



Subrogation and Medicare Set-Asides

Secondary Payer Reporting
Requirements Create Traps for
Subrogation Professionals

BY GARY L. WICKERT, MATTHIESEN,
WICKERT & LEHRER, S.C.

IN RECENT YEARS, MEDICARE HAS BEEN TAKING MORE OF AN INTEREST IN AND IS STARTING TO REVIEW WORKERS' COMPENSATION SETTLEMENTS MORE CLOSELY BECAUSE THE U.S. GOVERNMENT BELIEVES THAT THERE HAS BEEN AN ILLEGAL SHIFT OF MEDICAL BENEFITS FROM WORKERS' COMPENSATION INSURERS TO MEDICARE. AS MEDICARE'S ROLE IN WORKERS' COMPENSATION AND LIABILITY SETTLEMENTS EVOLVES, SUBROGATION PROFESSIONALS HAVE HAD TO BECOME INCREASINGLY EDUCATED ON THIS CONFUSING AND OFTEN CONFLICTING AREA OF THE LAW.

Medicare is the federal health insurance program that covers most people age 65 and older, as well as some younger people who are disabled or who have End-Stage Renal Disease (permanent kidney failure). Medicare benefits are provided in four parts – A, B, C and D. Part A helps pay for inpatient hospital care, some skilled nursing facilities, hospice care and some home health care. Part B is the part that helps pay for doctors, outpatient hospital care, and some care that Part A doesn't cover, such as physical and occupational therapy. Part C allows various HMOs, PPOs and similar health care organizations to offer health insurance plans to Medicare beneficiaries. Part D provides prescription drug benefits through various private insurance companies.

Clearly, there are accidents and injuries for which both Medicare and workers' compensation insurance will provide overlapping benefits and coverage. However, the attempt to shift

benefits in conjunction with the settlement of workers' compensation claims without proper Medicare approval can lead to serious liability on the part of compensation carriers and lawyers. According to some, Medicare's interest and authority is now spreading to settlement of third-party liability lawsuits. A lack of clear guidance has left many subrogation professionals – not to mention lawyers – perplexed and possibly at risk.

Medicare Secondary Payer Statute

Political pressure to preserve and protect the Medicare Trust Fund has reached critical mass. The population of beneficiaries that Medicare is intended to cover – older people and the severely disabled – is on the rise. To reduce Medicare costs, Congress enacted a collection of statutory provisions in the 1980s called the Medicare Secondary Payer (MSP) statute largely in recognition that workers' compensation carriers should be the primary source of medical insurance coverage

for workers injured on the job. It is overseen by the Centers for Medicare & Medicaid Services (CMS) of the Department of Health and Human Services (HHS), as part of their Coordination of Benefits (COB) initiative.

The Medicare Secondary Payer Act is found at 42 U.S.C. §1395y. It makes Medicare a secondary payer to not only workers' compensation, but also group health, auto, liability, and no-fault insurance.¹ Section 1395y(b)(2) provides that in order to recover payment made under this subchapter for an item or service, *"the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan."*²

What concerns subrogation professionals and workers' compensation carriers (and soon possibly liability carriers) is what the federal government

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may do to enforce its right of reimbursement, and how do they determine who to do it to. The italicized portion of § 1395y(b)(2)(B)(iii) above answers the former question. Section 1395y(b)(5) answers the latter. That section reveals that the Commissioner of Social Security (CSS) must annually transmit a list of names and Tax Identification Numbers (TINs) of Medicare beneficiaries to the Secretary of the Treasury (IRS). The Administrator for the CMS must annually request from the CSS a variety of information and provide this information to "fiscal intermediaries and carriers." These carriers then have an obligation to contact the employers of certain employees and the employers have an obligation, under penalty of law, to provide the information timely and completely, within 30 days of receiving the inquiry. Before a person applies for Social Security of Medicare, the Administrator mails them a questionnaire and obtains information on whether the individual is covered under a primary plan.³ It is government bureaucracy at its finest.

In 2003, President Bush signed into law the Medicare Prescription Drug Improvement and Modernization Act, further spelling out Medicare's recovery

rights and enforcement powers, and making it clear that any payments made by Medicare are considered to be "conditional," with Medicare having an absolute right to seek recovery of those conditional payments. Medicare can also suspend or terminate a beneficiary's medical coverage, allocate 100% of a third-party settlement to Medicare-eligible medical expenses and/or suspend a beneficiary's Social Security Disability benefits on a dollar-for-dollar basis until the MSP claim, including interest, has been satisfied.

