

MEDICARE AND LIABILITY CASES

I. The Significant Statutory and Code Provisions

A. The Medicare Secondary Payer Statute

The Medicare Secondary Payer statute (MSP) has been the law for well over 25 years. On December 5, 1980 the Omnibus Budget Reconciliation Act amended Section 1862(b) of the Social Security Act with the goal of making Medicare a secondary payer in certain situations. The MSP requires payment of medical expenses be withheld “to the extent that payment has been made or can reasonably be expected to be made under a workers’ compensation law or plan or under an automobile or general liability insurance policy or plan or under no-fault insurance.” 42 U.S.C. §1395y(b)(2)(A)(ii).

- Liability insurance means insurance, including a self-insured plan which provides payment based on legal liability for injury, illness or damage to property.
- A liability insurance payment is a payment by a liability insurer or an out-of-pocket payment, including a payment to cover a deductible required by a liability insurance policy, by an individual or other entity that carries liability insurance or is covered by a self-insured plan.

In certain circumstances Medicare may issue medical payments despite the possibility of a primary payer. These payments are called conditional payments and are generally what people refer to as the Medicare lien, though technically it is not a lien. Please note Medicare’s right to reimbursement likely also extends to future medical benefits. This is where the debate about Medicare Set-Asides comes into play. This will be discussed further below.

B. Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA)

The new Medicare reporting requirements are a major topic of conversation amongst insurers and self-insureds. Section 111 of the MMSEA will require all applicable plans to report to the Centers for Medicaid and Medicare Services (CMS) *any payment* made by an applicable plan to a Medicare beneficiary. An applicable plan includes liability insurance, self-insurance, no-fault insurance and workers’ compensation laws or plans. 42. U.S.C. 1395y(8)(F). Entities with a responsibility to report were required to register with CMS by September 30, 2009. Thereafter CMS will engage in a period of testing with Reporting Agents and/or Account Managers. Actual reporting will begin during the second quarter of 2010.

Even though reporting will not begin until the second quarter 2010, cases settled on or after **January 1, 2010** may still need to be submitted as a part of the

first quarter of reports. All settlements, regardless of liability, on or after January 1, 2010 must be reported with the following threshold exceptions: liability:

January 1, 2010 – December 31, 2011:	\$0.00 - \$5000.00
January 1, 2012 – December 31, 2012:	\$0.00 - \$2000.00
January 1, 2013 – December 31, 2013:	\$0.00 - \$600
January 1, 2014 and after:	No exceptions

Please note, that in the event you settle a case and accept on-going responsibility for medical expenses, different reporting dates and thresholds apply.

II. Why is there so much talk about Medicare of late?

Technically, nothing has changed since 1980 from the standpoint of Medicare as a secondary payer. Medicare was and still is a secondary payer per the Act. What has happened is the passage of the MMSEA placed reporting requirements and significant penalties for non-compliance on insurers and self-insureds. As those entities began preparing to meet these new reporting requirements, a greater awareness developed as to both the immediate and long term impact of Medicare's involvement.

Administratively, Section 111 reporting is very significant to insurers and self-insureds. Payments to Medicare beneficiaries must be reported, regardless of liability. Insurers and self-insureds are now charged with the task of identifying individuals who are Medicare beneficiaries. A significant hurdle in complying with Section 111 is reaching a level of confidence with whether a claimant payee is or is not a Medicare beneficiary. Attached is a copy of model language CMS recommends be used for identifying Medicare beneficiaries. It is crucial this document be used in all cases going forward and retained even after cases are settled.

Under Section 111, those required to report are subject to a \$1000 per day per claim penalty for failure to report. There are also penalties under the MSP for failure to protect Medicare's interests. If Medicare is required to take legal action to recover a conditional payment, Medicare can recover up to twice the amount of the Medicare primary payment as a penalty in addition to recovering the payment itself. Medicare has a direct cause of action against all primary payers responsible for *making* payment and any entity that *received* a primary payment including a beneficiary, provider, supplier, physician, attorney, state agency or private insurer.

III. Is a Medicare Set-Aside Necessary or Appropriate?

My answer in liability situations is unequivocally *maybe*. The analysis is rather involved and I would be happy to discuss it further with any of you who are interested or need more information. As briefly as possible, my reasoning is as follows:

Medicare Set-Asides are NOT required in ANY case. However, as to Workers' Compensation, the Code of Federal Regulations references Set-Asides as a good and preferred vehicle for protecting Medicare's interests as to future Medical expenses. The CFR does not contain that same language for liability and no-fault cases. As to Workers' Compensation, Medicare has been a secondary payer since 1965, long before the provisions pertaining to liability. Despite being so since 1965, MSAs did not come onto the scene until approximately 2001 when the Centers for Medicaid and Medicare Services (CMS) issued the Patel Memo recommending the use of the MSAs.

Some believe the Section 111 reporting requirement will be a springboard to introduce MSAs into the liability arena. Again, there is nothing in this new legislation requiring the use of MSAs. Informally, however, CMS has indicated that it would like to see its interests protected in liability cases. As to the issue of future medical expenses, Medicare only reviews MSAs which meet certain threshold requirements, even in Workers' Compensation cases. These thresholds are not safe harbors but only working guides. Most recently Medicare has begun reviewing MSAs in certain liability cases. No guidance has been offered as to values or situations CMS considers appropriate for liability MSA review.

