When Medicare Is a Secondary Payer

Mandatory Insurer Reporting

By Matthew L. Garretson and Sylvius H. von Saucken

A current Medicare law could make it more difficult for parties to settle single event and mass tort personal injury claims on or after October 1, 2010. Now more than ever, practitioners must embrace new procedures on the front end of cases in order to minimize disruption on the back end.

On December 29, 2007, President George W. Bush signed into law the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), Public Law No. 110-173, adding yet more teeth to the Medicare Secondary Payer (MSP) Statute. 42 U.S.C. §1395y(b). Section 111 of the MMSEA requires the providers of liability insurance, including self-insurance, no-fault insurance, and workers' compensation insurance, to determine the Medicare-enrollment status of all claimants and report certain information about their Medicare claims to the Secretary of Health and Human Services. With the objective of assisting the secretary to coordinate benefits and uncover potential reimbursement claims, this important legislation reinforces the federal government's intent to ensure that Medicare always is treated as the payer of last resort. The penalty for noncompliance has teeth indeed—$1,000 per day, per beneficiary, for each day an insurer is out of compliance. This penalty is in addition to the often feared, rarely levied "double damages plus interest" penalty that the government can impose on defendants, as primary payers, if Medicare's reimbursement claim is ignored in a settlement. *See* 42 U.S.C. §1395y(b)(2); 42 C.F.R. §411.24. The new rules will apply to settlements on or after October 1, 2010. *The MMSEA Section 111 Liability Insurance, No-Fault Insurance, and Workers' Compensation User Guide, Version 3.1* (July 12, 2010), available at http://www.cms.gov/MandatoryInsRep/Downloads/NGHPUserGuideV3.1.pdf.

The Centers for Medicare & Medicaid Services (CMS) is responsible for collecting data from applicable reporting entities to implement the mandatory MSP reporting requirements of Section 111 of the MMSEA. This information will assist the CMS in its "post-payment" debt-recovery activities arising from medical expenses paid by Medicare on a conditional basis. Because Medicare is a secondary payer to liability insurance, including self-insurance, no-fault insurance, and workers' compensation, the MSP rules are intended to identify those situations in which Medicare does not have primary

■ Matthew L. Garretson is the founding partner of The Garretson Firm Resolution Group, which has offices in Cincinnati, Ohio, Charlotte, North Carolina, Syracuse, New York, and Chattanooga, Tennessee. The Garretson Firm is a corporate member of DRI, with a presence on DRI's MSP Task Force. They provide mass tort/class action settlement allocation and fund administration services. Sylvius H. von Saucken joined The Garretson Firm in 2005 and currently serves as its Chief Compliance Officer, Fiduciary and General Counsel.

responsibility for paying for the medical expenses of Medicare beneficiaries.

The MMSEA signifies the next turbulent adjustment in the long continuum of change since President Bush signed the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) in December 2003. Medicare Modernization Act, Pub. L. No. 108-173, 117 Stat. 2066 (2003) (codified as amended in scattered sections of 42 U.S.C. §1395). The MMA further defined Medicare's recovery rights, clarified its enforcement powers, and erased all doubt that attorneys need to adopt formal processes to verify, resolve, and satisfy conditional Medicare payments, from the date of an injury through the date of a settlement, if they work on cases involving Medicare beneficiaries who receive personal injury settlements or judgments. *See* 42 U.S.C. §1395y(b)(2)(B)(iii) (2000 and Supp. 2004); 42 C.F.R. §§411.24(g)–(i). Whereas the teeth added to the MSP framework by the MMA in 2003 targeted the Medicare beneficiary community and attempted to clarify that community's obligations, those added by the MMSEA have targeted insurers or other primary plans. The ongoing transformation of Medicare reimbursement policy and practice creates continual challenges for lawyers and their clients in personal injury and workers' compensation cases. Simply put, the days of either treating Medicare as the proverbial sleeping dog or punting the issue until the end of the case are long gone.

Who Will Have to Report?

Business entities responsible for complying with the reporting requirements of Section 111 of the MMSEA are referred to by the CMS as "responsible reporting entities" (RREs). For liability and workers' compensation settlements, the applicable plans, including the fiduciary or administrator of the law, plans, or arrangements, or the insurers, will have to comply with specific reporting requirements. For purposes of MMSEA compliance, these reporting entities are considered "non-group health plans," or "non-GHPs."

