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A HIGHER STANDARD IN MSA COMPLIANCE

The Perfect Storm:
Final Warnings from the Feds About Liability MSAs

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Introduction.

The *Andrea Gail* never had a chance. The Gloucester, MA fishing boat was old and rickety. Its grizzled crew experienced but vastly overmatched. And the storm it faced was simply perfect.

One fateful decision doomed the *Andrea Gail*. Instead of heeding warnings about the powerful storm, it ignored all warnings and tried to push through the storm unprepared. Getting home before its cargo of swordfish spoiled was more important than protecting themselves.

The third-party liability insurance settlement community stares today at its Perfect Storm. The combination of rapidly rising Medicare enrollment rates, a longer American life expectancy and the pending repeal/replacement of the Patient Protection and Affordable Care Act (ACA aka Obamacare) leaves government officials seeking alternate means to maintain the solvency of the Medicare Trust Funds.

Meanwhile, the Medicare Secondary Payer (MSP) Act sits by, ready and waiting. While Medicare has considered active enforcement of the MSP Act's future medical provisions previously for liability insurance settlements, no final indication has been given to that occurring until now. Late in 2017, Medicare began rejecting certain repayment requests from medical providers, advising providers to seek repayment from the patient's Liability Medicare Set-aside Arrangement (LMSA). In late 2018, Medicare issued a regulatory placeholder for future rules to be announced in September 2019. In early 2019, it came to light that Medicare was seeking repayment of future medical expenses incurred post-settlement which it had paid on a conditional basis on behalf of its beneficiary.

The Perfect Storm is set to hit third-party liability insurance settlements later this year. Parties settling these cases need to heed the warnings and be prepared. Addressing LMSA exposure on all cases involving future medicals is now your best chance to ride out the storm.

The Storm Brewing: How We Got Here.

After World War II, birth rates in the United States skyrocketed. The resulting Baby Boomer generation came of age in the 1970s. Understanding the potential strain this generation may later place on a Medicare program in its infancy, Congress passed, and President Carter signed into law the MSP Act on December 5, 1980.

The MSP Act provides a broad prohibition on Medicare paying certain medical expenses. In part (and relevant to our discussion), is the following provision: Medicare will not pay for a beneficiary's medical expenses where payment has been made under a liability insurance plan (including self-insurance).[1] To the extent that a liability insurance carrier or a self-insured pays a claimant for future medical expenses related to the settlement (in whole or in part), the federal government (and the American taxpayer) will not pay those bills but for one exception.

Conditional payments represent the only exception to this broad statutory prohibition. Medicare may make a conditional payment on behalf of its beneficiary when an entity has not yet accepted responsibility to make payment.[2] Medicare pays on the condition that it will be reimbursed when an entity accepts responsibility for that payment and that responsibility is evidenced in a judgment, a compromise for release or other means.[3]

For years, most stakeholders in the liability insurance settlement community ignored these future medical statutory provisions. Settling parties rarely addressed them and Medicare never said one word about them. Only after the Centers for Medicare & Medicaid Services (CMS) provided guidance about future medicals for the workers' compensation community did parties in the liability insurance community begin asking questions.

Slowly, CMS began to address the LMSA issue publicly. In 2011, CMS released its only LMSA policy memorandum addressing use of a treating physician's letter to conclude that no LMSA was needed. In 2012, CMS released an Advanced Notice of Proposed Rulemaking (ANPRM) about LMSAs.[4] In 2013, CMS issued a Notice of Proposed Rulemaking (NPRM), though that was never released publicly. In 2014, CMS voluntarily withdrew the NPRM.

Many lobbying groups took the opportunity to congratulate each other when CMS withdrew the NPRM. "Mission Accomplished," they said. The LMSA issue was dead according to them. Since the statute does not contemplate LMSAs specifically, that must mean the issue could be ignored, right? It leads one to wonder how they missed the storm brewing on the horizon.

The Weather Map: Why Now?

Three primary factors driving the LMSA issue at this point: 1) rapidly rising Medicare enrollment rates short term; 2) longer life expectancies compared to previous generations; and 3) the repeal/replacement of the ACA. This combination will rapidly deplete the Medicare Trust Funds over the next ten (10) years. Something must be done to preserve the integrity of the Medicare program, and CMS knows that.

News about rising Medicare enrollment rates cannot be considered "Breaking News." For years, government officials have tracked how Baby Boomers age and at what point they enroll in Medicare. Until recently, Medicare enrollment for Baby Boomers happened not due to age, but after receiving Social Security Disability Income (SSDI) benefits, having End Stage Renal Disease (ESRD) or being afflicted with amyotrophic laterals sclerosis (ALS aka Lou Gehrig's Disease). Now, Baby Boomers are aging into Medicare enrollment status, driving enrollment rates higher.

The statistics are striking. When the MSP Act was signed into law, just over 28 million Americans were Medicare enrolled.[5] That number grew to 41 million over the next 25 years. Around 2005, the numbers began to rise more rapidly. As of 2017, approximately 58 million Americans were Medicare enrolled. Officials predict that figure will exceed 80 million by 2030.[6] After that, the growth projects to ease.

