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CASE STUDY

What Attorneys Should Understand about Medicare Set-Aside Allocations: How Medicare Set-Aside Allocation Is Going to Be Used to Accelerate Settlement Claims in Catastrophic Personal Injury Cases

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1 | INTRODUCTION

Medicare Set-Aside Allocation (MSA) is not required by federal statute, nor is there a legal requirement to create an MSA. However, an MSA is the preferred method for protecting Medicare's future interests when attempting to settle cases pretrial, that involve a Medicare beneficiary because the government is a "secondary payer" until the MSA monies are completely exhausted. The monetary amount in the MSA is determined by the finalized settlement negotiations, which often relies on reports from life care planners and forensic economists as evidence during the negotiations.

Recently, plaintiffs who are entitled will receive Medicare coverage for many medical tests, equipment, items, services, and prescriptions upon turning age 65 qualify for an MSA. In short, liability insurers, self-insurers, no-fault insurers, and workers' compensation carriers are no longer considered the "primary payer" once the plaintiff turns 65. This automatically lowers the cost projections calculated in the forensic economic reports by a significant amount. During the settlement negotiations, many plaintiff attorneys will be surprised at the lower cost projections detailed in the forensic economic reports that result from crediting MSA qualified medical costs.

2 | BACKGROUND

Medicare was first enacted in 1965 to provide national health insurance for the elderly. Until 1980, Medicare was the "primary payer" in all cases involving the aged, destitute, and needy. Cases involving workers' compensation were the only exception.

To curb the rising cost of Medicare, the Medicare Second Payer (MSP) Act was enacted in 1980 to protect the financial integrity of the Medicare program. These MSP provisions
required certain "primary plans," including liability insurance, self-insurance, and no-fault insurance plans, to be the "primary payer" for items and services provided to Medicare beneficiaries. Consequently, Medicare became the "secondary payer"

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and the Medicare Trusts began saving some $6 billion annually in 1980 dollars. In 2021 dollars, this equals to over $20 billion in annual savings.

The MSP provisions of 1980 provided two methods to protect the financial integrity of the Medicare Trust and ensure Medicare is the "secondary payer." First, the provisions prohibit Medicare from making payments on claims that are the responsibility of another "primary payer." Second, the provisions authorize Medicare to make payments in order to minimize concerns over continuity of care issues resulting from delayed payment of medical bills by another insurer with "primary payer" responsibility. However, such payments must be reimbursed to the Medicare Trust Funds, handled by a single contractor known as the Medicare Secondary Payor Recovery Contractor (MSPRC).

In the eyes of the CMS, there are two obligations that arise when dealing with the application of the MSP provisions. First, Medicare payments made before the date of the case settlement, known as conditional payments, are an obligation in terms of compliance with the Medicare Second Payer Act of 1980. This is a "before settlement" obligation. Second, future Medicare payments for covered services, known as Medicare Set-asides Allocation (MSA).**An MSA is a projection of the cost of the future treatment for injury including doctor's visits, tests, surgical procedures, and medications. By design, an MSA is a "primary payer" for injury treatments in the future until the allocation is completely spent. This is an "into the future" obligation, and in October 2010, the government extended its ability to enforce the MSP provisions by making effective Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA). In other words, the Section 111 requirements exist to safeguard the Medicare Trust Fund against beneficiaries not exhausting their MSA monies.**

Any organization that must report under Section 111 is referred to as a **Responsible Reporting Entity (RRE)** , which generally includes liability insurers, self-insurers, no-fault insurers, and workers' compensation carriers. All RREs must complete a process called Mandatory Insurer Requirement (MIR), in which the claimant is deemed a Medicare beneficiary, and therefore its information is provided to the Secretary of Health and Human Services when the claim gets resolved.

All RREs fall into two categories that are subject to mandatory reporting under Section 111 requirements. First, Group Health Plan (GHP) arrangements that businesses offer to employees. Second, Non-Group Health Plan (NGHP) arrangements for Medicare beneficiaries who receive settlements, judgements, awards or other payment from liability insurance (including self-insurance), no-fault insurance, and workers' compensation. **For these NGHPs, any claim with a total payment obligation to the claimant (TPOC) valued over $750 is subject to Section 111 reporting.**

Mandatory reporting is accomplished by two methods. One, the submission of a liability, no-fault, and workers' compensation claim information, whereby the injured party is a Medicare beneficiary. Two, by entry of this claim information directly into a secure Web portal, depending on the volume of data to be submitted.

Upon receipt of this information, CMS checks whether the injured party associated with the claim report is a Medicare beneficiary, and determines if the other insurance is primary to Medicare. If Medicare was indeed the "secondary payor," then the reimbursement to the Medicare Trust Fund is handled by the Medicare Secondary Payor Recovery Contractor to seek repayment from the other insurer or the Medicare beneficiary. **Under the MSP provisions of 1980, the United States may sue the primary payer or the Medicare beneficiary for double damages.**

Each RRE must maintain specific data related to the beneficiary, including patient name, Social Security Number, gender, date of birth, litigation information, and injury information. Additionally, each RRE must register with a coordination of benefits contractor (COBC). As new information becomes available, the RRE is responsible for reporting all new info. Regardless of how a settlement is structured between the patient and the insurance entity, the RRE is responsible for reporting the same to CMS through the COBC.