To better understand the Section 111 MMSEA reporting concepts, it helps to distinguish who reports for non-GHP purposes and who does not. Under the MSP, the term "group health plan" (GHP) means a plan, including a self-insured plan, of, or contributed to by, an employer, including a self-employed person, or an employee organization, to provide health care, directly or otherwise, to the employees, former employees, the employer, or others associated or formerly associated with the employer in a business relationship, or their families. 42 U.S.C. §1395y(b)(1)(A)(iv). For example, any employer-sponsored plan that provides health insurance coverage, such as Blue Cross/Blue Shield, or a self-insured plan, such as Wal-Mart Associate's Health & Welfare Plan, would have a reporting obligation that started January 1, 2009. Non-GHPs, then, are everyone else who has an obligation or assumes the responsibility for medical payments for Medicare-entitled beneficiaries. For non-GHPs, the beginning reporting time lines have been delayed so that everyone can coordinate, as necessary, including the CMS, which will receive a crush of electronic data starting in 2011.

In addition to the user guide, three documents clarify which business entities need to report: the statute, 42 U.S.C. §1395y(b)(8)(F), which includes clarifying language, the MMSEA's Paperwork Reduction Act Supporting Statement, which provides definitions, and the Alert for Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Workers' Compensation: Who Must Report, published May 26, 2010, 42 U.S.C. §1395y(b)(8) (CMS-10265) (Aug. 1, 2008); *see also* https://www.cms.gov/MandatoryInsRep/09_Alerts.asp (last visited August 4, 2010).

Can Agents Report on Behalf of RREs?

Yes, agents can register with the CMS on behalf of RREs during the initial, data-file

set-up process. The CMS recognizes that business entities use third-party administrators and other agents to handle the large volume of claims and administration processes. Agents are not, however, RREs for purposes of Section 111 of the MMSEA. RREs may contract with agents to handle reporting; however, the RREs remain solely responsible and accountable for complying with the CMS instructions for implementing Section 111 and for the accuracy of the submitted data.

Reporting obligations for non-GHPs are event-specific, as opposed to the ongoing reporting obligations of GHPs.

What Triggers a Reporting Obligation for Non-GHPs?

Reporting obligations for non-GHPs are event-specific, as opposed to the ongoing reporting obligations of GHPs. The reporting triggering events for a non-GHP entity are accepting responsibility for medical services payments or settling or concluding a dispute resulting in an award, judgment, settlement, or other payment involving an injured person currently entitled to Medicare. When one of these events occurs, a non-GHP needs to report. Non-GHPs should not report pending settlements, and attempting to report them does not constitute compliance with Section 111 reporting obligations.

RREs only report to the CMS about Medicare beneficiaries, including deceased individuals who were Medicare beneficiaries at the time of a settlement, award, judgment, or other payment. If a reported individual is not a Medicare beneficiary, or if the CMS is unable to validate a particular Social Security Number or Health Insurance Claim Number (HICN) based on the submitted information, the CMS will reject the record for that individual. This does not mean, necessarily, that the reported individual is not a Medicare beneficiary, but rather that the CMS was unable to identify the individual based on the information provided. If that happens, an RRE would need to further investigate identification numbers for the next required submission. RREs must report quarterly.

Equally important is an RRE's monitoring responsibilities. If, for example, an individual was not a Medicare beneficiary at the time that an RRE assumed responsibility for ongoing medical services payments, the RRE must continue to monitor the entitlement status of that individual and report to the CMS when that individual does become entitled to Medicare coverage, unless the responsibility for ongoing medical services payments ends before the individual qualifies for Medicare.

Understanding triggering events in the context of the MSP is simple. The sole purpose of Section 111 of the MMSEA is to ensure that settling parties fully comply with the MSP: *conditional payments* must be verified and resolved in all liability, workers' compensation, and no-fault settlements so that Medicare's status as a secondary payer is honored. If Medicare beneficiaries' attorneys already verify and resolve Medicare's reimbursement claims in all their settlements, these new reporting rules should result in business as usual for those attorneys and their clients. And, according to the Supporting Statement of the MMSEA, for most non-GHPs, gathering the required data may not create a huge burden for those entities that have traditionally coordinated proper claim payments with Medicare to ensure proper order of payment. 42 U.S.C. §1395y(b)(1)(A)(iv). Non-GHP entities not currently reporting to the CMS, on the other hand, will need to adopt the CMS reporting methodology outlined in the user guide.

