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MONTHLY ELECTRONIC SUBROGATION NEWSLETTER **JANUARY 2010**

TO CLIENTS AND FRIENDS OF MATTHIESEN, WICKERT & LEHRER, S.C.:

This monthly electronic subrogation newsletter is a service provided exclusively to clients and friends of Matthiesen, Wickert & Lehrer, S.C. The vagaries and complexity of nationwide subrogation have, for many lawyers and insurance professionals, made keeping current with changing subrogation law in all fifty states an arduous and laborious task. It is the goal of Matthiesen, Wickert & Lehrer, S.C. and this electronic subrogation newsletter, to assist in the dissemination of new developments in subrogation law and the continuing education of recovery professionals. If anyone has co-workers or associates who wish to be placed on or removed from our e-mail mailing list, please provide their e-mail addresses to Rose Thomson at rthomson@mwl-law.com. We appreciate your friendship and your business.

IN THIS SPECIAL MEDICARE SECONDARY PAYER ISSUE . . . .

HEALTH INSURANCE SUBROGATION

SUBROGATION AND THE GREAT MEDICARE SET-ASIDE DEBATE

Extent of Liability for Failure to Prepare and File MSA in Dispute

By Gary L. Wickert

The adage about unintended consequences of good intentions is nowhere more clearly illustrated than in the confusing interplay between the settlement of workers' compensation, third-party liability claims, and the Medicare Secondary Payer Statute. Insurance companies have been given conflicting information about possible future exposure to the Centers for Medicare & Medicaid Services ("CMS") when they lump-sum a workers' compensation claim or settle a third-party liability case in which the claimant/plaintiff has received or likely will receive Medicare benefits, without submission and approval by CMS of a proper Medicare Set-Aside ("MSA"). Carriers are wary about potential future liability. Subrogation professionals settling cases are faced with strange, new releases and Medicare documentation which they are being asked to execute before they can settle even the smallest of PIP subrogation files. New CMS notification and reporting requirements threaten to complicate even the simplest of settlement transactions. The panic may be worse than the actual potential for future Medicare liability, but, these days, even a little liability makes our industry uncomfortable. Digging for answers uncovers even more questions. But, we'll try anyway.

As is usually the case, the message depends on the messenger. Those benefitting from MSA cottage industries, which have sprung up in the wake of all the confusion, beat the potential liability drums loudly, while trial lawyers and Medicare advocacy groups downplay any potential liability and even deny it exists. One thing is certain, our industry deserves solid answers and does not deserve to be left scrambling and wondering whether expensive and time-consuming MSAs are necessary in order to protect itself.

The issue surrounds two common scenarios. **Scenario One** involves a lump-sum commutation of a workers' compensation claim by a workers' compensation carrier with an injured worker who either currently receives or within 30 months is expected to receive Medicare benefits. This commutation could be a stand alone compensation claim or done in conjunction with settlement of a third-party lawsuit. **Scenario Two** involves an insurance company settling a personal injury lawsuit with a plaintiff who either currently or is expected to receive Medicare benefits. In either case, if the carrier settles and Medicare later has to provide benefits because no provisions were made for payment of future medical expenses related to the original injury, the insurance company may, according to some, be liable when CMS comes looking for reimbursement of its "conditional payments" under the Medicare Secondary Payer Statute.

Some Medicare background is necessary to properly understand the issues. 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 ("ESRD") (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 that both Medicare and workers' compensation insurance will provide overlapping benefits and coverage. In recent years, the United States government, specifically Medicare, has taken more of an interest in and is starting to review workers' compensation settlements more closely because it 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 to become increasingly educated on this confusing and often conflicting area of the law. Settlement of workers' compensation claims without proper Medicare approval can lead to significant liability on the part of workers' 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

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 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 to group health, auto, liability, and no-fault insurance. See Social Security Act at 42 U.S.C. § 1395y(b)(2)(A). Section 1395y(b)(2) provides that in order to recover payments 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." Id. It's this "action" that forms the basis of future potential liability which has carriers and lawyers concerned.

