

# **The Practical Effects of Section 111 on Medical Malpractice – How to Protect Yourself, Your Client, Your Hospital and, Most Importantly, Your Bank Account**

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**Medicare Liability Set-Aside Arrangements  
and Other Medicare Secondary Payer Matters**

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# Overview of the MSP Program

Goal of the Medicare Secondary Payer (“MSP”) Statute, 42 U.S.C. § 1395y(b), is to Shift Primary Payment Responsibility from Medicare to Other Third Party Payers (“TPPs”):

- Employer Group Health Plans (“GHPs”)
- Workers’ Compensation (“WC”)
- Automobile, Liability, and No-Fault Insurance
- Congress sought to use the MSP provisions to reduce the growth of Medicare by shifting primary payment responsibility to EGHPs “to place the burden where it could best be absorbed.” *See Provident Life & Accident Ins. Co. v. United States*, 740 F. Supp. 492, 498 (E.D. Tenn. 1990).

# Overview of the MSP Program

## Three Interlocking Concepts

- Make Medicare Secondary
- Prohibit Health Benefits “Discrimination” Against Medicare Beneficiaries
- Prohibit Incentives for Medicare Beneficiary to Reject Coverage that would be Primary to Medicare

# Overview of the MSP Program

- Substance – Laws, Regulations, Sub-regulatory Documents, *etc.*
- Process – IEQ, Mandatory Reporting, Data Match, VDSA, COB Claims Processing, *etc.*
- Enforcement – CMPs, Tax Penalties, Collection Actions, *etc.*

# Overview of the MSP Program

The MSP statute affects:

- Rules for coordination of benefits (“COB”) where Medicare is involved
- Rules for calculating Medicare’s secondary payment
- Claims filing
- Plan design
- Government enforcement authorities
- Government collection rights
- Repayment obligations/limitation on repayment defenses
- Mandatory reporting of MSP information

# Overview of the MSP Program

- Separate COB rules for individuals entitled to Medicare on the basis of:
  - **Age (the “working aged”)**
  - **Disability**
  - **End-Stage Renal Disease (“ESRD”)**
- Rules for calculating Medicare’s secondary payments - 42 C.F.R. § 411.33

# Overview of the MSP Program

## Claims Filing

- Affects liability and no-fault insurance and WC
- Dictates When Medicare:
  - **Can't be billed**
  - **May be billed**
  - **Must be billed**

# Overview of the MSP Program

## Statutory Repayment Obligation:

- Applies to a “*primary plan, and an entity that receives payment from a primary plan*” - 42 U.S.C. § 1395y(b)(2)(B)(ii)
- Reimbursement is due within 60 days or interest accrues
- If Medicare is not properly reimbursed, and the primary payer paid another entity when it knew or should have known that Medicare had made a conditional primary payment, Medicare can seek payment from primary payer “*even though it had already reimbursed the beneficiary or other party.*” 42 C.F.R. § 411.24(i).



# Overview of the MSP Program

## Government Collection Rights

- Direct and Subrogated Causes of Action
- Federal Claims Collection Act
- Debt Collection Improvement Act of 1996
- Treasury Offset Program
- Administrative Offset
- Medicare does not use “liens”

# Overview of the MSP Program

## Government Collection Rights

- If government must “*take legal action to recover from primary payer, CMS may recover twice*” the amount otherwise due.” 42 U.S.C. § 1395y(b)(2)(B)(iii); 42 C.F.R. § 411.24(c)(2).
- Joint and several liability – “*United States may bring an action against any and all entities that are or were required or responsible*” to make payment. 42 U.S.C. § 1395y(b)(2)(B)(iii).