The history of the MSP further illuminates the true meaning of Section 111 of the MMSEA. On December 5, 1980, the MSP as we know it today was modified to include Medicare's conditional payment recovery rights. It was not until 23 years later, under Section 301 of the MMA, that additional enforcement provisions were added to the MSP that focused compliance on reimbursement obligations for settling parties, including attorneys and their Medicare-enrolled clients. Now, Congress has closed the loop with Section 111 of the MMSEA by placing a reporting obligation on self-insured defendants and insurance carriers. The user guide emphasizes that Section 111 of the MMSEA did not change or remove any existing MSP recovery rules, but it added reporting obligations to existing MSP requirements. As a result, for claimants and their attorneys, the obligation is still to "verify and resolve" Medicare's conditional payments. But for defendants, the sole obligation, through the MMSEA, is to verify Medicare entitlement and report to the CMS when appropriate.

What Are the Reporting Rules?

For all triggering events occurring on or after October 1, 2010, a RRE must engage in a two-step process:

1. Determine whether a claimant, including an individual whose claim is unresolved, is *entitled* to Medicare benefits.
2. If the claimant is entitled to Medicare benefits, electronically submit data about the claimant, the injury, and other, more specific information concerning the settlement to the Secretary of Health and Human Services through the "Coordination of Benefits Secure Website" (COBSW).

While seemingly straightforward, when the MMSEA first became law, practitioners needed clarification regarding the intended scope of the words "entitled" and "information." Since then, practitioners have received guidance in the form of multiple "town hall" teleconferences with CMS representatives to ensure that they understand this process and will comply. On July 12, 2010, the CMS published Version 3.1 of the user guide, cited above, which provides copious information about Section 111-compliant reporting.

Through these open forums, detailed interim record descriptions, and the user guide, the following points can be gleaned:

- RREs must report a settlement, judgment, award, or other payment, including, for instance, when a case has not settled, but an initial payment for medical expenses has been made because an RRE has accepted that responsibility.
- RREs must report one-time payments for settlements, judgments, or awards.
- If a RRE has accepted an ongoing responsibility for medical services payments, referred to as an "ORM," for instance,

as with a workers' compensation settlement, the RRE must report only two events: (1) the acceptance of that medical payment responsibility; and (2) termination of that responsibility. The RRE would submit only two reports. For example, if an insurer starts making medical payments based on an injury, the RRE would submit the first report marking the initial payment obligation date. Then, when the insurer stops making medical payments, when the case settles and that obligation ends, the RRE would submit the second, final report, marking the date of settlement. The RRE need not report every occasion a payment is made.

- RREs must report settlements, judgments, awards, or other payments regardless of an admission or denial of, or determination of liability.
- A RRE, for reporting purposes, only needs to report the total obligation, and does not have to allocate damages between indemnity and medical payments.
- Section 111 of the MMSEA does not require reporting for "property damage only" claims.
- A RRE must, however, report settlements, awards, judgments, or other payments in which medical services payments are claimed or released, regardless of allocation by the parties or a determination of "no medicals" by a court. This does not actually affect a RRE's reporting obligation, although it may impact whether CMS can claim recovery from that settlement, judgment, award, or other payment.
- Section 111 of the MMSEA does not establish an age threshold for reporting purposes.
- A RRE has no reporting obligation if the RRE is ready to close a Medicare beneficiary's file but no settlement, judgment, award, or other payment related to the case has been made.
- However, if a Medicare beneficiary's file is closed due to a "return to work," but a payment responsibility is subject to reopening, or otherwise subject to an additional payment request, the RRE must add this claimant to its reporting list.
- For liability insurance cases, including self-insurance, a RRE must report each new payment obligation as a *separate* settlement, judgment, award, or other payment. But, if a payment is made through a structured settlement or an annuity purchase, then only a single report is required, reporting the total amount of the obligation.
- The CMS is considering appropriate modifications to reporting rules for mass tort or Multi-District Litigation.

Importantly, the CMS provides interim reporting thresholds in version 3.1 of the user guide. Those interim reporting thresholds are as follows:

1. For no-fault insurance, there is no de minimis dollar threshold for reporting the assumption/establishment of the "ongoing responsibility for medical payments" (ORM), or for reporting the "total payment obligation to the claimant," referred to as "TPOC," that is, a lump-sum settlement amount "in addition to or apart from an ongoing responsibility for medical payments."
2. For liability insurance, there is no de minimis dollar threshold for reporting the assumption/establishment of ongoing responsibility for medical payments.
3. For workers' compensation ORM, claims meeting all of the following criteria are excluded from reporting for file submissions due through December 31, 2011: (a) "medicals only"; (b) "[t]he associated 'lost time'" for a worker is no more than the number of days permitted by the applicable workers' compensation law for a "medicals only" claim, or seven calendar days, if the applicable law has no such limit; (c) all payments have been made directly to the medical provider; and (d) the total payment does not exceed $750.
4. For liability insurance and workers' compensation "one-time" or "lump sum" payments (TPOCs), the following dollar thresholds apply: (a) Claim reports where the last (most recent) TPOC date is *prior to January 1, 2012*, with TPOC amounts totaling $0–$5,000 are exempt from reporting, except as specified in number "5" in this list; (b) Claim reports where the last (most recent) TPOC date is between January 1, 2012, through December 31, 2012, amounts of $0–$2,000 are exempt from reporting, except as specified in number "5" below; and (c) Claim reports where the last (most recent) TPOC date is between January 1, 2013, through December 31, 2013, amounts of $0–$600 are exempt from reporting except as specified in number "5," which follows.
5. Where there are multiple TPOCs associated with the same claim record, the combined, cumulative TPOC amounts must be considered in determining whether or not the reporting threshold is met; however, multiple TPOCs must be reported in separate TPOC fields. For TPOCs involving a deductible, where the RRE is responsible for reporting both any deductible and any amount above the deductible, the threshold applies to the total of these two figures.