The 2003 amendments also clarified that the United States may bring an action against any entity that "*are or were required or responsible...to make payment...*"⁴ As a result, all payments made by Medicare both before and after settlement of a workers' compensation claim are still considered "conditional" and repayment is required by the MSP Act.⁵ The Act provides for a private cause of action against "*any entity, including a beneficiary, provider, supplier, physician, attorney, State agency or private insurer...*" which has received any portion of a third-party payment, directly or indirectly, where those funds should have covered Medicare expenses.⁶

The Act precludes Medicare from

paying in a primary capacity on behalf of a Medicare beneficiary when another entity has primary payer responsibility. In workers' compensation, this means that Medicare will not pay a workers' compensation bill since the primary payer should be the employer. If Medicare makes such a payment, it has a priority right to recovery that payment from the compensation carrier or employer. Any payment Medicare makes is considered a lien. If Medicare has to initiate any type of legal action in order to be reimbursed, they are entitled to double damages. Medicare has a right of action to recover its payments from any entity, including a beneficiary, provider, supplier, physician, attorney, state agency or private insurer. Section 42 C.F.R. §411.40 indicates that all workers' compensation plans of the United States are included with regard to recovery.

In §411.46(b)(2), the Act says that if a compensation claim settlement has the effect of shifting medical bill liability to Medicare, the settlement will not be void. Subsection (d) says that with regard to lump-sum compromise settlements of compensation claims, "*If a lump sum compromise settlement forecloses the possibility of future payment of workers' compensation benefits, medical expenses incurred after the date of the settlement are payable under Medicare.*" Apparently, however, that is not the end of the story.

Commutation of Workers' Compensation Claims

A carrier will often lump-sum a settlement (in states where allowed) in lieu of recovering its lien reimbursement under the subrogation statute of a particular state (or for a reduced lien recovery). When a subrogated compensation car-

rier lump sums a compensation claim as part of a settlement involving a third-party recovery (e.g., a dollar contract in Illinois), the Act provides a trap for the carrier because one never knows when medical conditions will worsen and Medicare will be called upon. Although it appears from federal regulations that Medicare should only be involved in cases where Medicare benefits are at issue, there literally are no rules or guidelines governing how and when Medicare might swoop in and involve itself. Therefore, subrogation professionals and compensation claims handlers must always be aware of this potential liability. Sadly, Medicare gives us no rules or regulations regarding the amount of compromise settlement that Medicare would examine for invalidation. It is easy to take Medicare into consideration when Medicare has paid for past treatment expense that should have been paid as part of a workers' compensation claim. In that instance, all parties are required to reimburse Medicare for the payments it made or

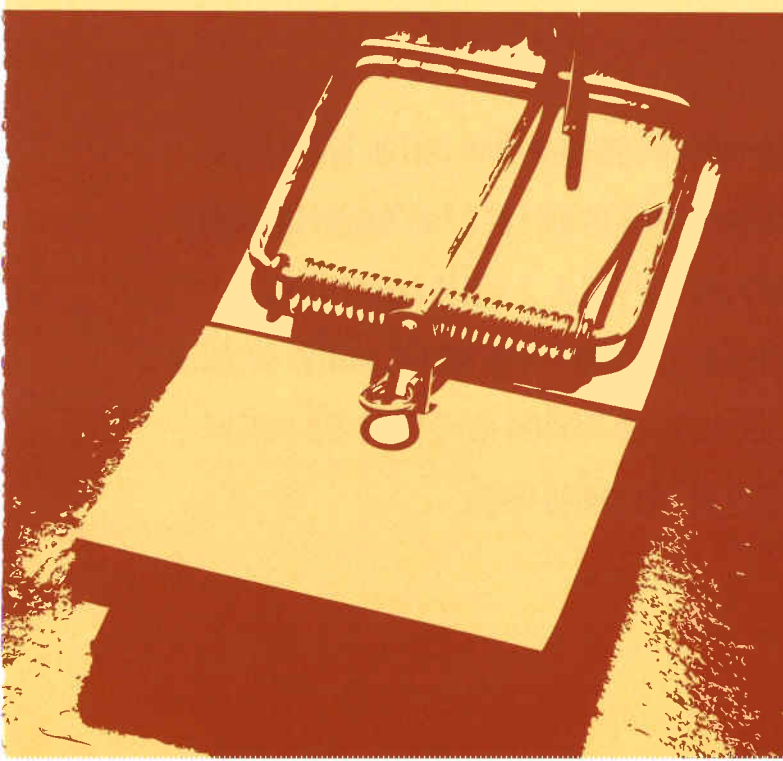
face liability. The problem arises when you have potential future medical treatment, which may or may not be payable by Medicare months or even years down the road.

