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What to Expect From the MSA proposed rulemaking on Liability, No-Fault, and Work Comp Claims

November 18, 2020 | 2:00-3:00 p.m. ET

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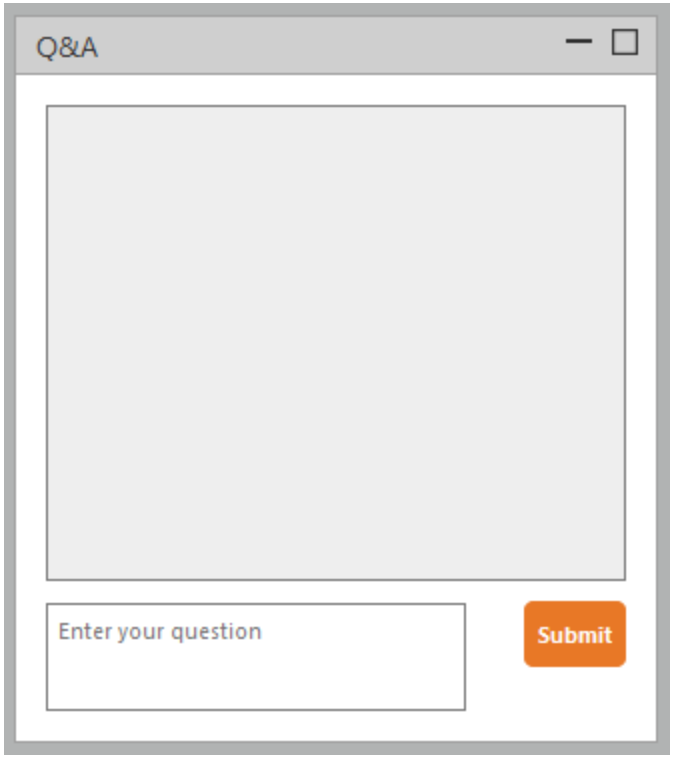

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Presenter

Lavonya Chapman, Esq, RN, CMSP
Associate General Counsel

Lavonya Chapman is Optum Settlement Solutions' Medicare Secondary Payer (MSP) Compliance Counsel and a member of the management team responsible for strategic planning and product development with legal, regulatory, and compliance oversight of all services provided to include MSP settlement language, Mandatory Insurer Reporting, ICD injury code reporting, Conditional Payment Resolution, Medicare Set-Aside Allocations (MSA), CMS approval, and professional administration of MSAs.

Lavonya joined Optum Settlement Solutions in 2014 with more than 25 years of experience as an attorney, claim director, and registered nurse. Her casualty insurance experience began as a medical case manager at USF&G insurance.

As an attorney, Lavonya has litigated medical malpractice, premises, and auto liability claims, as well as workers' compensation cases. As a registered nurse and pharmacology instructor at the University of Alabama at Birmingham, Lavonya is an expert in utilization review and emergency medical services.

Lavonya is a frequent conference speaker and mentor on all aspects of the Medicare Secondary Payer Act as it pertains to claim compliance in the property & casualty industry. She received a Bachelor of Science degree in nursing from the Samford University and a Doctorate of Jurisprudence from Birmingham School of Law.

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Objectives

- Explain a liability, no-fault, and work comp insurer's essential obligations under the Medicare Secondary Payer Act
- Discuss potential rules that CMS may employ to provide all parties involved the best opportunity to protect the Medicare Trust Fund
- Highlight potential regulations that CMS may adopt when a beneficiary receives liability, no-fault, and work comp settlements, judgments, awards, or payments that results in a need to satisfy MSP obligations

The Federal Law

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Federal Statute

42 USC 1395y

(b) Medicare as secondary payer

(1) Requirements of group health plans

(2) *Medicare secondary payer*

(A) In general,

Payment under this subchapter may not be made, except as provided in subparagraph

(B), with respect to any item or service to the extent that—

(i) payment has been made, or can reasonably be expected to be made, with respect to the item or service as required under paragraph (1), or

(ii) payment **has been made** or **can reasonably be expected to be made** 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.