The user guide also informs us that these thresholds are solely for purposes of Section 111 reporting and have no applicability to any other obligations or responsibility with respect to any other MSP provisions. CMS representatives made this very clear during a March 24, 2009, "town hall" conference call. CMS officials have also stressed on subsequent conference calls that these are *interim* thresholds and may be changed by CMS at any time.

General Reporting Requirements

A RRE will submit Section 111 information electronically through the "Coordination of Benefits Secure Website," referred to as the "COBSW." Each RRE will have a separate identification number (RRE ID) unique unto itself. A RRE will submit files on a *quarterly* basis, within an assigned, seven-day submission period during each quarter.

Input claim files will contain at least 49 "data points," organized by: (1) injured party/Medicare beneficiary information; (2) injury, incident, or illness information; (3) self-insurance information; (4) plan information; (5) injured party's attorney or other representative information; (6) settlement, judgment, award, or other payment information; and (7) additional claimant information (where the beneficiary is deceased or incapacitated). Further data point details are available at www.garretsonfirm.com.

A RRE will also submit a Tax Identification Number (TIN) "Reference File." The TIN may also be the RRE's federal employee identification number (FEIN). For the self-insured, the TIN may be an Employer Identification Number (EIN) or Social Security Number, depending on the particular situation. The TIN "Reference

File" is submitted with the "Claim Input File" so that a RRE does not have to reenter its name and address information with every "Claim Input Record."

Reporting Time Line

Because the CMS is still completing its Coordinator of Benefits Secure Website, RREs will have to adhere to a specific time line. While the original statutory interpretation of Section 111 of the MMSEA suggested to settling parties that reporting would have to occur starting on July 1, 2009, in practice, *registration should have been complete by September 30, 2009*. As a result, RREs should implement the following time line for non-GHP matters:

RRE Registration:	9/30/2009 (ongoing if not yet registered)
Test/production query input files accepted:	07/01/09
Trigger date for ORM	01/01/10
Claim input file testing begins:	01/01/10
Production claim input files accepted:	01/01/10
Trigger date for TPOC	10/01/10
Initial production claim input files due:	First Quarter, 2011

The user guide details the recent changes to the implementation time line. While RREs are permitted to test until December 31, 2010, once testing has been completed successfully, RREs are required to submit their first, live production files during an entity-specific, designated, seven-day window during the first quarter of 2011.

Coordination of benefits is Medicare-speak for ensuring that if another source of coverage is available for someone's injury-related care, he or she should use it.

File Submission Steps and Timing Issues

Once insurers and other RREs identify a reporting obligation, they will need to take steps to both register and implement claims procedures that will gather information for Section 111 reporting purposes. The key element of any claims procedure will be determining whether an injured party is a Medicare beneficiary. A RRE will have to submit to the CMS either the Social Security Number or the Health Insurance Claim Number for an injured party in each "Input Claim File" detail record. A RRE will have to submit reports for all claims, whether an injured party is or no longer is a Medicare beneficiary, that have been resolved or partially resolved through a settlement, judgment, award, or other payment on or after October 1, 2010, regardless of the assigned date for a particular RRE's first database submission. A RRE will not need to report ongoing responsibility for medical payments, or ORMs, that are complete before January 1, 2010. But if an ongoing payment responsibility starts before January 1, 2010, and continues past that date, the RRE will need to list that claim in its first submission, which will start after January 2011. Even though RREs will not need to report settlements completed before October 1, 2010, any ongoing payment responsibility assumed by a RRE on or after October 1, 2010, will still require reporting, according to the CMS' most recent guidance. And in practice, many RREs have been voluntarily reporting to test these compliance waters

Identification Numbers' Importance to the Section 111 Reporting Process

The CMS recognizes the critical importance of RREs being able to obtain Social Security Numbers or Health Insurance Claim Numbers. This is because a Social Security Number is the basis for a Health Insurance Claim Number. The Medicare program uses Health Insurance Claim Numbers to identify Medicare beneficiaries receiving health-care services and to otherwise meet its administrative responsibilities to pay for health care and to operate the Medicare program. The CMS also uses Health Insurance Claim Numbers to ensure that the Medicare program makes payments in the proper order or takes the proper recovery actions. Without this cornerstone, the CMS could not systematically link reported data to a particular beneficiary.

