"IT'S CRAZY, BUT IT'S TRUE"
Medicare Issues in Liability Cases

by
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Recently, there has been much buzz in the liability arena about the upcoming "$1,000.00 a day penalty" and MSA's. However, the reality is these are two distinct topics, although there is an intersection of Medicare and liability cases.

In December 2007, the "Medicare, Medicaid, and SCHIP Extension Act of 2007" (the Act) was passed. "Section 111" of the Act is what all the buzz is all about. This law, specifically Section 111(a)(8), requires liability insurers (including self-insurers), no fault insurance, and workers' compensation to determine a claimant's Medicare benefits status and report the status to Medicare when the claimant is a Medicare recipient.

It's crazy, but it's true that Medicare is requiring the insurers to check the Medicare benefits status with Medicare, then report this status back to Medicare. The cause for alarm, however, is the provision of a $1,000.00 a day penalty, per claim, when this obligation is not met. The start date for this responsibility is now July 1, 2009.

Unfortunately, the Act is incomplete about how exactly an insurer (or self-insured) should go about fulfilling its responsibilities, and thus avoiding the $1,000.00 a day penalty. Recently, the Centers for Medicare and Medicaid Services (CMS) has been holding public "town hall forums, or conference calls, with the CMS representatives, to provide guidance. These forums were held on October 1, October 29, January 22, and January 28. Future forums are scheduled for February 25, March 24, and April 22. Details about these forums can be found at http://www.cms.hhs.gov/MandatoryInsRep/03_Liability_Self_No_Fault_Insurance_and_Workers_Compensation.asp#TopOfPage. CMS representatives attempt to answer the questions of hundreds of callers each time, but unfortunately, many questions still remain about how exactly this determination and reporting is to occur.

With less than five months to go until the threatened penalty is to be implemented, risk managers must start putting into place protocols now to determine which claimants are Medicare-entitled, and developing with their IT department's ways that this information will be compiled and transmitted to CMS. For determining who is Medicare-entitled, CMS is in the process of developing a query function, which will be available only to entities who have registered to receive this information. CMS has also published an "Interim Record Layout," which will be the required format for transmitting this documentation to Medicare by the "Responsible Reporting Entity" (RRE), which is the insurer (or self-insured) or their appointed representatives. The updated Interim Record Layout can be viewed at https://www.cms.hhs.gov/MandatoryInsRep/Downloads/NGHPInterim120508.pdf

Understandably, the Act has triggered an upheaval among risk managers. Interestingly, however, the rumor is that Medicare Set-Asides are now required in liability cases by the Act. This, in fact, is not the case. A careful reading of the new Section 111 itself shows that there are no references to Medicare Set-Asides, or explicitly, a directive to protect Medicare's future interest in liability cases.

This is not to say, however, that liability carriers do not have a responsibility to protect Medicare's interest in liability cases. They do, but they had this responsibility long before the Medicare, Medicaid and SCHIP Act of 2007.

The Medicare Secondary Payer Statute has required that the obligations of a primary payer not be shifted to Medicare in any liability, automobile, and no-fault insurance situation since 1980. For workers' compensation cases, this has been true since the Social Security Act of 1965. In fact, it appears that 42 CFR 411.46 gave rise to a series of memorandums, first published by CMS in 2001, which introduced the concept of a "Medicare Set-Aside" in workers' compensation cases. A Medicare Set-Aside (MSA), put simply, is just a vehicle for doing that which was always required by the Medicare Secondary Payer Statute. It is, essentially, carving out a specific portion of a settlement, and earmarking it specifically for future medical treatment of the type normally covered by Medicare, so that no prohibited "burden shifting" occurs. In workers' compensation cases, it has been used as a way of identifying that Medicare shall not pay for a work-related condition, until that portion of the settlement has been correctly exhausted. Some may say, "It's crazy," but it's true, there is nothing in the Medicare Secondary Payer Statute which requires that future medical expenses formally be addressed in liability settlements. In other words, there is no liability equivalent to 42 CFR 411.46, which does at least address future medical responsibility in workers' compensation cases.

Presently, there is no statute, case law, or even CMS memorandum, which specifically directs that a Medicare Set-Aside be used in the liability arena. It does make sense, however, that the same vehicle, an MSA, could be used in liability settlements to show that the parties are not trying to shift the burden from the primary payer to Medicare.

Part of the confusion, however, has probably been spurned by CMS representatives, participating in panel discussions at various workers' compensation seminars. There, they have informally stated that while CMS has no requirements for MSA's, nor any formal review process for MSA's, in liability cases, CMS has been reviewing such, when voluntary submitted in very large settlements.

It is clear that the intention of the passage of the Act is to further expand Medicare's ability to identify instances where Medicare is making payments for financial obligations, which should be, or at least could be, the responsibility of some other payer. This information will allow Medicare to better identify primary payers, and most importantly, seek reimbursement for conditional payments made by Medicare, a statutory right long-provided by 42 USC 1395y. Because of Medicare's intention to further attempts at preserving its financial integrity, it is, therefore, reasonable to anticipate that over time, additional statutory changes may be made, extending primary payers' obligations, in not just the workers' compensation arena, but also in the liability arena.

It is now necessary for risk managers to develop a program to address the fast approaching obligations under the new Medicare, Medicaid, and SCHIP Extension Act of 2007. Congruent with the "old" law, the Medicare Secondary Payer Statute, it is still necessary to ensure "burden shifting" to Medicare does not occur in liability cases, and now with the new Act, Medicare has made it clear that it will begin to crack down and seek reimbursement, otherwise. As such, competent, experienced legal counsel is recommended to ensure that maximum protection is afforded under the law. ■