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Medicare Secondary Payer Act (MSP): What Is It? and What Impact Will It Have?

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Introduction

Beginning January 1, 2010,¹ insurers and self-insured entities will be required to report claims made by Medicare-eligible claimant/plaintiffs to the Centers for Medicare and Medicaid Services (“CMS”) and will be subject to a \$1,000 daily fine,² plus “double damages” for failure to comply.³ Generally, a claimant/plaintiff sixty-five or older is considered Medicare-eligible.⁴ By imposing this mandatory reporting requirement on Responsible Reporting Entities (“RREs”),⁵ Medicare hopes to increase its ability to identify individuals who received Medicare payments and to recoup an estimated \$1.74 billion of inappropriately paid benefits per year.⁶ While this practice has been required in workers’ compensation matters for decades, the application to civil matters has dramatic implications. Counsel for self-inured, insured, and plaintiffs should take note that Medicare’s status as a secondary payer under 42 U.S.C. § 1395y(b) creates, for Medicare, the right to reimbursement which has the potential to simultaneously impede settlement and impose a possible risk of future liability against all parties.⁷

¹ CMS has delayed implementing the MSP until January 1, 2010 but responsible reporting entities (RREs) must report retroactive to July 1, 2009. CENTERS FOR MEDICARE AND MEDICAID SERVICES, ALERT FOR LIABILITY INSURANCE (INCLUDING SELF-INSURANCE), NO-FAULT INSURANCE, AND WORKERS’ COMPENSATION, Mar. 20, 2009, available at http://www.cms.hhs.gov/MandatoryInsRep/Downloads/Alert_UserGuideSupp_NGHP.pdf.

²*Id.*

³ Robert G. Trusiak, *The Medicare Secondary Payer Statute: Medicare’s Recovery Rights in Relation to Liability and No-Fault Insurance*, B. ASS’N OF ERIE COUNTY BULL., Oct. 2008, at 21, 21.

⁴ A 65 year old individual is Medicare-eligible if the individual (or their spouse) worked for at least 10 years in Medicare-covered employment. LINDA FLOWERS, AARP, THE MEDICARE PROGRAM: A BRIEF OVERVIEW, 1 (2007), http://assets.aarp.org/rgcenter/health/fs102r_medicaid.pdf. Additionally, some disabled people under age sixty-five, and people of all ages with end-stage renal disease are considered Medicare-eligible. *Id.*

⁵ Specifically, a client will be considered an RRE if it has a deductible plan and directly pays settlements to claimants. However, if an insurance carrier makes payments on the client’s behalf and the client merely reimburses the insurance carrier, then the insurance carrier is the RRE.

⁶ *CMS Insurer Reporting Requirements Call for Fast, Thorough Action*, INGENIX.COM, April 14, 2009, <http://www.ingenix.com/thoughtleadership/innovations/041409>.

⁷ Roy A. Franco et al., *Resolution of a Case with a Medicare Claimant?*, FOR THE DEFENSE, May 2009, at 10–11.

What Is The Medicare Secondary Payer Act (MSP)?

In the 1980s, Congress amended the Social Security Act to include the Medicare Secondary Payer Act (“MSP”), which effectively enacted Medicare liens.⁸ In 2003, the Government clarified its position that self-insured entities were also included in the MSP in passing the Medicare Act of 2003. The 2003 revisions altered MSP to expressly include self-insured entities as “responsible” parties obligated to reimburse Medicare.⁹ Prior to the Act, Medicare did not have an efficient mechanism to identify or evaluate instances where Medicare’s liability should have been secondary to the “responsible” party (or its insurance), and could only recoup payment from insurance plans to the extent that payment had been made or could “reasonably be expected to be made promptly.”¹⁰

In part, the intent of the MSP revisions was to make persons or entities “responsible” for injury(ies) to a Medicare recipient also responsible for reimbursing those expenses, rather than waiting on the “expectation” of prompt payment.¹¹ To that end, the MSP revisions included a new, broadened definition of what constituted an insured entity. The 2003 MSP defined a self-insured entity as one “that engages in a business, trade or profession . . . [which] carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.”¹² The MSP also expanded the scope of persons subject to reimbursement (including a Medicare beneficiary who receives settlement or award), and delineated a timeline for “responsibility” of reimbursement.¹³

In 2003 the Federal government took no steps to actively pursue settling tortfeasors or Medicare-eligible Plaintiffs. Medicare lacked efficient mechanisms to identify or pursue cases where its liability should have been second to the responsible party or its insurance. Accordingly effectiveness of the MSP was hindered by lack of enforcement.¹⁴

⁸ CENTERS FOR MEDICARE AND MEDICAID SERVICES, MEDICARE SECONDARY PAYER MANUAL, at 3 available at <http://www.cms.hhs.gov/manuals/downloads/msp105c01.pdf> [hereinafter MSP MANUAL].

