

# **Medicare Secondary Payer Act the Medicare, Medicaid and SCHIP Extension Act and their Impact on Marine Litigation**

AIMU - Marine Insurance Day  
2012



# Medicare Overview

- Statistics (Kaiser Family Foundation)
  - 47M Americans currently have Medicare coverage
    - 8M are permanently disabled under 65
  - 16% of the Medicare population is under 65 and permanently disabled
  - Medicare is 12% of the Federal budget and 20% of the total national healthcare expenditures
  - Medicare spending is predicted to double from \$528B (approx. £330B) in 2010 to \$1,038B (approx. £649B) in 2020
  - Next 20 year predictions:
    - People on Medicare is projected to rise from 47M to 79M
    - Ratio of workers per beneficiary will decline from 3.7 to 2.4
  - By 2017, Part A Medicare trust fund is projected to be depleted
  - Part A spending has exceeded income since 2008

# Social Security

- The Social Security Act (42 U.S.C.A. § 301 et seq.), designed to assist in the maintenance of the financial well-being of eligible persons, was enacted in 1935
- Social Security pays benefits to people who cannot work because they have a medical condition that is expected to last at least one year or result in death
- US Federal law requires this very strict definition of disability

# Social Security (cont.)

- US workers are required to make payroll contributions to Social Security
- In general, to qualify for disability benefits, one must meet two different earnings tests:
  - A “recent work” test based on age at the time of disability
  - A “duration of work” test to show sufficient work quarters under Social Security
- After 24 months of receiving Social Security Disability Insurance benefits, Medicare eligibility is automatically established

# Medicare

- A US Federal health insurance program for individuals:
  - Age 65 or older
  - Under age 65 with certain disabilities
    - After 24 months of receiving Social Security Disability Insurance (SSDI)
  - Suffering from End-Stage Renal Disease (ESRD) or Amyotrophic Lateral Sclerosis (ALS)

# Medicare – Part A

- Part A Hospital Insurance
  - Beneficiary is automatically enrolled if eligible for Medicare benefits
  - Benefit coverage under Part A includes inpatient care in hospitals and short term skilled nursing facilities (but not custodial or long-term care)
  - Hospice (palliative) care
  - Home Health care services as defined by Medicare coverage guidelines (Beneficiaries must meet certain conditions to receive these benefits)

# Medicare – Part B

- Part B Medical (Outpatient) Insurance
  - Beneficiary is required to elect and enroll for Part B benefits upon eligibility
  - Benefit coverage under Part B includes:
    - Outpatient physician office visits
    - Outpatient rehabilitation (physical and occupational therapy)
    - Home Health Care (as defined by Medicare coverage guidelines)
    - Outpatient surgical and ambulatory care procedures

# Medicare – Part D

- Part D Prescription Drug Coverage
  - 1 January 2006, Medicare prescription drug coverage became available to Medicare beneficiaries
  - The Medicare Beneficiary may choose to elect and enroll for Part D benefits upon eligibility
  - Private companies provide prescription drug coverage. Beneficiaries choose the drug plan they wish to enroll in, and most pay a monthly premium.
- Formulary
- Prescription Drug coverage
- Exclusions



# Medicare Secondary Payer Act

- 42 U.S.C. 1395y(b) [section 1862(b) of the Social Security Act], and 42 C.F.R. Part 411
- Medicare has been secondary to workers' compensation benefits from the inception of the Medicare program in 1965.
- The liability insurance (including self-insurance) and no-fault insurance MSP provisions were effective December 5, 1980.

# Medicare Secondary Payer Act

- Medicare is precluded from paying for a beneficiary's medical expenses when payment "has been made or reasonably can be expected to be made under a workers' compensation plan, an automobile or liability policy or plan (including a self-insurance plan), or under no-fault insurance."
- Primary Payers (CFR 411.20): Workers' Compensation, Liability, Auto No Fault, USL&H, and Jones Act

# Conditional Payments

- Medicare may make conditional primary payments and seek reimbursement from the primary payer both pre and post Settlement, Judgment, or Award (S/J/A).
- Demand for conditional payments come from CMS' Lead Contractor (Chickasaw Nation / MSPRC).
- Pre-S/J/A - Conditional payment amount *should* be resolved at the time of the S/J/A.