# Overview of the MSP Program

## Private Cause of Action

- If successful, private plaintiff can recover “double damages”
- Must first establish primary plan’s responsibility to pay *National Committee to Preserve Social Security and Medicare v. Philip Morris, NSA Inc.*, 2009 W L 590573 (E.D.N.Y. March 5, 2009).
- Recent private actions dismissed for lack of standing because private individuals do not have economic interest. *But see National Renal Alliance LLC v. Blue Cross Blue Shield of Georgia Inc.*, 2009 WL 426001. \*9 (N.D. Ga. 2009).
- MSP statute is not a private False Claims Act

# Mandatory Reporting

- Mandatory Reporting was enacted by Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (“MMSEA”).
- Section 111 applies to GHPs and liability insurance (including self-insurance), no-fault insurance, and workers’ compensation (“WC”), known as, grouped together, Non-Group Health Plans (“NGHPs”).

# Mandatory Reporting

- Penalty for non-compliance is severe – Civil Monetary Penalty (“CMP”) of “\$1,000 for each day of noncompliance for each individual for which the information” should have been submitted.

## Mandatory Reporting

- CMS not required to issue regulations to implement mandatory reporting
- Under 42 U.S.C. § 1395y(b)(7)(D) and (8)(H):  
*“Notwithstanding any other provision of law, the Secretary may implement this paragraph by program instruction or otherwise.”*
- CMS apparently does not intend to issue a rulemaking on mandatory reporting.

# Mandatory Reporting

- CMS guidelines regarding implementation are addressed at <http://www.cms.hhs.gov/MandatoryInsRep>
- Section 111 is part of the long-standing effort to give CMS more, better, and faster MSP information.
- Should reduce CMS need for other MSP data collection processes, such as the Data Match.

# Mandatory Reporting

- Guidance on CMS Website includes User Guides.
- “MMSEA Section 111 MSP Mandatory Reporting – Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Workers’ Compensation User Guide”
- Version 3.0, issued on February 22, 2010
- <http://www.cms.gov/MandatoryInsRep/Downloads/NGHPUserGuideV3022210.pdf>



# Mandatory Reporting

- Although CMS has been obtaining MSP information about GHP coverage for many years, this is the first time that liability, no-fault, and workers' compensation carriers will be required to report MSP information to CMS.
- Although Section 111 did not substantively change the MSP statute, its enactment seems to be having a significant effect on liability settlements.
- CMS has estimated that there are approximately 2.9 million NGHP claims per year that are subject to this reporting requirement.

# Mandatory Reporting

- Important to understand difference between cost avoidance and pay-and-chase.
- For NGHPs, Mandatory Reporting will help CMS address both cost avoidance (for future claims) and pay-and-chase (for recovering “conditional” payments).
- “TPOC” – total payment obligation to claimant
- “ORM” – ongoing responsibility for medicals

# Mandatory Reporting

- In liability MSP situations, Medicare may make “conditional payments” that are subject to recovery. This is pay-and-chase.
- *“The Secretary may make payment under this title with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.” 42 U.S.C. § 1395y(b)(2)(B)(i) (emphasis added).*

## Mandatory Reporting

- *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— . . . (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. 42 U.S.C. § 1395y(b)(2)(A)(ii) (emphasis added).*

## Mandatory Reporting

- In general, therefore, Medicare is prohibited from paying if payment “*has been made or can reasonably be expected to be made*” by a primary plan. 42 U.S.C. § 1395y(b)(2)(A)(ii). This is cost avoidance.
- Medicare costs can be avoided where a settlement allocates payments for future medical services because Medicare is secondary to these future payments and, therefore, should not pay until after claim has been processed by primary payer.

# Medicare Set-Aside Arrangements

## Medicare Set-Aside Arrangements ("MSAs")

- Where a settlement agreement allocates payments for future medical services that would otherwise be payable by Medicare, "*Medicare does not pay for those services until medical expenses related to the injury or disease equal the amount*" of the settlement so allocated. 42 C.F.R. § 411.46(d)(2). This is cost avoidance.
- In place for many years for WC plans.