⁹ 42 U.S.C. § 1395y(b)(2)(A)(ii)(2002).

¹⁰ See 42 U.S.C. § 1395y(b)(2)(A)(ii)(2002).

¹¹ See 42 U.S.C. § 1395y(b)(2)(A)(ii)(2002).

¹² *Id.* (b)(2).

¹³ *Id.*

¹⁴ Kenneth Paradis, *New Requirements for Medicare Set-Aside Arrangements*, 18 J. WORKERS COMP. 32, 32 (2009).

However, on December 29, 2007, the Medicare, Medicaid, and SCHIP Extension Act of 2007 (“MMSEA”) was signed into law.¹⁵ MMSEA amended the MSP to impose new reporting duties on liability insurance plans, private self-insured entities, Group Health Plans, no fault insurance plans and workers’ compensation plans.¹⁶

Beginning January 1, 2010, Section 111 of the MMSEA requires certain entities to directly report potentially eligible claimant/plaintiffs to the Centers for Medicare and Medicaid Services (“CMS”).¹⁷ The new reporting requirements are imposed directly on self-insured entities and insurance carriers. Under the new Medicare legislation, insurance carriers and self-insured entities will be fined \$1,000 per day for failure to comply. Further, in paying a settlement or award to a Medicare-eligible claimant/plaintiff, the insurance carrier or self-insured entity will be responsible for “double damages” if the lien is not satisfied in a timely fashion.

Mechanics of Compliance with MMSEA

Under MMSEA, Responsible Reporting Entities (“RRE”), including liability insurance plans, Group Health Plans, no fault insurance plans and workers’ compensation plans, will be required to directly report *potentially* eligible claimant/plaintiffs to the Centers for Medicare and Medicaid Services (“CMS”). An RRE must register electronically with CMS between May 1 through September 30, 2009.¹⁸ CMS has announced it would impose an interim reporting threshold in 2010 for liability claims of \$5,000, below which claims need not be reported to the new system.¹⁹ In 2011, the threshold will reduce to claims greater than \$2,000, and greater than \$600 for the year 2012. These thresholds are based on the RRE’s Total Payment Obligation to the Claimant (“TPOC”). Multiple TPOCs to the same claimant/plaintiff must be bundled in determining the reporting obligation of the RRE.²⁰

¹⁵ See John J. Campbell, *New Medicare Secondary Payer Reporting Requirements*, MEDICARE SET ASIDE BULL., Feb. 2008, <http://www.jjcelderlaw.com/MMSEAMSABull.htm> (last visited June 1, 2009).

¹⁶ *Id.*

¹⁷ Franco, et. al., *supra* note 7.

¹⁸ CENTERS FOR MEDICARE AND MEDICAID SERVICES, ALERT FOR LIABILITY INSURANCE (INCLUDING SELF-INSURANCE), NO-FAULT INSURANCE, AND WORKERS’ COMPENSATION, Mar. 20, 2009, *available at* http://www.cms.hhs.gov/MandatoryInsRep/Downloads/Alert_UserGuideSupp_NGHP.pdf.

¹⁹ *Id.*

²⁰ *CMS User Guide: Changes to Compliance Timeline, Reporting Thresholds and Look-Back Provision; and an Extended Web Seminar Schedule*, Sedgwick CMS Information e-Bulletin: MMSEA/SCHIP Update, March 31, 2009, <http://www.sedgwickcms.com/clientbulletin.aspx?Bulletin=cb033109>.

In complying with MMSEA, it is important for the RRE's not to assume that all claimant/plaintiffs aged 65 and older are Medicare beneficiaries, or that those aged 65 and under are not. For example, in 2003 the AARP reported 16% of Medicare beneficiaries were under the age of 65.²¹

Under MMSEA, all insurers, including self-insured entities, must determine the Medicare entitlement of all claimant/plaintiffs and report specific information about the claims to CMS. To determine the Medicare entitlement status of a claimant/plaintiff, the RRE may ask the claimant/plaintiff directly whether he/she is eligible. However, because the RRE may not rely on the validity of the claimant/plaintiff's response, the RRE must obtain the claimant/plaintiff's Social Security number for submission to CMS for verification.²²

Verification may be completed through the submission of electronic queries by RREs once during the course of each month. To complete the query, the RRE must submit the social security number, name, date of birth and gender of the injured party, for each request.²³ Following submission of the query, Medicare will determine the beneficiary's status within 14 days. However, RREs must remain diligent because their obligation does not end at this point—RREs must continue to ensure that a person that was not a Medicare beneficiary does not become a beneficiary.²⁴

Additionally, RREs will be required to retain their records regarding MSP-related information for ten years, since administrative offset and False Claim Act actions can be taken for ten years.²⁵ Further, CMS has the authority to audit an RRE at any point.

