The Impact of the MMSEA on Personal Injury Claims

By: James E. Logan, CSSC

One of the most impacting actions taken by Congress affecting personal injury claims and Medicare was signed into law on December 29, 2007. The Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110-173) reinforces the Medicare Secondary Payor (MSP) statute passed 27 years earlier (42 U.S.C. 1395y). The new Act provides the Secretary of Health and Human Services with uncommon authority to ensure that group health care plans, no-fault policies, workers' compensation claims and liability settlements protect Medicare's interests by remaining the primary payment source of Medicare-covered expenses. The passage of the Extension Act, now commonly referred to as MMSEA, achieves three key objectives.

1. It serves as a catalyst for the voluntary reimbursement or enforced collection of Conditional Payments made by Medicare in situations where Medicare should have been, or was, secondary in the order of payment priority.
2. It develops procedures and processes for Medicare to be placed on "notice" whenever a Medicare eligible beneficiary was presenting a claim under a health care plan, no-fault policy, workers' compensation statute or in a liability action. In other words, Congress intends for Medicare to be notified anytime their secondary status came into play.
3. It develops methods through which Medicare remains secondary in the payment priority scheme, even after a settlement has been achieved.

This legislation applies only to Medicare eligible beneficiaries who are making a claim against their health care plan, no-fault policy, workers' compensation insurer or self-insured or in a liability action. It took immediate effect where conditional payments were concerned. These payments must be reimbursed to Medicare. Over the years, this requirement has been well addressed by all but those involved in the liability settlement arena. Rarely did the parties involved in a liability settlement recognize or understand the need to protect Medicare's interests and reimburse Medicare for the conditional payments made for accident-related treatment and services. With the passage of MMSEA, the Centers for Medicare and Medicaid Services (CMS), a division of the Department of Health and Human Services (HHS), is now in the process of promulgating new rules that will enable them to better identify entities that fail to protect Medicare's interests. This can result in the assessment of a double damage penalty. The penalty may be assessed against one or more parties to a settlement, including the attorneys involved.

Recently, CMS released their initial draft of proposed rules concerning Registration and Reporting. The proposed rules are neither binding nor final at this time and are expected to be refined over the coming months. Unlike the requirements concerning reimbursement of conditional payments, the remainder of MMSEA does not take effect until July 1, 2009, the exception being its applicability to group health care plans, which will take effect on January 1, 2009. This article will focus on Non-Group Health Care exposures. The proposed rules provide the following:

- Between May 1, 2009 and June 30, 2009 Responsible Reporting Entities (RREs) who are insurers, and self-insured entities, must register with CMS via their secure website. The specific data and information that will be required for registration compliance will be published before the end of this year. Parent companies may register for their subsidiary companies but, as the rules currently appear, agents, such as third party administrators (TPAs) and lawyers, may not register for the RREs.

- Effective July 1, 2009, all claims for Non-Group Health Plans (NGHP) must determine if Medicare has any interest in the pending settlement or the provisions of insurance benefits (i.e. no-fault insurance, workers'

compensation insurance, and liability claims). This will require all parties to the claim to develop a method of determining if a claimant or plaintiff is or will soon be eligible for Medicare benefits. In the case of first party benefits such found with no-fault and workers' compensation claims, Medicare eligibility of the claimant should be determined as soon as possible following the notice of the claim. It is highly recommended that determination of a liability claimant's Medicare eligibility be conducted well before settlement negotiations take place.

- CMS requires reporting within a time specified by the Secretary of Health and Human Services after the claim is resolved through a settlement, judgment, award, or other payment ***regardless of whether or not there is a determination or admission of liability.*** *[Emphasis added]* Failure to do so could result in a $1,000 per day penalty being assessed for each day timely reporting has not been received. Keep in mind, this provision of the Act does not take effect until July 1, 2009. Reporting will take place on a quarterly basis. Once published, the final rules concerning reporting requirements should be carefully examined to ensure compliance. It is worth noting that while MSP and MMSEA mandate all parties protect Medicare's interests, the initial rules seem to place the registration and reporting responsibilities only on self-insured entities and insurers. CMS estimates they will collect more than $1.1 billion in penalties in the first five years following implementation of MMSEA.

  Initial information from CMS indicates there are 45 data fields that will be reported by RREs. They are classified as Mandatory, Optional and Situational. The final required data fields will be published before year's end; however, it is recommended that RREs begin looking at the claimant data they currently have available in their existing records, files, and data management systems. Although reporting will take place through the COB secure website, it is likely RREs will have to modify their existing systems to capture the required data. Since additional computer programming will most likely take place after the first of next year, it is advisable that consideration be given to budget requirements now.

- All claims and settlements (no-fault, workers' compensation, and liability) must discover and resolve conditional payments issues. This is an immediate requirement for all personal injury claims and settlements made with Medicare beneficiaries and does not share the MMSEA July 2009 effective date.

- No-fault and workers' compensation insurers have the immediate requirement to reimburse conditional payments made by Medicare even if a settlement is not being made.

