The Medicare Secondary Payer Act: How Does It Impact My Case?

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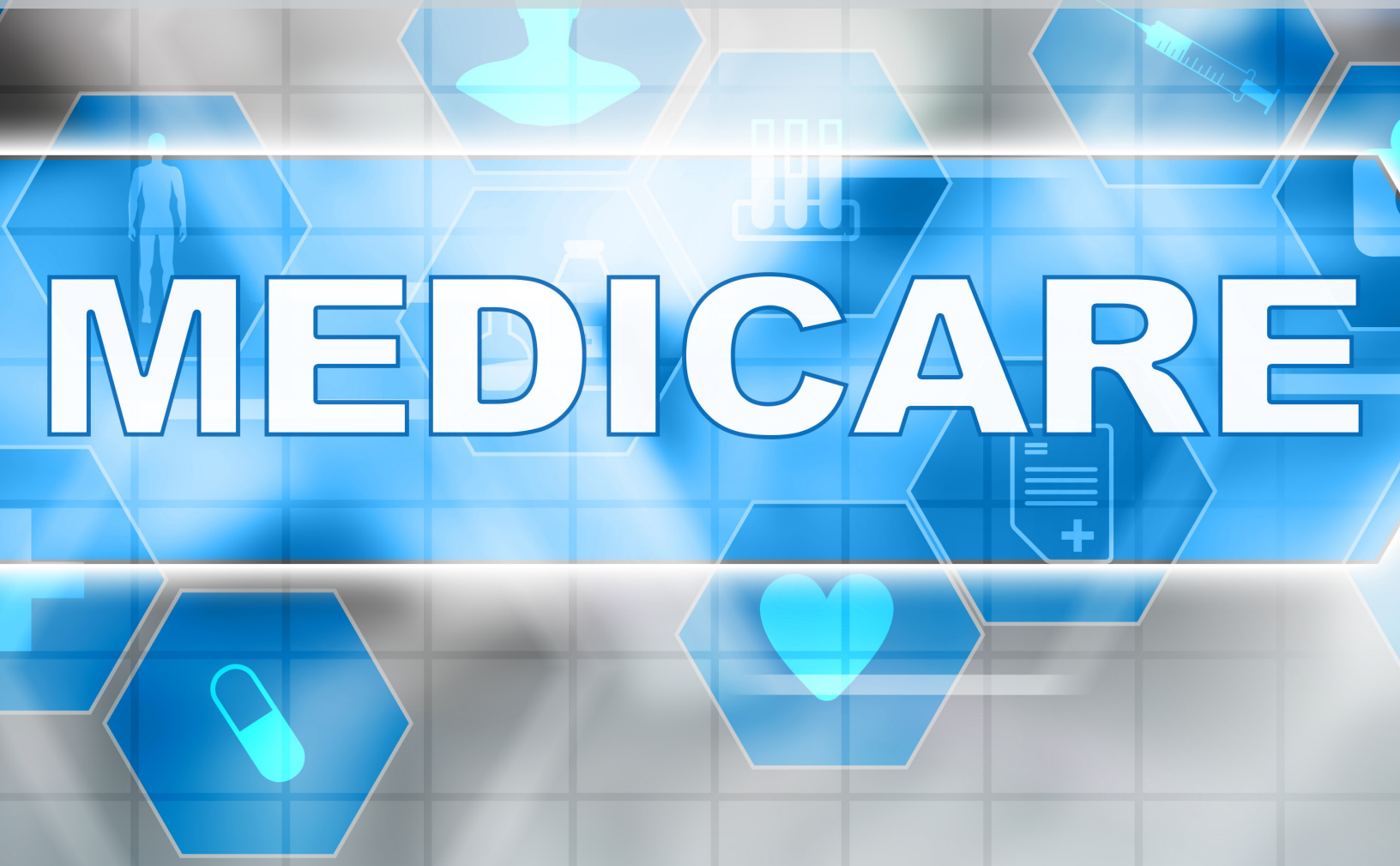

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Solving the Medicare maze

The Medicare Secondary Payer Act: *How Does It Impact My Case?*

In 1980, Congress passed the Medicare Secondary Payer Act, which has been codified under 42 U.S.C. §1395y (b)(2)(A)(ii). While the Act remained largely unenforced for years, the increasing cost of health care and burdens placed on the Medicare Trust Fund caused legal practitioners to take note of the Act in the mid-1990s. In a general sense, the Medicare Secondary Payer Act places an affirmative obligation on parties and persons receiving funds from a Medicare primary plan to consider the interests of Medicare in all workers' compensation, no-fault and liability claims.