In 2001, the Medicare Set-Aside review system was set up as a means of protecting Medicare from having to make benefit payments after a third-party settlement and closure of a workers' compensation claim. Amazingly, for years, there was no statute or regulation referencing this review system. Medicare began to "encourage" the submission of settlement to the CMS regional offices for prior approval. The system – known as Medicare Set-Asides (MSA) – was developed with an internal Medicare policy memo dated July 23, 2001. A copy of this and other memos can be found at www.cms.hhs.gov/WorkersCompAgencyServices/. It makes a distinction between the "compromise" of workers' compensation claims (when liability for future medical is in dispute) and "commutation" of such claims

(when the parties agree on a lump-sum in exchange for giving up lifetime medical care). The memo goes into much more detail on MSA than this article does. In short, Medicare has made clear that its "stamp of approval" is the only way for the parties to be certain that Medicare will not come back at a later date requesting reimbursement of Medicare conditional payments made for care that the compensation carrier should have paid for.

In 2003, CMS clarified its position that self-insured entities were also included in the MSP by passing the Medicare Act of 2003. The 2003 revisions altered MSP to expressly include self-insured entities as "responsible" parties obligated to reimburse Medicare.⁷

Not every workers' compensation settlement can be reviewed and approved by Medicare. Until recently, CMS had set its own internal workload review thresholds, which were not binding on, nor did they fully protect those who failed to get compensation settlements approved. These require-



The Medicare Secondary Payer Act makes Medicare a secondary payer to not only workers' compensation, but also group health, auto, liability and no-fault insurance.¹

ments relied on fear – fear of a future CMS reimbursement claim – to motivate compliance. CMS did give some level of comfort as far as whether they will review a particular lump-sum settlement or commutation of a workers' compensation claim that would lead to future liability of the carrier or attorney involved. CMS's policies provided that they would review workers' compensation settlements that met either of the following two criteria:

1. Cases involving a current Medicare beneficiary where the total settlement amount is greater than \$25,000; or
2. Cases where the claimant has a reasonable expectation of Medicare entitlement within 30 months where the total settlement amount is greater than \$250,000.

The "total settlement amount" includes, but is not limited to:

1. The total indemnity being paid as part of the settlement;
2. The total medical expenses (including future medical expenses) being paid as part of the settlement;
3. The amount of any Medicare conditional payments to be repaid;
4. Attorney's fees;
5. The total amount of any civil settlement arising out of the same accident or occurrence; and
6. Sums for any previously settled portions of the case.

These parameters may be broader than they initially appear. For example, if the injured individual is permanently and totally disabled, has filed for Social Security disability, and

the settlement apports \$25,000 per year (combined for both future medical expenses and disability/lost wages) for the next 20 years, then the CMS regional office should review that workers' compensation settlement because the total settlement amount over the life of the settlement agreement is greater than \$250,000 (\$25,000 x 20 years = \$500,000) and the injured individual has a "reasonable expectation" of Medicare enrollment within 30 months of the settlement date. For purposes of the 30 month requirement, claimants must wait six months after applying for Social Security before they can receive their first Social Security check, and they are eligible for Medicare 24 months after their entitlement date. Therefore, you should evaluate whether a claimant is likely to become a beneficiary in all cases where the claimant has been off work for two years or more or is 62.5 years or older. However, the "*reasonable expectation of Medicare entitlement within 30 months*"

criterion is much broader than this. The CMS has indicated that the situations where an individual has a "reasonable expectation" of Medicare enrollment for any reason include, but are not limited to:

1. The individual has applied for Social Security Disability Benefits;
2. The individual has been denied Social Security Disability Benefits but anticipates appealing that decision;
3. The individual is in the process of appealing and/or re-filing for Social Security Disability Benefits;
4. The individual is 62.5 years of age (*i.e.*, may be eligible for Medicare based upon his/her age within 30 months); or
5. The individual has an End Stage Renal Disease (ESRD) condition but does not yet qualify for Medicare based upon ESRD.⁸

The need for an MSA can be necessitated by something as simple as the

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injured worker having filed for Social Security. The review process is applicable nationwide to workers' compensation cases, but what about the settlement of third-party liability lawsuits pending in state and federal courts?