- Like current workers' compensation settlements, it is anticipated future rules will require that some portion of the settlement will have to be set aside for future medical expenses that Medicare would otherwise have to pay. This requirement alone will have a significant impact on the manner in which settlements are negotiated and on the cost of settlements.

CMS has also recommended a record retention period of ten years for Medicare Secondary Payor (MSP) related information. This is a change from CMS' prior "required 10 years" to "recommended 10 years "in the last MSP PRA Information Collection submission in July 2005 (PRA refers to the Paperwork Reduction Act). Absence of related information does not constitute a valid defense against an MSP collection action. CMS has pointed out that Federal False Claim Act actions can be brought for 10 years following settlement. Some lawyers argue that Medicare does not need to take action under the provisions of the Federal False Claims Act and may commence their collection efforts anytime after discovery of their overpayment and without regard to a statute of limitation. If correct, the government could seek recovery of conditional payments made from December 1980 to today.

It is important to emphasize that Medicare (CMS) asserts a statutory *claim* as opposed to a lien. Liens typically attach to a settlement and are the responsibility of the claimant or plaintiff to respond to and satisfy from settlement proceeds. In addition, in most jurisdictions, lien holders are required to place the claimant or plaintiff on notice of their lien interests. This is not the case where Medicare is concerned. By statute, Medicare is not required to

place any party to the settlement on notice of their interests in the claim or settlement. Quite the opposite is the case. Once MMSEA is fully implemented next year, insurers or self-insured parties to the claim or settlement must place CMS on notice through the mandatory reporting mechanism. Claims that are denied or disputed do not require reporting until such a time as the claim is accepted or settled.

Many parties incorrectly assume that inserting indemnity and hold harmless terms into settlement documents will protect the defendant/insurer from Medicare's statutory claim. It is worth remembering Medicare is not a party to the settlement and, therefore, is not bound by the terms of the settlement or any associated settlement documents. They have not been involved in negotiations and have not waived any of their statutory rights against all parties to the settlement. If Medicare's interests have not been protected, as required by federal statute, they may commence a collection action against any and/or all parties to the settlement, including the involved attorneys. State laws or judicial orders will not trump Medicare's federal entitlements.

The Department of Health and Human Services (HHS) and the Centers for Medicare and Medicaid Services (CMS) have created a website at www.cms.hhs.gov/MadatoryInsRep. This site will include documents, which may be downloaded. The site will include draft and final documents, including information on how interested parties may comment on the documents and/or CMS implementation of the MMSEA, Section 111. Interested parties may also subscribe to updates and current information at the site.

Federal and state departments are well known for their use of acronyms and unique terms of references. CMS is no exception. Because of the complicated and broad nature of issues surrounding Medicare, a Glossary of Terms and Acronyms can be found in the resource section of www.jeloganltd.com. This, of necessity, remains a work in progress and will be updated as new information is developed and introduced.

Notwithstanding the passage of nine months since the initial introduction of MMSEA to the claim and legal community, little more is known today than was known in January. Rules and procedures continue to be developed by CMS. That is not an easy task when considering the multitude of claim and settlement circumstances that could involve Medicare-eligible claimants/plaintiffs. Keep in mind, MMSEA indicates the obligation to protect Medicare's interests shall be without regard to fault or disputed liability. This gives rise to a series of questions yet to be answered.

- How will we deal with Medicare when liability is disputed, compromise settlements are made or comparative fault is assessed?
- How will we deal with situations where Medicare's interests are close to or greater than the settlement amount, policy limits or jury award?
- Who will have primary interest in the settlement proceeds when attorney fees and costs must be paid and other lien holders, possibly including Medicaid, are seeking financial recovery from the Medicare beneficiary's settlement?
- How can a settlement be made "on the court house steps" at the eleventh hour before trial if Medicare's interests in the settlement are unknown?

These are only a few of the questions that must be addressed between now and July 1, 2009. No doubt more will surface in the very near future.

While we are waiting for CMS to promulgate and publish their rules for compliance with MSP and MMSEA, insurers and self-insured entities would be wise to quickly develop a system that will identify those claimants or plaintiffs who are or will soon be eligible for Medicare benefits. Likewise, attorneys should consult with their clients to determine if they are eligible or will soon become eligible for Medicare benefits. Once Medicare eligibility and conditional payment issues have been determined, the parties to the settlement would be well advised to reveal and discuss Medicare's interests because all parties, in every circumstance, must protect Medicare or face serious consequences for failing to do so.

James E. Logan & Associates, Ltd. provides diversified settlement-consulting services to clientele across the country. The firm's Medicare Set-Aside Unit assists clients in determining if conditional payments have been made and with the development of cost-effective Medicare Set-Aside Arrangements (MSAs). For more information or assistance, contact Jim Logan at 248-865-3900.

"The Impact of the MMSEA on Personal Injury Claims" by James E. Logan, CSSC, published in the Fall 2008 Newsletter of the American Bar Association, Tort Trial & Insurance Section. Copyright by the American Bar Association – Reprinted with permission.