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Fixed Percentage Option Offers An Uncomplicated Alternative to Otherwise Potentially Complicated Settlements Involving Medical Liens

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Negotiating personal injury settlements in cases involving persons who receive medical assistance through Medicare and/or Medicaid can be complicated. Recently, Medicare implemented the Fixed Percentage Option ("FPO") that helps to abrogate some of the complication for settlements under $5,000. This article will briefly discuss Medicare's right of reimbursement and mandatory reporting requirements. Then, with that background in mind, the article will explain the FPO and provide practical considerations for practitioners utilizing this option.

I. Background to Medicare

Medicare was established as part of the Social Security Act of 1965. Medicare is a federal health insurance program for people over the age of sixty-five or people under the age sixty-five with certain disabilities and permanent kidney failure.[1] Originally, Medicare mandated that all services covered under Medicare be paid by the government as a primary payer. The

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[1] Office of Financial Management/Financial Services Group, *Introduction to Section 111 Mandatory Medicare Secondary Payer Reporting*, CTRS FOR MEDICARE AND MEDICAID SERV., 1 (Feb. 23, 2009), http://www.cms.gov/Medicare/Coordination-of-Benefits/MandatoryInsRep/downloads/RevisedSection111022309.pdf; Christopher S. Berdy & Steven Nichols, *The Medicare, Medicaid and SCHIP Extension Act of 2007: A Practitioner's Introduction to Resolving Injury Liability Claims Medicare Beneficiaries*, 76 DEF. COUNS. J. 393, 393 (2009); *see generally* www.medicare.gov (the official government website for Medicare) (last visited June 8, 2011).

passage of the Medicare Secondary Payer Act ("MSP")[2] in 1980 provided for a redistribution of the primary payment burden.[3] Today, Medicare is a secondary payer to other available payment sources for health-related costs arising out of a qualifying event, and primary payment must be made by private organizations (called primary payers or primary plans).[4] This includes liability insurance (including self-insurance), no fault insurance, and workers' compensation.[5] Accordingly, the MSP provides that if a beneficiary receives medically-necessary care for which payment has been, or is reasonably expected to be paid by a primary payer source, then Medicare may not have any obligation to pay the costs.[6]

Although Medicare is a secondary payer, it often makes the first payment to providers for health care services because the existence of a primary payer may be unknown or ambiguous when care is provided to the Medicare beneficiary.[7] To protect the beneficiary, Medicare may issue a conditional payment to the provider. In doing so, Medicare obtains a right to reimbursement from the primary plan, or entity, or payer when a conditional payment is made. Essentially, if it is determined that conditional payments made by Medicare were the

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[2] The Medicare Secondary Payer Act is codified at 42 U.S.C. § 1395y. The regulations regarding the administration of the Medicare Secondary Act are codified at 42 C.F.R. § 411. *See generally* Ctrs. for Medicare and Medicaid Serv., *Medicare Secondary Payer Manual*, Pub. No. 100-05, Ch.1 § 10 (65th rev. ed. 2009), http://wayback.archive-it.org/2744/20111201224940/http://www.cms.gov/manuals/downloads/msp105c01.pdf (hereinafter "MSP Manual").

[3] 42 U.S.C § 1395y(b)(2)(A). Medicare is prohibited from making payment when payment has been or will be made by group health plans, workers' compensation plans, liability insurance, or no-fault insurance*; see also* MSP Manual, *supra* note 2, Ch. 1, § 10–General Provisions. A primary payer is an entity responsible to pay the health-related costs of a qualified beneficiary. The following are examples of primary payers: a Group Health Plan or a Non-Group Health Plan (NGHP), which includes liability insurance (including self-insurance), no-fault insurance, and workers' compensation.

[4] Tamela J. White, *The Medicare Secondary Payer Act and Section 111 of the Medicare, Medicaid, SCHIP Extension Act of 2007: Implications for Claim Management and Resolution for Liability Insurance Plans*, 77 DEF. COUNS. J. 180, 181 (2010).

[5] CTRS. MEDICARE AND MEDICAID SERV., MMSEA SECTION 111 MEDICARE SECONDARY PAYER MANDATORY REPORTING LIABILITY INSURANCE (INCLUDING SELF-INSURANCE), NO-FAULT INSURANCE, AND WORKERS' COMPENSATION USER GUIDE, Version 3.3 at 13 (Dec. 16, 2011).

[6] 42 U.S.C § 1395y(b)(2)(i); White, *supra* note 4, at 183-4.