Future Credits and Settlement of Third-Party Cases

The most common scenario subrogation professionals confront is a simple future credit granted under the laws of most states when the worker makes a tort recovery (by settlement or judgment) against a third-party tortfeasor who is responsible for causing the work-related accident or injury. Depending on the state and terms of the settlement, the carrier stops making medical benefit payments until the credit is used up. If the credit is exhausted, the compensation carrier usually kicks back in with payment of benefits. However, if the worker has spent all of his money and has nothing left to pay his medical bills, and Medicare is called on to make conditional payments, the problem falls back on the compensation carrier and the lawyers who were involved in the settlement of the third-party case. The reason is simple: the worker has no money. So how do the compensation carrier and all parties involved in such a third-party settlement protect themselves from future liability to Medicare?

In 2003, CMS approved a Medicare Set-Aside procedure for third-party liability case settlements similar to the one employed in workers' compensation commutation cases. In cases where a third-party liability lawsuit settlement is made and the carrier receives a future credit under a state's workers' compensation subrogation laws, a


CMS-approved MSA arrangement is equally appropriate, and advisable - but it still was not "required."

The same fundamental statutory principles requiring settling parties to protect Medicare's interests in workers' compensation settlements, as well as the same criteria for its application, appear to apply equally to third-party liability settlements. The MSP above clearly indicates that Medicare is always secondary to workers' compensation and other insurance, including no-fault and liability insurance. Payment "*may not be made under Medicare for covered items or services to the extent that payment has been made, or can reasonably be expected to be made promptly, under a liability insurance policy or plan.*" Also, Medicare's authority to review liability settlements arises under the same statute as its authority to review workers' compensation settlements does.

MSA's in third-party liability settlements may prove to be much more complicated than in compensation claim commutations, and they certainly are a Pandora's Box for carriers, claims handlers and lawyers alike. Unlike workers' compensation claims, which cover a worker's lifetime injury-related care, liability insurance policies generally have limits, and the doctrines of comparative fault and contributory negligence inherent in personal injury cases work to offset the damages to an amount less than full value. CMS's current methodology assumes the full-value, "no fault" nature of the workers' compensation schemes. Workers' compensation cases deal with "liquidated" economic damages such as lost wages and medical expenses, while third-party lawsuits involve both economic and non-economic (pain and suffering, mental anguish, etc.) damages.

Trial lawyers, insurance companies

Until recently, CMS had set its own internal workload review thresholds, which were not binding on, nor did they fully protect those who failed to get compensation settlements approved. These requirements relied on fear – fear of a future CMS reimbursement claim – to motivate compliance.



Trial lawyers, insurance companies and subrogation professionals should not assume that settling parties have no obligation to protect Medicare's interests when they consider future medical expenses.

and subrogation professionals should not assume that settling parties have no obligation to protect Medicare's interests when they consider future medical expenses. Medicare's concern that the payment burden could be shifted from a liable third-party payer to the government as it is the same in workers' compensation settings as it is in liability settlements. Because CMS regulations give them broad power to disregard a settlement and assess penalties to any party that attempts to shift payment responsibility inappropriately to Medicare, care should be taken to protect Medicare even in liability settings. Whether or not it is necessary to set aside a portion of every liability settlement to take care of future medical needs is not made clear in current regulations. Trial lawyers will have difficulty balancing their duty to zealously represent their clients' interests with this gray area of MSAs in liability settlements. The same concerns should be shared by workers' compensation carriers, liability carriers, and subrogation professionals. Until CMS provides further

guidance, the following tips and guidelines should be considered:

- Use common sense and a good-faith approach to determining whether the settlement amount was based on some specific recognition of the cost of future medical treatment and will be adequately preserved to take care of future medical needs.
- Try to express the care taken in preserving the handling of future medical needs in the calculations of the settlement and the settlement documents.
- Take steps to set aside and preserve those funds which are necessary to take care of future medical needs, as in a medical trust.
- Err on the side of caution and submit your set-aside calculation to CMS for approval.
- Keep and maintain accurate records and receipts for injury-related care in case CMS ever inquires.

But is this approach too conservative, since CMS does not yet have a formalized process for acquiring future medical costs associated with third-party injury? The agency may never formally release standards for liability set-asides. In a typical legal malpractice case, the question is whether the attorney breached a duty to the client and failed to conform to the appropriate standard of care. Where does this leave you? It is likely that the CMS will release a position statement on this issue in the near future. Until then, when settling a liability case in which you have not specifically negotiated payments for future medical expenses, draft a general release using broad language—referring, for example, to “all claims past and future”—to avoid the assumption that the settlement covers lifetime medical costs. Be prepared to prove that the settlement did not contemplate a specific future medical component—that the parties, acting in good faith, came up with one indivisible sum of money for release of all

claims. Make sure your assessment is consistent with key documents, such as the complaint, the subsequent procedural aspects of the litigation and the ultimate settlement agreement. Conversely, if you are settling a liability case that does specify future medical costs and the settlement is of significant value, you should consider addressing both past (conditional) and future interests of Medicare. Furthermore, keep in mind that some liability settlements involving critically injured plaintiffs are so large that CMS may presume the plaintiff is being compensated for future medical expenses.