Certainly the Section 111 reporting requirement will allow Medicare to keep better tabs on Medicare beneficiaries receiving funds from other sources which are potentially primary. In a recent decision from the Northern District of West Virginia, *United States v. Harris*, CMS sought to recover against a Plaintiff's attorney for failure to reimburse a conditional payment of \$10,253.59. The total settlement in the underlying cause of action was only \$25,000.00. The District Court Judge allowed CMS' cause of action against the attorney. Arguably, this case suggests CMS is actively pursuing recoveries, even smaller ones. The case also confirms CMS' ability to pursue at least a plaintiff attorney to recover medical payments.

And finally, the United States Code does state, as outlined above, that Medicare is a secondary payer to liability insurance, self-insureds and no-fault. This is literally the same provision which began the Set-Aside process in Workers' Compensation cases. Clearly there is a duty to protect Medicare's interests. The question is simply when and to what extent.

IV. Options for Protecting Against MSP and Section 111 Liability

A. At the Initial Case Intake

Plaintiff's attorneys should consider establishing a process for identifying Medicare beneficiaries and/or have a reasonable expectation of becoming beneficiaries. Consider investigating all types of available medical insurance. Does the potential claimant have a Medicare card? If so, a copy for the file may be handy for settlement purposes later.

Medicare points to the following as having a reasonable expectation of becoming a Medicare beneficiary:

- 62 ½ years of age (those individuals may enroll in Medicare in 30 months at age 65) or older
- Current Social Security Disability recipients (SSD recipients are entitled to Medicare after 24 months of SSD), those who have applied for SSD, and those whose SSD application was denied but anticipate appealing
- Individuals with end stage renal disease (ESRD)

Most plaintiff's firms are already adept at this process given obligations to reimburse Medicare conditional payments.

As a claims handler with or without representation on the part of the claimant it is recommended you also begin this investigation process as early as possible and whether or not the legal process has been initiated. You might consider sending a copy of CMS' model language to all claimants as a part of your initial investigation process. You should also be aware of the three factors listed above. If a claimant meets any of those qualifications, the claimant may already be a Medicare beneficiary or may become one while the claim is being investigated and prior to settlement.

B. During the Discovery Process

Interrogatories should query the Plaintiff as to Medicare status. Generally Medicare has required its interests be protected if someone has a reasonable expectation of becoming a Medicare beneficiary. If someone has a reasonable expectation of becoming a beneficiary, insurers need to know this information as payments to that particular claimant will likely need to be reported to CMS.

A Medicare number is needed to comply with the Section 111 reporting requirement. Defense attorneys can assist their clients by propounding interrogatories inquiring whether an individual is receiving Medicare, is receiving SSD, has applied for SSD, has end stage renal disease and investigating a claimant's age. If the claimant is a Medicare beneficiary, request the Medicare number. These requests do several things. With the Medicare number, the insurer or self-insured

can easily comply with the reporting requirement and it is less likely settlement will be delayed. Second, even if the plaintiff is not a Medicare beneficiary at the time discovery is served, in Illinois the plaintiff has a duty to seasonably supplement discovery answers, disclosing any change in status at a later date. Third, discovery questions are one avenue to protect an insurer, a self-insured, and their attorneys when it is later learned a claimant was a Medicare beneficiary while the case was pending. It allows one to show steps were taken to investigate the issue and plaintiff failed to disclose critical information or otherwise obstructed efforts to do so. Finally, when it does come time to issue payment and the insurer or self-insured is unwilling to do so because the plaintiff has not disclosed his or her Medicare status it can be shown the appropriate questions were asked, that plaintiff had the obligation to supply the requested information some time ago and plaintiff failed to do so.

If a defense attorney learns a plaintiff is a Medicare beneficiary, request production of Medicare's conditional payment letter. The larger well versed plaintiffs' firms are likely already requesting conditional payment letters as a matter of course. It is the smaller cases with less sophisticated counsel where this is more likely to be a problem. Conditional payment letters take some time to receive from Medicare, thus attorneys should not wait until the end of a case to address the issue. Conditional payment letters can be requested as soon as treatment has concluded. After the conditional payment letter is received Medicare will, upon the request, issue a letter of final determination as to the dollar amount required to satisfy the conditional payment. Again, this takes some time to obtain. With both together, it may be several months assuming they are requested correctly.

We do not recommend settlement payments be issued given reporting requirements, penalties and other adverse exposures without satisfactory proof of resolution of the conditional payment issue.

A. At Settlement

1. Payment

If a settlement amount has been agreed upon but the plaintiff is not yet in receipt of the final determination from CMS, the insurer may choose not to or, due to internal policy, cannot issue payment. Previously, settlement drafts were issued to the plaintiff and his attorney and plaintiff's attorney was relied upon to place a sufficient amount of the draft in his or her trust account to cover the conditional payment. This may no longer be advisable from a defense standpoint given the current developments in Medicare. One avenue might be to issue separate drafts. The first draft should be for the amount of the settlement less the conditional payment amount. It is unlikely Medicare's final determination will exceed the

conditional payment letter amount. A second option is to name Medicare as a payee on the actual draft.