# Conditional Payments (Cont'd)

- Post-S/J/A - CMS may also recover up to the entire settlement amount (minus certain costs) from the plaintiff a.k.a. the Medicare beneficiary.
- Reimbursement must be made to Medicare when the conditional payments were made for injuries that are the responsibility of a “primary payer”.
- 42 USC 1395y(b)(2)(b) allows for recovery of double damages, plus interests, and costs of litigation.

# How the COBC is Notified?

- Method: Phone or Mail
- Beneficiary Information:
  - Name, HICN, DOB, Gender, Address, Phone
- Case Information:
  - DOI, Description of injury, Insurer type
- Representative Information:
  - Name of representing attorney & practice name, address, phone

# Conditional Payment Research

- What is required to conduct conditional payment research?
  - Begin the process early to prevent future conditional payments!
  - Notify the COBC
  - Send Conditional Payment request with the required release forms; or MIR reporting
  - Request Final Demand at time of settlement

# Medicare Recovery Rights: Past Payments

- Compromise: Medical payments made by Medicare where a primary payer has not paid promptly
- Medicare makes a “Conditional Payment” reserving their rights to proceed against the primary payer for reimbursement
  - Conditional Payment Research (CPR)
  - Conditional Payment Negotiation (CPN)

# Penalties for Non-Compliance: Conditional Payments

- 42 USC 1395 (y)(b)(2)(B) allows the US Federal Government to bring an action against “any” responsible party
- Double damages plus interest may be collected from the primary payer
- Medicare may refuse to recognize any settlement contrary to the MSP
- Medicare may refuse future benefits to claimant for treatment related to alleged injury



# Conditional Payment Negotiation: Procurement Costs

- Medicare reduces its recovery to take account of "the cost of procuring the judgment or settlement. . . ." If payment is the result of a judgment or settlement, a proportionate share of attorney's fees and costs can be subtracted from the amount recovered by Medicare.
- **Example:** Plaintiff received a settlement of \$50,000 following an accident. His medical expenses were \$40,000, of which Medicare paid \$25,000; his pain and suffering were valued at \$10,000; lost wages were \$20,000; and his permanent loss of limb was valued at \$30,000.
- Despite the fact that Plaintiff's settlement was only 50% of his \$100,000 damages, Medicare will demand recovery of its entire \$25,000 outlay, reduced only by its proportionate share of the procurement costs. Assuming a 30% contingency fee arrangement, Medicare will claim \$17,500 (30 % of \$25,000), Plaintiff's personal injury attorney will receive a fee of \$15,000 (30% of \$50,000), and Plaintiff will receive \$17,500.

# Conditional Payment Negotiation: Strategies for Lien reduction

- MSP recovery is limited to Medicare pay for health services resulting from the accident or other incident that gave rise to liability. The itemized list of health services for which Medicare claims recovery should not include care due to, or aggravated by, a preexisting condition or co morbid condition.
- A beneficiary can request a “compromise” claim for MSP recovery before a settlement is reached. Compromise is appropriate when the amount of recovery is too small to merit pursuit of the claim, and it is in the best interests of the Medicare program. [42 U.S.C. § 1395y(b)(2)(B)(v); 42 C.F.R. § 411.28(b)] The CMS Regional Offices handle requests for compromise.
- A beneficiary may request Medicare to waive recovery of some or all of the amount of its MSP claim on the ground of hardship. [42 U.S.C. § 1395y(b)(2)(B)(v); 42 C.F.R. § 411.28(a) ] Out-of-pocket expenses incurred by the beneficiary, age, assets, income and expenses, and impairments of the beneficiary may be grounds. All of these factors must be documented by specific information. Medicare’s decision about whether to waive recovery in whole or in part is not an appealable.