The dispute involves what the federal government can do to enforce its right of reimbursement, and how and when they determine to do it. Section 1395y(b)(5) 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 they provide this information to "fiscal intermediaries and carriers." These carriers then have an obligation to contact the employers of certain employees. 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. See 42 U.S.C. § 1395y(b)(5). It's 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 clarified that the United States may bring an action against any entity that "are or were required or responsible…to make payment…" See 42 U.S.C. § 1395y(b)(2)(B)(iii). As a result, all payments made by Medicare before and after a workers' compensation claim settlement are still considered "conditional" and repayment is required by the MSP Act. See 42 U.S.C. § 1395y(b)(2)(B)(ii). 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. See 42 C.F.R. § 411.24(g).

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 recover that payment from the compensation carrier or employer. Any payment Medicare makes isn't technically considered a lien. It's actually an inchoate right of reimbursement. If Medicare has to initiate any type of legal action in order to be reimbursed, they're 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 says that all workers' compensation plans of the United States are included with regard to recovery.

In § 411.46(b)(2), the regulations state if a compensation claim settlement has the effect of shifting responsibility for payment of future medical bills to Medicare, the settlement won't 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 compensation benefits, medical expenses incurred after the settlement date are payable under Medicare." Apparently, however, that's not the end of the story.

Scenario One: Commutation of Workers' Compensation Claims

In Scenario One, a carrier lump-sum settles a workers' compensation claim (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). Putting aside for a moment the fact that far too many carriers throw significant liens overboard, when simply waiting for resolution of a third-party case would provide them with a significant future credit, which would accomplish the same thing, without sacrificing a significant workers' compensation lien. When a subrogated compensation carrier 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 workers' compensation settlement 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's 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 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 simply agree on a lump-sum in exchange for giving up lifetime medical care). For lump-sum commutations which stipulate that the payment includes future medical expenses, Medicare will not pay for future medicals until the lump-sum is exhausted. For mere compromise settlements, a determination is required that a fair amount is allocated to future medical expenses. If not, Medicare will not pay for future medicals. If so, Medicare will only pay once that "fair amount" is used up in payment of future medicals. The vehicle for setting aside a "fair amount" for future medical is the MSA, which is submitted to, reviewed, and approved by the CMS.

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 entitles as "responsible" parties obligated to reimburse Medicare. See 42 U.S.C. § 1395y(b)(2)(A)(ii) (2002).

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 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. CMS did give some level of comfort as far as whether they will review a particular lump-sum 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 apportions $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. But 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 old (*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. 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.

It appears that there is a great deal of disagreement and confusion as to whether or not potential Medicare liability with regard to workers' compensation settlements requires that an MSA be submitted to the CMS. According to Heather Schwartz, Staff Counsel at Gould & Lamb, L.L.C., in Bradenton, Florida, the CMS can seek reimbursement of conditional payments made both before and after the settlement of a qualifying workers' compensation claim. At the same time, Sally Hart, Senior Litigation and Policy Attorney with the Center for Medicare Advocacy, Inc., points out that neither the Medicare Statute nor its regulations discuss CMS approval of settlements or MSAs. According to Hart, their use is not required and a beneficiary can also set aside monies for future medical expenses and self-administer this arrangement. See MSP Manual, Chap. 7, § 40.3.5. However, she adds, they do so at their own risk. Clearly, there is some risk of future liability with workers' compensation claims, depending on their size and the other requirements set forth above. But what about liability claims?

Scenario Two: Settlement of Liability Cases

With regard to Scenario Two, 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 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 insurance companies 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 all parties involved in such a third-party settlement protect themselves from future liability to Medicare?

In 2003, CMS approved a MSA procedure for third-party liability case settlements similar to the one employed in 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, although some regional offices (*e.g.*, Region IX, covering the states of Arizona, California, Hawaii and Nevada) will not review the settlement of liability cases. Those which do frequently have monetary cut-off points (*e.g.,* $700,000). A contact list for CMS Regional Offices can be found at http://www.cms.hhs.gov/CLIA/downloads/CLIA.RO.pdf.

MSAs 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.