## MSAs

- CMS has provided extensive Guidance concerning establishing WC-MSAs, which can be found at:  
[http://www.cms.gov/WorkersCompAgencyServices/04\\_wcsetaside.asp#TopOfPage](http://www.cms.gov/WorkersCompAgencyServices/04_wcsetaside.asp#TopOfPage)
- A WC-MSA “*may be submitted to CMS for review*” if the claimant (a) “*is currently a Medicare beneficiary and the total settlement amount is greater than \$25,000,*” or (b) “*has a ‘reasonable expectation’ of Medicare enrollment within 30 months of the settlement date and the anticipated total settlement amount for future medical expenses and disability/lost wages over the life or duration of the settlement agreement is expected to be greater than \$250,000.*”

## MSAs

- *“CMS is moving forward with the development of the Workers' Compensation Medicare Set-Aside Portal (WCMSAP). As you know, the WCMSAP will allow for the electronic submission of WCMSA proposals for future medical and future prescription drug costs on a more expedited basis. With the introduction of the WCMSAP web portal, scheduled for the first quarter of 2011, WCMSA submitters will receive a real-time acknowledgement of their proposal submissions. Rest assured that comprehensive educational material will be provided on this website for all interested parties before the implementation of the WCMSAP. Keep checking back for updates that will be coming from CMS about the WCMSA Web Portal.”*
- *See [http://www.cms.gov/workerscompagency/services/01\\_overview.asp](http://www.cms.gov/workerscompagency/services/01_overview.asp)*



## Liability MSAs

- CMS has stated the statutory authority for it to require WC plans to “adequately consider” Medicare’s interest in payments for future injury-related medical claims, 42 U.S.C. § 1395y(b)(2)(A), also provides authority for the agency to require the same of liability plans.
- Although CMS has issued far less guidance specifically on liability MSAs, the agency has acknowledged their existence.

# Liability MSAs

- The CMS MSP Manual definition of “Set-Aside Arrangement” recognizes liability MSAs:

*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 Medicare Set-Aside Arrangement (LMSA).*

*MSP Manual, Ch. 1, § 20 (emphasis added).*

## Liability MSAs

- CMS has stated that liability MSAs can be reviewed by CMS Regional Offices (“ROs”), within their sole discretion.
- CMS has not publicly issued criteria for the ROs to use to evaluate liability MSAs.
- CMS may use the WC-MSA criteria.

# Liability MSAs

- The following Q and A appears in an April 22, 2003 CMS Memorandum:

*19) Does CMS require that a Medicare set-aside arrangement be established in situations that involve both a WC claim and a third party liability claim?*

*Answer: 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.*

<http://www.cms.gov/WorkersCompAgencyServices/Downloads/42203Memo.pdf> at 7

## Liability MSAs

- During the October 29, 2008 Town Hall Teleconference on the Mandatory Reporting requirements of NGHPs, the CMS presenter stated *“I don’t believe there is a General Counsel Memo that says there are no liability set asides.”* She also stated *“we have a very informal, limited process for liability set asides. We don’t have the same extensive ones we have for worker’s comp.”* She also noted that *“CMS approval of a set aside amount is not required. It is a voluntary process.”* See Transcript at 18.

## Liability MSAs

- During the September 30, 2009 Town Hall Teleconference on the Mandatory Reporting requirements of NGHPs, the CMS presenter stated: *“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.”* See Transcript at 25.

## Liability MSAs

- During the October 22, 2009 Town Hall Teleconference on the Mandatory Reporting requirements of NGHPs, CMS stated that the obligation for those involved with liability settlements to consider Medicare “*has existed essentially since 1980.*” See Transcript at 65
- “*And if an entity has not been taking this into consideration and taking steps whether it’s to do a set aside or some how else take care of it. It’s something they now need to be documenting and taking care of.*” *Id.*

## Liability MSAs

- During the October 22, 2009 Town Hall Teleconference, the CMS presenter also stated that the review process for liability settlements was voluntary and the CMS Regional Offices can decide whether to review but 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.*” *Id.*



## Liability MSAs

- If CMS believes that liability MSAs actually are required, why has the agency issued virtually no guidance?
- What are current “best practices” regarding establishment of liability MSAs?
- Does dollar amount of settlement matter?
- Does allocation of damages matter?
- How would the failure to establish a liability MSA be enforced?

