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Medicare's New Reporting Rules: Confusion Reigns

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The passage of Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) and its reporting deadline of July 1, 2009, have caused a tremendous amount of confusion among insurance professionals, lawyers, and settlement planners alike. As a result of the MMSEA, new discovery is being sought to assist insurers in complying with the reporting requirements. While the new discovery is proper, some changes attributed to the MMSEA are completely inaccurate. For example, some insurers are insisting on putting Medicare on the check, claiming the "new law" requires it. In addition, some insurers are insisting that Medicare Set-Asides are now required in all liability cases. Neither is true. The simple fact is that the MMSEA imposes a mandatory insurer reporting requirement upon responsible reporting entities (RREs). The Centers for Medicare and Medicaid Services (CMS) has created a 224-page manual explaining what is required and defining terms used in the MMSEA. A discussion of all the aspects of the MMSEA is beyond the scope of this article; I will delve into the MMSEA briefly to explain what it is and what is required, but the article's focus is on what it does *not* require in an attempt to clear up widespread misconceptions.

Section 111 of the MMSEA

What is the MMSEA and what does it require? Section 111 of the Act extends the government's ability to enforce the Medicare Secondary Payer Act (MSP). (Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110-173); see *The ElderLaw Report*, "An Examination of the Medicare Secondary Payer Act and Set Aside Obligations," November 2008, p. 1.)

As of April 1, 2011, an RRE (liability insurer, self insurer, no-fault insurer, and workers' compensation carriers) shall determine whether a claimant is a Medicare beneficiary ("entitled") and if so provide certain information to the Secretary of Health and Human Services when the claim is resolved. The RREs/insurers must report the identity of the Medicare beneficiary to the Secretary and such other information as the Secretary deems appropriate to make a determination concerning coordination of benefits, including any applicable recovery of claim. Failure of an applicable plan to comply with these new requirements will incur a civil money penalty of $1,000 for each day of noncompliance with respect to each claim. A single claimant can have more than one claim but the penalty is per claim. These new reporting requirements will make it very easy for CMS to review settlements to determine whether Medicare's interests were adequately addressed by the settling parties.

Section 111 and Resulting New Discovery Requests

As a result of the MMSEA and of RREs' fears of not reporting promptly and being subjected to fines, many insurers are propounding discovery aimed at securing information to comply with the reporting. The RREs are requesting a Social Security number in order to verify whether a claimant is Medicare-eligible. According to CMS, RREs may "submit a query to the COBC [Coordination of Benefits Contractor] to determine Medicare status of the injured party prior to submitting claim information for Section 111 reporting." The query process

is designed to assist RREs in determining whether the claim must be reported or not. The query must contain the injured party's SSN or Medicare Health Insurance Claim Number (HICN), name, date of birth, and gender. The COBC, upon submission of the information outlined above, will respond and indicate whether the individual is a Medicare beneficiary. If the injured party is a Medicare beneficiary, the HICN and other information found in the Medicare Beneficiary Database will be provided to the RRE. This process is done electronically with HEW (HIPAA Eligibility Wrapper) software provided by CMS, but the RRE must have the SSN or HICN. This is the reason why the new discovery requests are being implemented.

MMSEA and Conditional Payments

The stated intent of the new reporting requirements was to identify situations where Medicare should not be the primary payer and ultimately allow recovery of conditional payments. The MSP prohibits Medicare from making payments if payment has been made or is reasonably expected to be made by a workers' compensation plan, liability insurance, no-fault insurance, or a group health plan. However, Medicare may make a "conditional payment" if one of the aforementioned primary plans does not pay or cannot be expected to be paid promptly. 42 U.S.C. § 1395y (2007) These "conditional payments" are made subject to being repaid when the primary payer pays. When Medicare makes conditional payments, the government has a right of recovery against the settlement proceeds.

Congress has given the CMS both subrogation rights and the right to bring an independent cause of action to recover its conditional payment from "any or all entities that are or were required or responsible . . . to make payment with respect to the same item or service (or any portion thereof) under a primary plan." 42 U.S.C. § 1395y (2007) Furthermore, CMS is authorized under federal law to bring actions against "any other entity that has received payment from a primary plan." Most ominously, the government may seek to recover double damages via an independent cause of action.

