FERRERI PARTNERS
PLLC, Attorneys at Law

MEDICARE SECONDARY PAYER
42 U.S.C. 1395y

WHAT IS THE PROBLEM?

A 1999 GAO Study revealed the Federal Government paid $40 billion for medical care in cases where Medicare was a secondary payer. The purposes of the Medicare Coordination of Benefits (COB) program are to identify the health benefits available to a Medicare beneficiary and to coordinate the payment process to prevent mistaken payment of Medicare benefits. The intent of Congress is to reduce federal spending and to protect Medicare's financial integrity by expanding its recovery rights. Federal law takes precedence over State law, and thus Medicare is the secondary payer regardless of state law or plan provisions.

WHAT IS CMS?

The Centers for Medicare and Medicaid Services (CMS) is the federal agency that runs the Medicare program. The CMS has Regional Offices (ROs) in ten major cities throughout the United States, in addition to the main office in Baltimore, Maryland. The ROs make sure all proposed set-aside arrangements take Medicare's interests into consideration.

WHAT IS A CONDITIONAL PAYMENT?

Conditional payments are the total dollar amount of payments Medicare has made to providers and physicians for claims identified to be related to the treatment of the injury/illness for which a third party payer is responsible. Medicare may pay for a beneficiary's covered medical expenses conditioned on **reimbursement** to Medicare from proceeds received pursuant to a third patty liability settlement or judgment. This conditional payment is made if it is determined that the primary insurer will not pay "promptly." "Promptly" means 120 days from the date the claim is filed or the date the covered medical service was furnished. Once a beneficiary has received payment from a primary plan, a signed settlement agreement/release and Claimants' Attorney's fee agreement and ledger sheet of costs must be submitted to the lead contractor assigned by the regional office. The contractor will issue an "initial determination" which contains: the amount to be reimbursed to Medicare from the settlement and information on appeal and waiver rights. A final claim amount cannot be issued until final settlement has taken place, however, conditional payment amounts can be requested to provide up-to-date figures of how much Medicare has paid. Medicare's claim for reimbursement (final demand amount) must be paid up front out of settlement proceeds before any distribution occurs, within 60 days of receipt of proceeds from the third party, following which interest will be assessed. If repayment is not received within the 60 day time frame, the debt will be referred to the Department of Treasury for collection and pursuit.

WHAT IS A MEDICARE SET-ASIDE ALLOCATION?

A Medicare Set Aside is the designation of a portion of a workers' compensation settlement of future medical expenses that would normally be covered by Medicare. The amount of the allocation is determined through the analysis of medical reports and records of the particular case and must be approved by CMS. An account is created in the settlement of an individual's worker's compensation claim that is used to pay for future medical expenses that are attributable to an individual's work injury and that would otherwise be covered under Medicare.

WHEN IS A SET-ASIDE ARRANGEMENT NECESSARY?

SSDI benefits do not begin until 5 months after disability date. Eligibility effective 24 months after the individual's commencement of SSDI benefits. Thus, Medicare entitlement takes place 29 months after the date of disability.

A Medicare set-aside arrangement is necessary any time the parties to a settlement are attempting to close-out liability by the primary payer for future medical expenses (commutation) if:

- Claimant is entitled to Medicare (Part A, B, or both) REGARDLESS of the settlement amount; **OR**
  A claimant is entitled to Medicare if they meet one of the following:
  1. 65 years old ;
  2. Receiving Social Security Disability for 24 months;
  3. End stage renal disease

- Claimant has a "reasonable expectation" of Medicare enrollment within 30 months of the settlement date AND a total settlement of greater than $250,000.00. When calculating whether or not your settlement will exceed the $250,000.00 threshold amount, the following applies: in a situation where there has been a prior settlement agreement, you must include ALL benefits paid out as part of that previous agreement, including income benefits, attorneys' fees, consideration for waivers of the right to reopen, vocational rehab, etc., and all medical expenses paid to date; if there has not been a previous settlement agreement, then you only have to consider what is being paid out under the settlement agreement. Until the individual actually becomes entitled to Medicare, funding for an approved WC Medicare Set-aside arrangement must not be used to pay the claimant's medical expenses.

- Medicare issued a memorandum on April25, 2006 advising that CMS will only review new workers' compensation Medicare Set-Aside proposals where the total settlement amount exceeds $25,000.00. Even if the claimant is Medicare eligible, formal approval by CMS is not mandatory if the total settlement amount is less than $25,000.00. CMS emphasized that this amount is a workload review threshold and not a "safe harbor" threshold, meaning that Medicare's interests must still be considered if claimant is a Medicare beneficiary to ensure that Medicare is secondary to workers' compensation in such cases. The computation of the $25,000.00 amount should include income benefits, attorney fees, all future medical expenses (including prescription drugs) and repayment of any Medicare conditional payments, assuming that there has not been a previous settlement agreement(s) for the claim. If there was a prior settlement agreement(s), then any prior amounts paid out must also be included in calculating the total settlement amount.