None of these approaches are without issue. However, if both sides make the correct inquiries and investigation on a timely basis, arrangements for issuance of the settlement draft should not be an issue as everyone will have all the information needed *before* settlement.

2. Releases and Documentation

Per the statute there is *always* an obligation to protect Medicare's interests as a secondary payer. As such, releases should speak to that obligation and indicate that Medicare's interests were appropriately considered in arriving at the settlement and its terms. If the individual is not a Medicare beneficiary, consider language reflecting a representation by the plaintiff that he or she is not a Medicare beneficiary nor a SSD beneficiary. If the individual is not a Medicare beneficiary and there is no indication future medical care will be necessary, clearly Medicare has no interest in the settlement in terms of condition payments or future medical issues.

If a treating physician has indicated future medical care is likely, attention should be given to the terms of the settlement. MSP provisions suggest where no sum is dedicated to medical expenses, Medicare can utilize as much or all of the settlement as Medicare deems appropriate. If there is an appearance of shifting the burden of medical care to Medicare, Medicare can disregard the settlement terms. In certain cases then, it may make sense to delegate a specific dollar amount of the settlement toward medical care. One might also choose terms which include Set-Aside type language, specifically dictating how the medical portion of the settlement money is to be spent further protecting all parties to the settlement.

If there are questions as to future medical care, to the extent possible, secure a statement from the treating physician that the plaintiff will not need treatment in the future related to this incident. Medicare generally does not consider the opinions of experts, only treaters.

Life care plans or other evidence of future expenses may be helpful in the larger cases when combined with the appropriate release language.

The key is to document your file to the extent possible to avoid future problems. Remember, both the plaintiffs' and the defendants' interests are similar as they relate to this issue so cooperation is in everyone's interests.

3. Medicare Set-Asides

Some insurers and self-insureds are demanding Medicare Set-Asides. As previously noted MSAs certainly are a vehicle recognized by CMS as a valid means of protecting Medicare's secondary payer status. Set-Asides can either be self

administered by the plaintiff or professionally administered. There are specific requirements as to funding, use of funds and accounting.

If CMS agrees to review the Set-Aside and subsequently approves the same, CMS is essentially saying that assuming the funds are used in accordance with the Set-Aside agreement, then Medicare's interests are adequately protected. Parties may also decide a Set-Aside is in everyone's best interests regardless of any submission to or review by CMS.

V. Penalties and Exposure

1. Plaintiffs

Plaintiffs have obligations to cooperate with efforts by CMS to recoup conditional payments. Failure to cooperate will subject Plaintiffs to exposure for those expenses individually. In situations where CMS has determined a Medicare beneficiary received payment from a primary payer and failed to appropriately allocate the sums received to medical expenses otherwise payable by Medicare, Medicare may withhold Medicare benefits from the beneficiary in an amount equal to that which Medicare claims should have been paid by the primary source.

Under the conditional payment provisions, failure to reimburse Medicare within 60 days of settlement can result in interest accruing on the conditional payment amount.

2. Plaintiffs' attorneys

As to conditional payments, when plaintiffs' attorneys take a fee from a case, they are in receipt of a portion of the payment from the primary plan. Any entity which receives payment from the primary payer is subject to liability under the provisions of the MSP. Thus, plaintiff's attorneys are exposed any time they settle a case.

As noted above, interest accrues on conditional payment demands which have not been paid within 60 days of a settlement. This is one potential exposure. Plaintiffs' attorneys may also have professional liability exposure in circumstances where they fail to appropriately counsel their clients on how to avoid having their Medicare benefits withheld.

3. Insurers and Self-Insureds

Insurers and self-insureds have exposure in multiple areas. They have a \$1000/day per claim exposure for failure to report payments to Medicare beneficiaries. Insureds and self-insureds are also exposed to claims by CMS to recoup conditional payments. If successful, damages can be as much as three times the cost of the payment.

4. Defense attorneys

Defense attorneys are likewise subject to professional liability claims from their clients in the event of failures to appropriately counsel against Medicare exposures.

VI. Conclusion

The recent Section 111 reporting requirements have heightened awareness as to various Medicare provisions. Expect everyone, particularly insurers and self-insureds to be more vigilant as to Medicare status and other issues associated with the same. Insurers and self-insureds, attorneys and claimants, are obligated to protect the interests of Medicare. As such, the entire litigation process should take those obligations into consideration. Simple discovery questions will help insurers and self-insureds meet their obligations while also providing added protection. Likewise release language and file documentation protect the defense side of the claim both as to reporting obligations as well as to obligations under the MSP.

Jennifer S. Burke | Partner
Cassiday Schade LLP | Phone: 312.444.1872 | Fax: 312.444.1669
20 N. Wacker Drive, Suite 1040, Chicago, IL 60606 | www.cassiday.com

cassidayschade^{LLP}