[7] 42 U.S.C § 1395y(b)(2); White, *supra* note 4, at 183.

responsibility of a primary plan, entity, or payer, then Medicare is entitled to reimbursement to recover on its conditional payments.[8]

II. Medicare's Right to Reimbursement and Mandatory Reporting Requirements

a. Notification of Settlement or Judgment by Medicare Beneficiary

A beneficiary must notify Medicare of a settlement or judgment that is over $300.[9] Notice to Medicare can be given before or after settlement or judgment. Notification made to Medicare before the settlement or judgment with the primary payer provides Medicare time to compile information for the total lien amount. On the other hand, notification to Medicare after a settlement payment could create a problem. The Medicare beneficiary runs the risk of settling for an amount that is less than Medicare's lien. As a result, the beneficiary may owe Medicare more than the settlement amount.

Nonetheless, when Medicare is notified that a settlement or judgment has occurred, it can exercise its right to reimbursement for conditional payments made.[10] If Medicare cannot recover its total lien from the medical beneficiary, it can take legal action to recover previously made conditional payments from individual Medicare beneficiaries, medical providers and suppliers, attorneys, private insurers, and/or defendants.[11] In situations where Medicare is unable to secure reimbursement from a beneficiary, it may instead go after the primary payer. Put simply, a Medicare beneficiary must disclose known actual or potential alternative payment sources.[12] Failure to comply could jeopardize a beneficiary's plan participation.

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[8] 42 U.S.C § 1395y(b)(2)(B)(iv); MSP Manual, *supra* note 2, at Ch. 1, § 10–General Provisions.
[9] *See* http://www.msprc.info (explaining that Medicare has implemented a $300 threshold for certain Liability Insurance cases); *see also* http://www.msprc.info/forms/$300%20Threshold%20%20for%20Some%20 Liability%20Insurance.pdf (a presentation explaining the $300 threshold)
[10] 42 U.S.C. § 1395y(b)(2)(B)(iv)
[11] *Id.* at (iii); *see also* 42 C.F.R. § 411.24.
[12] *Id.* at (i); *see also* 42 C.F.R. § 411.26.

b. Mandatory Reporting by Responsible Reporting Entities

The 1980 amendment which gave Medicare secondary payment status created new challenges for the government in trying to secure reimbursement of its conditional payments.[13] Thus, Section 111 of the Medicare, Medicaid, and State Children's Health Insurance Program Extension Act ("SCHIP") was implemented in 2007 and adds mandatory reporting requirements for Responsible Reporting Entities ("RREs")[14] with respect to Medicare beneficiaries who receive judgments, awards or other payments from liability insurance (including self-insurance), no fault insurance, or worker's compensation.[15] It is worth noting that RREs face severe penalties and may be subject to a private cause of action for failure to comply with reporting requirements.[16]

Reporting requirements for settlements are determined using the date[17] and amount[18] of the Total Payment Obligation to Claimant ("TPOC") for liability insurance carriers. By 2015, reporting requirements will apply to every claim. Currently, however, any settlement under $5,000 is exempt from reporting.[19] Next year (2013), any claims with a TPOC amount over $2,000 will be subject to reporting requirements, as will 2014 claims over $600.[20]

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[13] *See* 42 U.S.C. § 1395y(b)(3)(A) (providing the United States with a right of subrogation).
[14] *See* 42 U.S.C. § 1395y(b)(7)(A); 42 U.S.C. 1395y(b)(8)(A). A non-Group Health Plan Responsible Reporting Entity ("RRE") is an employer or defendant's insurance carrier. RREs are required to report to specified information regarding Medicare beneficiaries to ensure proper coordination of benefits with the Medicare program; *see also* Berdy, *supra* note 1, at 398-9.
[15] 42 U.S.C § 1395y(b)(8).
[16] *See* 42 C.F.R. §§ 411.24(f), 411.26(a).
[17] The TPOC date is the date the settlement, judgment or other award was entered.
[18] The TPOC amount is the amount of a settlement, judgment, or other award.
[19] Office of Fin. Mgmt./Fin. Serv. Grp., *GHP HRA Coverage – MMSEA Section 111 Reporting*, CTR. FOR MEDICARE & MEDICAID SERV., 1 (Sept. 27, 2011), https://www.cms.gov/Medicare/Coordination-of-Benefits/MandatoryInsRep/downloads/HRACoverage.pdf.
[20] Office of Fin. Mgmt./Fin. Serv. Grp., *Extension of Current Dollar Thresholds for Liability Insurance (Including Self-Insurance) and Workers' Compensation*, CTR. FOR MEDICARE & MEDICAID SERV., 2 (Nov. 9, 2010), https://www.harmonie.org/user_documents/CMC%20Revises%20Timeline%20for%20Reporting.pdf.