## Issues in Mandatory Reporting for NGHPs

- Reporting put off until 1/1/2011
- Who is the RRE?
- Calls for CMS to create “safe harbor” for identifying Medicare beneficiaries
- Difficulty in obtaining SSNs – August 24, 2009 Alert – protection for RRE if claimant refuses to provide information on Medicare coverage

## Issues in Mandatory Reporting for NGHPs

- When is reporting not required – NGHP thresholds
- Joint and Several Liability - “*United States may bring an action against any and all entities that are or were required or responsible*” to make payment. 42 U.S.C. § 1395y(b)(2)(B)(iii).
- 10/5/80 exposure date issue

## Important Recent Cases

*Haro, et al. v. Sebelius*, CV 09-134 TUC DCB  
(D. AZ 11/30/2009)

- Nationwide class action - motion to dismiss denied
- Allegation is that CMS's demand for recovery from beneficiary within 60 days of a liability settlement violates due process because not enough time to resolve appeal or waiver request.
- Could change how liability cases are handled

## Important Recent Cases

*United States v. Stricker et al.*, CA No. 09-PT-2423-E (N.D. AL filed December 1, 2009)

- United States seeks to recover under the MSP provisions payments made by Medicare to approximately 907 beneficiaries who were allegedly injured by PCB exposure.
- \$300M settlement in 2003 but no payments to Medicare
- The amount Medicare paid is for beneficiaries is not stated.
- Seeks reimbursement for past conditional Medicare payments and notice of future liability payments
- Double damages, plus interest

## Important Recent Cases

*United States v. Stricker et al.*, CA No. 09-PT-2423-E (N.D. AL filed December 1, 2009)

- Defendants in *Stricker* are (a) the defendants in the underlying tort suits, (b) their liability insurers, and (c) the attorneys and law firms that represented the plaintiffs in the underlying tort suits
- May be first case of this type seeking recovery from liability insurers
- Motions to dismiss pending

# Proposed Legislation

## H.R 4796 – Medicare Secondary Payer Enhancement Act of 2010

- Endorsed by the Medicare Advocacy Recovery Coalition (MARC) - <http://www.marccoalition.com>
- This bill would, *inter alia*, reduce CMPs for failure to report under the MMSEA by, for example, making imposition discretionary instead of mandatory
- Would create a \$5,000 settlement threshold for MSP recoveries and impose user fees

## Important Questions on Medicare Parts C/D and MSP

- 42 U.S.C. § 1395w-22(a)(4) states that MA plans may "*charge or authorize the provider to charge*" the primary plan.
- 42 C.F.R. § 422.108 states “(a) *Basic rule.— CMS does not pay for services to the extent that Medicare is not the primary payer under section 1862(b) of the Act and part 411 of this chapter.*
- (b) *Responsibilities of the MA organization.— The MA organization must, for each MA plan— (1) Identify payers that are primary to Medicare under section 1862(b) of the Act and part 411 of this chapter; (2) Identify the amounts payable by those payers; and (3) Coordinate its benefits to Medicare enrollees with the benefits of the primary payers.*
- (c) *Collecting from other entities.— The MA organization may bill, or authorize a provider to bill, other individuals or entities for covered Medicare services for which Medicare is not the primary payer, as specified in paragraphs (d) and (e) of this section.”*



## Important Questions on Medicare Parts C/D and MSP

- Courts have interpreted this to mean that if MA plans want to enforce their right to "charge" the primary plan, they must put "subrogation" language in the "insurance policy" issued to the MA beneficiary. *Care Choices HMO v. Engstrom*, 330 F.3d 786 (6th Cir., May 30, 2003).

# Q&A

## QUESTIONS & ANSWERS