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Medicare, the Bull in the Settlement China Shop

The Medicare Secondary Payer Act and the new SCHIP Extension Act of 2007 will have very different effects on workers' comp and liability cases.

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Using the Medicare Secondary Payer Act and the new SCHIP Extension Act passed in December of 2007, Medicare is bulling its way into workers' compensation and liability settlements. In an attempt to recover conditional payments and not expend future funds in cases where another carrier or self-insured might be liable, these new Medicare requirements are creating a minefield of problems, which could explode during any workers' compensation or liability settlement.

Web Extras

- 8 Steps to Subrogation, Specialization, Collaboration **(04/01/09)**
- SCHIP Act Reporting Requirements **(04/01/09)**
- Recommendations to Protect All Parties Interests in Liability Settlements (04/01/09)
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In order to accurately examine the effect of these two statutes, and their possible interplay, some explanation is necessary.

The Medicare Secondary Payer Act was passed in the late 1980's. Essentially, it gives Medicare the power to collect any conditional payments (commonly known as Medicare liens) from any first party carrier or any other participant who could make a payment or receive a payment in a case. If a Medicare beneficiary is involved in a workers' compensation or liability case, Medicare is able to collect from any of the insurers or plaintiffs or plaintiffs' counsel (fees) by virtue of the Medicare Secondary Payer Act. Further, if Medicare has filed suit against any primary payer or recipient, the law enables Medicare to receive a 100 percent penalty in addition to the amount owed.

Over the years, Medicare has looked for new ways to recover monies in cases where other carriers are primary. The Secondary Payer Act covers all carriers, self-insureds, no fault insurance, and workers' compensation insurance. Medicare's ability to track these cases has recently increased due to the

passage of the SCHIP Extension Act of 2007.

This Act empowers Medicare to require all responsible reporting entities (liability carriers, workers' compensation carriers, and self-insureds) to meet reporting requirements established by the agency in cases involving Medicare beneficiaries.

For workers' compensation carriers, the responsible reporting entity must report all current claims involving Medicare beneficiaries being paid on July 1, 2009, and continuing.

For liability carriers, the responsible reporting entity must report all settlements as of July 1, 2009, which involve Medicare beneficiaries.

If this reporting is not undertaken, the agency has the right to collect a $1,000.00 per day fine per person for cases which are not reported. This is a strong monetary incentive for all responsible reporting entities to provide the information required by the agency.

In terms of the information required, it appears that the agency will be requesting the identity of the claimant, claimant's social security number, the condition for which the claimant is being paid, and the date of injury. The agency will also require information such as the date and amount of the settlement.

In order to submit this information, the responsible reporting entity must determine whether or not the claimant is eligible for Medicare. The only way to obtain this information is to either ask the claimant to voluntarily provide it or send an inquiry to Medicare.

In order to send an inquiry to Medicare, an authorization must be signed by the claimant or Medicare will not provide any information. Thus, there is a built-in "catch 22" with regard to this information. While the claimant has no responsibility to report, the claimant actually controls the flow of information to the responsible reporting entity. If the claimant will not sign an authorization or answer the question as to whether or not they are entitled to benefits, the responsible reporting entity could be in the unenviable position of being unable to comply with the legislative mandate. There are no provisions within the Act requiring the claimant to provide this information.

In addition, there are practical problems with regard to the exchange of information between Medicare and the responsible reporting entities. Currently, Medicare is recommending electronic transfer of information to begin by May 1, 2009. However, as of the date of this article, the Web site allowing this electronic transfer has not yet been established. These hurdles will have to be overcome before May 1, 2009, when the registration period begins.

THE IMPACT ON COMP CASES

Prior to the passage of the SCHIP Extension Act, workers' compensation cases were reported to Medicare only at the time of settlement. However, as a result of this law, workers' compensation cases will have to be reported if the carrier is making payment to an eligible Medicare recipient.

The effect of this reporting will impact mainly older cases which have not yet settled. Medicare will now be able to determine the identity of every workers' compensation claimant and the condition for which they are being paid. They will compare this information with the information presently contained in the Medicare programming in order to determine if Medicare is paying for the work-related condition. If Medicare has made a payment for the same condition, the workers' compensation carrier will receive a notice of conditional payment letter and will be asked to repay any conditional payments made to date.

For example, a claimant is injured in 1985. Indemnity was settled for $50,000.00 in 1990. Since that time, the carrier has been paying only occasional medication bills, but has not paid an actual medical bill since 1990. The claimant was age 65 in 1990. Under this scenario, there is a good chance that all doctor visits and testing for the work-related injury have been submitted to Medicare. Medicare will use this information, compute the amount they have paid, and forward the request for repayment to the workers' compensation carrier. It is possible that carriers will have larger responsibilities for repayment in some of these old claims.

In workers' compensation, the impact will be negligible. Since 2001, we have been operating under a system, that provides distinct parameters for Medicare review in workers' compensation cases. Commonly known as Medicare Set-Asides, we have been able to create a method by which the participants close their case and bind Medicare and Medicare's future interests through the use of the Set-Aside.