# Conditional Payment Negotiation: Waiver

- Waiver on behalf of CMS, under 1870(c) of the Social Security Act and guidelines pursuant to found in 20 CFR 404.506-509. It can *only* be requested after settlement and final determination has been issued by MSPRC.
- All waiver requests must be in submitted in writing along with a completed questionnaire SSA-632K form. This questionnaire requests information regarding the beneficiary's monthly income, expenses and assets as well as the reasons for requesting a full or partial waiver. It is recommended that you provide the MSPRC with a compelling story of the facts of the case.
- CMS may waive all or part of its recovery in any case where an overpayment under Title XVIII has been made with respect to a Medicare beneficiary who is: without fault AND when adjustment or recovery would either defeat the purpose of Title II or Title XVIII of the Act (repaying Medicare would create a financial hardship), OR be against equity and good conscience for the beneficiary to repay Medicare.

# Conditional Payment Negotiation: Levels of Appeal

- Redetermination- (42 CFR 405.940) must be requested within 120 days of the receipt of the Initial Determination
- Reconsideration-within 180 days of receipt of the Redetermination
- Administrative Law Judge-within 60 days of receipt of the Reconsideration
- Department Appeals Board-within 60 days of the date of the ALJ Hearing Decision
- Federal Court Review-within 60 days of the DAB decision

# MSPRC Updates - Liability

- As of September 6, 2011, for settlements of \$300 or less, Medicare will not recover from that settlement under the following conditions:
  1. The settlement is related to an alleged physical trauma-based incident, not an alleged exposure, ingestion, or implantation, and
  2. There are no additional settlements related to the same alleged incident.
- Please note that this threshold specifically excludes settlements where an insurer is paying medicals bills directly or on an ongoing basis. This threshold also does not apply if a demand letter was already issued.

# MSPRC Updates - Liability

Effective November 7, 2011, the Centers for Medicare & Medicaid Services has implemented a new and simple fixed percentage option that is available to certain beneficiaries. This option is available to beneficiaries who receive certain types of liability insurance (including self-insurance) settlements of \$5000 or less.

# MSPRC Updates - Liability

A beneficiary who elects this option will be able to resolve Medicare's recovery claim by paying Medicare 25% of his/her total liability insurance settlement instead of using the traditional recovery process. This means that a beneficiary will know what he/she owes and will be able to immediately pay Medicare.

# MSPRC Updates - Liability

- **In order to elect this option, the following criteria must be met:**
  1. The liability insurance (including self-insurance) settlement is for a physical trauma based injury. (This means that it does **not** relate to ingestion, exposure, or medical implant), and
  2. The total liability settlement, judgment, award, or other payment is \$5000 or less, and
  3. The beneficiary elects the option within the required timeframe and Medicare has not issued a demand letter or other request for reimbursement related to the incident, and
  4. The beneficiary has not received and does not expect to receive any other settlements, judgments, awards, or other payments related to the incident.

When a beneficiary elects this option, he/she must understand that as part of choosing the option he/she will be giving up the right to appeal the fixed payment amount or request a waiver of recovery for the fixed payment amount.



# MSPRC Update- Liability

## "Self-Calculated Final Conditional Payment Amount" Option

The Centers for Medicare & Medicaid Services (CMS) will be implementing an option that will allow certain Medicare beneficiaries to obtain Medicare's final conditional payment amount prior to settlement. **This option will be available in February 2012**, for certain settlements involving physical trauma based injuries where treatment has been completed. Under this option, the beneficiary or his representative will calculate the amount of Medicare's conditional payment amount using information received from the Medicare Secondary Payer Recovery Contractor (MSPRC), the MyMedicare website, or other claims information available to the beneficiary. The MSPRC will review this amount and, if finding the amount accurate, will respond with Medicare's final conditional payment amount within 60 days. To secure the final conditional payment amount, the beneficiary must settle within 60 days after the date of Medicare's response.

# MSPRC Update- Liability

- In order to use this option, ALL of the following criteria must be met:
  1. The liability insurance (including self-insurance) settlement will be for a physical trauma based injury (the settlement does not relate to ingestion, exposure, or medical implant);
  2. The total liability settlement, judgment, award, or other payment will be \$25,000 or less;
  3. The Date of Incident occurred at least **six months** before the beneficiary or his representative submits his proposed conditional payment amount to Medicare;
  4. The beneficiary demonstrates that treatment has been completed and no further treatment is expected either through a written physician attestation or by certifying in writing that no medical treatment related to the case has occurred for at least **90 days** prior to submitting the proposed conditional payment amount to Medicare

# Medicare Secondary Payer Recovery Portal

- The MSPRP allows users the ability to electronically perform the following actions:
- Submit Proof of Representation (POR) and Consent to Release (CTR) authorization requests and supporting documentation;
- Request updates to the conditional payment amount and copies of a current conditional payment letter;
- Dispute claims included in a conditional payment and upload supporting documentation; and
- Submit case settlement information and upload supporting documentation.

