December 16, 2011

The Medicare Secondary Payer Act in 2011: A Busy, Busy Year

This year, 2011, was an extremely busy year for Medicare Secondary Payer Act (MSP) related information and case law-- quite possibly the busiest year in the past ten years. As 2012 is looking to be another active year, it is important to have a firm grasp and understanding of some of the information promulgated by the Centers for Medicare & Medicaid Services (CMS) in 2011, state level enforcement of the MSP, as well as MSP case law before moving onto 2012. Please find below a brief synopsis of some of the more seminal changes affecting MSP compliance which occurred in 2011. CMS Memoranda as well as full legal bulletins on most cases described below can be viewed in PMSI's Knowledge Center under CMS Memos and Other Communications and Legal Bulletins, respectively.

CMS Memoranda

May 11, 2011- CMS reiterates their guidelines for submission of Workers' Compensation Medicare Set-Asides (WCMSAs) for review and approval. Submission of WCMSAs to CMS that meet CMS review threshold is a *recommended* (voluntary) procedure and is not mandated. Settlements with MSAs that fall outside CMS review threshold will not be reviewed[1].

September 29, 2011- CMS issues their first memorandum addressing liability MSAs (LMSAs). The memorandum states that if the treating physician certifies in writing that no future treatment is needed, that Medicare will consider its interests protected.

MSP Case Law

Hadden v. U.S.[2]- On November 21, 2011, the Sixth Circuit affirmed the district court's opinion holding that the MSP required Vernon Hadden to reimburse Medicare to the full extent that the government advocated. It was hoped by those in support of the appeal that the Sixth Circuit would overturn the district court's decision, which held that the MSP requires full reimbursement of Medicare conditional payment demands regardless of apportionment or comparative fault principles. This case may ultimately be appealed to the Supreme Court. Until such time, tortfeasors and Medicare beneficiaries can continue to expect that Medicare may obtain full recovery of their conditional payment demands, up to the amount of the settlement.

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[1] The CMS review thresholds remain unchanged and are the following: Class 1: Medicare Beneficiary and Total Settlement Amount exceeding $25,000; Class 2: Reasonable Expectation of Medicare Entitlement within 30 months of the Settlement date and the anticipated Total Settlement Amount exceeds $250,000.
[2] 2011 U.S. App. LEXIS 23289, United States Court of Appeals for the Sixth Circuit.

Haro v. Sebelius[3]- On May 5, 2011, putative class Plaintiffs, Medicare beneficiaries, and an attorney representing the beneficiaries sought a summary judgment that the Secretary's conditional payment collection practices were not authorized by Congress, not a permissive interpretation of the MSP, and a violation of the Due Process clause of the Constitution. The Plaintiffs further sought class certification and an injunction against CMS from making premature threats from commencing a collection action before waiver or appeal was pursued. The Court found for the Plaintiffs and granted class certification as well as an injunction against CMS as requested.

USA v. Stricker[4]- On August 12, 2011, the District Court rejected the government's motion for reconsideration based upon a theory of continuing accrual, that the statute of limitations re-starts each time a class member receives a settlement payment. In September of 2010, the government's complaint was dismissed due to the fact that the claim was barred by the statute of limitations (a six year statute of limitations was to be applied to those claims in which the underlying claim was contract; three years was to be applied to those claims in which the underlying claim was a tort). In November of 2011, the government filed a notice with the court that they further planned to appeal the court's decision. Whether the government will revive their theory of continuing accrual is not yet known.

State Level MSP Enforcement

Maryland- On November 28, 2011, Maryland enacted regulations centered on requiring the consideration of Medicare's interests before a settlement can be formally approved. The regulations do not mandate submission of MSAs that meet the CMS workload review thresholds and that are purely voluntary, but require that specific items which address Medicare's interests be contained in the settlement documents.

Kentucky- On February 3, 2011, Kentucky introduced proposed legislation which would require "settlements for future medicals to be approved by the federal Medicare Secondary Payer Act." The proposed legislation did not pass and it is unclear whether it will be revived in 2012.

Western District of New York- On May 6, 2011, the U.S. Attorney's Office for the Western District of New York issued an MSP Protocol for liability settlements. If parties to a liability settlement of over $350,000 are not able to obtain review of the LMSA by CMS and meet other certain requirements, the U.S. Attorney's office will opine on the sufficiency of the LMSA.

MSP Trends in Liability

Conditional Payments- In September, the MSPRC issued an alert that it would not seek recovery of conditional payment demands where the settlement is $300 or less and other criteria are met.

Additionally, in October, the MSPRC issued an alert that beneficiaries who receive a liability settlement of $5000 or less and meet other criteria can pay a fixed percentage of their settlement instead of opting for the traditional recovery process. For more information, please visit www.msprc.info.

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[3] CV 09-134 TUC DCB, (D.AZ.) (May 5, 2011).
[4] No. CV-09-BE-2423-E (N.D. Ala. Aug. 12, 2011).

Liability MSAs (LMSAs)- In both of the following cases which occurred in 2011, the court included or required an LMSA to consider Medicare's interests as part of the liability settlement: Hinsinger v. Showboat Atlantic City[5] and Big R Towing v. Benoit[6].

Legislative Proposals

Strengthening Medicare and Repaying Taxpayers Act of 2011 (SMART Act) - This bill was introduced to the House of Representatives on March 14, 2011. The SMART Act seeks reform of the enforcement of the MSP, namely as it affects conditional payment collection and MMSEA Mandatory Insurer Reporting. Some examples of initiatives proposed would be to set the statute of limitations for conditional payment reimbursement at three (3) years, and make the MMSEA penalty of $1000 per claim/per day discretionary rather than mandatory. The SMART Act gained large bi-partisan support in the House and moved to the Senate in October of 2011. Whether the bill will pass in the Senate remains to be seen as we move into 2012.

In conclusion, 2011 was a very busy year for those affected by the MSP. We saw a dramatic rise in MSP case law, more states creating requirements for Medicare's interests to be considered as part of settlements, increased awareness surrounding liability MSAs, and reform efforts surrounding MSP enforcement. Stay up-to-date with future MSP developments by visiting and subscribing to our blog, MedicareInsights.com

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[5] 2011 N.J. Super LEXIS 96 (January 21, 2011).

[6] 2011 U.S. Dist. LEXIS 1392 (W.D. La. Jan. 5, 2011). This case involved a Jones Act claim which is considered a liability claim for CMS submission purposes.