
# LIEN ON ME

**A Guide to Complying with Medicare's Secondary Payor Act and Pennsylvania's Act 44**

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## Introduction

Medicare's **2007 Reporting Extension Act** amended the "Medicare Secondary Payer Statute," 42 U.S.C.§1395, to expand Medicare's ability to seek reimbursement for payments made to recipients from those responsible for injuring the recipients, including a liability insurer, workers compensation carrier and an uninsured tortfeasor. **Most significant is the July 1, 2009 implementation date for liability insurance, including self-insurance, no-fault insurance and workers compensation carriers to be registered on line with Centers for Medicare & Medicaid Services (CMS) at www.cms.hhs.gov/MandatoryInsRep so that mandatory reporting may begin. Registration will be open from May 1 through June 30, 2009.**

The amendment also allows Medicare to recover for future payments (Medicare Set-Asides) which may occur when a recipient is under or expected to have continuing care associated with the injury attributed to the tortfeasor. The expanded definition, coupled with a six (6) year statute of limitation for Medicare to bring a recovery action has placed pressure on counsel, insurers, carriers and TPA's to satisfy a Medicare lien before closing the books on a claim.

The **Commonwealth of Pennsylvania** recently followed the Federal government's lead in amending its "Medical Assistance Third Party Liability Law," commonly known as **Act 44**, to expand the Commonwealth's Department of Public Welfare's (DPW) right to recover payments made to its recipients **filing personal injury lawsuits on or after September 8, 2008.** Act 44 places a new burden on claims adjusters, insurers, insureds and their counsel to ensure DPW is repaid.

Monetary penalties may be imposed upon any involved party for failure to comply. Therefore, we recommend early discovery of any lien and proactive intervention with Medicare or PA DPW.

Based upon a review of the laws, regulations, guidelines and case law, we have put together the following summaries to be used as a guide to understanding the parameters of each law, as well as to provide a feasible manner to comply with each law so that once the claim settles, there is no threat of future litigation by Medicare or PA DPW. As with any guide, it is not all encompassing. You may encounter a situation requiring our advice and assistance and we encourage you to ask us for advice and guidance.

## Highlights of the Secondary Payor Act

- The general premise underlying the **Secondary Payor Act** is that Medicare wants to be reimbursed for money it has paid. Therefore, all parties to a settlement are potentially liable to Medicare for payment of Plaintiff's claim related treatment when there is a **primary payor**.

- Medicare **defines primary payor** as a liability insurer, workers' compensation insurers or a self-insured entity which provide liability insurance, no fault insurance, automobile insurance and/or workers compensation insurance.

- A person is Medicare eligible beginning at age 65 or if he/she has been on Social Security Disability for 24 months or longer or is in end stage renal failure.

- The Medicare program is administered by the "Center for Medicare and Medicaid Services (**CMS**)".

- For workers compensation claims, Medicare's right to recovery begins once benefit payments start.

- For liability claims, Medicare's right to recovery begins as soon as payment is made. Any payment by a tortfeasor constitutes a primary plan's payment regardless of whether there has been a determination of liability. Defense verdicts obviously negate any right Medicare has to recovery.

- Though not specifically noted in the statute, a payment from a medical payment provision may be interpreted by Medicare as a benefit payment triggering Medicare's right to recovery.

- Medicare seeks protection for projected Medicare covered medical and prescription drug payments Plaintiff will need in the future as a result of the claim related injury over his life span, **Medicare Set-Asides ( MSA's). MSA thresholds for workers compensation claims are defined**. **MSA thresholds for liability claims** are **not defined**.

- Medicare will be using a **web- based "query" system** for primary payors to verify which claimants are eligible and to monitor payments.

- Self-insured and insurance companies are **required to report** all judgments, awards or settlements to the Department of Health and Human Services (HHS).

- All insurance companies and self-insureds must be registered with HHS.