Federal regulations

42 C.F.R. § 411

Subpart B—Insurance coverage that limits Medicare Payment: General Provisions

§ 411.20 Basis and scope.
§ 411.21 Definitions.
§ 411.22 Reimbursement obligations of primary payers and entities that received payment from primary payers.
§ 411.23 Beneficiary's cooperation.
§ 411.24 Recovery of conditional payments.
§ 411.25 Primary payer's notice of primary payment responsibility.
§ 411.26 Subrogation and right to intervene.
§ 411.28 Waiver of recovery and compromise of claims.
§ 411.30 Effect of primary payment on benefit utilization and deductibles.
§ 411.31 Authority to bill primary payers for full charges.
§ 411.32 Basis for Medicare secondary payments.
§ 411.33 Amount of Medicare secondary payment.
§ 411.35 Limitations on charges to a beneficiary or other party when a workers' compensation plan, a no-fault insurer, or an employer group health plan is primary payer.
§ 411.37 Amount of Medicare recovery when a primary payment is made as a result of a judgment or settlement.

WC and Liability Federal Regulations

42 C.F.R. § 411

Subpart C—Limitations on Medicare payment for services covered under workers' compensation

§ 411.40 General provisions.
§ 411.43 Beneficiary's responsibility with respect to workers' compensation.
§ 411.45 Basis for conditional Medicare payment in workers' compensation cases.
§ 411.46 Lump-sum payments.
§ 411.47 Apportionment of a lump-sum compromise settlement of a workers' compensation claim.

Subpart D—Limitations on Medicare payment for services covered under liability or no-fault insurance

§ 411.50 General provisions.
§ 411.51 Beneficiary's responsibility with respect to no-fault insurance.
§ 411.52 Basis for conditional Medicare payment in liability cases.
§ 411.53 Basis for conditional Medicare payment in no-fault cases.
§ 411.54 Limitation on charges when a beneficiary has received a liability insurance payment or has a claim pending against a liability insurer.

The CMS Memos

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Stalculp Memo

May 25, 2011

- “Medicare's interest must always be protected; however, CMS does not mandate a specific mechanism to protect those interests.”
- “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 it is a worker's compensation or liability case. There is no distinction in the law.”
- “Set aside's are the method of choice and the agency feels they provide the best protection for the program and the Medicare beneficiary.”

* https://irp-cdn.multiscreensite.com/78727cfb/files/uploaded/Stalcup-CMS-Handout%202011.pdf

Stalculp Memo

May 25, 2011

- “The fact that a liability settlement, judgment, or award does not specify payment for future medical services does not mean that they are not funded. The fact that the liability agreement designates the entire amount for pain and suffering does not mean future medicals are not funded.”
- “The only situation in which Medicare recognizes allegations of liability payments for non-medical losses is when payment is based on a court of competent jurisdiction's order after a review of the merits of the case.”

Stalculp Memo

May 25, 2011

- “If plaintiff counsel determines that the settlement includes future medicals, they should see to it that those funds are used to pay for Medicare covered services related to what is claimed or released in the settlement, judgment, or award.”
- “If defense counsel/insurer determines that the settlement includes future medicals, they should document that the settlement funds future medicals which obligates them to report it to Medicare through mandatory insurer reporting and obligates them to protect the Medicare trust funds.”

Benson Memo

September 30, 2011

- "When beneficiary's treating physician certifies in writing that treatment for the injury related to the liability insurance settlement, judgment, award, or payment has been completed, and that future medical items and/or services for that injury will not be required, Medicare considers its interest, with respect to future medicals satisfied."
- "When the treating physician makes such a certification, there is no need for the beneficiary to submit the certification or a proposed LMSA amount for review."

Options previously proposed

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2012 Advance Notice of Proposed Rulemaking

- "Currently, individuals involved in workers' compensation situations are able to use Medicare's formal, but voluntary, MSA review process in order to determine if a proposed set-aside amount is sufficient to meet their MSP obligations related to future medicals."
- "To date, Medicare has not established a similar process to meet their MSP obligations with respect to future medicals in liability insurance (including self-insurance) situations."
- "We are soliciting comment on whether and how Medicare should implement such a similar process in liability, no-fault, and work comp insurance situations."