# What is a Medicare Set-Aside?

A Medicare Set-Aside is an account set up to pay future Medicare covered expenses for an injured party that would have been paid by Medicare had the injury NOT been the responsibility of the Primary Payer.

# Liability and MSP: Protecting Medicare's Future Interests

“Consider Medicare’s Interests” does not appear in the MSP Statute 42 U.S.C. 1395.

Medicare uses the term in its justification for Medicare set aside allocations.

No reported cases of CMS decisions being reviewed through the legal system.

Questions persist as to whether the review of MSAs is considered a “formal agency action” subject to appeal.

# CMS Guidance

- **CMS Memorandum of April 22, 2003. FAQ #19:**  
“Third party liability insurance proceeds are also primary to Medicare. To the extent that a liability settlement is made that relieves a Workers’ Compensation (WC) carrier from any future medical expenses, a CMS approved Workers’ Compensation Medicare Set-aside Arrangement (WCMSA) is appropriate. The WCMSA would need sufficient funds to cover future medical expenses incurred once the total third party liability settlement is exhausted. The only exception to establishing a WCMSA would be if it can be documented that the claimant does not require any further WC claim related medical services,. A WCMSA is also not recommended if the medical portion of the WC claim remains open, and WC continues to be responsible for related services once the liability settlement is exhausted.” (Emphasis added)

While clearly couched in WC context, it shows that the CMS position is that 3<sup>rd</sup> party proceeds are primary to Medicare always.

# CMS Guidance

**Barbara Wright (Acting Director of Medicare Debt Management Division, CMS), Town Hall Conference, October 29, 2008, NGHP Transcript, page 18:**

“I don’t believe there is a General Counsel Memo that says there are no liability set asides...we have a very informal, limited process for liability set asides. We don’t have the same extensive ones we have for workers’ comp.”

**September 30, 2009, NGHP Transcript, page 25:**

“...there is not-the same formal process for liability set asides that there is for workers’ compensation set asides. However, ***the underlying statutory obligation is the same.***” (Emphasis added)

# CMS Guidance

## **October 22, 2009 NGHP Transcript, page 65**

When there are “significant dollars at issue,” a CMS Regional office will review a Liability MSA.

The “fact that they decline to review in a particular case does not create any type of safe harbor. So you’re back to an obligation that has existed essentially since 1980.”

## **Regional Offices**

Review liability cases on a case-by-case basis



# Medicare Secondary Payer Manual

## Section 20, “Definitions”

Medicare set aside: “An administrative mechanism used to allocate a portion of a settlement, judgment or award for future medical and/or future prescription drug expenses. A set aside arrangement may be in the form of a Workers’ Compensation Medicare Set-Aside Arrangement (WCMSA), No-Fault Liability Medicare Set-Aside Arrangement (NFSA) or *Liability Set-Aside Arrangement* (LMSA).” (Emphasis added).

# The CMS Legal Analysis

“...A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means...” 42 U.S.C. Sec. 1395y(b)(2)(B)(ii).

# MSA Requirement-WC

- CMS Memorandum dated July 23, 2001  
(The Patel Memorandum)  
[www.hcfa.gov/medicare/mspmain.htm](http://www.hcfa.gov/medicare/mspmain.htm)
- Social Security Practice Guide, Ch.8,  
Social Security and Medicare Offset  
Workers' Compensation Benefits, App.  
8B[3] (LexisNexis)].

# Case Example

*In re: RJF Int'l Corp.*, 261 F. Supp.2d 101 (D.R.I. 2003), aff'd, 354 F.3d 104 (1st Cir. 2004).