As with workers' compensation claims, there is disagreement and confusion over the extent of potential liability to Medicare when settling third-party claims. Subrogation professionals and lawyers are seeing liability carriers, with whom they settle cases, forward CMS reporting questionnaires, special releases, and other documentation which arguably could violate HIPAA and often will complicate, delay, and even scuttle settlements. 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, but fear of the government should not lead to revamping the entire claims settlement process in America. Cooler heads need to prevail. Chances are slim that liability will attach in the settlement of smaller liability claims, and even with the larger claims, there still is no formal process for enforcing liability in place within CMS.

Medicare's concern that the payment burden could be shifted from a liable third-party payer to the government 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 still 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 in larger claims or where you are in doubt 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.

It looks as though the CMS currently is not officially pursuing anybody for future Medicare benefits made after settlement of a liability claim. It is likely that CMS will release a position statement on this issue in the near future. Until then, 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 a product liability context 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 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. See John J. Campbell, *New Medicare Secondary Payer Reporting Requirements*, Medicare Set-Aside Bulletin, Feb. 2008, http://www.jjcelderlaw.com/MMSEAMSABull.htm. 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, which detail the required submissions of information by group health plans, liability insurers (including self-insureds), no-fault carriers, and workers' compensation carriers. See 42 U.S.C. § 1395y(b)(7)(8) (2007).

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 were supposed to become effective July 1, 2009. However, CMS delayed implementing them until January 1, 2010. Nonetheless, Responsible Reporting Entities ("RRE") must report retroactive to July 1, 2009. See CMS*, ALERT for Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Workers' Compensation*, March 20, 2009, at http://www.cms.hhs.gov/MandatoryInsRep/Downloads/NGHPUserGuide2ndRev082009.pdf. Beginning January 1, 2010, MMSEA § 111 requires all of these new entities to directly report potentially eligible claimants/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 should consider implementing 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 and September 30, 2009, See CMS, *Medicare Secondary Payer Manual*, (Page 3) at http://www.cms.hhs.gov/manuals/downloads/msp105c01.pdf.

CMS has announced it would impose an interim reporting threshold in 2010 for liability claims below $5,000, need not be reported to the new system. See CMS, *ALERT for Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Workers' Compensation*, March 20, 2009, available at

http://www.cms.hhs.gov/MandatoryInsRep/Downloads/NGHPUserGuide2ndRev082009.pdf. In 2011, the threshold will reduce to claims greater than $2,000, and then 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's important for the RREs 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 claimants/plaintiffs and report specific information about the claims to CMS. To determine the Medicare entitlement status of a claimants/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's/plaintiff's response, the RRE must obtain the claimant's/plaintiff's Social Security Number for submission to CMS for verification. To make matters worse, claimants/plaintiff are not required to divulge their Social Security Numbers unless litigation is pending. See Roy A. Franco, et al., *Resolution of a Case With a Medicare Claimant?, For the Defense*, May 2009, at 9.

Social Security

Verification may be completed through the submission of electronic 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. See CMS, *COB Fact Sheets: MSP Laws and Third-Party Payers Fact Sheet for Attorneys*, http://www.cms.hhs.gov/ProviderServices/Downloads/thirdpartypayers.pdf. Following submission of the query, Medicare will determine the beneficiary's status within 14 days. However, RREs must remain diligent because their obligation does not end at this point - RREs must continue to ensure that a person that was not a Medicare beneficiary does not become a beneficiary. See Franco, et. al., *supra* note 14, at 10. If it is determined that the claimant is entitled to Medicare benefits, the RRE must report information about the claim and claimant to CMS once the claim is either fully or partially concluded and a payout has been made, or payout will be made in the future. If the RRE is the party responsible for the payout, reporting 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. See Kenneth Paradis, *New Requirements for Medicare Set-Aside Arrangements,* 18 J. Workers' Comp. 32, 32 (2009). If CMS is required to take legal action to secure recovery, CMS is entitled to recover "double damages" - 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. Specifically, MSAs should be submitted if there is any question as to future eligibility.

The onus to determine the Medicare eligibility status of every claimant seems to be placed on health plans, workers' compensation carriers, no-fault carriers and liability carriers, even before a 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 nearby 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 to be submitted. How this interfaces with HIPAA privacy regulations remains unclear. CMS extended testing of the program through March 1, 2010 and reporting will begin in the second quarter of 2010, for payments in the first quarter 2010.