III. Fixed Percentage Option –A New Method to Reimburse Medicare

A Medicare beneficiary who receives payment from a primary payer must reimburse Medicare within sixty (60) days of receiving payment.[21] Receipt of funds by the beneficiary constitutes the triggering event for repayment.[22] However, the process to reimburse Medicare can be time-consuming and confusing. Accordingly, in November 2011, the Center for Medicare and Medicaid Services implemented the FPO, a new method to reimburse Medicare. [23]

The purpose of the FPO is to streamline the recovery process so that calculation of Medicare recovery amounts is more expedient and predictable for all parties involved. The FPO is available to beneficiaries who receive certain types of liability insurance settlements of $5,000 or less.[24] Election of the FPO allows an eligible Medicare beneficiary to pay Medicare a flat 25 percent of the total liability insurance settlement.

There are several benefits associated with electing the FPO.[25] First, election of the FPO offers a simple, straight forward process and allows the beneficiary-claimant to know exactly how much is owed to Medicare. Second, the beneficiary can immediately pay Medicare 25 percent of the gross settlement (which is not reduced for any attorney fees and costs). Third, election of the FPO eliminates time and resources typically associated with the reimbursement process. Fourth, the FPO gives the beneficiary the opportunity to resolve their debt to Medicare quickly which means the beneficiary does not have to wait on a conditional payment amount from Medicare prior to settlement of claim with a primary payer.

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[21] 42 U.S.C. § 1395y(b)(2)(B)(ii); 42 C.F.R. § 411.24(h); Berdy, *supra* note 1, at 395.
[22] White *supra*, note 4, at 190-191.
[23] Centers for Medicare & Medicaid Services ("CMS") is the federal agency that manages the Medicare program. *See* Ctrs. For Medicare and Medicaid Serv., *MMSEA Section 111 Mandatory Insurer Reporting Quick Reference Guide* (Jan. 19, 2012) (http://www.nqbp.com/sites/default/files/NGHPQuickRef_Section%20111%20Reporting.pdf). CMS has engages Coordination of Benefits Contractor (COBC) to manage the technical reporting aspects. *Id.*
[24] *See* http://www.msprc.info/ (notifying readers of the fixed percentage option available to beneficiaries who receive certain types of liability insurance (including self-insurance) settlements of $5000 or less).
[25] *Id.*

The examples below illustrate how a settlement utilizing the FPO would work:

Example 1:

- Medicare's conditional payment amount is: $20,000
- Total liability insurance settlement is: $4,000
- Attorney fee is: $5,300
- Amount due to Medicare under FPO (i.e. 25% of recovery) is: $1,000

Example 2:

- Medicare's conditional payment amount is: $3,000
- Total liability insurance settlement is: $4,000
- Attorney fee is: $0
- Amount due to Medicare under FPO (i.e. 25% of recovery) is: $1,000

To utilize the FPO, a Medicare beneficiary must qualify for it.[26] A beneficiary becomes eligible to elect FPO if the following criteria are met: (1) the settlement, judgment award, or other payment is from liability insurance (including self-insurance); (2) the liability insurance (including self-insurance) settlement is $5,000 or less; (3) the settlement is for physical trauma based injury (not related to ingestion, exposure, or medical implant); (4) the beneficiary elects the FPO within the required timeframe *and* before Medicare has issued a demand letter or other request for reimbursement to the incident; and, (5) the beneficiary has not received nor does s/he expect to receive payments related to the incident.[27]

A written request to elect the FPO must be submitted to and approved by the Medicare Secondary Payer Recovery Contractor (MSPRC).[28] A response to an FPO request is to be generated within 30 days of the requested receipt. If the FPO election is approved, then the beneficiary will receive a bill for the amount due. As previously discussed, the bill will equal 25 percent of the total liability insurance settlement, judgment, award, or other payment. The beneficiary must make the payment to Medicare within the timeframe specified on the bill. Of

[26] See "Attorney Tool Kit" at http://www.msprc.info/index.cfm?content=includes/toolkits/attorney_nghp for a variety of helpful resources regarding the fixed percentage option (FPO).
[27] *Id.*
[28] According to MSPRC.info's contact page at http://www.msprc.info/index.cfm?content=contact, FPO elections are sent to: MSPRC– Fixed Percentage, PO Box 138880, Oklahoma City, OK 73113.

note, a Medicare beneficiary may not seek appeal or waiver of recovery if the FPO is elected and approved.[29]

If the request is rejected, (1) the beneficiary will receive an explanation of why the request was rejected and (2) the beneficiary will use the traditional recovery process and attorney fees and expenses will be used to issue a traditionally calculated demand amount.