Evaluation by CMS and Penalties for Non-Compliance

If a determination is made by CMS that the claimant/plaintiff is entitled to Medicare benefits, the RRE **must** report information about the claim and plaintiff/claimant to CMS once the claim is either fully or partially concluded and a payout has been made, or payout will be made in the future. If the RRE is the party

²¹ See FLOWERS, *supra* note 4.

²² Further, the claimant/plaintiff is not obligated to disclose his/her Social Security number unless litigation is pending. Franco, et. al., *supra* note 7, at 9.

²³ CMS, COB FACT SHEETS: MSP LAWS AND THIRD PARTY PAYERS FACT SHEET FOR ATTORNEYS, <http://www.cms.hhs.gov/ProviderServices/Downloads/thirdpartypayers.pdf>.

²⁴ Franco, et. al., *supra* note 7, at 10.

²⁵ See 31 U.S.C. § 3716(e)(1) (2002) (Administrative offset); 31 U.S.C. § 3731(2) (2002)(False Claim Act).

responsible for the payout, report is only required following *final* resolution of the claim. Parties to the claim have 60 days to reimburse Medicare, and failure to do so may result in CMS charging interest on the total outstanding amount.²⁶ If CMS is required to take legal action to secure recovery, CMS is entitled to recover “double damages” — twice the amount of the payments made on behalf of the beneficiary.²⁷

Following entry of an award or an order approving settlement, the RRE must complete CMS’s extensive report. More than 100 categories of information may be sought by CMS, depending on the identity of the plaintiff and the type of action pursued by the plaintiff.

Notably, the RREs must report regardless of any determination of liability. Meaning, a disclaimer of liability within a settlement document does **not** alleviate the RRE’s reporting requirement. Further, a statement by the claimant/plaintiff (or even a court) that there are “no medicals” does not eliminate the RRE’s reporting requirement if the Plaintiff originally claimed medicals in the claim.

Potential Negative Impact of MSP on Settlement

As outlined, the new legislation makes the “responsible” party obligated to reimburse Medicare for expenses incurred by the Medicare recipient claimant/plaintiff. Medicare’s right to reimbursement only accrues once the “responsible” party pays a settlement or award on the claim.²⁸ Responsibility is established not by liability, but simply through any payment by the accused tortfeasor. The claimant/plaintiff’s potential comparative fault is not taken into consideration, nor is the nuisance value of a claim.²⁹ This means that, in the case of settlement, Medicare’s threat of post-settlement involvement (by seeking reimbursement) may actually have the effect of impeding settlement.³⁰

The MSP does not provide for an allocation of fault or negotiation based on that fault. Under the MSP, Plaintiffs may be less inclined to settle and Defendants may find themselves in the courtroom more frequently. Under the current legislation, Medicare

²⁶ Paradis, *supra* note 14, at 35.

²⁷ *Id.*

²⁸ Heather K. Kelly et al., *Medicare Reimbursement Problems: Making the Possible Impossible*, FOR THE DEFENSE, Feb. 2008, at 8, 10.

²⁹ See Jeffrey J. Signor, *A Look Behind the Federal Government’s New Efforts to Track and Recover Medicare Liens*, B. ASS’N OF ERIE COUNTY B. BULL., Dec. 2008, at 18, (Dec. 2008).

³⁰ *Id.* at 19; see Kelly *supra* note 25, at 8.

can recover the entire amount of a settlement or award as reimbursement, regardless of how the settlement or award characterizes the amount.³¹ Thereafter, the offeree has the responsibility of paying the TPOC.³²

Looking Forward for Risk Managers: Potential for Medicare Set Aside Accounts and Other Issues

Under MMSEA, compliance with MSP may not end with identification, settlement, timely reporting and payment. In certain instances, Medicare is also considered the secondary payer for post-settlement, future treatment expenses. These instances arise where “responsibility” is attributed during settlement with a claimant/plaintiff who needs future treatment. Because the “responsible” party becomes the primary payer, Medicare is the secondary-payer for any future Medicare-covered expenses needed by the claimant/plaintiff.