If you are settling a third-party liability case and at the same time settling the workers' compensation plan's obligation to cover future medical expenses, you may need a MSA. The 2003 CMS memo states in answer to question 19, *"To the extent that a liability settlement is made that relieves a [workers' compensation] carrier from any future medical expenses, a CMS approved Medicare set-aside arrangement is appropriate."* This

set-aside would need sufficient funds to cover future medical expenses incurred once the total third-party liability settlement is exhausted.

The Medicare, Medicaid and SCHIP Extension Act of 2007

For many years, the cryptic answer to question 19 in the 2003 memo was the only indication we had that liability cases needed to be handled similarly to the commutation of workers' compensation claims. Originally, only workers' compensation carriers were primary payers under the MSP statute. Now, however, the law has been expanded to include group health plans and certain non-group health plan arrangements, such as liability insurance (including self-insurance) and no-fault insurance plans, as "primary payers." Any entity that "carries its own risk" with respect to tort liability (including the risk of having to pay a deductible in the event of a claim) may be a "primary plan" and subject to the MSP requirements once its obligation to make medical

payments has been "demonstrated." Therefore, the MSP statute is now broadened to impose liability on any entity that settles claims with potential Medicare beneficiaries. A product manufacturer or negligent tortfeasor, for example, is now considered a primary payer under the Act where it carries any liability for the payment of a claim of medical damages made by a Medicare beneficiary. This most commonly occurs in the context of a product liability or other lawsuit. Where a Medicare beneficiary sues a manufacturer alleging its product is defective and caused injury, the manufacturer is a primary payer if it is self-insured for any of the amount it eventually pays to the plaintiff in settlement or as a result of the verdict. An employee group health plan's primary liability (and that of the employer), on the other hand, might exist simply by virtue of the employee's particular health plan. The primary liability of an employer's workers' compensation carrier for health expenses could be indicated where an employee was simply injured on the job.

On December 29, 2007, President Bush signed into law the Medicare, Medicaid, SCHIP Extension Act of 2007 (MMSEA). Section 111 stipulates the required submission of claimant status *"by or on behalf of liability insurance (including self-insurance), No-Fault insurance, and workers' compensation laws and plans"* if a claimant is determined to be Medicare-entitled.⁹ The MMSEA heaped new obligations and responsibilities on Group Health Plans, liability insurance plans (including self-insureds), no-fault insurance plans and workers' compensation plans. Section 1395(y)(b) was amended to add §§ 7 and 8. They detail the

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required submissions of information by group health plans, liability insurers (including self-insureds), no-fault carriers, and workers' compensation carriers.¹⁰

Section 8 imposes similar new requirements on liability plans, self-insureds, no-fault plans and workers' compensation plans. The MMSEA specifically sets forth that whenever there is a settlement, judgment, award or other payment (regardless of whether there is an admission of liability) these plans must:

1. Determine whether a claimant (including an individual whose claim is unresolved) is entitled to benefits under the program under this title on any basis; and
2. If the claimant is determined to be so entitled, submit information described in subparagraph (B) with respect to the claimant to the Secretary in a form and manner (including frequency) specified by the Secretary.

The implementation date for the new MSP requirements was supposed to become effective July 1, 2009. However, CMS has delayed implementing the new MSP requirements until January 1, 2010. Nonetheless, Responsible Reporting Entities (RREs) must report retroactive to July 1, 2009.¹¹ Beginning January 1, 2010, MMSEA § 111 requires all of these new entities to directly report potentially eligible claimant/plaintiffs to CMS. The new reporting requirements are imposed directly on self-insured entities and insurance carriers. Under the new Medicare legislation, insurance carriers

and self-insured entities will be fined \$1,000 per day for failure to comply. Further, in paying a settlement or award to a Medicare-eligible claimant/plaintiff, the insurance carrier or self-insured entity will be responsible for "double damages" if the lien is not satisfied in a timely fashion.