Jones Act claim wherein CMS demanded an MSA be completed to protect their interests

# Policy Memorandum Sept 29, 2011

- Medicare Secondary Payer—Liability Insurance Settlements, Judgments, Awards, or Other Payments (S/J/A) and Future Medicals
  - Provides information regarding proposed Liability Medicare Set-Aside Arrangement (LMSA) amounts related to liability insurance S/J/A.



# Policy Memorandum Sep-29-11

## – What it means:

- LMSA TPOCs – If Physician Certification indicates no future treatment for related condition, CMS interest is satisfied.
- “Additional” settlements require separate Physician Certifications for each underlying injury or illness.
- CMS will not provide confirmation that settlement of future medical satisfies interests.



# Advanced Notice of Proposed Rule Making

“We are issuing this advance notice of proposed rulemaking (ANPRM) to solicit public comments on standardized options that beneficiaries and their attorneys or other representatives will be able to use to resolve MSP obligations related to settlements, judgments, awards, or other payments (hereinafter, for ease of reference in this document and unless otherwise indicated, "settlement(s)") involving future medical care while protecting Medicare's interest.”

“We want to ensure that the process related to "future medicals" is understandable, efficient, and reflects industry practice, while protecting beneficiaries and the Medicare Trust Funds.”

# Advanced Notice of Proposed Rule Making

## Exceptions:

- 300 Exemption. (See Option 5).
- Fixed Payment Option in cases settling for \$5,000 or less. (See Option 5).
- Self Calculated Conditional Payment Option in cases settling for \$25,000 or less. (See Option 5).
- Existence of another primary payer, like Workers' Compensation or No-Fault.
- 7 Options presented within the document



# Status

CMS believes there is an obligation to protect Medicare's interests in liability cases.

CMS will review liability MSAs with an aggregate settlement amount of \$250,000.00 or greater involving a Medicare beneficiary at the time of settlement.

MSP Manual recognizes liability MSAs as a device to protect Medicare's secondary status under MSP.

No statutory or regulatory guidelines have been published.

No litigation has been filed regarding the failure to set aside funds in any case (WC or Liability).

Bradley v. Sebelius- Impact of CMS guidance and policies do not have the “force of law.”

# Medicare Medicaid SCHIP Extension Act

- Former President George W. Bush signed the bill into law on December 29, 2007. The law is designed to provide a funding vehicle for the State Children's Health Insurance Program by establishing a series of reporting requirements and a civil money penalty for non-compliance.
- Section 111 requirements are applicable to Group Health Plans and Workers' Compensation, Liability and No-Fault Auto plans (collectively referred to as non-GHP).

# SCHIP/Section 111 Compliance

- 12/29/2007 –SCHIP EXTENSION ACT signed into Law
- Affects Liability, WC, Self, and No-Fault Insurance
- Requires primary payers to report to Medicare all settlements, judgments and awards involving Medicare beneficiaries
- \$1000/DAY/CLAIM civil money penalty for non-compliance with the reporting requirement
- Testing for MIR begins 1/1/2010 and mandatory reporting begins 1/01/2012
- Allows CMS to collect huge amounts of primary payer data and seek recovery for conditional payments and determine if their interests were protected


# MMSEA/MIR Reporting Criteria

- Requires reporting of claims involving Medicare beneficiaries to CMS on a quarterly basis
- ORM = Ongoing Responsibility of Medical
- TPOC = Total Payment Obligation to Claimant
  - Q1 2011 Required MIR:
    - Liability, No Fault, Work Comp with ORM Involvement:
      - ORM on or thru 1-Jan-2010
      - TPOC on or after 1-Oct-2010
  - Q1 2012 Required MIR:
    - Liability without ORM Involvement:
      - TPOC on or after 1-Oct-2011
- Interim Reporting Thresholds (Applies to WC and Liability TPOCs only):
  - Prior to 1-Jan-2013 = \$5,000
  - Prior to 1-Jan-2014 = \$2,000
  - Prior to 1-Jan-2015 = \$600
  - On or After 1-Jan-2015 = \$0
- Note: TPOC amount = the settlement, award or judgment amount. TPOC does NOT = Total Incurred amount
- Important Note: Section 111 Reporting is applicable regardless of whether future medicals are closed (i.e. MA, NV, TX, WA)

# Alert Sept-30-11

- NOTE: This Delay is Optional!

