

Workplace Injuries

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To Recover Millions
It Has Paid on Behalf of
Medicare Beneficiaries

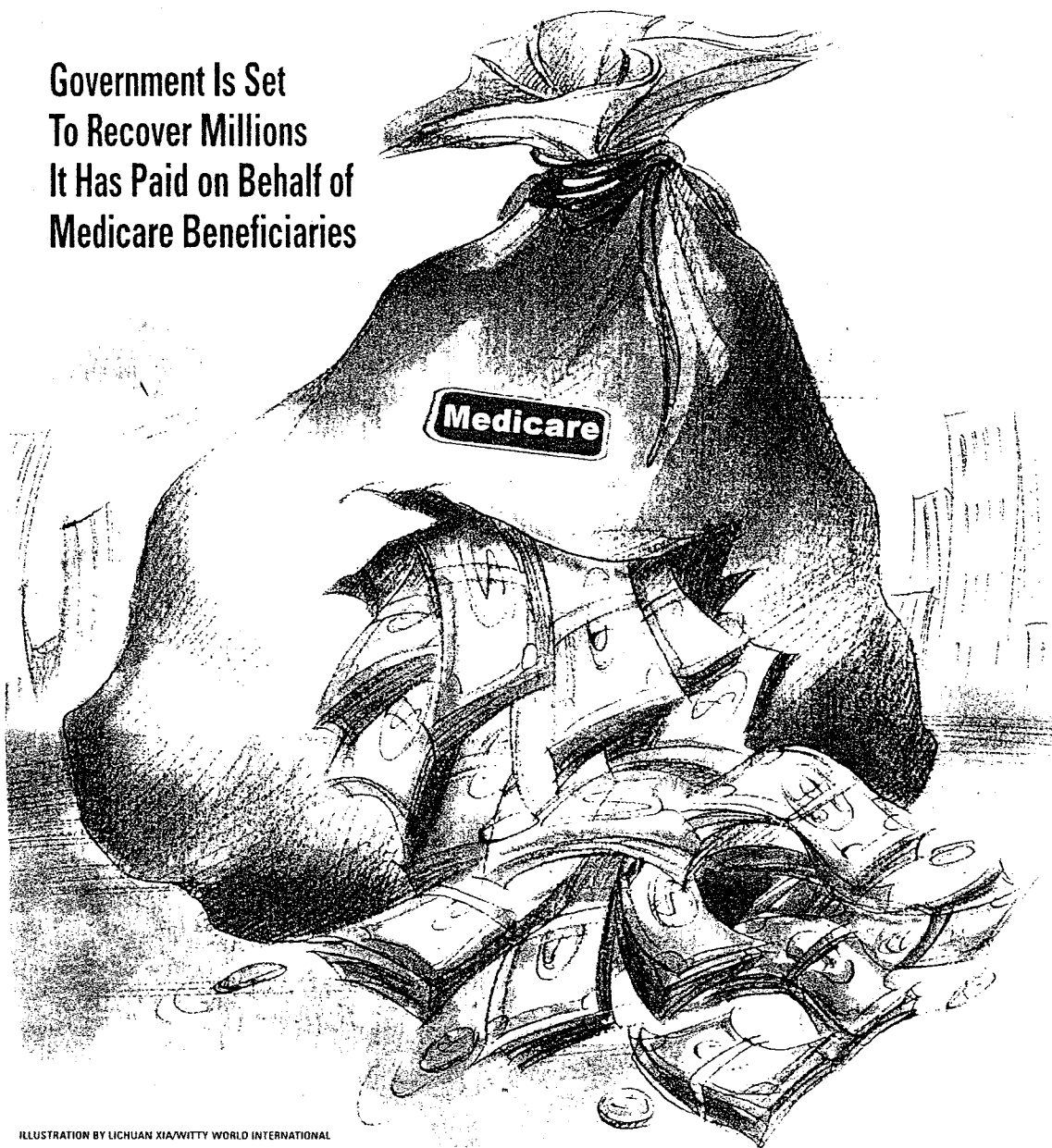


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WORKPLACE INJURIES

The Expanding Reach of the Medicare Secondary Payer Statute

The government is set to recover from insurance carriers for medical bills it has paid on behalf of Medicare beneficiaries

By Robert T. Lewis

A Sept. 15 decision by the Eleventh U.S. Circuit Court of Appeals demonstrates the government's intent to pursue claims impacted by the Medicare Secondary Payer Statute and expands the reach of the statute outside of workers' compensation and into the realm of civil litigation.