Complying With The New MMSEA Reporting Requirements

Carriers and plans will need to implement internal procedures for compliance with the new reporting laws. According to the MSP Manual, a RRE is required to have electronically registered with CMS between May 1 through September 30, 2009.¹²

CMS has announced it would impose an interim reporting threshold in 2010 for liability claims below \$5,000 which need not be reported to the new system.¹³ In 2011, the threshold will reduce to claims greater than \$2,000, and greater than \$600 for the year 2012. These thresholds are based

on the RRE's Total Payment Obligation to the Claimant ("TPOC"). In complying with MMSEA, it is important for the RRE's not to assume that all claimant/plaintiffs aged 65 and older are Medicare beneficiaries, or that those aged 65 and under are not. Under MMSEA, all insurers, including self-insured entities, must determine the Medicare entitlement of all claimant/plaintiffs and report specific information about the claims to CMS. To determine the Medicare entitlement status of a claimant/plaintiff, the RRE may ask the claimant/plaintiff directly whether he/she is eligible. However, because the RRE may not rely on the validity of the claimant/plaintiff's response, the RRE must obtain the claimant/plaintiff's Social Security Number for submission to CMS for verification. To make matters worse, claimants/plaintiffs are not required to divulge their Social Security Numbers unless litigation is pending.¹⁴

Verification may be completed through the submission of electronic

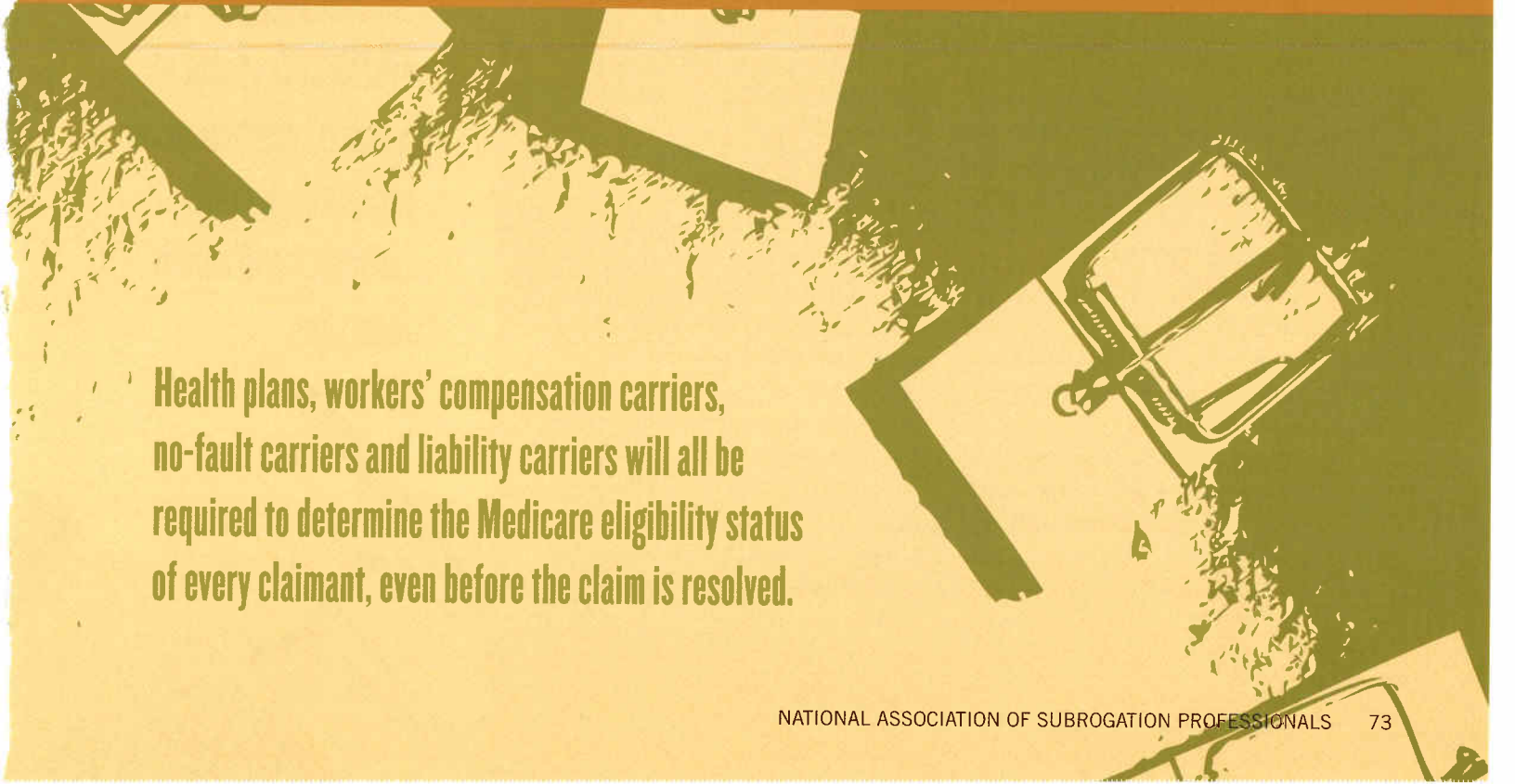
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queries by RREs, once, during the course of each month. To complete the query, the RRE must submit the Social Security Number, name, date of birth and gender of the injured party for each request.¹⁵ Following submission of the query, Medicare will determine the beneficiary's status within 14 days. The RRE's responsibility does not end here. They must continue to ensure that a person that was not a Medicare beneficiary does not become a beneficiary.¹⁶ If it is determined that the claimant is entitled to Medicare benefits, the RRE must report information about the claim and claimant to the CMS once the claim is either fully or partially concluded and a payout has been made or will be made in the future. This is known as a Medicare Set-Aside (MSA). If the RRE is the party responsible for the payout, report