In the context of workers' compensation plans, the obligations have been easier to understand. This is based partly on the issuance of policy memoranda from the Centers for Medicare and Medicaid Services (CMS), along with regulations codified in the Code of Federal Regulations. As a result, there has been little dispute over the years that when dealing with a Medicare beneficiary, or someone who likely will receive Medicare benefits in the foreseeable future, that something needs to be done to repay or compromise conditional payments, as well as considering Medicare's future interests. This can be accomplished through a Medicare Set-aside Arrangement (MSA) or similar legal mechanism.[1]

In the context of workers' compensation claims, CMS has advised parties that it will review WCMSA submissions under the following situations:

- If the claimant is a Medicare beneficiary at the time of the settlement **and** the total settlement amount is greater than $25,000; or
- The claimant is not a Medicare beneficiary at the time of settlement, but the total settlement amount is greater than $250,000, **and** there is a "reasonable expectation" of Medicare entitlement within 30 months of the settlement date.

There is a "reasonable expectation" of Medicare entitlement where:

- The claimant is 62 years and 6 months old;
- The claimant is receiving SSDI benefits;
- The claimant has applied for or is appealing a denial of a claim for SSDI benefits; or
- The claimant has End-Stage Renal Disease (ESRD), even though not currently Medicare eligible.[2]

Notwithstanding the clarity in the context of workers' compensation litigation, this area of law is more complex in no-fault or liability claims. Before 2011, all of the CMS policy memoranda setting forth agency policy discussed only workers' compensation claims. The Code of Federal Regulations is also void of specific language regarding these matters. As a result, attorneys are in a legal *Catch-22* regarding Liability Medicare Set-aside Arrangements (LMSAs).

Over the last several years, a growing body of case law suggests Medicare's future interests in no-fault or liability claims are of importance. For example, in *Finke v. Hunter's View*,[3] the attorneys for the parties brought a motion before the district court judge hearing the case regarding, among other things, the issue of considering Medicare's future interests.

Since the *Finke* decision, there has been a significant uptick in litigation involving the use of the federal courts to comply with the Medicare Secondary Payer Act. In *Big R. Towing v. Benoit*,[4] a motion was brought in federal court to "determine future medical expenses for purposes of allocating the settlement proceeds taking Medicare's interests into account consistent with the Medicare Secondary Payor (sic) Act, 22 U.S.C. 1395y."[5]

The Plaintiff, David Benoit, was injured while serving as a captain aboard a towboat in December 2009. Claims were brought under the Jones Act related to his injuries to his back and hip. It was noted that liability and the need for future medical care and treatment were "vigorously contested."[6] Parties have brought similar actions in other jurisdictions, which have virtually been unopposed by CMS.

Since the decision in *Big R. Towing*, Magistrate Judge Patrick Hanna has been involved in several additional cases where Medicare's future interests are at stake. In one recent case example, Judge Hanna determined Medicare's future interests should be scrutinized based on the underlying facts of the case and the overall recovery of the plaintiff/injured party. As a result, he applied the principles of equitable apportionment to Medicare's future interests.[7] This rationale is a significant departure from prior decisions such as *Hadden v. U.S.*, where the Sixth Circuit Court of Appeals expressly rejected these principles in the context of Medicare conditional payment resolution.[8] It is also inconsistent with numerous statements by CMS regarding well-established agency protocols and interpretations of federal regulations governing these matters.[9]

It is also noteworthy that the U.S. Department of Health and Human Services is in the process of implementing permanent rules regarding Medicare's interests in no-fault and liability claims through an Advance Notice of Proposed Rulemaking (ANPRM), which is titled CMS-6047-ANPRM, *Medicare Secondary Payer, and Future Medicals.*[10] One option under consideration in the ANPRM included merging the existing WCMSA submission process to include a review of LMSAs.

