

# MEDIATIONS & SETTLEMENTS

## Applicability of the Medicare Secondary Payer Act

By Robert S. Dampf

All attorneys involved in personal injury cases, regardless of whether representing plaintiffs or defendants, need to be aware of the issues presented by the Medicare Secondary Payer Act (MSPA).<sup>1</sup> The essence of the Act is that Medicare has a priority right of recovery for medical bills it has paid in the past and/or might pay in the future on behalf of claimants. The MSPA statute and regulations reflect the congressional intent to shift the burden of coverage from Medicare to private entities in an effort to reduce Medicare costs.<sup>2</sup> Consequently, Medicare in many instances will remain a secondary payer when there is an appropriate “primary payer.”

### Does It Apply in My Case?

Payments made pursuant to workers’ compensation laws and certain third-party payments are primary as to Medicare;

therefore, Medicare only pays as a secondary payer. Workers’ compensation claims include cases involving the Federal Employees’ Compensation Act and the U.S. Longshoreman’s and Harbor Workers’ Compensation Act. Medicare is also a secondary payer for medical expenses covered by accidental injury policies, automobile insurance policies, self-insured entities responsible for accident victims, and any personal injury coverages. Such personal injury coverages include all types of liability insurance, automobile med-pay coverage, and uninsured motorist coverage.<sup>3</sup>

### What is the Critical Determination?

Settlements in a tort or workers’ compensation type of case require Medicare considerations if the settlement involves the payment of any past or future medical bills. There are two circumstances that

trigger Medicare approval. One circumstance arises when the injured party has been both Medicare-eligible since the time of his or her injury, and when the injured person is 65 years of age or older, or has been on Social Security disability for 24 months or longer. If the above criteria have been met, Medicare must approve the settlement.

The second circumstance occurs when a gross settlement exceeds \$250,000, and the injured party has a reasonable expectation of being Medicare-eligible within 30 months. The beneficiary of the medical benefits must cooperate with the Centers for Medicare and Medicaid Services (CMS). If the beneficiary does not cooperate, the CMS may recover from him or her.<sup>4</sup>

### Who Administers This Program?

Originally the Medicare program was managed by the Healthcare Financing

Administration, a unit of the Department of Health and Human Services. The unit has subsequently been renamed the "Centers for Medicare and Medicaid Services" located in Baltimore, Md., with regional offices located around the United States.<sup>5</sup>

### What About Applicable Statutes of Limitations?

There is no statute of limitations that affects this program. The CMS may recover without any regard to claim filing requirements or statute of limitations.<sup>6</sup>

### What Needs to be Done if the Provisions Are Applicable?

Medicare pre-approval is required through the CMS. The CMS literature states that the process takes between 45 and 60 days; however, anecdotal history indicates that this is a bit optimistic. The CMS looks at a number of factors in determining whether to approve the settlement. These factors include the date of entitlement to Medicare, the type and severity of the injury or illness, whether the injured party's condition is stable or whether the party will require serious additional medical care in the future, and the amount of the settlement. Approval is required to preserve the beneficiary's benefits if certain medical expenses exceed projected costs.

### What Happens if Medicare is not Protected?

The beneficiary is responsible for obtaining payments reasonably expected under the workers' compensation or liability scheme. Medicare will not pay future benefits until the beneficiary has exhausted those remedies under the primary payer scheme. Therefore, the plaintiff can lose future Medicare benefits if the approval has not been obtained from the CMS. Additionally, CMS may either file suit against the party that received a payment or against the third-party payer.<sup>7</sup>



*The Medicare Secondary Payer Act and regulations have teeth. Therefore, claims made against defendants could result in a penalty repayment of medical bills after settlement.*

### What About Future Medical Expenses? (The MSA Issue)

The Medicare Set-Aside (MSA) is an arrangement by which future medical expenses and tort-related expenses can be paid, which will satisfy the Medicare Secondary Payer statutes. A MSA is required in situations where the MSPA is applicable. There are a number of private companies that will help establish the MSA. It is strongly suggested that practitioners use the Internet "search engine" available through their computers and research Medicare set-asides for the names of private companies that will assist in creating the Medicare set-aside fund. This will preserve Medicare benefits for their clients and relieve themselves of potential liability. These companies examine a number of relevant factors including the date and nature of the injury, the extent of the injury, the rated age, Medicare entitlement history, a comprehensive review of medical records, and physician recommendations into the future.

### What Happens if Medicare's Interests Are Ignored?

The CMS has a right to file suit against any entity to recover benefits that should have been paid to Medicare, regardless of whether the entity is a beneficiary, provider, supplier, physician, attorney, private insurer, etc.<sup>8</sup> The provisions of the Act clearly apply to both settlements and judgments. Further, Congress has created a private right of action for double damages.<sup>9</sup>

### Structured Settlements

In the establishment of a Medicare set-aside, the parties must satisfy the administrative requirements of the CMS. Structured settlements are allowed pursuant to the CMS rules promulgated in an Oct. 15, 2004, Policy Memorandum. The use of the structured settlement must be approved by the CMS.

