calculated to project an annual cost of the anticipated future medical care. A portion of the settlement is then "set aside" to cover these future expenses. In cases where significant future expenses are anticipated, an annuity may be purchased to fund the MSA. It is the responsibility of the recipient to monitor and administer the funds that have been set aside by the

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MSA, although a trust can be created if needed. Any funds that are not exhausted for a given year are then carried over to the next year. After a period of five years, a recipient can petition CMS to amend or dissolve the MSA if the actual medical benefits are lower than what was outlined in the original MSA.

Primary Payers may assign the task of preparation of an MSA to a third party administrator that specializes in Medicare set-aside allocation services, medical cost projection services and CMS submission services.

Who is Considered Medicare Eligible?

Persons currently 65 and older are automatically considered to be Medicare eligible. In addition, those that are 62 ½ years old are also, for purposes of an MSA, considered to be eligible as they will be qualified to receive Medicare within 30 months. The age threshold applies, regardless of whether Medicare is currently providing benefits. As such, any person who is 62 ½ years old and who settles a claim should be required to have an MSA as part of a liability settlement. In addition, persons who have filed for or are currently obtaining Social Security Disability (or SSD) are also considered to be eligible for Medicare and an MSA should be required as a condition of settlement.

Is there a Monetary Threshold for an MSA?

While the MSP **does not** establish a current monetary threshold for the preparation of an MSA in liability cases, Worker's Compensation (WC) cases are subject to several guidelines that may assist Primary Payers contemplating when to prepare an MSA. Under WC cases, two monetary thresholds exist: (1) if the WC claimant is Medicare beneficiary and the total settlement is **greater** than \$25,000; and (2) if the claimant is not a Medicare beneficiary but has a "reasonable expectation" to become eligible within 30 months of settlement date **and** total settlement is **greater** than \$250,000.

Three points stem from these two monetary thresholds. First, "total settlement" includes, but is not limited to, wages, attorney fees, future

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medical expenses, repayment of conditional payments, and payout totals for all annuities. Second, CMS states the “threshold” is a set of *guidelines*, not a bright-line rule. In other words, even though a recipient does not fall into a category, this does not provide a safe harbor relief provision for a primary payer. Third, “reasonable expectation” may include persons applying for social security disability, if a person has End State Renal Disease or is 62 ½ years old (potentially eligible). Thus, it is vital that primary payers know the age of the Plaintiff and any previous disability claims.

Again, the above WC guidelines do not apply in the settlement of liability claims. However, as the MSP is modeled closely on the prior WC requirements, it is very likely that in the future CMS will adopt similar guidelines for liability settlement. Having a basic understanding of the WC requirements will therefore be helpful if new guidelines are issued as expected.

Does the MSP define Medicare’s “Future Interests” in a Liability Context?

Unfortunately, the current text of SB 2499 does not provide any clear language outlining the methods to determine past and future interests, i.e. medical bills, relating to Medicare in the liability context. However, two approaches may assist primary payers whether MSA is applicable in the liability realm.

A Wait-And-See Approach?

The first approach under SB 2499 is that since the current statutory framework does not specifically address whether *future* medicals in liability cases are a “future interest”, thus an MSA is not required. Specifically, the statutory text does not speak to issue of future medicals in liability cases. In fact, purely from a textual standpoint, SB 2499 is far from the equivalent of WC requirements for MSA under 42 C.F.R. § 411.46. In other words, SB 2499 does not specifically require primary payers in liability context to begin including an MSA in their settlement agreements. Thus, primary payers may prefer a “wait-and-see” approach through judicial or legislative proclamation to then provide a system for MSA in the liability context. However, this

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approach has many risks and may result in significant exposure.

A Proactive Approach?