U.S. v. Harris: *A Trial Lawyer's Worst Nightmare*

The government takes its reimbursement rights seriously and is willing to pursue lawyers who ignore Medicare's interest. In *U.S. v. Harris*, a November 2008 opinion by the U.S. District Court for the Northern District of West Virginia, a personal injury plaintiff's lawyer lost his motion to dismiss against the U.S. government in a suit involving the failure to satisfy a Medicare subrogation claim. The plaintiff, the United States of America, filed for declaratory judgment and money damages against the attorney by virtue of third-party payments made to a Medicare beneficiary. The attorney had settled a claim for a Medicare beneficiary, James Ritchea, for $25,000. Medicare had made conditional payments in the amount of $22,549.67. After settlement, plaintiff's counsel sent Medicare the details of the settlement and Medicare calculated it was owed approximately $10,253.59 out of the $25,000. Plaintiff's counsel failed to pay this amount and the government filed suit.

The U.S. district court denied the motion to dismiss, despite plaintiff's counsel's arguments that he had no personal liability. *U.S. v. Harris* (N.D. W.Va., No. 5:08CV102, Nov. 13, 2008).

Plaintiff's counsel argued that he could not be held individually liable under 42 U.S.C. 1395y(b)(2) because he forwarded the details of the settlement to the government and thus the settlement funds were distributed to his clients with the government's knowledge and consent. The court disagreed, pointing out that the government may under 42 U.S.C. 1395y(b)(2)(B)(iii) "recover under this clause from any entity that has *received* payment from a primary plan or from the proceeds of a primary plan's payment to any entity." (emphasis added) Further, the court pointed to the federal regulations implementing the MSP, which state that CMS has a right of action to recover its payments from any entity including an attorney.*See* 42 C.F.R. 411.24 (g).

Subsequently, the U.S. government filed a motion for summary judgment against plaintiff's counsel. The court granted the motion in March 2009, holding that the government was entitled to a judgment in the amount of $11,367.78, plus interest. *U.S. v. Harris* (N.D. W.Va., No. 5:08CV102, March 26, 2009).

Medicare on the Settlement Check

Most trial lawyers understand their obligations under the MSP with regard to making sure conditional payments are repaid. The problem is the growing misconception among insurers that Medicare should be on the settlement check to ensure compliance with the MSP. Some insurers have even been told that the law requires Medicare be on the check. This is simply not so.

Last year I was asked by a trial lawyer to assist in a case where Medicare was put on the check despite this not being a term of settlement. The insurer moved to enforce the settlement and plaintiff's counsel was forced to defend his position that the law didn't require Medicare be on the check. I provided an affidavit arguing why the law did not require Medicare be on the check. That case resulted in a published federal district

court opinion, *Tomlinson v. Landers* (M.D. Fla., No. 3:07-cv-1180-J-TEM, April 24, 2009), regarding the issue of whether Medicare must be on the check.

The *Tomlinson* court found definitively that the MSP does not require Medicare be on the check. The court stated that "federal law does not mandate that a primary payer (or insurer) make payment directly to Medicare." The court did recognize, however, "an insurer may be liable to Medicare if the beneficiary/payee does not reimburse Medicare for any amounts owed to Medicare within sixty (60) days." Nevertheless, the court found the defendant's decision to "list Medicare as a payee on the settlement check may have been in [defendant's] . . . best interest, however, [defendant] . . . was not required by federal law to include Medicare on the settlement check." Given this fact, as well as the dispute concerning whether Medicare needed to be included on the check, the court found there was no meeting of the minds in terms of settlement. As a result, the settlement was not enforced and a bad faith action could be pursued. When an insurer takes a similar position in the future, it may open the door to similar holdings and bad faith causes of action.

Medicare Set-Asides in Liability Settlements

While "Medicare on the check" is a problematic issue, a larger issue is the alleged connection between Medicare Set-Asides (MSAs) and the MMSEA. A brief explanation of MSAs is in order before addressing the impact of the MMSEA on them. A client who is a current Medicare beneficiary or is reasonably expected to become one within 30 months should concern every trial lawyer because of the implications of the MSP. ("Reasonable expectation" is defined as an individual who has applied for Social Security Disability Insurance (SSDI) benefits; has been denied SSDI but anticipates appealing that decision; is in the process of appealing and/or refilling for SSDI; is 62 years and 6 months old (i.e., may be eligible for Medicare based upon his/her age within 30 months); or has an End Stage Renal Disease (ESRD) condition but does not yet qualify for Medicare based upon ESRD.)

