



Executive Summary

Second in a Series

Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA)

In January, we reported that President Bush signed this Act into law on December 29, 2007. At the time of our first report, we only knew with certainty that Congress was determined to enforce the Medicare Secondary Payor (MSP) statute passed in December 1980 (42 U.S.C. 1395y). The essence of the MSP statute was to make Medicare secondary to all other forms of payment for medical treatment and services when a Medicare beneficiary is entitled to health care coverage, no-fault insurance protection, workers' compensation benefits or is the recipient of a liability settlement. The passage of the Extension Act, now commonly referred to as MMSEA, was to achieve three key objectives.

1. To serve 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. To develop 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 wanted Medicare to be notified anytime their secondary status came into play pursuant to the provisions of the MSP statute.
3. To determine methods through which Medicare would remain secondary in the payment priority scheme, even after a settlement had been achieved.

Once signed by President Bush, the Act took immediate effect where conditional payments were concerned. Conditional 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 on both sides of a liability settlement recognize the need to protect Medicare's interests and reimburse Medicare for the conditional payments they made for accident-related treatment and services. This is a concern because failure to protect Medicare's interests can result in the assessment of a double damage penalty. The penalty may be assessed against all parties to a settlement, including the attorneys involved.

Recently, the Centers for Medicare and Medicaid Services (CMS) released their initial draft of proposed rules concerning "Notice". This is the second tier or layer of the process addressed by MMSEA. The proposed rules are neither binding nor final at this time and will 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 health care plans, which will take effect on January 1, 2009. The proposed rules provide the following:

- Effective July 1, 2009, all claims for Non-Group Health Plans (NGHP) must determine if Medicare has any interest [emphasis added] 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 an internal method of determining if a claimant or plaintiff is or will soon be eligible for Medicare benefits.
- If the claimant is or will soon be eligible for Medicare benefits, the insurer or self-insured will be required to electronically report specific information to CMS in a timely manner. Failure to do so could result in a \$1,000 per day penalty being assessed for each day timely notice has not been received. It is interesting to note that while MMSEA provides that all parties have the duty to place Medicare (CMS) on notice, the initial rules recently published seem to place that responsibility only on self-insureds and insurers.

There are 45 data fields (see attached Exhibit A) that CMS is interested in. They are classified as Mandatory, Optional and Situational. This information need only be reported if the claimant/plaintiff is or will soon become Medicare eligible. The initial reporting timeframe has not yet been defined, but reasonable minds could anticipate that reporting will be required once it has been determined the claimant/plaintiff is Medicare eligible and that determination requirement will be held to a reasonable standard. There will be more details to follow in the near future.

- All Non-Group Health Plan (NGHP) settlements (no-fault, workers' compensation, and liability) must discover and resolve conditional payments issues and allocate some portion of the settlement for future expenses that Medicare would otherwise have to pay.

CMS has also recommended a record retention period of 10 years for Medicare Secondary Payor (MSP) related information. This constitutes a change from CMS' prior "required 10 years" to "recommended 10 years" in the last MSP PRA Information Collection submission in July 2005. Absence of related information does not constitute a valid defense against an MSP collection action. Additionally, False Claim Act actions can be brought for 10 years. (Note: PRA refers to the Paperwork Reduction Act)

It is important to reemphasize that Medicare asserts a statutory claim as opposed to a lien. Liens typically attach to a settlement and are the responsibility of the settling party to satisfy. In addition, in most jurisdictions, lien holders are required to place their insured/beneficiary 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 settlement. Quite the opposite is the case. Parties to the settlement must place Medicare on notice of the possibility of a settlement or the presentation of a claim by a Medicare-eligible beneficiary.

Many parties assume that inserting indemnity and hold harmless terms into settlement documents will protect the defendant/insured from Medicare's statutory claim. It will not. Medicare is not a party to the settlement. 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, they may commence a collection action. Some lawyers argue that Medicare does not need to commence their action under the provisions of the federal False Claims Act and may seek their recovery anytime after December 1980 without regard to a statute of limitation. This has not been tested to our knowledge. It

is sufficient to know the government has great latitude and a long arm when seeking recovery of payments made as the secondary payor.

The Department of Health and Human Services (HHS) and the Centers for Medicaid and Medicare Services (CMS) are charged with reducing the amount of paper generated under the Paperwork Reduction Act (PRA) Notice published in the Federal Register, August 1, 2008, (Volume 73, Number 149). All instructions for implementation will appear at www.cms.hhs.gov/MandatoryInsRep. 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 (See www.jeloganltd.com, Resources, Medicare, Medicaid, and SCHIP Extension Act of 2007, pages 15 to 22).

ACRYNOMS AND TERMS:

Federal and state departments are well known for their use of acronyms and unique terms of references. Because of the complicated and broad nature of issues surrounding Medicare we have prepared a Glossary of Terms and Acronyms, attached as Exhibit B. This, of necessity, will remain a work in progress and will be updated as new information is developed and introduced. For the most current copy of this glossary, we recommend you visit the Resources section of our website, www.jeloganltd.com, after October 1, 2008.

CONCLUSION

Notwithstanding the passage of eight months since the initial introduction of MMSEA to the public and claim industry, little more is known today than was known in January. Rules and procedures continue to be explored by CMS. This is not an easy task when one considers the multitude of situations and circumstances that could involve Medicare-eligible claimants/plaintiffs. Just as importantly, MMSEA provides that the obligation to protect Medicare's interests shall be without regard to fault or disputed liability. This gives rise to a new series of questions yet to be answered.

- How will we deal with situations where Medicare's interests are greater than the settlement amount, policy limits or jury award?
- Who will have primary interest (claim) to the settlement proceeds when attorney fees and costs are involved and other lien holders, possibly including Medicaid, are seeking financial recovery from the settlement?
- To what degree will Medicare's interests be protected when a compromise or "nuisance value" settlement is made on a highly disputed liability, no-fault or workers' compensation claim?
- How can a settlement be made "on the courthouse steps" at the eleventh hour before trial if Medicare's interests in the settlement are unknown?

These are questions that must be considered and answered between now and July 1, 2009. Our concern is that with the forthcoming elections in November, we will likely see personnel changes within CMS and the Department of Health and Human Services (HHS). It is possible, with the new administration and change of personnel, rules may be delayed until well after the first of 2009 giving little time to prepare for compliance with CMS requirements.

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Two things are certain:

1. The settling parties must have a system in place that will identify those claimants or plaintiffs who are or will soon be eligible for Medicare benefits.
2. Parties to a settlement are obligated to determine if Medicare has made any accident- or settlement-related conditional payments to or on behalf of Medicare-eligible claimants/plaintiffs. This should be determined as early as possible and well before trial dates approach. To secure this information, the claimant/plaintiff will have to provide a signed authorization acceptable to CMS authorizing the release of information and an inquiry will have to be made to CMS. Turnaround time ranges from 60 to 120 days.

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 must, in every circumstance, protect Medicare or face serious consequences.

James E. Logan & Associates, Ltd. provides settlement-consulting services to clientele across the nation. These services include, but are not limited to, negotiation support, structured settlements, future damage analysis, medical record review, life care planning and life care plan analysis. Our firm has been involved with Medicare issues since 2001 and has gained valuable and extensive experience in this settlement area. We have a special unit devoted to assisting clients to determine if conditional payments have been made. We also assist clients with the development of economical Medicare Set-Aside Allocations (MSA's) and secure rapid CMS approvals. Mr. Logan and his associates are available to assist clients as they develop internal processes and procedures for compliance with the MSP statute and MMSEA.

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For more information or assistance, please contact Jim Logan at 248-865-3900.