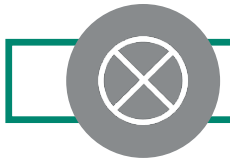
Beneficiary pays

OPTION 1

"The beneficiary may choose to govern his/her use of his/her settlement proceeds.

- He/she would be required to pay for all related care out of his/her settlement proceeds, until those proceeds are appropriately exhausted and documents it accordingly.
- Medicare would not routinely review documentation
- Medicare may occasionally request documentation from beneficiaries at random as part of Medicare's integrity efforts.

No future interests



"Medicare would not pursue future medicals if the following specific conditions existed:"

- "The amount of liability insurance (including self-insurance) "settlement" is a defined amount and the underlying claim did not involve a chronic illness/condition or major trauma."
- "The individual is not a current Medicare beneficiary and does not expect to become a beneficiary within 30 months of the date of settlement."

Date of care completion

OPTION 3

"The beneficiary provides an attestation regarding the Date of Care Completion from his/her treating physician."

Before or after the settlement, the physician must attest to the Date of Care Completion and attest that the beneficiary will not require additional care related to his/her settlement.

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Submitting MSA for review

OPTION 4

- "Currently, we have a formal process to review proposed MSA amounts in certain workers' compensation situations."
- "We are considering whether we should implement a formal review process for proposed liability insurance (including self-insurance) MSA amounts, where the beneficiary submits a proposed Medicare Set-Aside Arrangement amount for CMS' review and approval."

"We specifically solicit comment on how a liability MSA amount review process could be structured, including whether it should be the same as or similar to the process used in the workers' compensation arena, whether review thresholds should be imposed, etc…"

Limited settlements

OPTION 5

"When a beneficiary participates in any one of the recovery options, the beneficiary has also met his/her obligation with respect to future medicals:"

In settlement of…	
$300 or less	Medicare will not pursue recovery against that particular settlement.
$5,000 or less	The beneficiary may elect to resolve Medicare's recovery claim by paying 25% of the gross settlement amount
$25,000 or less	Medicare would review the beneficiary's self-calculated amount and provide agreement/disagreement, and ultimately confirmation of Medicare's final conditional payment amount.

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Upfront payment

OPTION 6

If ongoing responsibility for medicals **was imposed**, demonstrated or accepted from the date of settlement through the life of the beneficiary or life of the injury:

We may review and approve a proposed amount to be paid as an upfront lump sum payment for the full amount of the calculated cost for all related future medical care.

If ongoing responsibility for medicals **has not been imposed,** demonstrated by or accepted by the defendant:

The beneficiary may elect to make an upfront payment to Medicare in the amount of a specified percentage of beneficiary proceeds.

- "This option would most often apply in liability insurance, primarily due to policy caps."
- "Beneficiary proceeds would be calculated by subtracting from the total settlement the amount of attorney fees and procurement costs borne by the beneficiary, and Medicare's demand for reimbursement of conditional payments."

Compromise or Waiver

OPTION 7

If the beneficiary obtains either a compromise or a waiver of recovery :

Medicare would have the discretion to not pursue future medicals related to the specific settlement where the compromise or waiver of recovery was granted.

If the beneficiary obtains an additional settlement, judgment, award, or payment related to the same claim :

Medicare would review the conditional payments it made and adjust its claim for past and future medicals accordingly.

The insurance industry's response to 2012 Notice of Proposed Rulemaking

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No statutory authority

- “There is no statutory authority permitting CMS to impose any obligation or granting a right of recovery against an insurer or self insured with regard to future medicals.”
- “CMS lacks authority with respect to insurers and self- insureds regarding future medicals.”
- “There is no current law that imposes any obligation on insurers or self-insureds for medical expenses incurred after the date of a liability settlement.”

WCMSA process is inadequate

- “The workers’ compensation MSA process is inefficient, ineffective, and inadequate. Using that same process would undercut the ability of insurers, self-insureds, and beneficiaries to handle and timely settle claims.”
- “The WCMSA process is flawed with a current volume of less than 30,000 annually. Can anyone imagine the chaos in liability when the number of claims within the United States involving bodily injury payments is estimated in the millions annually?”

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Costs and system concerns

- "Tort settlements will grind to a halt and administrative costs will increase exponentially."
- "An already overburdened and underfunded state and federal courts system will be unable to move cases along."