3 | IMPLICATIONS FOR ATTORNEYS

It is clear that personal injury attorneys representing Medicare beneficiaries have no fiduciary relationship with Medicare, and have no direct responsibility for reporting to the CMS. However, the Section 111 requirements can charge civil penalties and damage claims to any personal injury attorney representing a client with a legal obligation to reimburse Medicare, and such attorney has a legal obligation to ensure that Medicare is reimbursed for conditional payments subject to a recovery by the beneficiary. In US v. Harris (N.D. W.Va Mar 26, 2009) , the government pursued trial lawyers who ignored Medicare's interests.

For any case involving a plaintiff alleging bodily injury, attorneys should perform the following steps to protect their own interest without violating the fiduciary responsibilities to their clients.

Plaintiff counsel:

1. When representing a Medicare beneficiary, counsel should immediately contact the Benefits Coordination and Recovery Center (BCRC) and provide the beneficiary's name, gender, date of birth, Social Security Number or Medicare Health Insurance Claim Number, date of incident, and a description of the incident

2. After review of the information by the Medicare Secondary Payor Recovery Contractor (MSPRC), counsel should access the interim conditional payment information and communicate the same to the client.

3. Upon reaching a settlement, judgment or award of this matter, counsel should notify in writing the MSPRC, including the date of such agreement or otherwise, amount recovered, any attorney's fees or other procurement costs associated with the same. A copy of the executed settlement, judgment or award should also be forwarded.

4. Upon receipt of a demand letter from the MSPRC, counsel should review with the client and submit an appeal or request a compromise if desired.

Defense counsel:

1. At the initiation of a suit, counsel should contact the Responsible Reporting Entity (RRE) to determine if it has promulgated any forms to be completed related to the information to be obtained.

2. In the discovery phase of any case, the attorney should obtain all basic information pertaining to a plaintiff. Additionally, written discovery should include inquiries as to whether or not a plaintiff is a Medicare beneficiary, including the individual's Social Security Number and Medicare health claim insurance number if there is one. This should be obtained as early in the litigation as possible and updated as applicable. The information as provided by the plaintiff should be verified or certified.

3. All information should be reaffirmed or reviewed in the deposition phase of litigation.

4. Upon payment of a settlement or judgment in a case, include language listed under Section IX, Representations and Warranties, Subsection 9 to release the defendant in a matter from all Medicare/Medicaid liens. In a case where the beneficiary fails to reimburse Medicare, if the settlement does not expressly release the defendant, CMS may seek reimbursement from the defendant or its insurer, even though it has already paid the beneficiary and even if liability is expressly denied.

WHAT ARE THE PENALTIES FOR NON-COMPLIANCE?

The Center for Medicare and Medicaid Services (CMS) may refuse to recognize a settlement and seek reimbursement for medical expenses paid by Medicare for which another primary payer was responsible, pursuant to 42 USC 1395y.

In addition to the risk that the claimant could lose their Medicare benefits, the CMS has the right and may pursue a private cause of action for double damages against the carrier for failure to provide primary payment and reimbursement. Additionally, the CMS may also seek reimbursement directly from the claimant and from attorneys.

Since 2007, Section 111 originally carried the threat that noncompliant entities "shall be subject to a civil money penalty of $1,000 for each day of noncompliance with respect to each claimant." The CMS comment period for the proposed new rule closed on April 20, 2020 and the regular timeline for publication of the final rule has been extended until

September 6, 2021.

The proposed new rule essentially modifies 42 CFR Sections 402.1 and 402.105. These sections currently cover the reasons why CMS would seek civil monetary penalties, as well as the amounts of the penalties for each occurrence.

New proposed Section 402.1(c)(22) will subject a NGHP RRE to penalties if:

1. The RRE does not report a beneficiary within one year of the date of claim settlement, judgement, award or other payment.

2. The RRE contradicts its reporting in response to CMS recovery efforts.

3. The RRE exceeds any "error tolerance threshold" established by CMS in any 4 of 8 consecutive quarterly reporting periods.

Exception from this rule is possible if the RRE can show its failure to report stems from the NGHP's inability to obtain the beneficiary's information following a good faith effort to collect the same.

New proposed Section 402.105(b)(3) sets the amount of the penalty up to $1,000 per beneficiary and maximum $365,000 annually per beneficiary. These penalties are stringent and apply to three types of infractions. First, failure to report. Second, for a response to CMS recovery that contradicts the RRE's reporting. Third, for exceeding the error tolerance. The penalty for exceeding the error tolerance is percentage based.

In addition to these changes, CMS will not access penalties for a minimum of two reporting periods after any CMS policy or procedural changes. Additionally, CMS stated that it will apply the five-year statute of limitations under 28 USC 2462 from the date when the noncompliance was identified by CMS.

The CMS has intricate instructions for every aspect of the MSA, from submission to administration. For personal injury attorneys, giving advice about financial options, taxation of damages, and preservation of public benefits fall within the purview of advice. When the two categories of "advice" and "settlement negotiation" were merged together, they ranked first in a 2003 Profile of Legal Malpractice Claims by the American Bar Association report.

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