However, not all commentators agree as to potential liability for *future* (post-settlement) medical expenses in the settlement of liability claims. The position of the Center for Medicare Advocacy is that, in contrast to workers' compensation claims, Medicare does *not* look to the proceeds of liability cases for payment of

medical expenses incurred after settlement of the liability claim. There is much speculation about the extension of MSP requirements to future medicals in liability cases and the need for MSAs in such situations. Gould & Lamb, L.L.C. has released an Industry News Bulletin sounding the clarion warning about a pending class action styled *U.S.A. v. Stricker*, wherein Medicare is seeking reimbursement for post-settlement medicals in a class action liability case where no notice of the settlement was given to Medicare. The position of the government in the *Stricker* lawsuit gives clear indication of the aggressive position they will pursue and underscores the need for liability claims handling and settlement practices to be compliant with the MSP. By its actions, the government appears to seek to establish a right to proceed against the liability carriers for pre- and post-settlement Medicare expenses. Either way, it is a potential problem and is a concern to any insurance professional.

Playing It Safe

Sadly, and as is always the case when the unintended consequences of government programs collide with the reality of the insurance marketplace, 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 size of these consequences cannot be accurately predicted. Implementation will necessarily add steps to underwriting, claims handing, 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. See Edward M. Welch, *Medicare And Workers' Compensation After The 2003 Amendments*, § 7.14, at 23 (2004).

Pending Legislation

Some clarification may be on the horizon, at least with respect to workers' compensation claims. On May 21, 2009, Rep. John Tanner (D-TN) and three co-sponsors introduced H.R. 2641, entitled *Medicare Secondary Payer and Workers' Compensation Settlement Agreements Act of 2009.* See http://www.opencongress.org/bill/111-h2641/show for bill tracking and information. The proposed bill provides clear and consistent standards for the CMS administrative process and amends § 1862 of the Social Security Act (42 U.S.C. § 1395y(b)(2)(A)) with respect to the application of Medicare secondary payer rules to workers' compensation settlement agreements and Medicare set-asides 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 § 223 (c)(1) 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 ("ESRD").

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 the following requirements for a Qualified Medicare Set-Aside. The specifics of the bill's requirements, along with the text of the relevant statutes outlined above, have been withheld from this article due to length. In summary, however, 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 "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.

Medicare questions

It should be remembered that the above is a "proposed" piece of legislation in the U.S. House of Representatives and it likely won't become law in its current form or even reach the floor for a vote. If you have any questions or if we can be of any assistance to you with regard to MSAs, settlement of health insurance claims, liability claims, workers' compensation claims and/or their effect on future credits, or subrogation in general, please contact Gary Wickert at gwickert@mwl-law.com.

CLASS ACTION FILED AGAINST MEDICARE

Patricia Haro, et. al. v. Kathleen Sebelius, Secretary, et. al.,
2009 WL 4497456 (D. Ariz. 2009)

On March 10, 2009, a class action lawsuit was filed by the Center for Medicare Advocacy, Inc. against the Secretary of Health and Human Services and the federal government responsible for Medicare, urging a federal judge in Arizona to rule that the new practices used by CMS under its Medicare Secondary Payer ("MSP") program to recover Medicare reimbursement claims when a beneficiary receives a third-party recovery, violate both the Due Process Clause of the U.S. Constitution and the Medicare statute itself. On November 22, 2009, a motion to dismiss filed by the defendants was denied by Federal Judge David Bury. The case remains a beacon of hope for trial lawyers and insurance companies alike, struggling to deal with and understand the onerous and costly requirements put upon them by the MSP program.

This interesting class action suit seeks declaratory and injunctive relief prohibiting the defendant's MSP recovery practices, including termination of Social Security benefits before there has been resolution of an administrative appeal of the MSP claim or waiver of recovery request, and requiring attorneys to withhold liability proceeds from their clients. The defendant's motion to dismiss sought a ruling that the plaintiffs had no standing to bring the suit. The court denied the motion and allowed the suit to proceed.