Prior and current attempts

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Advance Notice of Proposed Rulemaking (ANPRM)

Published by CMS:
June 14, 2012

- Solicits comments on seven options to protect Medicare's interest with respect to MSP claims involving automobile and liability insurance (including self-insurance), no-fault insurance, and workers' compensation when future medical care is claimed or released in a settlement, judgment, award, or other payment
- Voluntarily withdrawn in 2014 after comments were received and reviewed

Expanding MSA announcement

Published by CMS:
June 8, 2016

- CMS is “considering expanding its voluntary MSA amount review process to include the review of proposed liability insurance (including self-insurance) and no-fault insurance MSA amounts.”
- Indicated that “CMS plans to work closely with the stakeholder community to identify how best to implement this potential expansion.”
- Informed that “CMS will provide future announcements of the proposal and expects to schedule town hall meetings later this year.”

MSP Clarification and update

Published by CMS:
December 18, 2018

- Medicare does not currently provide beneficiaries with “guidance to help them make appropriate choices regarding their future medical care expenses when they receive automobile and liability insurance (including self-insurance), no fault insurance, and workers compensation settlements, judgments, awards, or payments, and their need to satisfy their MSP obligations.”
- The proposed NPRM would “produce Code of Federal Regulations (CFRs) to provide beneficiaries options for meeting future medical obligations that fit their individual circumstances, while also protecting the Medicare Trust Fund.”
- Expected to be published by October 2019, then November 2019, and February 2020.

Pending MSA proposed rulemaking

View Rule

View EO 12866 Meetings | Printer-Friendly Version | Download RIN Data in XML

HHS/CMS **RIN:** 0938-AT85 **Publication ID:** Spring 2020

Title: Miscellaneous Medicare Secondary Payer Clarifications and Updates (CMS-6047)

Abstract:

This proposed rule would clarify existing Medicare Secondary Payer (MSP) obligations associated with future medical items services related to liability insurance (including self-insurance), no fault insurance, and worker's compensation settlements, judgments, awards, or other payments. Specifically, this rule would clarify that an individual or Medicare beneficiary must satisfy Medicare's interest with respect to future medical items and services related to such settlements, judgments, awards, or other payments. This proposed rule would also remove obsolete regulations.

Agency: Department of Health and Human Services(HHS)
RIN Status: Previously published in the Unified Agenda
Major: Yes
EO 13771 Designation: Other
CFR Citation: 42 CFR 405 42 CFR 411
Legal Authority: 42 U.S.C. 1395y(b)
Legal Deadline: None

Priority: Economically Significant
Agenda Stage of Rulemaking: Proposed Rule Stage
Unfunded Mandates: No

Timetable:

Action	Date	FR Cite
NPRM	08/00/2020	

https://www.reginfo.gov/public/do/eAgendaViewRule?pubId=202004&RIN=0938-AT85

Spring 2020 abstract of the "Miscellaneous Medicare Secondary Payer Clarifications and Updates" proposed rule states that:

- "Clarify **existing MSP obligations** associated with funding **future** medical items and services" otherwise reimbursable by Medicare
- Clarify payment obligations once there is a "settlement, judgment, award, or other payments" made
- Pertain to "liability insurance, self-insurance, no-fault insurance, and workers' compensation" insurance/plans, the primary payer and applicable plan
- "Clarify that an individual or Medicare beneficiary must satisfy Medicare's interest" with respect to future medical items and services related". Not shifting the burden to pay related medical expenses to Medicare post claim resolution. (In other words, the claimant does not use a Medicare (Parts A, B, C, D) card to pay for them)
- Clarify how part of the payment made to claimant/beneficiary will be set-aside and used to pay for future related Medicare expenses otherwise reimbursable by Medicare

Pending MSA proposed rulemaking

The proposed MSA rule states that it:

- Is a **major** rule for CMS
- Is an **economically significant priority** to CMS
- Would **remove "obsolete" regulations** in use by CMS

We know that:

- CMS does not recognize Non-Submit or Evidence Based MSAs
- CMS cannot measure and coordinate benefits if they are unaware of the existence of a Non-Submit MSA