### Valuation of the \$250,000 Threshold

The use of a structured settlement may trigger the requirement for an MSA where one would not otherwise be required. As discussed above, one of the circumstances in determining whether the Medicare Secondary Payer Act is applicable is whether or not the gross settlement exceeds \$250,000, and whether the injured party has a reasonable expectation of being Medicare-eligible within 30 months of settlement. The determination of the \$250,000 value is measured by the total to be paid out over the life of the payments, and not by the present value cost of the annuity.<sup>10</sup> Special attention should be paid because this is the one circumstance where the use of a structured settlement can actually be harmful to your client. This is because the use of the structured settlement may trigger the applicability of the statute when a lump sum valuation would not.

## Has This Been Tested in the Courts?

In *United States of America v. Baxter International*, 345 F.3d 866 (11 Cir. 2003), the court was faced with a claim by the government that Medicare had a right of recovery in the class action involving breast implants. In *Baxter, supra*, the parties had resolved the class action lawsuit without protecting Medicare's right of recovery. The United States Court of Appeals determined that Medicare did have a right of recovery. The court also expanded and explained the reach of the Medicare Secondary Payer Act with an excellent discussion of congressional intent and the obligation imposed by the statutory scheme. The court noted the congressional intent of reducing federal health care costs and shifting the burden to those who are rightfully the primary payers. The court also observed that the statutes are complex and have created confusion.<sup>11</sup>

## How Do I Deal with This After Obtaining a Judgment or Participating in a Mediation or Settlement Discussion?

Start by explaining it to the client. There are no options, no exceptions and no prudent alternatives in dealing with the problem. The simplest solution after recognizing the applicability of the problem is mentioned above. Go to the "search engine" and find a company that specifically deals with the set-aside issue. The company will assist you in navigating through this complex medical and Medicare bureaucracy. Under some circumstances, CMS may waive recovery if either the probability of recovery or the amount involved is considered by CMS to be insignificant.<sup>12</sup>

The CMS will consider procurement expenses when certain factors have been met. First, the third-party payment must have been made as a result of a settlement or judgment. Secondly, the procurement

costs (legal fees and expenses) were incurred because the claim was disputed. Lastly, the plaintiff was required to incur this expense in order to obtain a recovery.<sup>13</sup>

## Prepare Ahead

If you are the attorney for either plaintiff or defendant, you must work through the analysis to see if your case is subject to the MSPA.

If the case does fit the criteria, determine what amounts have been paid in the past. Put Medicare on notice of the potential secondary recovery. Then, hire the entity that specializes in computing the amount of the set-aside. Explore with the entity the appropriate funding mechanism.

Be certain that all the parties entering the mediation or negotiation are aware of the issue. They also must realize that each and every one involved will be at risk for penalties if the issue is not resolved.

## Conclusion

The MSPA and regulations have teeth. Therefore, claims made against defendants could result in a penalty repayment of medical bills after settlement. The plaintiff that received the settlement funds is subject to penalties and the lawyers may be as well. Claims may be made against the lawyers and health care providers for recovery of funds paid by Medicare.

A claim made against a defendant may result in a "three-fold" payment of medical bills. One such example occurs when the original settlement with a plaintiff constitutes one payment, and the paying party has been subject to a penalty of two times the medical bills. This would result in the "three-fold" payment.

The plaintiff's counsel should have worked out the set-aside issue prior to a mediation or settlement. This will help the client to understand that the entirety of the settlement fund does not necessarily get "pocketed."

The purpose of the MSPA is to en-

force responsibility for the payment of benefits to private payers under the defined circumstances. It bears repeating — the statutory and regulatory scheme has teeth.

## FOOTNOTES

1. 42 U.S.C. § 1395y (2006).
2. See *United States of America v. Baxter International*, 345 F.3d 866 (11 Cir. 2003).
3. 42 C.F.R. § 411.20 *et seq.* (2006).
4. 42 C.F.R. § 411.23 (2006).
5. Department of Health and Human Services, Centers for Medicare and Medicaid Services, 7500 Security Blvd., Mail Stop C2-21-15, Baltimore, MD 21244-1850.
6. 42 C.F.R. § 411.24 (f) (2006).
7. 42 C.F.R. § 411.37 (2006).
8. See for example, 42 C.F.R. § 411.24 (b), (e) and 42 C.F.R. § 411.26 (2006).
9. 42 U.S.C. § 1395y(b)(3)(A) (2006).
10. See Centers for Medicare and Medicaid Services Memorandum Directive dated 4/22/03, available at <http://new.cms.hhs.gov/WorkersCompAgencyServices/Downloads/42203Memo.rtf>.
11. *Id.* at 875.
12. 42 C.F.R. § 411.28 (2006).
13. 42 C.F.R. § 411.37 (2006).

## ABOUT THE AUTHOR

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