is only required following final resolution of the claim. Parties to the claim have 60 days to reimburse Medicare, and failure to do so may result in CMS charging interest on the total outstanding amount.¹⁷ If CMS is required to take legal action to secure recovery, CMS is entitled to recover "double damages," which equate to twice the amount of the payments made on behalf of the beneficiary. Following entry of an award or an order approving settlement, the RRE must complete CMS's extensive report. More than 100 categories of information may be sought by CMS, depending on the identity of the plaintiff and the type of action pursued by the plaintiff.

Health plans, workers' compensation carriers, no-fault carriers and liability carriers will all be required to

determine the Medicare eligibility status of every claimant, even before the claim is resolved. This means each claimant will have to fill out a Social Security Form SSA-3288 (Consent to Release Information), so you will need to have plenty of those on hand. This will need to be submitted to the nearest Social Security office, requesting complete eligibility benefit information. This probably should be done when a claim is opened and when it is settled or closed – because conditions could change in the interim, and the responsibility is on the plan. Subrogation claims complicate the issue because the claimant is often not even involved in the prosecution and settlement of such claims. Most likely, information such as Social Security Number, medical records, life care plans and similar information will need



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to be submitted. How this interfaces with HIPAA privacy regulations remains unclear. CMS extended testing of the program through March 1, 2010 and reporting began in second quarter of 2010, for payments in the first quarter 2010.

This new legislation is a clear signal that Medicare is going to be stringently enforcing its status as secondary payer in liability settlements just as it currently does in workers' compensation settlements. Details on the requirements and information needed will undoubtedly be promulgated in the near future.

Playing It Safe

Sadly, and as is always the case when the unintended consequences of government programs collide with the reality of the free market, Medicare's new reporting requirements portend long-term complications and consequences for the overall cost of risk of workers' compensation insurance, liability insurance and health insurance, although the extent of these consequences cannot be accurately predicted. Implementation will necessarily add steps to underwriting, claims handling, and program administration. It has the potential to delay a settlement by several months, if not years. The claimant and insurer may agree on everything, but still must hold their breath that Medicare approves the deal. Claim life cycles and durations will be extended if settlements are delayed. Because of the great uncertainty surrounding whether or when to seek Medicare approval or MSAs, workers' compensation carriers, health plans, liability carriers, attorneys

and subrogation professionals should probably err on the side of caution in determining whether to involve Medicare in their third-party or workers' compensation settlements. The law either does or will require you to determine whether a claimant (including an individual whose claim is unresolved) is entitled to benefits under the program under this subchapter on any basis. It puts the burden on you. If you do determine this, then you will be required to submit information necessary for CMS to determine its secondary payer status and take action accordingly. There is nothing in the law or the published regulations that require the parties to seek preapproval of settlements or that require a set-aside. But both the burden and the potential liability are on us and doing so may be the only way to sleep at night when there is any question about future involvement of Medicare. At a minimum, the CMS has indicated that it will impose penalties or at least treat people differently if they do not obtain preapproval or make the necessary submittals.¹⁸

Pending Legislation

On May 21, 2009, Rep. John Tanner (D-TN) and three co-sponsors introduced H.R. 2641, entitled the *Medicare Secondary Payer and Workers' Compensation Settlement Agreements Act of 2009*.¹⁹ The proposed bill provides clear and consistent standards for the CMS administrative process and amends Section 1862 of the Social Security Act (42 U.S.C. §1395y(b)(2)(A)) with regard to the application of Medicare secondary payer rules to workers' compensation



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settlement agreements and MSAs under such agreements. In essence, it proposes to provide some of the guidance which practitioners have been craving.

