

New Role of Medicare Secondary Payer Act

I. Introduction

Pursuant to the Medicare Secondary Payer Act 42 U.S.C. §1395y (“The Act”), Medicare assumes the role of secondary payer in cases where a primary payer exists. A primary payer is considered any workers’ compensation, liability or automobile policy or no fault insurance. In other words, if a portion of the proceeds of a workers’ compensation or personal injury settlement agreement are intended to cover future medical expenses that would normally be covered by Medicare, Medicare becomes a secondary payer which is only responsible for paying the excess medical expenses if or when the anticipated annual amount is exhausted.

Specifically, §1395y (b)(2)(A) reads:

In general. Payment under this title may not be made, except as provided in subparagraph (B), with respect to any item or service to the extent that –

(i) payment has been made, or can reasonably be expected to be made, with respect to the item or service as required under paragraph (1), or

(ii) payment has been made or can reasonably be expected to be made under a workmen’s compensation law or plan of the United States or a State or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance.

To facilitate compliance with this statute, all parties to a settlement involving a potentially Medicare-eligible person must propose a Medicare Set Aside (“MSA”), i.e. a separate trust account that is intended solely to cover future medical costs that would otherwise be covered by Medicare. If the account is properly administered and the MSA is adequate, once those funds have been exhausted Medicare will resume making payments on behalf of the claimant for and Medicare-covered treatment.

Medicare is authorized by statute to seek reimbursement, interest and penalties for any payment it makes that was the responsibility of the primary payer.¹ By establishing an MSA account, parties to a settlement are protecting Medicare’s interest,

¹ Notably, Medicare can seek recovery from any party or entity who received funds from the primary payer, including the attorney. See United States v. Harris, 2009 U.S. Dist. LEXIS 23956 (N.D. W. Va. Mar. 26, 2009).

their clients' interests, and their own interests and are complying with the Medicare Secondary Payer Act.

II. History

This statute was enacted in 1980; however the Centers for Medicare and Medicaid Services (CMS) did not begin enforcing it until approximately 2000-2001. The statute applies to workers' compensation, no fault, liability and automobile plans, but was typically only enforced in workers' compensation cases.

However, recent legislative amendments to The Act have led those in the industry to anticipate stricter enforcement in liability and automobile policy cases. Most notably, the SCHIP Extension Act was passed in December 2007, and is scheduled to go into effect on July 1, 2009. Specifically, Section 111 of the SCHIP Extension Act details new heightened reporting requirements for primary payers. Failure to comply with the new reporting requirements subjects a primary payer to substantial penalties, including a \$1,000.00 fine per day per claimant.

Because these new reporting requirements will make it exponentially easier to track whether it is a secondary payer, the legal and insurance fields have correctly concluded that the long-standing MSA requirements need to be adhered to. As stated by an attorney specializing in this particular field of litigation:

However, most knowledgeable folks practicing in the area of MSAs realize that CMS would not be launching such a mammoth information gathering venture unless it planned to put that information to use. Those of us who practice in this area recognize that the type of information being required by CMS under [SCHIP Extension Act] is hauntingly familiar in character - it is precisely the type of information required to accompany a typical proposal to CMS for review and approval of an MSA in a WC settlement.

III. Applicability of the Medicare Secondary Payer Act

The Act applies to all settlements where an injured party has foreseeable future medical treatment that will arise at a time when he is Medicare eligible (regardless of whether he or she is Medicare-enrolled) and Medicare would otherwise cover that treatment. Thus, whether a claimant is a Medicare beneficiary at the time of settlement is not determinative of whether an MSA is required. The issue is whether it is reasonably likely that the subject-injuries will necessitate future medical treatment at a

time when the party is Medicare eligible. Medicare eligibility is based on the following criteria:

- People of 65 years of age or older;
- People with disabilities under the age of 65 who have been in receipt of Social Security Disability benefits for at least 24 months; and
- People with End-Stage Renal disease/Lou Gehrig's disease.

Generally speaking, almost all claimants will eventually become Medicare eligible and thus MSAs should always be considered. The simplest situation involves an injured-party who will require continued treatment throughout his or her life (55 year old quadriplegic). Clearly, such a case would require an MSA. On the opposite end of the spectrum is if no portion of a settlement or judgment is intended for future medical expenses (25 year-old with broken arm). An MSA would not be required in those cases. Of course, to be safe, supporting documentation should be secured, such as a letter from the claimant's treating physician(s) stating that to a reasonable degree of medical certainty he or she concludes claimant will no longer required any Medicare-covered treatment.