MSAs are a device approved by CMS for protecting Medicare's interests under the MSP. An MSA is a portion of settlement proceeds set aside, called an "allocation," to pay for future Medicare-covered services that must be exhausted prior to Medicare paying for any future care related to the injury. The amount of the set-aside ("allocation") is determined on a case-by-case basis and may be submitted to CMS for approval if the case fits within the review thresholds established by CMS.

CMS has made it very clear in numerous conference calls and public meetings that the MMSEA is totally unrelated to MSAs. In an October 29, 2008, MMSEA town hall meeting, Barbara Wright, acting director of the Medicare debt management division at CMS, stated that Section 111 of the MMSEA "does not mandate or specify anything about liability set asides." It cannot be made any clearer than that. There is no relationship between MMSEA and MSAs in liability cases. However, Wright did say in that same meeting "we have a very informal, limited process for liability set asides." She acknowledged CMS didn't have the "extensive" rules or procedures like the "ones [they] . . . have for workers' comp." Finally, she indicated that "CMS approval of a set aside amount is not required. It is a voluntary process." Despite Wright's comments, each regional office sets its own policy on whether to review liability set-asides. Out of the ten regional offices informally surveyed, two will not review (Boston and San Francisco).

The question becomes, What to do when faced with an insurer who insists on an MSA in a liability case? A trial lawyer could ask for the insurer's legal basis for mandating an MSA in such a case. The attorney could ask for a cite to the federal statutes, code of federal regulations, case law, or any rules/process regarding MSAs for liability cases. There are currently none; no one will find any law that directly addresses the issue of MSAs for liability cases. However, I am not advocating ignoring Medicare's interest under the Medicare Secondary Payer Act. For lawyers to adequately protect themselves or their clients who are Medicare beneficiaries or reasonably expected to become beneficiaries within 30 months of settlement, an MSA evaluation may be in order. As described below, this is a voluntary process and CMS may not review the proposed set-aside.

A trial lawyer may want to take the position that the insurer should bear the costs of the MSA evaluation and costs of the set-aside (including professional administration of the account). In addition, there are many non-Medicare medical expenses that must be considered in arriving at a settlement for future medical costs (certain durable medical goods, custodial care, certain prescription medications, and the Part D doughnut hole, to name a few). If a set-aside will be established, a thorough examination of non-Medicare expenses, along with an allocation of future Medicare-covered future services, should be undertaken. There are other options besides a formal set-aside if a trial

lawyer is faced with an insurer who requires addressing Medicare's interest.

One option is to estimate the future Medicare-covered expenses the client will potentially incur and to document that amount in the settlement agreement. The estimate can be created from doctors' reports or life-care plans. The client then sets aside this amount and is told to use it for future Medicare-covered expenses. No submission to CMS is done if this option is exercised. However, the release provides evidence that Medicare's interests were taken into account at settlement. Since CMS admits there is no formal review process for liability settlements and submission is voluntary, an argument can be made that all that the current law requires has been done, and then some.

Another option is to do the formal allocation report and again document it as described above. Because CMS does not guarantee a review of a liability set-aside, a formal allocation along with documenting it in the settlement agreement provides the necessary evidence that Medicare's interests were adequately addressed. A formal allocation also gives the trial attorney an independent third party to review the future medical expenses and determine what Medicare does and does not cover. This provides an extra layer of E&O protection.

Conclusion

It is this author's opinion that Medicare protocols and procedures regarding the repayment of conditional payments should not change because of the MMSEA. However, insurers' behavior will change and has most certainly changed. Insurance companies are fearful of all the reporting requirements under the MMSEA because failure to comply is a $1,000-per-day, per-claimant fine. For a large insurer, that is significant exposure. Therefore, new discovery has been created to help insurers comply. Medicare may be put on the settlement check, and unfortunately some insurers are insisting on MSAs in liability cases. Each trial lawyer and law firm will have to interpret the MSP laws and deal with the insurers on these issues to protect the client as well as their practices. There are many unanswered questions with little clarity or law to help guide attorneys.

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