The decision in *United States of America v. Baxter International et al.*, 2003 U.S. App. LEXIS 19067, applied the MSP statute to a class-action products liability suit.

Baxter arose out of a 1995 class-action products liability suit against manufacturers of silicone breast implants.

The settlement in that suit resulted in the creation of a reimbursement mechanism by which several manufacturers agreed to cover health care expenses incurred by qualified members of the class.

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Pursuant to the MSP statute, the government sought to recover for medical bills it paid on behalf of Medicare beneficiaries who received treatment related to the silicone breast implants. Initially, the district court dismissed the government's complaint for failure to state a claim. However, the Eleventh Circuit reversed and remanded the case.

Medicare and the MSP Statute

In order to understand the implications of the *Baxter* decision, it is important to begin with a basic understanding of Medicare and the MSP statute. Medicare is a health insurance program that covers nearly 40 million Americans. It is available for people 65 years of age and older, some disabled people under 65 years of age and people with End-Stage Renal Disease (permanent kidney failure treated with dialysis or a transplant).

Medicare is administered by the Center for Medicare and Medicaid Services (CMS). There are ten CMS regional offices throughout the United States. They include: Boston, New York, Philadelphia, Atlanta, Chicago, Dallas, Kansas City, Denver, San Francisco and Seattle. New Jersey claims are administered through the Atlanta regional office.

The MSP statute provides that CMS may pursue damages against any person or entity that attempts to shift

the burden of medical costs to Medicare. The purpose of the MSP statute is to ensure Medicare is only secondarily responsible for payment of medical expenses for Medicare beneficiaries who were also covered by another type of insurance. The provisions of the MSP statute may be found at 42 U.S.C. §1395y (b).

The MSP provides that Medicare does not pay for any services for which payment has been made or can reasonably be expected to be made promptly "under a workmen's compensation law or plan of the United States or a State or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance." See 42 U.S.C. §1395y (b)(2)(A)(i)(ii).

Therefore, the insurance carrier is considered the "primary plan" and Medicare is considered the "secondary plan" for the payment of *injury-related medical expenses*.

Under the MSP statute, CMS has the right to seek reimbursement of medical expenses paid by Medicare that the insurance carrier should have paid. *Id.* 42 U.S.C. §1395y (b)(2)(B)(i)(ii)(iii). Additionally, the MSP statute provides for a private cause of action for double damages against the insurance carrier for failure to provide primary payment or appropriate reimbursement. *Id.* 42 U.S.C. §1395y (b)(3)(A).

The rationale behind the MSP statute was explained by the court in *Baxter*: the MSP statute is a "collection of statutory provisions codified during the 1980s with the intention of reducing federal health care costs." See *Zinman v. Shalala*, 67 F.3d 841, 845 (9th Cir. 1995).

The court in *Baxter* also noted that since enactment of the MSP statute, "Congress has expanded its reach several times, making Medicare secondary to a greater array of primary coverage sources, and creating a larger spectrum of beneficiaries who no longer may look to Medicare as their primary source of coverage."

In a nutshell, the government wants to avoid the shifting of responsibility for medical treatment from the primary payer to Medicare. If CMS believes that the settling parties "shifted the responsibility to Medicare" they will not recognize the terms of the state settlement.

This has become an increasingly important issue as CMS has stepped up its identification and enforcement procedures. This policy is evident in the memos published by CMS on July 23, 2001, April 22, 2003, and May 23, 2003.

The *Baxter* court noted that studies have shown that failure to follow the MSP statute "is costing the taxpayer billions of dollars."