- Medicare can recover the entire award of settlement as reimbursement despite the fact that a settlement agreement characterizes a portion of medical treatment as preexisting conditions or conditions otherwise not related to the accident. In addition, Medicare can initiate a recovery action against any and all parties to a settlement if payment had been made or could have been made under a primary plan. The amount of recovery in such action can either be the amount of Medicare's payment or **double** the amount of the payment depending upon the circumstances.

- Medicare has the authority to compromise claims of less than $100,000. Medicare will consider the following factors when compromising a reimbursement:

1. A debtor's inability to pay;

2. The government's inability to collect in a prompt manner;

3. The cost of collecting a debt versus the cost of collecting the full amount; and

4. The existence of significant doubt as to the government's ability to prove its case in court.

**Reporting Requirements**

- From May 1 through June 30, 2009, a primary payor must register at www.cms.hhs.gov/mandatoryinsRep to designate its mandatory "Responsible Reporting Agent" **(RRE**).

- Beginning July 1, 2009, liability insurance, workers compensation and self-insured carriers **will be required to verify a Plaintiff's benefit status and make a timely report to HHS of any settlement, judgment or award made to a Medicare eligible Plaintiff.** July 1, 2009 also begins the testing phase of the implementation process, including a compilation of required information for the initial report to **CMS** by each **RRE** until December 31, 2009.

- First reporting will be from September 1, 2009 through December 31, 2009. Quarterly reports will be made after December 31, 2009.

- A $1,000 per claim per day penalty can be imposed for non-compliance.

- In addition to registering on-line, the RRE must notify Medicare of a beneficiary's 3rd party claim by calling "Coordination of Benefits Contractor" **(COBC)** at 1-800-999-1188 and writing to:

  MSPRC Liability (For 3rd party liability claims)
  P.O. Box 33828
  Detroit, MI 48232-5828

  or

  MSPRC WC (For workers compensation claims)
  P.O. Box 33831
  Detroit, MI 48232-5831

- Correspondence to MSPRC must include all identifying information of the Plaintiff, counsel, insurance carrier and clam number.

- www.MSPRC.com has been set up by HHS to provide information.

**Settlements**

- **Medicare must approve a settlement before checks are issued. Please wait to obtain a final letter of demand before issuing checks.**

- A primary payor cannot make payment to anyone other than the appropriate reimbursement entity.

**Medicare Set-Asides**

- **A set-aside is a projection of the Medicare covered medical expenses for treatment and prescription medications only that a Plaintiff will be required to have as a result of an injury for which a claim is being made.**

- Medicare must approve the set-aside before settlement can be completed.

- Statutory **thresholds have been established for workers compensation**:

    - claimants currently receiving Medicare benefits **with a settlement in excess of $25,000 must have a set-aside approved**

    - claimants who will expect to receive Medicare within 30 months of the settlement of their workers compensation case and **settlement exceeds $250,000** must obtain approval. Please note, this category of claimants may include someone 62 ½ year old, someone who has applied for SSD or appealing an SSD decisions.

- There are **no statutory thresholds for liability actions.** Medicare has publically claimed scrutiny will be paid to liability actions with "substantial" settlements, judgments, awards or in cases in which there is going to be obvious ongoing medical care. A regional office will determine if it will process the set-aside. Therefore, always obtain a letter confirming or denying Medicare decision on a set-aside.

**Release Language**

- Characterizing a settlement as payment for non-injury exposes a insurer because Medicare can require reimbursement for treatment it provided to the injured Plaintiff.

- A protective clause in a settlement agreement stating the plaintiff will pay Medicare or indemnify the defendant or insurer will not protect the defendant or insurer when the plaintiff has no money to pay Medicare directly.

- Medicare's right to reimbursement is independent of a subrogation right to medical payment due to a Medicare beneficiary. Therefore a insurer's healthcare contract which precludes any Medicare recovery have not been enforced by courts.