The bill exempts the following workers' compensation settlement agreements from having to comply with MSA Agreements and/or review by the CMS:

1. Settlements with present value less than \$25,000;
2. Worker is ineligible for Medicare benefits as of the date the bill is enacted and who is unlikely to become so eligible within 30 months after the settlement agreement;
3. Worker is not entitled to future medical under the compensation laws of that state; or
4. The settlement agreement does not limit or extinguish future medical benefits.

A worker is deemed "unlikely" to be eligible for Medicare benefits within 30 months after the effective date of the settlement agreement unless such claimant is insured for disability insurance benefits as determined under subsection (c)(1) of § 223 and meets any of the following requirements:

1. The claimant has been awarded disability insurance benefits;
2. The claimant has applied for disability insurance benefits and the claimant's application has been pending without decision for 90 days or less after the date of filing the application;
3. The claimant has been denied disability insurance benefits and is

- appealing (or intending to appeal) a denial of such benefits under subsection (a) of such section.
4. The claimant is at least 62.5 years of age; or
5. The claimant has end stage renal disease.

The new bill also clarifies that: If a workers' compensation settlement agreement, related to a claim of a workers' compensation claimant, includes a qualified Medicare set-aside, such set-aside satisfies any obligation with respect to the present or future payment reimbursement under subsection (b)(2), with respect to such claim. The government will have no further recourse, directly or indirectly, under this title if a set-aside is obtained.

The new bill specifies certain requirements for a Qualified Medicare Set-Aside. In summary, subsection (b)(2) of the new bill details the criteria to be taken into consideration with regard to what qualifies as a "reasonable" set-aside, what the set-aside must include, and the details of the process for approval of Qualified Medicare Set-Asides by the Secretary. It also contains

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"safe harbor" protection for workers' compensation where the present value of the workers' compensation settlement agreement does not exceed \$250,000 as determined by subsection (n)(3) of the bill and 10% of the present value of the settlement is considered a "safe harbor" amount. Obviously, the bill itself must be consulted for the details and specifics.

The proposed bill also provides an option by which a workers' compensation claimant or workers' compensation payer who is party to the agreement may elect, but is not required, to transfer to the Secretary a direct payment of the qualified Medicare Set-Aside or an annuity purchased to directly fund the set-aside amount. This would obviate the need to have a set-aside as required under the current law.

It should be remembered that the above is a "proposed" piece of legislation in the U.S. House of Representatives and it likely will not become law in its current form, or it might not even reach the floor of Congress for a vote. It does, however, provide some guidance as to what may be required by the CMS in the future.

- 1 See Social Security Act § 1862(b)(2) (42 U.S.C. § 1395y(b)(2)(A)).
- 2 *Id.*
- 3 42 U.S.C. 1395y(b)(5).
- 4 42 U.S.C. 1395y(b)(2)(B)(iii).
- 5 42 U.S.C. 1395y(b)(2)(B)(ii).
- 6 42 C.F.R. § 411.24(g).
- 7 42 U.S.C. 1395y(b)(2)(A)(ii) (2002).
- 8 See April 22, 2003 *Policy Memo to All Regional Administrators* authored by the Centers for Medicare & Medicaid Services, Department of Health & Human Resources. See www.cms.hhs.gov/WorkersCompAgencyServices/.
- 9 See John J. Campbell, *New Medicare Secondary Payer Reporting Requirements*, Medicare Set Aside Bull., Feb. 2008, <http://www.jjcelderlaw.com/MMSEAMSABull.htm>.
- 10 42 U.S.C. 1395y(b)(7)(8) (2007).
- 11 Centers for Medicare and Medicaid Services, *ALERT for Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Workers' Compensation*, Mar. 20, 2009, available at <http://www.cms.hhs.gov/MandatoryInsRep/Downloads/NGHPUserGuide2ndRev082009.pdf>.
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- 14 Roy A. Franco et al., *Resolution of a Case with a Medicare Claimant?, For the Defense*, May 2009, at 9.
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- 17 Kenneth Paradis, *New Requirements for Medicare Set-Aside Arrangements*, 18 J. Workers' Comp. 32, 32 (2009).
- 18 Edward M. Welch, *Medicare and Workers' Compensation After The 2003 Amendments*, §7.14, at 23 (2004).
- 19 See <http://www.opencongress.org/bill/111-h2641/show> for bill tracking and information.