Any discussion of providing Social Security Numbers cannot happen without referring to federal privacy rules under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA created regulations that strictly regulate data transfer, such as when a Social Security Number can be used for personal health information, how that information is to be managed and used, who can collect it, and how it can be shared. Understandably, in today's "information age," given legitimate concerns about identify theft, claimants may hesitate to provide their Social Security Numbers to insurers and other RREs. However, collecting Social Security Numbers and similar protected health-identification information for the purposes of coordinating benefits with the CMS is a required, legitimate, and necessary use of Social Security Numbers under federal law. *See* 42 U.S.C. §§1395y(b)(1)(A)(iv), 1395(b)(8)(F).

Despite serving a legitimate function, Section 111 does not provide "implied consent" allowing RREs to request Medicare entitlement information. Section 111 of the MMSEA also does not require a claimant to authorize a RRE to obtain entitlement information from the Social Security Administration. The CMS has clarified in its many "town hall" teleconferences and in its guidance on the MMSEA reporting that RREs remain responsible for creating procedures to determine claimants' Medicare status. Nevertheless, on April 16, 2010, the CMS issued an Alert designed to assist RREs to prove to settling parties the necessity of gathering a settling claimant's Social Security Number. *See* http://www.cms.gov/MandatoryInsRep/Downloads/RevisedCollectionSSNEINs.pdf.

To attempt to address this seeming dichotomy, the CMS has developed a "Query Access System," accessible from the website where RREs will submit Section 111 MMSEA website reports. A RRE, once registered, can use this system to determine a claimant's Medicare entitlement status, provided that the RRE submits the appropriate, identifying health information. To match an individual to determine if he or she is a Medicare beneficiary, the CMS' Co-

ordination of Benefits Contractor (COBC) uses (1) a Health Information Claim Number or a Social Security Number, (2) the first initial of the first name, (3) the first six characters of the last name, (4) date of birth, and (5) gender. First, the COBC must find an exact match in its database for the Health Information Claim Number or Social Security Number. Then, at least three out of the four final remaining criteria must be matched exactly. If a match is found, the COBC returns the correct Health Information Claim Number to the RRE.

How Will Medicare Use This Information?

As MMSEA implementation begins, we should spend a moment contemplating how Medicare will apply this information. The statutory language of Section 111 of the MMSEA provides that the secretary will specify the information that insurers must submit that will enable the secretary to make "an appropriate determination concerning coordination of benefits, including any applicable recovery claim." 42 U.S.C. §1395y(b)(8)(B)(ii).

The phrases "coordination of benefits" and "applicable recovery claim" address two separate but interrelated issues. The former refers to two of the MSP's activities: "prepayment activities" and "post-payment activities." Prepayment activities are generally designed to stop mistaken payments from occurring when Medicare should be the secondary payer. Post-payment activities are designed to recover mistaken or conditional payments made by Medicare when there is contested liability insurance, including self-insurance, no-fault insurance, or workers' compensation that has resulted in a settlement, judgment, award, or other payment. The latter phrase involves squaring which entity should have paid those expenses.

More specifically, in the personal injury and workers' compensation context, *coordination of benefits* is Medicare-speak for ensuring that if another source of coverage is available for someone's injury-related care, he or she should use it. If no other source of coverage is available, and the person is eligible for Medicare, Medicare will begin to pay for injury-related care. Further, *recovery claim* refers to finding some other source of funds later that should have paid for care all along. In that instance, Medicare will seek and should receive reimbursement for injury-related payments.