TPOC Amount	TPOC Date On or After	Section 111 Reporting Required in the Quarter Beginning
TPOCs over \$100,000	October 1, 2011	January 1, 2012
TPOCs over \$50,000	April 1, 2012	July 1, 2012
TPOCs over \$25,000	July 1, 2012	October 1, 2012
All TPOCs over min. threshold *	October 1, 2012	January 1, 2013



TPOC Amount	TPOC Date Range	Reporting Required as of
Over \$5,000	October 1, 2011 to December 31, 2012	1-Jan-12
Over \$2,000	January 1, 2013 to December 31, 2013	1-Jan-13
Over \$600	January 1, 2014 to December 31, 2014	1-Jan-14
Over \$0	January 1, 2015 and later	1-Jan-15



# Responsible Reporting Entity (RRE)

- What is an RRE?
  - The self insured entity or carrier that has assumed, been assigned or adjudicated as the primary payer responsible for ongoing medical care or has entered into a settlement/judgment/award to or for the benefit of the injured party
  - An insured entity that engages in a business, trade, or profession and acts without recourse to its insurance
    - “Self-Insured Retention” refers to the risk the insured retains that is not included in the coverage provided by the insurer

# Responsible Reporting Entity

- An RRE is not:
  - A third party claims administrator
  - An entity that is responsible for payment within a deductible
    - “Deductible” refers to the risk the insured retains with respect to the coverage provided by the insurer
  - The entity that reimburses the assumed, assigned or adjudicated primary payer

# Triggering Events for Reporting

- For claims involving Medicare eligible injured parties:
  - Acceptance of Ongoing Responsibility for Medical (ORM)
    - Responsibility for making a payment to or for the benefit of the injured party/beneficiary
    - Post 1 January 2010
  - Termination of ORM
  - Settlement/Judgment/Award
    - Total Payment Obligation to the Claimant (TPOC)
    - Post 1 October 2010



# Penalties for Non-Compliance

- Section 111 of SCHIP serves 4 purposes:
  - \$1,000 per day, per claim fine (approximately £640)
    - Estimated \$1.1B in fines to fund SCHIP (approximately £702,068,400)
  - Discover billions in unresolved Medicare liens (conditional payments) and seek immediate recovery
  - Cease making ongoing conditional payments in the future
  - Ensure that all settlements “adequately consider” (allocate) Medicare’s interests as required by law

# Practice Pointers

## 1. Check the plaintiff's Medicare Beneficiary Status

G&L must have the plaintiff name, SSN, or HICN to obtain and provide accurate data on beneficiary status

G&L, through a VDSA agreement with CMS, will determine Medicare beneficiary status on all claims

## 2. If the plaintiff is on Medicare, be prepared to resolve conditional payments

G&L will contact Medicare's Lead Contractor to determine the amount of the conditional payments made related to the injury.

Once the Conditional Payment Amount has been determined G&L will advise you of the amount Medicare determines is owed.

Simply advise us of your decision to accept or negotiate and our experts will work with Medicare to resolve the conditional payment amount.

# Practice Pointers, Cont'd

## 3. Determine allocation towards future medical care

- Depending on the type of insurance and settlement amount, an MSA Allocation may be needed (follow your MSA protocols)
- For cases not requiring an MSA, a Claim Settlement Allocation may be indicated based on S/J/A amount, Medicare status, age, insurance type, and/or client protocols
- All S/J/A should demonstrate consideration of Medicare's interest and disclose the responsibilities of the claimant post-S/J/A

# Practice Pointers

## 4. Reporting claims and S/J/As to CMS

- Data requirements were provided by CMS on 8/1/08
  - There are up to 45 data fields that CMS will need on all cases
  - The insurer must report quarterly through a secure web-site
- G&L will report to CMS on all cases referred to us for SCHIP compliance that meet the requirements for MIR (Mandatory Insurer Reporting)
- Some S/J/As will need both CMS approval and SCHIP Reporting

# Thank you.

Russell S. Whittle, Esq., MSCC  
[russell.whittle@gouldandlamb.com](mailto:russell.whittle@gouldandlamb.com)

866-672-3453 Ext. 1554