Obsolete is generally defined as "no longer useful"

- Does obsolete mean that it will remove the "voluntary" CMS review of MSAs?
- Does removing "obsolete" regulations imply that something new will **replace** the "obsolete" regulation, like:
  - Making CMS' BCRC aware of all MSA funding
  - Offering LMSA "voluntary" CMS review which is usually not available for liability claims
  - Disclosing the existence of a Non-Submit MSA to CMS by submitting a copy to the BCRC or via Section 111 reporting field
  - "requiring more accountability when MSA is "self-administered

The last five years

Published opinions

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Early v. Carnival Corporation

February 7, 2013

United States District Court, Southern District of Florida, Miami Division

- Refused to render an advisory opinion as to whether an MSA was required in this liability case
- The Court finds that it may not rewrite the terms of parties' private settlement agreement or render advisory opinions.
- The Court concludes that the parties do not in fact have a settlement agreement and orders the case back on the Court's trial docket.

Welch v. American Home Assurance

February 26, 2013

United States District Court for the Southern District of Mississippi

- In order to comply with MSP on this liability claim, since CMS has provided no procedure for protecting Medicare's interests for future medical needs and/or expenses, the Court determines the necessity of the MSA and the amount of the MSA.
- The Court concludes that the interests of Medicare have been reasonably considered and protected by all parties through the creation, funding, and maintenance of the MSA.

Benoit v. Neustrom

April 17, 2013

United States District Court of Louisiana

- Court finds that since the net settlement proceeds after reimbursement of conditional payments to Medicare was $55,707.98 and the mid-point range of the MSA projections was $305,512.50, the net settlement is 18.2% of the MSA.
- Using that percentage applied to the net settlement proceeds, the Court concludes that the sum of money to be set aside in trust for future medical expenses is $10,138.00.

Aranki v. Burwell

October 16, 2015

United States District Court for the District of Arizona

- Court concluded that this case is not ripe for review because no federal law mandates CMS to decide whether Plaintiff is required to create a MSA.
- "There may be a day when CMS requires the creation of MSAs in personal injury cases, but that day has not arrived."
- Court concludes that although it is sympathetic to the uncertain predicament that CMS has placed upon Plaintiff, judgment in favor of the Defendants is proper.

Humana v. Bi-Lo

August 6, 2018

United States District Court for the District of South Carolina

- Humana filed declaratory judgment to recover double damages pursuant to the MSP Act in the amount of $32,754.02 despite the existence of a settlement agreement in which the Medicare beneficiary and her counsel agreed to be responsible for such reimbursement.
- However, because the Medicare beneficiary did not reimburse the Medicare payments advanced by Humana, Humana sought reimbursement from Bi-Lo.

Future medical in liability, no-fault and workers' compensation claims

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A claimant is a current Medicare beneficiary if they are…

- 65 years of age or older
- Receiving SSD benefits for more than 24 months
- Diagnosed with ESRD or Lou Gehrig's Disease

OR

If not any of the above, there is **reasonable expectation** they will become a Medicare beneficiary within 30 months of the settlement because they…

- 62 ½ years of age or older
- Applied, denied, appealed, or awarded SSD benefits

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CMS guidance on future medical

- Create an LMSA allocation that will remain voluntary (but recommended)
- CMS will allow for no allocation in “minimum value” cases, and percentage of settlement in “low value” cases.
- CMS will provide guidance as to when LMSA is necessary, what should be included in LMSA.
- Current WCMSA contractor to review LMSAs and provide approval.

Liability Medicare Set Asides

Settlement includes future medical needs related to claim (claimed and released), irrespective of liability defenses.

LMSA must include:

- Anticipated future medical and prescriptions based on treating physician's opinion
- Medical treatment priced at U&C fee schedule
- Prescriptions priced at AWP per Red Book
- Based on claimant's life expectancy (rated age)

Liability issues in MSA allocations

- Policy limits (will allow pro rata share reduction)
- Contributory negligence (will allow percentage reduction)
- Comparative negligence (will allow percentage reduction)
- Statutory caps (will allow pro rata share reduction)
- Jury/Judicial findings and decisions (will allow for funding based binding court opinion)

Thank you!

Questions?

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 CEU-20708