MMSEA Does Not Equal Liability MSAs

The point of this article is to spark dialogue and provide an MMSEA roadmap. In recent years, Medicare's recovery interest time frame in personal injury matters has been the subject of tremendous scholarly and practical debate. Specifically, debate has focused on whether Medicare's recovery interest only extends to injury-related care costs from the date of an injury through the date of a settlement, or whether Medicare has an interest in settlement proceeds related to the cost of future care. In previous articles, our firm explored whether Medicare requires parties settling a liability claim to calculate a "set-aside" amount that the injured claimant must spend on injury-related care before Medicare would pick up the tab again. This set-aside is referred to as a "Medicare set-aside allocation," or "MSA." The roots of the set-aside are similar to the coordination of benefits concept, which, in effect, stands for the proposition that *if another source of coverage exists, that is, settlement dollars earmarked to pay for medical services, a claimant should use it first.*

In the workers' compensation arena, the debate has been squarely yet controversially answered. If a workers' compensation carrier settles its future obligation to pay for injury-related care, a proper settlement must allocate a portion of the settlement proceeds to cover those care costs. 42 C.F.R. §411.46 (2005). Medicare does not pay for care—before or after a settlement—until a beneficiary has exhausted his or her other funds under workers' compensation. 42 C.F.R. §411.45 (2005) (specifying two exceptions). So, a beneficiary must first spend the portion of a settlement earmarked for future injury-related medical expenses before Medicare will pay for such care. 42 C.F.R. §411.46 (2005).

Many personal injury practitioners think that the federal government has never satisfactorily addressed the set-aside in liability settlements. Certainly, the fundamental statutory principle requiring settling parties to protect Medicare's interest in workers' compensation settlements already exists and could potentially apply to liability settlements as well. 42 U.S.C. §1395y(b)(1), *amended by* Pub. L. No. 109-171, 120 Stat. 4 (2006). Yet, while the government may not need to promulgate new laws or regulations before Medicare could extend set-asides to liability settlements, obstacles currently exist that have made it, in our opinion, very difficult to fairly, efficiently, and uniformly apply set-asides to liability settlements.

Specifically, unlike workers' compensation, liability insurance policies generally have caps, and the doctrines of comparative fault and contributory negligence inherent in personal injury cases work to decrease final damages amounts. Currently, the CMS "set-aside calculation" methodology is geared toward the full-value, "no-fault" workers' compensation statutes. The types of damages in workers' compensation cases, such as "indemnity" and "medical" payments, are readily delineated. But personal injury settlements tend to categorize an array of damages as either "general" or "special." Absent a court finding on the merits of a case, presently the CMS does not have an efficient mechanism to determine the parties' intent in paying a claimant—that is, which portion of a settlement has been allocated to medical damages and which portion has been allocated to non-medical damages.

"MSA," or "Medicare set-aside," has become a buzzword in the settlement community due to various memoranda from the CMS. In the "Patel Memorandum," issued in 2001, the CMS expressed a preference for practitioners to use MSAs as the means to consider Medicare's interest in workers' compensation settlements. Subsequent memoranda further elaborated on the proper application of MSAs in workers' compensation settlements. However, the CMS has yet to address the use of MSAs in liability settlements. This lack of guidance has created uncertainty among practitioners involved in liability settlements.

When Section 111 of the MMSEA was announced some opined that Medicare would begin requiring liability settlements to include MSAs starting July 1, 2009, and they expected guidance shortly thereafter from the CMS. That interpretation of the MMSEA missed the mark as the act did not include provisions that protected Medicare's future recovery interests. The CMS has not offered formal guidance on the issue of MSAs in liability settlements,

and we believe that it will not in the near future. Moreover, the CMS has repeated in its "town hall" teleconferences that the MMSEA's settlement reporting requirements are not intended to replace or change the CMS' recovery practices. The user guide emphasizes that Section 111 did not change or remove any existing MSP rules, but only added new requirements to the existing MSP requirements. The MMSEA is not a "Trojan horse" for liability MSAs.

Simply put, Section 111 of the MMSEA's new requirement that defendants (RREs) report information about resolved or unresolved claims signals that that CMS is not yet content with the regulatory framework used to enforce Medicare's secondary payer status. The MSP is a work-in-progress.

A Time to Change Habits

From the start of every new case, a claimant's counsel has familiar worries about possible third-party recovery rights against the client's claims. These concerns, however, are largely new for defendants and insurers. Accordingly, insurers will need to institute internal procedures to make sure that they comply with the MMSEA, taking cues from the user guide. Two considerations in particular are worth mentioning.

First, since insurers will need to determine the Medicare eligibility status of every claimant, regardless of whether a claim has been resolved, they may need to require each claimant to sign a Social Security Form SSA-3288 (Consent to Release Information). Insurers can submit this to the Social Security office closest to the claimant's residence with a request for complete benefit eligibility information. Ideally, an insurer should do this when a claim is opened and *again* when the claim is resolved through judgment, settlement, or award. A claimant who is not eligible for Medicare when a claim is initiated may have become eligible by the time that the claim is finally resolved. The form allows a claimant to specify that he or she wants the information released to more than one person. An insurer should make sure that the claimant's counsel is listed in that section of the form so that he or she also receives all resulting correspondence.