Currently, it is unclear whether the insurers or insurance carriers have an affirmative duty to Medicare after the case is settled and the reporting is complete. For decades, parties settling workers’ compensation claims have created Medicare Set Aside Accounts (“MSA”) in order to protect themselves and the interests of Medicare. In the past, these MSAs were created based on an evaluation of the claimant/plaintiff’s past treatment together with an estimation of the need for future Medicare-covered treatment expenses.³³ As time progresses and the claimant/plaintiff is treated with the Medicare-covered expenses, the MSA kicks in as the primary payer (thereby protecting Medicare’s status as secondary payer).³⁴

Failure to create a sufficient MSA has its own implications for the “responsible” party. If Medicare concludes that the parties failed to adequately account for Medicare’s future interests, it reserves the right to disregard the settlement and fine the “responsible” party.³⁵ If Medicare concludes the MSA is insufficient, Medicare may not pay for future treatment expenses or, Medicare may pursue an action against the parties for failure to consider Medicare’s interests.

³¹ See MSP MANUAL CHAPTER 7, at 50.4.4.4.; 42 U.S.C. § 1395y(b)(2)(B)(ii).

³² See e.g., CENTERS FOR MEDICARE AND MEDICAID SERVICES, ALERT FOR REPORTING MULTIPLE TOTAL PAYMENT OBLIGATION TO THE CLAIMANT (TPOC) AMOUNTS FOR LIABILITY INSURANCE (INCLUDING SELF-INSURANCE), NO-FAULT INSURANCE, AND WORKERS’ COMPENSATION, Apr. 7, 2009, available at <http://www.cms.hhs.gov/MandatoryInsRep/Downloads/NGHPAlertTPOC.pdf>.

³³ Paradis, *supra* note 14, at 35.

³⁴ *Id.*

³⁵ *Id.*

The uncertainty surrounding the potential need for “responsible” parties to create MSAs under the new MSP requirements has dangerous implications. Until CMS takes steps to clarify its stance regarding the need for MSAs, the “responsible” party should ensure that all settlement agreements address responsibility for, or the absence of, future Medicare-covered treatment expenses. Notwithstanding such diligence, it is unclear how CMS would evaluate the validity of (or even honor) such an agreement.

Other uncertainties exist. For instance, what will happen when a party successfully tenders defense of the claim to a co-defendant? The parties should include language in the tender agreement that the co-defendant will indemnify the tendering party and comply with MSP. Nonetheless, CMS has no obligation to honor such an agreement if/when the co-defendant who accepted tender of the claim fails to comply with MSP. CMS may pursue an independent action against the tendering-party, seeking interest and “double-damages.” Further, though third party claims administrators and vendors may seek to assume RRE liability by contract, CMS requires that the RRE retain its position as “responsible party.”

As a result of the hassles and potential for fines created by MSP, plaintiffs’ attorneys may become reluctant to take on cases involving Medicare-eligible individuals. These individuals may go unrepresented. Alternatively, MSP may result in the development of a specialized legal field with attorneys knowledgeable and experienced in handling CMS, from both sides of the bench. Regarding settlement, parties are likely to see a change in case closing patterns, as cases may have the tendency to remain open for longer periods of time.

What Now? An Update:

On March 20, 2009, CMS made an announcement regarding extensions of MMSEA Section 111 reporting dates and deadlines.³⁶ First, CMS has delayed implementing the MSP until January 1, 2010, but RREs must report retroactive to July 1, 2009.³⁷ Registration has been extended from May 1 through September 30, rather than June 30 (as discussed above). Second, CMS extended testing of the program through March 1, 2010 and reporting will only begin in second quarter of 2010, for payments in the first quarter 2010.

³⁶ ALERT FOR LIABILITY INSURANCE, *supra* note 1.

³⁷ *Id.*

This recent announcement indicates that CMS is, at the very least, aware of some of the potential difficulties involved with implementation of the new reporting requirement. However, insurers and self-insured entities should take advantage of the window of time currently available to prepare for the upcoming requirements under MSP, and to seek settlement of matters involving Medicare-eligible claimant/plaintiffs. MSP will undoubtedly have a profound impact on insurance companies and self-insured entities, ushering in a fundamental change in the way claims are processed, investigated, evaluated, negotiated and settled.³⁸

³⁸ Franco, et. al., *supra* note 7, at 13.