- **Medicare's interests as a secondary payor should be included in all releases and must be included when the settlement involves a set-aside.**

**Medicare Statutes of Limitation**

- Medicare has six years to sue for recovery of secondary payments after the right of the action accrues. **Please note that the beneficiary and the insurer have a duty to inform Medicare of its potential right to reimbursement.**

- When a claims filing deadline has been established, Medicare has one year from the date on which that notification is sent to the insurance carrier to file a claim for recovery.

- Medicare has three years from the date on which an item of service was furnished to seek recovery in the absence of an insurer's claim filing deadline.

- When Medicare is forced to file suit to recover its payments, beneficiaries and primary plans are exposed to paying interest on the amount of the reimbursement, as well as double Medicare's conditional payments. Interest accrues 60 days from the primary plan's payment to the beneficiary though in practice the manual for Medicare's contractors describes interest being charged 60 days from Medicare's final demand.

**Protecting your Assets until the Lien is Satisfied**

- We suggest setting aside an estimated amount of Medicare payment. While the Defendant and insurer cannot close their books on a claim for several months after settlement, we believe this is the safest way to ensure that the Defendant and/or insurer is not penalized at a later time. Defendants and insurers should, therefore, establish a claim with Medicare as soon as possible and request updates of the calculations of the benefits paid by Medicare to ensure the set aside is adequate.

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**Understanding Pennsylvania's DPW, Act 44**

- DPW is available to Pennsylvania residence age 65 and older, blind and disabled, families with children under 21 who meet certain income and household sizes and people 59-64 who are temporarily disabled with limited income or special circumstances.

- Pennsylvania's medical assistance requires notification regarding possible liens for **any lawsuit filed on or after September 2, 2008.** The change in the law expands the burden to work with DPW to the third party tortfeasor, its insurer and/or agent.

- DPW now has the option of suing the liable third parties separately **or** asserting a claim against the money owed by the third party in a tort claim brought by the medical assistance recipient.

- If a third party, insurer and/or its agent does not comply with the law, DPW will impose monetary penalties.

- Parents may now recover medical expenses on behalf of their minor child up until the child reaches 18 years old, which could be after the statute of limitations on the parents' claim has expired.

- Plaintiff may opt out of seeking recovery for medical payments made by DPW. Act 44 refers to this as a "negative election." The "negative election **does not let Defendants and their insurance carriers off the hook!** Instead, in exchange for making a negative election, Plaintiff is required to allow DPW to intervene in the lawsuit on its own behalf, provide DPW with all discovery, testimony on behalf of DPW and **agree not to indemnify the Defendant** for legal expenses associated with defending the DPW claim. DPW may fine the recipient up to $5,000 if the he/she does not follow the procedure for making the election.

**Mandatory Notification Requirements**

- First establish whether the Plaintiff is receiving PA public assistance.

- Once PA public assistance is established, third party tortfeasor and/or insurer and its representative have duty to place DPW on notice the lawsuit.

- Notice of a lawsuit, settlement and any election made by the recipient must be made in writing and sent by **certified** or **registered** mail to:

  Division of Third-Party Liability
  Department of Public Welfare
  P.O. Box 8486
  Harrisburg, PA 17105

- Notification should include:

  1. The name of the DPW recipient;
  2. His/her medical assistance identification number;
  3. The recipient's date of birth;
  4. The name of the recipient's attorney;
  5. The insurance carriers and claims numbers and
  6. The court term and number of the pending lawsuit.

**Failure to provide any of this information may result in a $5,000 fine to either the recipient, the defendant or the defendant's insurance company.**

**Settlements**

- Plaintiff may not settle or release DPW's claim against a third party or its insurer with out DPW's **written** consent.

- DPW's claim must be resolved before any indemnification agreement is signed between the recipient and a defendant or its insurance carrier.

- Third parties or its insurers may obtain a written statement from DPW has no claim against settlement.

**Issuing Checks**

- The third party or its insurer may issue a separate check to DPW or make DPW a payee along with Plaintiff on a settlement draft.

Please feel free to contact any of the following partners should you care to discuss this topic in further detail.

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