Lastly, to clarify the most common misconception regarding MSAs, the monetary value of the settlement and the age of the claimant are not determinative of whether an MSA is necessary. Often, the Centers for Medicare & Medicaid Services' ("CMS") guidelines for limiting the review of MSAs are erroneously interpreted as "safe harbor" provisions, obviating the need for an MSA. CMS has stated that MSAs related to workers' compensation settlements need to be reviewed where either (a) the claimant is currently eligible for Medicare and the settlement is greater than \$25,000.00; or (b) the claimant is reasonably expected to become eligible for Medicare within 30 months of the settlement and the total settlement is greater than \$250,000.00. These thresholds are to limit the amount of MSAs CMS must review, and in no way eliminate the need for MSAs.

The need for an MSA is governed strictly by whether Medicare will be responsible for payments that are the responsibility of a primary payer. Further, those threshold guidelines apply only to workers' compensation settlements. CMS has never issued guidelines regarding thresholds for liability settlements. However, some in the industry have suggested that around \$200,000.00 is the lowest liability settlement where they have seen CMS review an MSA.

IV. MSA Creation and Review

The preparation of an MSA appears to require some specialization in that area of law. Generally, the claimant's medical background and illness and/or injury are

reviewed. Based upon the past treatment for that particular illness and/or injury and treating physicians' recommendations, an MSA is created that is intended to include all reasonably anticipated costs that could fall under Medicare's responsibility. The MSA and all necessary settlement language/information are then forwarded to Medicare for approval. If it is approved, the settlement funds allocated to the MSA are placed in a trust and limited to use for Medicare-covered treatment for that particular injury.

Failure to create an MSA subjects the entire settlement to Medicare's subrogation. For instance, suppose a claimant receives a \$100,000.00 settlement, \$25,000.00 of which is a reasonable estimate as to the portion of the settlement dedicated to future medical payments. If an MSA is not created, Medicare has the right to recover the entire \$100,000.00 should that amount ultimately be exhausted by the claimant.

V. Liens v. MSAs

It is important to note the distinction between Medicare liens and Medicare Set-Asides. Attorneys are still responsible for determining whether Medicare has made any past payments for treatment and are entitled to reimbursement from any settlement or judgment proceeds. Thus, the attorneys should conduct a lien inquiry prior to any settlement so that they are aware of the funds that must be repaid. A lien inquiry can be conducted over the phone through the COBC at 1-800-999-1188 and a letter should also be mailed to:

MSPRC Liability
P.O. Box 33828
Detroit, MI 48232

MSPRC WC
P.O. Box 33831
Detroit, MI 48232

However, attorneys are also responsible for any future payments made by Medicare, which are covered by the MSAs. Liens deal with past payments and MSAs deal with potential future payments.

VI. SCHIP Extension Act Compliance

Section 111 of the SCHIP Extension Act requires insurers to determine benefit status of all claimants and report all claims to the Centers for Medicare & Medicaid Services - a division of the Department of Health and Human Services - so that Medicare is on notice and its interests remain protected. The failure to comply with the reporting requirements can lead to a fine of \$1,000 per day per claimant.

Section 111 applies to Responsible Reporting Entities (“RREs”), which in the context of liability and automobile policy claims is the insurer. The RREs will first register online with CMS and setup a data reporting and response process. The RREs will then submit the relevant information (claimant’s name, SSN, DOB and gender) for each particular claim electronically to CMS’ Coordination of Benefits Contractor (“COBC”). If the query matches three of the four data elements, the COBC will forward the claimant’s Medicare file. If the data does not reveal a match, CMS will inform the RRE that there is no Medicare beneficiary based on the information provided. (Note: electronic registration for all RREs is currently being conducted via the Coordination of Benefits secured website.) Additionally, the RRE is responsible for a “timely” reporting to CMS of any settlement, judgment or award to a Medicare-eligible party.

In response to concern that had been expressed regarding the various provisions of the new amendment and how to comply with the reporting requirements, CMS published proposed guidelines for insurers to follow. See <http://www.cms.hhs.gov/MandatoryInsRep>.