CMS has also been active in providing agency comments regarding the use of LMSAs. In early 2011, Sally Stalcup, the MSP Regional Coordinator for CMS's Region VI (Dallas) office, offered an opinion on the matter, which stated, "Medicare's interests must be protected; however, CMS does not mandate a specific mechanism to protect those interest. The law does not require a 'set-aside' in any situation. The law requires that the Medicare Trust Funds be protected from payment for future services, whether a Workers' Compensation or liability case. There is no distinction in the law."[11] The issuance of this policy interpretation was later followed by a more widely circulated memorandum authored by Charlotte Benson on September 29, 2011, which reiterated CMS support for the use of LMSAs.

Notwithstanding the current lack of federal regulations regarding no-fault or liability claims under the Medicare Secondary Payer Act, cases such as *Hadden* and *U.S. v. Stricker*,[12] suggest CMS is ramping up enforcement efforts of these claims. Attorneys seeking to be proactive on these issues for their client(s) should consider an LMSA or similar legal mechanism in the following instances:

- Cases where a Life Care Plan was included;
- Combined workers' compensation/liability claims;
- Catastrophic injury cases (e.g., amputations, traumatic brain injuries, injuries including a psychological component);
- Settlements that include a structured settlement; or
- Any case in which future medical treatment is expected to continue.

The issue of Medicare's future interests in workers' compensation, no-fault and liability cases is a hot-button topic that dominates our legal community. Regardless of your position on the issue of an MSA, it is essential to remember that each case needs to be analyzed on its own merits, and attorneys should explain all possible adverse ramifications to their clients.

About the Author

Aaron Frederickson has practiced law since 2002 and is licensed in Minnesota, Wisconsin, and the federal courts. He gained his initial experience in Medicare Secondary Payer compliance by litigating countless cases in workers' compensation law and civil litigation. Aaron serves a diverse client base on numerous Medicare compliance matters and currently concentrates his work on state and federal regulatory matters. Aaron is active in several groups and organizations regarding Medicare and government regulatory matters, including the National Alliance of Medicare Set-Aside Professionals (NAMSAP) and the Hennepin County Bar Association. He can be contacted at (651) 485-7036 or aaron@mspComplianceSolutions.com.

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[1] The Workers' Compensation Medicare Set-aside submission process is referred to as a "WCMSA."
[2] CMS Policy Memorandum, May 11, 2011. The MSA submission process is never required, and is voluntary. As of July 10, 2017, CMS does not recognize previous guidance not incorporated into the Workers' Compensation Medicare Set-Aside Arrangement Reference Guide.
[3] 2009 U.S. Dist. LEXIS 126830 (D. Minn. 2009).
[4] 2011 U.S. Dist. LEXIS 1392 (W. Dist. La. 2011).
[5] *Id.*, at 1.
[6] *Id.*
[7] *Benoit v. Neustrom*, 2013 U.S. Dist. LEXIS 55971 (W. Dist. La. 2013). In *Benoit*, it was determined that Medicare's future interests should be apportioned using the percentage of the recovery obtained.
[8] *Hadden v. U.S.*, 661 F.3d 298 (6th Cir. 2011), *writ of certiorari denied, Hadden v. U.S.*, 133 S. Ct. 106 (2012).
[9] CMS Policy Memorandum dated, July 11, 2015, Q. 11, p.5.
[10] https://www.federalregister.gov/articles/2012/06/15/2012-14678/medicare-program-medicare-secondary-payer-and-future-medicals
[11] This undated memorandum was directed to Medicare beneficiaries in the states of Oklahoma, Texas, New Mexico, Louisiana and Arkansas. It has since been cited in a number of federal district court cases in these states as controlling authority.
[12] 2010 U.S. Dist. LEXIS 106981, CV 09-BE-2423-E, (E. Ala. 2010).

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