Some examples of a reasonable expectation of Medicare enrollment within 30 months are as follows:

- The claimant has applied for Social Security Disability benefits
- The claimant is in the process of appealing or re-filing for Social Security Disability benefits
- The claimant is at least 62 years and 6 months old

If both of the threshold criteria are not met in a settlement involving an individual who is not yet enrolled in Medicare, a CMS-approved Medicare set-aside arrangement is not necessary and Medicare will make payments for workers' compensation related services that are otherwise reimbursable under Medicare once the individual enrolls in Medicare even when funds still remain in the individual's settlement. The CMS will honor threshold levels in effect as of the date of the workers' compensation settlement. Before finalizing a workers' compensation settlement, you should check both the CMS website and the appropriate CMS RO contact to make sure the review thresholds have not changed since they are subject to adjustment.

WHAT ARE MEDICARE BENEFIT ELIGIBILITY REQUIREMENTS?

An individual is eligible to receive Medicare benefits for certain medical and hospital expenses if they meet one of the following criteria:

- Received their Medicare card
- Are 65 years of age or older;
- Have been receiving Social Security Disability benefits for at least twenty-four (24) months; or
- Are suffering from end-stage renal disease.

WHAT IF MEDICARE IS NOT INVOLVED IN SETTLEMENT OF FUTURE MEDICAL BENEFITS?

Lump Sum

- Medicare does not pay until beneficiary has exhausted the entire lump sum on Medicare covered services

Scheduled payments

- Medicare does not pay until the scheduled payment for the designated time period has been exhausted on Medicare covered services

WHAT IS MEDICARE'S RIGHT TO REIMBURSEMENT FOR PAST CONDITIONAL PAYMENTS?

Pursuant to 42 C.P.R. Section 411.24(b), CMS may initiate recovery upon learning that payment has been made or could have been made under workers' compensation from the beneficiary, the attorney for the beneficiary, or the third party primarily liable. As to the amount of recovery allowable, if CMS does NOT have to take legal action to recover, CMS can recover the lesser of the following:
(1) the amount of the Medicare primary payment; or
(2) the full primary payment amount that the primary payer is obligated to pay.
However, if legal action is undertaken by CMS, CMS may recover double the amount of the payment Medicare made as a primary payer.

WHAT IS MY RESPONSIBILITY AS AN ATTORNEY?

According to CMS, you must: (l) immediately, upon taking a case that involves a Medicare beneficiary, inform the COB Contractor about a potential liability lawsuit, and (2) contact the assigned lead contractor regarding Medicare's interest in a liability, auto/no-fault, or workers' compensation lawsuit, and determine if any conditional payments were made.

WHAT IS MY RESPONSIBILITY AS AN INSURER?

According to CMS, you must contact the COB Contractor immediately when the Claimant is a Medicare beneficiary. Contact the Coordination of Benefits Contractor (COBC) at the following address:
CMS
c/o Coordination of Benefits Contractor P. 0. Box 33849
Detroit, MI 48232-5849
-or-
1-800-999-1118

Once you have notified the COBC, a lead contractor will be assigned and all further inquiries are made through the lead contractor.

WHERE DO I SEND A WCMSA PROPOSAL?

Beginning on May l, 2004, all WCMSA proposals submitted for review by CMS's Regional Offices must be sent to a national, centralized point of receipt at: Centers for Medicare and Medicaid Services, c/o Coordination of Benefits Contractor, Attention: WCMSA Proposal, Post Office Box 33849, Detroit, Michigan 48232. Any WCMSA proposal received in CMS's Regional Offices on or after May I, 2004, will be forwarded to the Coordination of Benefits Contractor for entry into the centralized database with approval being the responsibility of the appropriate Regional Office.

HOW DO I FUND A MSA ACCOUNT?

Several methods can be utilized to fund a set-aside. Specifically, a MSA can be funded via a lump sum payment, a structured settlement annuity, or a combination of both. If the set-aside is exhausted between annuity payments, Medicare will step in and pay for qualified medical expenses until the release of the next annuity payment.

HOW IS A MSA ACCOUNT ADMINISTERED?

A MSA account can be self-administered by the injured worker, a custodian or guardian. A MSA account can also be administered by a third party administrator. The account must be an interest-bearing FDIC-insured account and the administrator of the account should only allow distribution for those medical expenses related to the work injury that would otherwise be covered by Medicare. The administrator will also have to provide CMS (through the lead contractor) with an annual accounting of the expenditures from the account.

MEDICARE, MEDICAID, AND SCHIP EXTENSION ACT (MMSEA)

Section 111 of MMSEA, which became effective on July 1, 2009, requires liability insurance (including self-insurance) plans, no fault insurance plans, and workers' compensation laws or plans to report a claim involving a Medicare beneficiary to CMS. It is the primary payer's, or Responsible Reporting Entity's (RRE), responsibility to establish whether the claimant is a Medicare beneficiary. The RRE must report the claim to the COBC when the injured party is a Medicare beneficiary and medicals are claimed and/or released, or a settlement, judgment, award, or other payment has the effect of releasing medicals. Claim information is reported after On-going Responsibility for Medical Payments (ORM) has been assumed by the RRE or after a Total Payment Obligation to the Claimant (TPOC) settlement, judgment, award or other payment has occurred. The penalty for non-compliance with Section 111 is steep, $1,000 per day for each day of non-compliance with respect to each claimant in addition to any other applicable penalties prescribed by law. CMS released a several hundred-page User Guide which can be obtained by going to https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Non-Group-Health-Plans/NGHP-User-Guide/NGHP-User-Guide.html.