IV. Practical Considerations for Practitioners

Election of the FPO is more straightforward for counsel when both parties are represented. This situation, assumes that both practitioners have knowledge of Medicare's requirements in electing the FPO.[30] On the other hand, settling a claim with a pro se Medicare beneficiary can make electing the FPO more complicated and merits further discussion.

Practitioners should consider necessary disclosures and the ethical requirements of dealing with pro se plaintiffs.[31] To avoid misunderstandings between defense counsel and pro se plaintiffs, a lawyer should advise the pro se plaintiff that their interests are not aligned. Model Ethics Rule 4.3 prohibits attorneys from "giving any advice, apart from the advice to obtain counsel."[32] However, a lawyer may negotiate the terms of the transaction or settle a dispute with an unrepresented plaintiff.[33]

In general, if the pro se plaintiff is willing, he or she can authorize the opposing counsel to communicate on his or her behalf directly with Medicare. This can benefit the pro se plaintiff because an attorney may be better suited to handle the deadline-intensive procedures outlined by MSPRC. However, if the pro se plaintiff is unwilling to make this authorization, opposing

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[29] See http://www.msprc.info/forms/Fixed%20Percentage%20Option%20Information.pdf for an explanation of when to elect the FPO.

[30] MSPRC Attorney Toolkit, MSPRC.INFO, http://www.msprc.info/index.cfm?content=includes/ toolkits/ attorney_nghp (last visited June 20, 2012)

[31] *See generally* MINN. R. PROF. CONDUCT RULE 4.3 (2011) (stating ethical requirements of an attorney dealing with an unrepresented person).

[32] *Id*.

[33] *Id.* at comment [2].

counsel must rely on the pro se plaintiff to properly and timely communicate with Medicare. If the pro se plaintiff fails to do so, all parties could be subject to legal action by Medicare to recover previously made conditional payments.

If the settlement is more than $300 but less than $5,000, the Practitioner should determine when notification of Medicare should be made. While it is generally most prudent to notify Medicare of a pending action or settlement prior to judgment, award, or settlement, notification may be more easily reported after the aforementioned occurs by submitting the request for the FPO election. This is because Medicare's conditional payment amount plays little to no role in settling a matter where an FPO is possible. As previously discussed, regardless of the settlement amount, Medicare can only receive 25 percent of the settlement amount, so long as the settlement was $5,000 or less.

Finally, Practitioners should consider whether the settlement amount due to the plaintiff, particularly if the plaintiff is pro se, will jeopardize any other government assistance the person is receiving. In Minnesota, Medical Assistance is the state-run version of Medicare. A Medicare beneficiary who receives Medical Assistance may lose certain health care eligibility if their settlement amount exceeds the monthly income limit. The monthly income limit is established by the Minnesota Health Care Program. [34] However, this concern may be alleviated if the practitioner is able to negotiate that the payments will be made directly to the care providers for out-of-pocket expenses incurred by the plaintiff and not directly to the plaintiff.

[34] Visit the Minnesota Department of Humans Services website for an explanation of income and asset limits available at http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION &RevisionSelectionMethod=LatestReleased&dDocName=id_052537. The income and asset limits are updated annually and are effective July 1- June 30. See also the income "Income and Assets Limits" brochure provided at https://edocs.dhs.state.mn.us/lfserver/Public/DHS-4346-ENG.

V. Fixed Percentage Option Resources

A thoughtful practitioner should proactively take steps to keep informed of changes that could impact Medicare beneficiaries. Specifically, the Medicare Secondary Payer Recovery Contractor website offers a user-friendly resource that explains the Medicare Secondary Payer recovery process.[35] In addition, the website offers the option to sign up for an electronic newsletter. Although briefly mentioned in this is article, practitioners should also become familiar with the tedious reporting requirements of RREs.[36] Further, 42 U.S.C. § 1395y and 42 C.F.R. § 411 implement the guidance of the Medical Secondary Payer Act.

VI. Conclusion

As a general rule, practitioners should ensure reasonable consideration of Medicare's interests in resolving personal injury liability disputes involving Medicare beneficiaries. While the FPO is only available in certain limited circumstances, it can provide for a relatively uncomplicated resolution of claims made by Medicare beneficiaries.

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[35] *See supra* note 9

[36] *See supra* note 14 and accompanying text.