Medicare Secondary Payer Act: Selected Cases

- *Mason v. American Tobacco Co.*, 346 F.3d 36 (2d Cir. 2003)

In a proposed class action under the MSP, Medicare recipients alleged tortious conduct by tobacco companies caused illness which prompted the recipients to seek Medicare payments for treatment. The United States District Court for the Eastern District of New York denied the recipients' motion to certify the class, resulting in dismissal of the action. The recipients appealed and the Court of Appeals held: 1) tobacco companies had no liability under the MSP for payments made by Medicare to treat recipients because tobacco companies do not fall with the designation of "self insured plans;" 2) no liability was imposed on the tobacco companies because of their status as alleged tortfeasors, and; 3) the Health Care Financing Administration Agency's interpretation of the MSP is not subject to the *Chevron* deference standard.

- *Arkansas Department of Health and Human Services v. Ahlborn*, 547 U.S. 268, 126 S.Ct. 1752 (May 2006)

A Medicaid recipient filed an action against the Arkansas Department of Human Services (ADHS), which asserted a lien against proceeds received by the recipient from a settlement of a personal injury lawsuit. Summary judgment was granted in favor of ADHS by the District Court for the Eastern District of Arkansas. The Plaintiff appealed, and the Court of Appeals reversed. On certiorari, the Supreme Court affirmed and held: 1) Federal Medicaid law does not authorize a statute that automatically imposes a lien on tort settlement proceeds, to the extent that statute allows an encumbrance on proceeds meant to compensate Medicare recipient for damages distinct from medical costs, and; 2) the Federal Medicaid law anti-lien provision precludes a statute's encumbrance on proceeds other than medical costs.

- *Fanning v. United States*, 346 F. 3d 386 (3d Cir. 2003)

After settlement was approved in a products liability class action against manufactures of orthopedic bone screws, the Federal Government attempted to recover settlement proceeds as reimbursement for Medicare costs under the MSP. Class members subsequently filed another class action against the United States, challenging the government's attempt to recover the settlement proceeds. The United States District Court held in favor of the plaintiffs, and the government appealed. The Court of

Appeals held that Federal question jurisdiction over the class action was barred by the Social Security Act because the special review channel created by Medicare statutes created was not utilized by the class members.

- ***Tomlinson v. Landers*, 2009 WL 1117399 (M.D. Fla 2009).**

After the Plaintiff was involved in automobile accident, the Plaintiff's attorney rejected a settlement check from the Defendant's insurance company that listed Medicare as a payee and requested that the settlement check be reissued without the identification of Medicare as payee. The Plaintiff's attorney assured the insurance company that Medicare would be reimbursed, and agreed to hold the insurance company harmless for any Medicare claims. Medicare had already paid certain benefits to the Plaintiff. Fearing that the Plaintiff would not reimburse Medicare and that they would be held liable under the MSP regardless of whether they paid the Plaintiff, the insurance company refused to remove Medicare as an payee from the check. The United States District Court for the Middle District of Florida held: 1) Federal law does not mandate that a primary payer or insurer make payment directly to Medicare; 2) the insurance company would not have violated Federal law if it omitted Medicare from the settlement check, and; 3) an insurer may be liable to Medicare if the beneficiary/payee does not reimburse Medicare for any amounts owed to Medicare within 60 days.

- ***Zinman v. Shalala*, 835 F. Supp. 1163 (N.D. Cal. 1993).**

Certain provisions of the MSP recovery plan were challenged by Medicare beneficiaries. The District Court held: 1) due process requires that a Medicare beneficiary personally receive notice of government reimbursement claims, and that notice directed to a beneficiary's attorney is insufficient, and; 2) such a notice cannot assert that Medicare has a lien against a beneficiary settlement award with insurers.

- ***Smith v. Travelers Indemn. Co.*, 763 F. Supp. 554 (D. Fla. 1989).**

In state court, a Medicare beneficiary sought declaratory judgment as to whether the United States was entitled to reimbursement for Medicare payments made to the beneficiary as a result of a automobile accident. The United States removed the case to Federal court. The District Court held: 1) Florida's collateral source rule which reduces an auto insurers liability by the amount of Medicare payments made to the beneficiary is preempted by the MSP; 2) the United States is entitled to reimbursement of those

payments made to a beneficiary which were covered by the automobile insurer; 3) reimbursement could not be avoided by insurers refusing to pay an arbitration award to the beneficiary, and; 4) since the insurers refused to pay the arbitration award, the United States was not entitled to reimbursement from the beneficiary.

- [Medicare Advocacy Recovery Coalition](#)
- Medicare, Medicaid, and SCHIP Extension Act of 2007:
 - <http://www.govtrack.us/congress/bill.xpd?bill=s110-2499&tab=summary>
- 42 U.S.C. Sec. 1392y
 - http://www.law.cornell.edu/uscode/uscode42/usc_sec_42_00001395---y000-.html
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