Every one of those individuals will need healthcare coverage, whether related to a liability insurance settlement or otherwise. You may not be one of those individuals today. If not, chances are good you will be within twenty-five (25) years or less. Funds deposited to the Medicare Trust Funds going forward need to exceed funds withdrawn from the Medicare Trust Funds to ensure the long-term solvency of the Medicare program.

Longer life expectancies exacerbate this problem. Americans live longer lives in 2019 than they have historically. Despite a recent blip due to our country's opioid epidemic, American life expectancies have increased 5.1 years from 1980 to 2017.[7] Our diets are better, science is better, and we lead more active lifestyles. That translates into a larger elderly population using Medicare as the primary insurance provider. The elderly see the doctor more, need more medical procedures and take more prescription medications. Living longer is good news, but only if the elderly has Medicare to pay for healthcare in their 70s, 80s and beyond.

The third ingredient to the Perfect Storm is the anticipated repeal and replacement of the ACA. The ACA extended the life of the Medicare program. By moving more uninsured individuals to private health plans, less strain was placed on Medicare. According to Medicare, studies show that the ACA contributed to the life of the Medicare Trust Funds being extended by approximately twelve (12) years.[8] With this question currently pending in federal courts, we must wait and see how this may affect the Medicare program.

Today's Forecast: CMS Moves to Announce LMSAs.

In 2019, we have more people in the Medicare system living longer lives, and incurring more medical expenses. At the same time, we are removing a tool that had extended the life of the Medicare Trust Funds. Understanding these volatile atmospheric conditions, CMS officials have no choice but to act.

Officials know that it has future medical provisions of the MSP Act, which have been in effect for thirty-six (36) years, sitting on the shelf. They know the law already exists for CMS to deny payment appropriately where payment has already been made under a liability insurance plan.[9] They know that responsibility is evidenced by a primary plan or payer as part of a settlement of a

liability insurance claim.[10] They know that responsibility is transferred from defendant/insurer to the claimant as part of settling the case.[11] They know that the plaintiff is then responsible for future medical expenses related to the compensable claim going forward as the primary payer under the terms of most settlement agreements. They know its right of recovery is not linked to the actual establishment of an LMSA, but rather when CMS is presented a bill prematurely, which CMS then pays in error. CMS officials understand all this. They also understand the high level of non-compliance and complete ignorance settling parties in the liability insurance settlement community have had on this issue for decades now.

Knowing that the liability insurance settlement community would need time to prepare, CMS has issued several warnings recently. On June 8, 2016, CMS announced that it was considering expanding its formal MSA review process to include LMSAs and NFMSAs. The announcement fell mainly on deaf ears in the liability insurance settlement community.

Late in 2016, CMS released a Request for Proposal (RFP) to find a new Workers' Compensation Medicare Set-aside Arrangement (WCMSA) review contractor. Contained in the RFP was work flow for LMSA and NFMSA review. At CMS' discretion, it would ask the new WCMSA review contractor to review upwards of 51,000 LMSAs and NFMSAs per year in addition to the 19,700 WCMSAs it anticipates reviewing annually. This contract was awarded in 2017 at a price of over $60 million. After protests were resolved, the new review contactor assumed control in spring of 2018. CMS is now paying for LMSA review, which it has never done before.

CMS has also told the medical community about LMSAs.[12] In a Change Request dated February 2, 2017, CR 9893 advised the medical community to expect certain reimbursement claims to be denied starting later this year. CMS tells the medical community instead to seek reimbursement from the beneficiary's LMSA since Medicare is prohibited from paying for that same expense for which its beneficiary got paid as part of a prior liability insurance settlement. CMS issued a similar Change Request for WCMSAs back in 2007.[13]

In late 2018, CMS moved forward with the regulatory process to introduce rules and regulations about MSAs. Titled in the Unified Agenda as Miscellaneous Medicare Secondary Payer Clarifications and Updates, the abstract of the rule as of Spring 2019 now states, "**This proposed rule would ensure that beneficiaries are making the best health care choices possible by providing them and their representatives with the opportunity to select an option for meeting future medical obligations that fits their individual circumstances, while also protecting the Medicare Trust Fund** (emphasis added)."[14] By providing us with this regulatory "heads up", CMS gives us one last warning about the Perfect Storm on the horizon.

Will the Storm Break: What About Enforcement?

Storms sometime dissipate. A Category 5 hurricane in the middle of the Caribbean may only make landfall in the US as a tropical depression. Maybe things won't be as bad as it appears. So, while CMS makes these moves and gives us warnings to prepare, you may be asking, "How can CMS enforce this? What gives it the right?"

From the statutory perspective, CMS already has enforcement tools in hand. It's true that the MSP Act does not require MSAs of any kind (WC, liability or otherwise). The MSP Act, however, does clearly provide rights of repayment when another entity has responsibility to pay that same item, service or expense.[15] CMS is actively identifying situations where another entity is responsible to pay future medical expenses.[16] What results is either denial of future medical benefits or payment of future medical benefits followed by reimbursement of those same expenses.