Considering the government's need to prevent financial leaks and the increased efforts at identification and enforcement, it is critical to understand this statute and ensure compliance.

When Must Medicare Be Considered?

Consideration should be given to Medicare's interest whenever entering into a settlement that closes future medical benefits and *either* of the following conditions apply. [Please note that the May 23, 2003 Memorandum, Page 1, states: "the current review thresholds are subject to adjustment. The CMS reserves the right to modify or eliminate its review criteria if it determines that Medicare's interests are not being protected."]

(1) *The petitioner is Medicare eligible — regardless of amount.* See July 23, 2001 memorandum.

A petitioner is Medicare eligible if he or she is: (a) 65 years or older; or (b) on Social Security Disability for 24 months or longer; or (c) suffering from End-Stage Renal Disorder.

(2) *The petitioner has a "reasonable expectation" of becoming a*

Medicare beneficiary within 30 months of the date of settlement and the anticipated amount of the settlement, including indemnity, is expected to be greater than \$250,000.

An individual would have a reasonable expectation of becoming a Medicare beneficiary if any of the following factors apply: (i) the individual has applied for Social Security Disability Benefits; or (ii) the individual has been denied Social Security Disability Benefits but anticipates appealing that decision; or (iii) the individual is in the process of appealing and/or re-filing for Social Security Disability Benefits; or (iv) the individual is 62 years and 6 months old (i.e., may be eligible for Medicare based upon his/her age within 30 months); or (v) the individual has an End-Stage Renal Disease condition but does not yet qualify for Medicare based upon the disease.

Ensuring Compliance

Recommendations for compliance are based on the author's experience in obtaining Medicare approval in workers' compensation claims. The decision in *Baxter*, however, makes it clear that similar protective measures should be considered in any civil litigation where the proposed settlement falls within any of the above criteria.

Attorneys must consider *both* future injury-related Medicare payments and past injury-related Medicare payments prior to settlement of the claim.

With regard to future injury-related Medicare payments, this will often require the establishment of a Medicare Set-Aside arrangement.

MSA arrangements are designed to "set-aside" a portion of the settlement for payment of future medical expenses. The expenses must be related to the workers' compensation injury and must be of the type typically covered by Medicare.

An approved MSA is the preferred method to close future medical benefits for the carrier and still preserve a petitioner's rights under Medicare for future medical treatment.

The MSA may be professionally or

self-administered and may be funded with either a lump sum or an annuity. These are decisions that must be made on a case-by-case basis.

Once the fund is depleted, the beneficiary becomes eligible for Medicare to pay ongoing future medical expenses. CMS has stated that "once CMS agrees to a Medicare set-aside amount, the individual can be certain that Medicare's interests have been appropriately considered."

In order for CMS to approve the arrangement and the amount, CMS must be provided with all relevant information about the claim and anticipated future medical expenses.

The following information is considered by CMS to ensure the adequacy of the fund and to ensure that there has not been any attempt to shift liability to Medicare.

- Date of entitlement to Medicare.
- Basis for Medicare entitlement.
- Type and severity of injury or illness. Is full or partial recovery expected? What is the projected time frame if partial or full recovery is anticipated? As a result of the accident is the individual an amputee, paraplegic or quadriplegic? Is the beneficiary's condition stable or is there a possibility of medical deterioration?
- Age of beneficiary.
- Workers' compensation classification of beneficiary.
- Prior medical expenses paid by workers' compensation carrier due to the injury or illness in the one- or two-year period after the condition has stabilized — if Medicare has paid any amounts, they must be recovered.
- Amount of lump sum or amount of structured settlement.
- Is the commutation for the beneficiary's lifetime or for a specific time period?
- Is the beneficiary living at home, in a nursing home, or receiving assisted living care? If the beneficiary is living in a nursing home, or receiving assisted living care, it should be determined who is expected to pay for such care.
- Are the expected expenses for Medicare covered items and services appropriate in light of the beneficiary's condition? See July 23, 2001 memo-