Property Casualty 360

Medicare Set-Asides and Third-Party Liability Cases: Part One

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By NEIL SELMAN

When it comes to lawyers for injured parties, defense lawyers, and insurance claims professionals, Medicare is probably causing more ulcers than it has ever paid to cure. Under the rubric that "all persons must protect Medicare's interests," insurers and lawyers on both sides are being told by people who have a vested financial interest in doing so that when a liability personal injury case is resolved by judgment or even settled, a Medicare Set-Aside (MSA) account should be established. This is a groundless position, and MSAs are not required as a means of protecting Medicare's interest for future medical bills. In fact, I believe that insurers who utilize MSAs in an attempt to "safeguard Medicare's interests" for future medical costs are putting their companies at risk of increased litigation costs and possible extra contractual (bad faith) exposure.

In the first of this three-part series, we will examine the basics of MSAs, applicable federal statutes and regulations regarding MSAs, and discuss conditional payments and new reporting requirements that affect insurers.

The Problem

Imagine a personal injury suit where the insurer is either settling or getting ready to pay a judgment that has been entered in that suit. The carrier knows that the injured plaintiff is a Medicare beneficiary, and at least in part, during the lawsuit, the plaintiff sought recovery of his or her past and future medical expenses.

The settlement will typically include a general release of all of plaintiff's claims, both known and unknown, including all future claims. In this situation, claims professionals and lawyers are now being told that to properly resolve this liability case and protect the lawyers' client and the carrier, they need to use an MSA because it is either required by law or a good idea since the law is ambiguous. To understand the purpose of an MSA, one must read the Medicare regulations. While the Lord's Prayer contains 66 words, the Gettysburg Address is 286 words, and the Declaration of Independence weighs in at 1,300 words, the Association of American Physicians and Surgeons, Inc., states that there are more than 132,000 pages of Medicare rules and regulations. Cutting through these regulations to gain an understanding of when MSAs are required is not easy, and that is probably the reason why the myth of MSAs being required, or even being a good idea in third-party liability cases, continues to be the Kool-Aid that more and more insurers are being asked to drink.

The broad definition of an MSA is "an administrative mechanism used to set-aside monies for specific purposes (such as medical expenses) including a self-administered arrangement." The mechanism is usually a separate trust account. Use of an MSA has been and is required by the Centers for Medicare & Medicaid Services (CMS), the federal agency that administers the Medicare program, in situations involving payment of medical expenses under workers' compensation insurance. In the workers' compensation context, a portion of the settlement proceeds is placed in the MSA for the payment of future medical expenses subject to review by CMS, and it is only once CMS determines that the MSA amount is properly exhausted that Medicare will agree to be the primary payer of future Medicare-covered expenses incurred by the Medicare beneficiary.

Whether the liability insurer or self-insured should be required or advised to use an MSA in resolving a personal injury suit brought by a Medicare beneficiary, otherwise known as a liability MSA, has become a hotly debated issue. Some contend that use of an MSA is required in the liability insurance context. Others assert that, even if a liability MSA is not required, an MSA would be a good tool to use to protect the settling plaintiff Medicare beneficiary, his or her counsel, and the liability insurer or self-insured, from a future Medicare Secondary Payer (MSP) Act recovery action brought on behalf of Medicare. Most of the proponents of mandatory or discretionary use of liability MSAs have been people engaged in the operation of businesses which deal in the preparation of structured settlements and Medicare lien resolution situations, people who would, obviously, be more than happy from an economic standpoint if liability MSAs are commonly used.

Applicable Federal Statutes and Regulations

The applicable statute is the MSP Act, found at 42 U.S.C. 1395y(b), and in particular, 42 U.S.C. 1395y(b)(2)(A) and (B). The regulations are stated in 42 CFR Part 411. Under the Medicare law as originally enacted in 1965, Medicare was the primary payer for medical services required by a Medicare beneficiary except those services covered by workers' compensation. However, in 1980, in reaction to the rising costs of Medicare, Congress passed the MSP Act. Pursuant to the MSP Act and regulations adopted to implement it, Medicare also became a secondary payer to liability

insurance and no-fault insurance programs, in addition to workers' compenmesation programs. Effective Dec. 5, 1980, all of these programs were now primary payers. (For purposes of the MSP provisions, liability insurance includes a self-insurance plan.)