The MSP Act also provides CMS with a stiffer enforcement penalty. CMS has the statutory right to collect not only the amount of the overpayment made in error, but the right to collect twice that amount or double damages.[17] The United States also has subrogation rights under the MSP Act.[18]

Even more potent, CMS also has the option to tap the federal False Claims Act.[19] If CMS believes actors are committing fraud against the Medicare program by billing Medicare for services rendered instead of paying for those out of settlement proceeds received for that specific purpose, the potential penalties are steep. Fines between $10,781 and $21,563 per occurrence plus three times (3x) the amount of financial harm caused to the Medicare program can be levied by the U.S. Department of Justice (DOJ).[20] In fact, DOJ is actively using threats of the federal False Claims Act to ensure MSP compliance.[21]

These various penalty provisions provide the devastating force behind any enforcement in this area. Nothing else needs to develop or be enacted for these penalty provisions to be used. Enforcement tools are in place, and ready for CMS and/or the DOJ to use immediately if desired. No notice or warning from CMS about choosing to use the penalty provisions is needed.

"But how will Medicare find out about the LMSA?" A reasonable question to ask today though one that sounds in policing and enforcement as opposed to understanding and following the current law. No formal review process currently exists for LMSAs today. Expect that to change in 2019 when CMS exercises its option to have its new WCMSA review contractor also review LMSAs. We expect this review process to be incorporated into the anticipated MSA regulations.

Also expect CMS to add new data points to the MMSEA Section 111 report. Those new data points could ask if an LMSA was funded and if so, for how much. When CMS does this, every liability insurance carrier or self-insured in the U.S. will need to change the way they report to Medicare to take this issue into account. A change in reporting will lead to changes in how the issue is addressed. Simply put, too much is at stake for CMS to wait any longer, especially when the fix can be so simple to implement.

Conclusion.

The liability insurance settlement community has received plenty of warning about the Perfect Storm. Nothing needs to be changed in the law or the regulations for CMS to deny payments for future medical expenses. As detailed above, it's already happening.

The release of LMSA regulations will be the warning heard loud and clear for many. Some, though, will ignore the warnings. Whether its ego, ignorance or incompetence, their fate is sure to be the same as the *Andrea Gail*. The crew of the *Andrea Gail* faced a fateful decision. Push through the storm or seek shelter and safe harbor? The *Andrea Gail* took a risk, pushed forward unprepared and lost everything.

The time for your fateful decision is at hand. It's time to heed the multiple storm warnings. You should seek shelter and safe harbor. You should take the time to become informed on LMSA issues and how they may affect your organization. If not that, then work with someone knowledgeable about LMSA issues that can provide you protection in the storm. Preparing for a storm costs little; cleaning up from the storm could cost much more. Maybe former U.S. Deputy Attorney General Paul McNulty said it best: "If you think compliance is expensive, try non-compliance."

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[1] *42 U.S.C. § 1395y(b)(2)(B)(i)*.
[2] *42 U.S.C. § 1395y(b)(2)(B)(ii)*.
[4] https://www.regulations.gov/document?D=CMS-2012-0073-0001.
[5] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareEnrpts/Downloads/SMI2013.pdf.
[6] https://kaiserfamilyfoundation.files.wordpress.com/2013/06/projected-change-in-enrollment-2000-2050-medicare.png.
[7] https://www.cdc.gov/nchs/fastats/life-expectancy.htm.
[8] https://www.medicare.gov/about-us/affordable-care-act/affordable-care-act.html.
[9] *42 U.S.C. § 1395y(b)(2)(A)(ii)*.
[10] *42 U.S.C. § 1395y(b)(2)(B)(ii)*.
[11] https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Workers-Compensation-Medicare-Set-Aside-Arrangements/Downloads/WCMSA-Reference-Guide-Version-2_5.pdf.
[12] https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9893.pdf.
[13] https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM5371.pdf.
[14] https://www.reginfo.gov/public/do/eAgendaViewRule?pubId=201904&RIN=0938-AT85.
[15] *42 U.S.C. § 1395y(b)(2)(A)(ii)*.
[16] See https://img1.wsimg.com/blobby/go/897dcfc2-0ffc-429c-85fb-6b4d67f66e9a/downloads/Medicare-Denial-Letter-Future%20Medicals.pdf?ver=1559581548198 and https://img1.wsimg.com/blobby/go/897dcfc2-0ffc-429c-85fb-6b4d67f66e9a/downloads/Medicare%20Recovering%20for%20Future%20Medicals%20in%20CPN.pdf?ver=1559581548198.
[17] *42 U.S.C. § 1395y(b)(2)(B)(iii)*.
[18] *42 U.S.C. § 1395y(b)(2)(B)(iv).*
[19] *31 U.S.C. §§ 3729, et seq*.
[20] *31 U.S.C. §§ 3729(a).*
[21] See https://cattielaw.com/f/usdoj-settles-with-plaintiff-law-firm-over-conditional-payments and https://cattielaw.com/f/250k-buys-plaintiff-law-firm-buys-peace-with-usdoj-medicare.