Alternatively, another view is that SB 2499 is attempting to trend towards the similar WC provisions. Future legislation may address this plain language statutory gap. Although primary payers are not currently required to prepare MSAs at this time, legislators will likely draft clearer language equal to WC large sum settlements. Tellingly, CMS panelists have begun indicating an interest in public arenas since 2005, whereby its representatives have issued a deep-rooted interest in becoming *protected* in certain “large” liability settlement claims. As a result of this interest, some parties have actually begun to include liability MSAs in their settlements and submit same to CMS for review. CMS has actually agreed to review MSA submissions in certain liability cases. Such a review has occurred despite the CMS having no formal review process for liability cases. These Primary Payers are taking a “proactive approach” in order to minimize potential liability for non-compliance, despite having no standards or guidelines on MSA’s in liability settlements.

Other SB 2499 Problems

Several aspects of the SB 2499 also remain unclear. First, the bill does not tell primary payers what information needs to be provided to Medicare as part of the notice of settlement. The only information mentioned is “identity of the claimant.” There is no definite statement to whether a name, date of birth, social security number or other information will be required. Further, providing personal information (or even worse, the wrong information) may cause other problems SB 2499 has not contemplated.

Second, SB 2499 is unclear whether notice to Medicare is only for “resolved” claims or not. Although the statute intimates this, it is unclear whether “unresolved” claims fall under this category. The statute does not prohibit such action and courts may broadly interpret the purpose to the underlying statute.

Third, the MSP states the “primary payer is [ultimately] responsible”, but does not state whether the statute allows for assigning this to another party. It will be difficult to determine whether one can contract out this obligation to a third party or whether this is a required obligation under law

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that is prohibited from assignment in exchange for like consideration.

Finally, the time period for notice to Medicare states “after” but does not reveal a deadline for “after” a claim is resolved. Without a bright-line rule, it is difficult to discern how much time passes before a non-compliance penalty is assessed. Likely, courts may take the approach of “reasonable” time under the circumstances. Although the primary payer may take time through appeals, gathering payment check, and finalizing all necessary documents, this likely does not allow primary payers to go through unscathed without first notifying CMS.

Thus, the reality is SB 2499 likely creates more than alleviates problems. Primary payers should brace themselves for more legislation, expenses, and defense litigation costs if Medicare decides to pursue any potential non-compliance claims.

Suggested Recommendations for Compliance

We have developed a checklist of suggestions for your referral and use in establishing MSP compliance in liability settlements.

- First, remember that the MSP requirements do not apply to everyone. Make sure that the Plaintiff and the settlement fall within the requirements before considering compliance with the MSP.
- Red Flag Potential Medicare Recipients such as Plaintiffs that are over 62 ½ years old. In every case send out a Social Security Release to see if a Plaintiff has applied for or is receiving SSD.
- Re-think general releases for existing or possible Medicare recipients as every release will require some language that mentions Medicare and makes it clear that Medicare's interests were taken into account as a part of the settlement.
- Draft MSAs for liability claims even though they are not currently required as you may risk being sued if it is later decided that they were required after 7/1/09. Once an MSA has been completed, the burden of compliance will shift to the Plaintiff who will be responsible for the administration of the MSA funds.

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- ❑ Contemplate using third parties for MSP Compliance, and if using third parties, assess how to absolve liability if non-compliance is issued.
- ❑ Consider seeking CMS approval of an MSA even though it is not currently required. This is especially true in larger settlements where a Plaintiff is expected to have significant ongoing medical care. Once CMS approves an MSA, they will not be able to claim that the Primary Payer failed to take Medicare's future interests into account.
- ❑ Even if Plaintiff refuses to take responsibility, make it clear in your Proposal for Settlement that monetary sums are going towards protecting Medicare's interests.
- ❑ Obtain your own Liability MSA Settlement Agreement and make sure you clearly identify and define in your own settlement agreement specifically what funds are being utilized for Medicare.
- ❑ Re-think Final Judgment Orders by Court issuing not only dismissal with prejudice but also setting a possible compliance date.

Prepare your company for the reality that SB 2499 is only laying the foundation for more legislation in liability cases. For information on Luks, Santaniello Legal, Reporting and Administration Services for MSP Compliance and Insurer Mandatory Reporting, please e-mail **LS-MSP@LS-LAW.COM** or contact David Gold, Workers' Compensation Practice Partner at 954.761.9900.

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