The suit was filed by Attorney Sally Hart with the Center for Medicare Advocacy, Inc. The Center for Medicare Advocacy, Inc. is a national non-profit, non-partisan organization that provides education, advocacy, and legal assistance to help people with disabilities obtain Medicare and necessary health care. The Center was established in 1986. The organization is involved in writing, education, and advocacy activities of importance to Medicare beneficiaries nationwide. The Center's central office is in Connecticut, with offices in Washington, D.C. and throughout the country. Interestingly, this pro-Medicare organization felt strongly enough about the onerous requirements of the MSP procedures and potential liability to beneficiaries, insurance companies, and lawyers, that it filed a class action lawsuit on behalf of a number of Medicare recipients who had been forced to reimburse Medicare for charges that were not related to a third-party accident which became the subject of litigation.

One of the plaintiffs in this case is John Balentine, an attorney who represented Patricia Haro. Balentine alleges that under the threat of an enforcement action, including financial penalties against him, he had been instructed by the CMS that he must hold settlement funds for Plaintiff Haro and other clients like her; he may not disburse these funds to his clients until the MSP claim has been paid, and he must use these funds to pay the disputed Medicare claim promptly. Medicare charged interest and penalties for failure to promptly pay them even though part of the monies sought to be reimbursed were legitimately disputed. The crux of the complaint is that Medicare demands immediate reimbursement before resolution of any appeal or request for a waiver of reimbursement.

This case doesn't directly deal with the Medicare Set-Aside ("MSA") issues and potential liability of insurance companies and trial lawyers for failure to comply with the MSA legislation and procedures, but it is a good step in the right direction. What is also interesting is that Sally Hart, the attorney who filed the suit, feels strongly that the potential liability to Medicare on the part of insurance companies and trial lawyers for failure to comply with MSA requirements is largely overblown and hyped. She believes that lawyers and companies who have created a cottage industry out of doing MSA's are responsible for the sky-is-falling mentality in this area. She does agree, however, that Medicare needs to provide some clarification and explanation in this

area in order to avoid beneficiaries, insurance companies and lawyers wasting a good deal of time struggling with MSA's which she feels are not as big of a problem as they are being made out to be.

UPCOMING EVENTS.....

February 10-12, 2010 - MWL will be exhibiting at the NAMIC 2010 Claims Conference being held in St. Petersburg, Florida. Jamie Breen will be at our exhibit booth so stop by if you plan on attending this conference. For more information on this conference, please go to http://www.namic.org/seminars/10claimsexhibit.asp.

February 23, 2010 - Gary Wickert will present MWL's first live webinar entitled *"WC - 101 - Basics of Workers' Compensation Subrogation*" at 10:00 a.m. (CST). Last week, a webinar invitation was sent via e-mail to everyone on our newsletter list, which contained a registration link for this webinar. If you didn't receive an invitation, feel free to click on the link to the right to register for this webinar. We will have more information on this webinar and a link to register for it on our website soon.

April 27-30, 2010 - Gary Wickert will be presenting at the 2010 NOPLG Conference in Savannah, Georgia. He will be presenting "Recent Developments In Workers' Compensation Subrogation". For more information on this conference, please go to https://www.signup4.net/public/ap.aspx?EID=2008838E&OID=147.

May 11-14, 2010 - MWL will be exhibiting at the 5th Annual Claims Education Conference being held in New Orleans, Louisiana. Jamie Breen will be at our exhibit booth so stop by if you plan on attending this conference. For information on this conference, please go to http://www.claimseducationconference.com.

June 22-24, 2010 - MWL will be exhibiting at the 14th Annual America's Claim Event in Las Vegas, Nevada. Jamie Breen will be at our exhibit booth so stop by if you plan on attending this conference. For information on this conference, please go to http://www.summitliveevents.com/sites/ace09/pages/default.aspx.

November 10-11, 2011 - MWL will be exhibiting at the19th Annual National Workers' Compensation and Disability Conference Expo in Las Vegas, Nevada. Jamie Breen will be at our exhibit booth so stop by if you plan on attending this conference. For information on this conference, please go to www.wcconference.com.