The purpose of the MSP provisions was to ensure that the primary payers assume the responsibility for the Medicare beneficiary's medical treatment for accident-related injuries. If someone else was responsible for the medical costs, Medicare wanted to avoid having to pay. Pursuant to the provisions, Medicare is prohibited from making any payment of a Medicare beneficiary's medical expenses if payment has been made or can reasonably be expected to be made by a primary payer. 42 U.S.C. §1395y(b)(2)(A)(ii). However, as the secondary payer, Medicare is required to pay for a Medicare beneficiary's care if the primary payer is not expected to pay promptly. Medicare's payments are conditional payments, subject to reimbursement to the appropriate Medicare Trust Fund when funds become available. Essentially, Medicare is allowed to make payment, but only on the condition of being reimbursed. 42 U.S.C. §1395y(b)(2)(B).

Additionally, Medicare can sue others to recover payments that should have been paid by others. The CMS, on behalf of Medicare, has the right to recover conditional payments from all primary payers responsible for making payment and anyone that received a primary payment, including a Medicare beneficiary, provider, supplier, physician, attorney, state agency, or private insurer (including a self-insurance plan). 42 C.F.R. §411.24(g). With respect to the costs of medical services for which Medicare has paid, Medicare also has subrogation and joinder and intervention rights. It is subrogated to any individual or entity entitled to payment by a primary payer and may join or intervene in any action related to events that gave rise to the need for services for which Medicare paid. 42 C.F.R. §411.26.

Conditional Payments

This part is crucial. Liability must pay conditional payments, known as payments that Medicare has made, subject to a right to be reimbursed. It is *not* a future payment that Medicare may have to make for medical in the future.

The primary payer, perhaps a tort feasor or his or her insurer, is obligated to reimburse Medicare for conditional payments when it is demonstrated that the primary payer "has or had a responsibility" to make payment. A primary payer's responsibility may be demonstrated by a judgment or a payment conditioned upon a recipient's compromise, waiver, and release. A settlement, award, or contractual obligation is evidence of responsibility under the MSP provisions, whether or not there is a determination or admission of liability. If Medicare is not paid within 60 days of a demand for payment, then the CMS, on Medicare's behalf, can pursue a direct recovery action and recover double damages. 42 U.S.C. §1395y(b)(2)(B)(ii).

New Reporting Requirements

The latest change, and the one that has created new jobs and headaches at insurance companies, occurred in December 2007 when Congress enacted Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007. This Act amends the MSP Act to additionally provide that any entity making a payment, including a liability insurer and self-insurance plan, that does or could

include the payment of a Medicare beneficiary's medical expenses, is required to report such payment to the CMS, the Section 111 mandatory reporting program. Every such payment to as well as every assumption of ongoing responsibility for medical payments regarding every Medicare beneficiary must be reported, and the reported information will be used for both Medicare claims processing and for MSP recovery actions. A penalty of $1,000 per day per claim applies for failure to report as required by the program. 42 U.S.C. 1395y(b)(8).

Pursuant to the Section 111 mandatory reporting program, it is required that the responsible reporting entities, including insurers and, in the case of liability insurance, self-insureds, report every settlement or other payment made to a Medicare beneficiary where a claim of medical expenses is being made or is being released, even by way of a protective general release of known or unknown claims. The required reporting of situations involving the assumption of ongoing responsibility for medicals (ORM) began on Jan. 1, 2011. (ORM refers to the responsibility to pay, on an ongoing basis, for the Medicare beneficiary's medicals associated with an injury claim and, typically, only concerns no-fault insurance and workers' compensation situations.) On Jan. 1, 2012, liability insurers and self-insureds must also begin to report total payment obligation to the claimant (TPOC) situations. (A TPOC is the total dollar amount of a settlement, judgment, award or other payment to a Medicare beneficiary in addition to or apart from ORM.) The insurers and self-insureds will be required to submit a report where the TPOC date is on or after Oct. 1, 2011 and the TPOC amount meets the applicable reporting threshold. (Until Jan. 1, 2013, this threshold is $5,000; thereafter, it gets lower.)

However, Section 111 is merely a section requiring, reporting of cases involving potential Medicare recipients and has nothing to do with MSAs. While Section 111 is a great concern to insurers, the reporting issue is separate from the MSA problems.

In the next part of this series, look forward to discussion regarding when MSAs are in fact required and when it makes sense to use them.

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