Second, insurers must take steps to ensure that they can collect, manage, store, and transmit required data in a HIPAA-compliant manner. Insurers will need to deal with claimants' Social Security Numbers, or Medicare Heath Identification Claim Numbers, and the other data specified in the user guide. In some situations, such as resolving Medicare reimbursement claims after settlement or seeking approval of Medicare set-asides, an insurer will need the following to provide the required data: a copy of the judgment or settlement, medical records, applicable ICD-9 codes, life-care plans or cost projections, life expectancy information, the insurer's payment history on the claim, and all other documentation that Medicare deems helpful in determining whether its interests were reasonably considered.

Will the new requirements ultimately change the process by which defendants pay claims? In recent years, many insurers have placed both a claimant's name and Medicare on a settlement check, which has left the claimant and his or her attorney with the responsibility of having Medicare endorse the check. The carrier assumes that this process, which imposes a terrific burden on a claimant and his or her attorney, ensures that the insurer has met its obligation to Medicare since Medicare must sign off before the claimant can cash the check. Those insurers who like to wear a "belt with suspenders" take it even further, agreeing on settlements in principle, but requiring some written verification by Medicare, provided by the claimants or their attorneys, demonstrating that no reimbursement obligation exists, or that it has been satisfied. However, recently attorneys have started challenging this strategy, pointing out that the manner of payment is a material condition of a settlement, which if not agreed to by both sides, can lead to further litigation to modify settlement agreements or, specifically, to enforce those provisions absent a Medicare check endorsement. *Tomlinson v. Landers*, No. 3:07-cv-1180-J-TEM, 2009 WL 1117399 (M.D. Fla. Apr. 24, 2009).

Indeed, on this point, Medicare's intent is clear: Medicare wants its interest satisfied in a settlement before distribution to a claimant or an attorney. Medicare states that insurers should not disburse settlement proceed to claimants or attorneys until Medicare's interests have been satisfied in full. Ctrs. For Medicare & Medicaid Servs., *Medicare Secondary Payer Manual* §50.4.1, available at http://www.cms.gov/manuals/downloads/msp105c07.pdf. The timing of such satisfaction can cause a practical problem: where an insurer is not willing to settle absent proof Medicare has been reimbursed first, and Medicare will not issue its final demand until the case has settled, a stalemate takes place. That is because Medicare's final demand creates a sum certain reimbursement, which the Medicare Secondary Payer Recovery Contractor does not issue until settlement information is provided.

The authors believe that the stalemate can be broken if insurers' attorneys can confirm that claimants' attorneys' firms have in place formalized processes to identify, verify, and resolve Medicare claims early through case management procedures, insurers can avoid putting Medicare's name on checks or asking for proof that Medicare's interests have been satisfied as precautionary measures Identifying, verifying, and resolving Medicare claims early will allow claimants' attorneys to (1) demonstrate to RREs that they reported cases timely to the CMS' Coordination of Benefits Contractor; and (2) provide the RREs with the data that was already reported to the benefits contractor, to ensure that it comports with the RRE's data reporting, as well as the most current, conditional-payment summary so that the only remaining step is to secure the final demand by presenting the Medicare Secondary Payer Recovery Contractor with the settlement details. Integrating an RRE's procedures with those of a claimant's counsel will only serve to protect that RRE from the penalties associated with Section 111 reporting. If undertaken properly, this collaboration can yield great efficiencies and protection throughout the settlement process, eliminating the need to add Medicare to a settlement check, which does not satisfy an insurer's reporting obligations in the first place.

Issues for Settling Parties' Counsel

Medicare's role in settlements is undeniably evolving. As most claimants' attorneys already understand, *everyone* must now implement formal procedures in their practice, and they cannot wait to receive a notice of a potential claim from the CMS before taking action. The agency is not required to give notice, so lawyers must proactively identify, verify, and satisfy

Medicare, continued on page 87

Medicare, from page 34
Medicare's interests before distributing settlement proceeds. 71 Fed. Reg. 9466-01 (Feb. 24, 2006).

For those practitioners representing claimants who have not yet created solid, internal protocols, this new law places greater importance on making sure that an appropriate Medicare *verification* and *resolution* strategy is fully integrated into their practice. The facets of a successful strategy include protocols for starting early, enhancing client-intake information, offering client-education modules, and for complex cases, perhaps changing retainer agreements to allow an attorney to seek outside assistance to handle lien verification and resolution.