In cases where the claimant is eligible for a Medicare card and the settlement is over $25,000.00, Medicare will review the future medical costs of the claimant and provide an approval which binds the agency. In these types of cases, the parties submit to Medicare an amount that the parties believe are the future medical costs, which will be paid by Medicare. Medicare then provides a formal review of the proposal and, if Medicare approves the amount, the parties will put this sum of money into a Set-Aside account which the claimant will use to pay those medical expenses into the future for the lifetime of the claimant. The amount agreed upon by Medicare binds the agency.

If the claimant is not eligible for a Medicare card, this procedure is not necessary unless the claimant has a reasonable expectation of receiving benefits within 30 months and the settlement amount is $250,000.00 or more. In summary, the workers' compensation system has a proven way of finalizing Medicare's claims, both for past payments and future expected payments. As a result, workers' compensation settlements will be minimally affected because the parties have been dealing with these issues since 2001.

IMPACT ON LIABILITY CASES

There will be a major impact on liability settlements as a result of the passage of the SCHIP Extension Act. Prior to the passage of this law, Medicare had no direct method to monitor liability settlements. Thus, while the responsibility of liability carriers was the same as workers' compensation carriers, there was no method to track liability settlements. Therefore, in cases where Medicare may have a future interest, there was very little activity by the agency.

As a result of the SCHIP Extension Act, liability carriers must now report all of

their settlements which involve a Medicare beneficiary. As previously noted, it will be difficult to determine what cases are reportable since the information as to whether or not someone is qualified for Medicare is controlled by the plaintiff. This problem may be resolved through discovery. However, in small cases where formal discovery is not initiated, it will be an ongoing problem.

The next problem is what Medicare will do with this information. The agency has always taken a position that its interests must be taken into account in any settlement involving a Medicare beneficiary. If another carrier is primary, Medicare does not wish to make any payments for the injury which arises out of the accident.

Since Medicare will now be able to track all of the settlements, the agency will be more diligent with regard to recovering past conditional payments. They will also now have a method to track each settlement and will be able to put that information into their electronic system and generate conditional payment letters. The parties will have to know if any conditional payments are outstanding before the case settles in order to take Medicare's interests into account prior to settlement. If the conditional payments are not taken care of prior to settlement, the agency can come back to the insurance carrier at a later time and collect their conditional payments, even if they were paid to the plaintiff at the time of settlement. Thus, in essence, the medical portion of the settlement would not be closed, even though general releases were signed, since Medicare would still have an interest for collecting their conditional payments.

A more subtle problem occurs if there are future medical payments or damages involved in the settlement. In workers' compensation cases, these future damages can be accounted for through the use of the Medicare Set-Aside. However, there is no such method available currently with regard to liability settlements. Sources within the agency have explained that there are no plans to establish guidelines regarding the review of liability settlements.

Currently, there are no guidelines in effect. All cases involving Medicare recipients must make provisions to protect Medicare's interests. While the reporting Act does not require the parties to establish Medicare Set-Aside accounts, the agency's interests still have to be taken into account. Further, the agency will now be able to track all settlements. As a result, the agency will have the information regarding the accident and condition caused by the accident. As with other health carriers, the agency then would have the information to either refuse to pay any future claims or indicate that no future claims will be paid until the settlement amount was accounted for.

A plaintiff would have to be able to show receipts for expenses to Medicare to indicate that the entire settlement was used before Medicare would make any payments regarding injuries in an accident. In the alternative, the agency could continue making conditional payments and require the parties to reimburse them as these payments were made into the future. This would mean that although the general releases were signed, there would still be an open claim with Medicare for the life of the plaintiff. The case would not be finally closed.

Both of these results cause headaches for the participants in a settlement. On the plaintiff's side, a plaintiff may not be able to receive Medicare benefits for any said injury suffered in an accident and the plaintiff's counsel could be liable to Medicare for the amount of fees collected in the case if there has been a

Medicare payment.

On the defense side, if payments continue by Medicare after a settlement is concluded by the parties, the insurer could continue to be liable for future medical payments. This creates a reserving nightmare and results in added administrative costs.

Currently, Medicare's policy is to allow voluntary review at the request of the parties. However, Medicare has also been firm in noting that this policy is voluntary in every region. If the region does not have the manpower to review cases, there is no duty for them to do so. If the agency will not review, it is up to the parties to initiate a method to guarantee that the case is closed.

The Medicare Secondary Payer Act and SCHIP Extension Act, when taken together, provide a powerful tool for Medicare to continue to collect payments from litigants in the workers' compensation and liability systems.

Having negotiated the guidelines with Medicare for Medicare Set-Asides in workers' compensation cases and reviewing all of the new legislation, as well as talking with the agency concerning their expectations, Medicare will continue to be involved in settlements for the foreseeable future.

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