For those practitioners representing insurers and other RREs, a claimant's obligations to "verify and resolve" will be complemented by the insurer's new obligation to verify Medicare entitlement, provided that the claimant has representation. In the case of an unrepresented claimant, the necessity to verify *and* resolve becomes more imperative. In those cases, insurers should implement a protocol to seek assistance to ensure proper compliance with the MSP rules, including satisfaction of conditional payments. Simply put, given the impact of Section 111 of the MMSEA, a RRE's mandatory duty to verify Medicare entitlement by electronically reporting to the CMS may not be enough to properly address Medicare's recovery interest when a plan has made conditional payments. In that case, an insurer's best response may involve outsourcing to a qualified lien resolution firm to ensure absolute Medicare compliance.

Neutral Assistance for the Parties

The notion of seeking outside assistance for lien resolution is relatively new, yet it does serve a good purpose. Claimants' attorneys are keenly aware that they struggle to keep up with the changing health-care regulations, protocols, and contractors associated with the liens competing for a "share" of their client's recovery. Many believe that their clients' interests are best served if an attorney's time and efforts are spent addressing damages and liability. With the MMSEA, defense attorneys now share these same concerns.

For example, the authors' firm, serving as a neutral party, has developed programs for parties, including those involved in asbestos and product liability settlements, which involve a protocol that the parties agree to adhere to. At the time of a settlement, or similar negotiation a plaintiff presents to the defendant a form that shows that a tort recovery record has been established with Medicare. Then, the defendant releases settlement proceeds to the plaintiff with an understanding that the plaintiff will hold all net settlement proceeds until a conditional payment summary report has been received from Medicare or its lead contractor. Once the conditional payment is received, in many cases, the parties agree to hold back a percentage of the settlement, based on conditional payment amounts and other available medical expense information, which they have used to determine the scope of conditional payment liability. Those funds are held until a final demand is received from Medicare and the reimbursement claim is paid in full. Then, the plaintiff provides the defendant with a copy of the final payment sheet or other proof of satisfaction to permit the parties to close their files, as has Medicare. Of course, a disbursement program could take multiple forms. But the point is that using a neutral to verify these steps has proved successful in identifying respective duties and obligations of settling parties and resolving those obligations to protect settlement programs and the participating plaintiffs and defendants.

Conclusion

As discussed above, the MMSEA impacts insurers. The new reporting requirements are designed to close the MSP reporting loop, ensuring that claimants and their counsel alike have satisfied their obligations to verify and resolve Medicare's conditional payment reimbursement claim interests. At the same time, the new reporting requirements have sharp teeth, with a $1,000 per day per beneficiary penalty for non-compliance. And, the MMSEA also allocates $35 million towards assisting the CMS in its compliance activities, which the CMS has been using, in part, to fund regular town hall teleconferences, websites updating, and increasing communications concerning Medicare compliance.

Undeniably, lien resolution is no longer an administrative function that attorneys can address on the back end of cases. Nor is it any longer a subject that parties can address simply with an indemnification clause. Rather, lien resolution has evolved over the last several years into one of the most demanding *preconditions* in a settlement agreement, often requiring counsel to affirmatively notify Medicare and Medicaid, in the case of dual-entitled beneficiaries, depending on state notice statutes, of claimants who are settling their cases, and then proactively to satisfy those agencies' interests before disbursing settlement proceeds to those claimants.

In light of the MMSEA, claimants, defendants, and insurers must communicate and cooperate to make sure that the MMSEA does not add yet another disruptive layer to the already complex, dense, and time-consuming settlement process. With all settlement-related Medicare issues, a proactive rather than reactive approach yields a better result. Integrating claims procedures to verify entitlement with claimants' attorneys, if any, with existing procedures to verify and resolve those subrogation issues will insulate the settling parties from the potentially harsh realities of today's MSP program.

It is equally important to keep from falling into a hysterical trap of believing that the MMSEA does more than add a reporting requirement for insurers and other RREs. The statutory history and recent CMS guidance does not bear out the premature and incorrect missives that the new reporting obligations means Medicare set-asides are required under the law due to Section 111 of the MMSEA. Instead, if parties focus on compliance through collaboration on the reporting end, and analyze cases to identify and quantify Medicare's interests under the law through formalized processes, including implementing standard operating procedures based on CMS guidance, you can settle your cases with confidence that Medicare's recovery interests have been properly addressed without worries that your clients will face double damages and penalties.

However, given the lead time needed to gather the required information, the parties need to start earlier in the settlement process. That is the true meaning of Section 111 of the MMSEA. Simply put, if you know you are going to have to deal with it in the end, why not start addressing it in the beginning? FD