

2009 PARMA Annual Risk Managers Conference:

## The Role of the Medicare Secondary Payer Law and Medicare Set-Asides in Settling Work Comp and Liability Claims

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### Background

- **1965: Medicare Law Enacted.**
  - Medicare is established to provide medical care to the elderly and to certain disabled individuals
  - Workers' Compensation is named as a Primary Payer
  - It addressed the situation where a Medicare Beneficiary received a settlement for future medical expenses from Workers' Compensation – Medicare only pays second.
- **1981: Medicare Secondary Payer Statute**
  - 42 U.S.C. § 1395y(b)2
  - Identified types of insurance that are primary to Medicare: Work Comp, Liability, Auto, Group Health, etc

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### Background

#### 1981: Medicare Secondary Payer Statute (continued)

- This law imposes two duties regarding insurance settlements
  - Reimbursement of payments made by Medicare relating to the injury that is the focus of the settlement. (Repay conditional payments)
  - A duty to prevent double dipping. If a settlement includes future medical care, then the injured individual must use that money first before Medicare makes any payment. (Medicare Set-Aside)
- Enacted to prevent the burden of medical expenses which rightfully should be paid by primary insurance plans from being shifted to Medicare.

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## Background

- 1999: GAO study finds \$43 billion of WC medical expenses paid by Medicare from 1991-1998
- 1/2001: The Centers for Medicare & Medicaid Services (CMS) assigns the task of Medicare Secondary Payer (MSP) Claims Investigation to the Coordination of Benefits (COB) contractor. Database created to identify Medicare beneficiaries with Work Comp claims
- 7/2001: CMS Memorandum introduces Medicare Set-Asides and identifies criteria indicating when they are appropriate

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## What is a Workers' Compensation Medicare Set-Aside (WCMSA) arrangement?

- The vehicle created to comply with the MSP law
- The WCMSA is a portion of the WC settlement. It is calculated to cover the amount of the future medical expenses related to the industrial injury that would otherwise be paid for by Medicare.
- Only appropriate when settling future medicals
- The WCMSA amount is placed in a separate account and used to pay the industrial injury related Medicare covered medical expenses
- When the WCMSA account is completely exhausted, Medicare steps in as the secondary payer and pays for any further medical expenses.

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## When is a WCMSA Appropriate? 2001, 2005, 2006 CMS Memos

- CMS approval of MSA is appropriate when:
  - Applicant is currently entitled to Medicare and the total settlement amount is greater than \$25,000; OR
  - The total settlement is over \$250,000 AND the applicant is reasonably expected to become entitled to Medicare within 30 months
- MSA without CMS approval is appropriate when:
  - Applicant currently entitled to Medicare and the total settlement amount is \$25,000 or less; OR
  - Total settlement under \$250,000 AND applicant within 30 months of becoming entitled to Medicare

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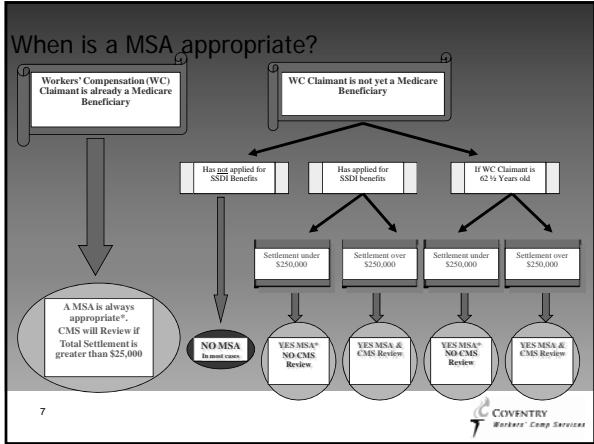
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### Who is entitled to Medicare?

- Individual at age 65 with qualifying work record
- Individual who completes the Social Security Disability Insurance (SSDI) process
  - Individual of any age can apply
  - Individual is automatically enrolled in Medicare after they have received disability benefits for two years

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COVENTRY  
Workers' Comp Services

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### Social Security Disability Insurance (SSDI)

- Cash benefits to individuals who are unable to work because of a disability
- Qualifications:
  - Disability – Cannot perform substantial gainful activity (any type of work). Must last or expect to last at least one year or result in death.
  - Worked long enough and recently enough.
- Payments start 6 months after disability began
- Medicare is automatic after 2 years on SSDI

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Workers' Comp Services

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**What Constitutes Reasonable Expectation of Medicare Enrollment within 30 months?**

- Includes but are not limited to:
  - The individual has applied for Social Security disability benefits (SSDI)
  - The individual has been denied SSDI; anticipates appealing that decision
  - The individual is in the process of appealing and or re-filing for SSDI
  - The individual is 62 ½ years old
  - The individual has End Stage Renal Disease

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**What Red Flags may Identify a Potential WCMSA file?**

- The claimant is 62½ years old
- The claimant is receiving Social Security Disability benefits
- The claimant has been out of work for 2 or more years
- The claimant has an ESRD condition

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**Calculation of the WCMSA amount**

- Based on the last two years of medical reports from all treating sources.
  - CMS requires these reports sent to them with MSA
  - CMS demands more costly treatment when doctor recommendations differ.
- Based on the claims payout history for the last two years
- Must be calculated to cover the life expectancy of the individual

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**Strategies for Keeping the MSA Low (while still obtaining CMS approval when applicable)**

- Set up WCMSA account using an annuity instead of a lump sum
- Rated Age can lower MSA (obtained from Structured Settlement Broker)
- Latest medical reports. If treatment changed, cost can be eliminated from MSA with new report.
- Drug Utilization Advisory. Licensed Pharmacist identifies areas where changes/reductions are justified leading to cost savings (ex. generics vs. brands, abuse, etc).

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**MSA Account Funding Options**

- Funding the MSA using an Annuity
  - Structured Settlement Broker–valuable resource
  - Rated Age – Reduces the amount of the MSA
  - Provides more money for claimant's use
  - Lessens the chance of misuse of MSA funds
  - Seed Money + annual payment
- Funding the MSA with a lump sum
  - Entire MSA amount is deposited into account upon settlement of claim

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**Annuity funded MSA**

- Seed Money = Amount to cover 1<sup>st</sup> surgery/procedure and 2 years annual payout
- The remaining amount is divided by the claimants life expectancy.
- Subsequent annual deposits are made into the Medicare Set-Aside account.
- If the funds are not exhausted at the end of the year then they are carried forward.
- If all the funds are exhausted during the year then Medicare pays the bills until the next annual payment is deposited into the MSA account.

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### Example of case to Structure the Medicare Set-Aside

Applicant: age 47 female with 37 yr life expectancy  
Total Settlement = \$70,000  
MSA comes in at \$43,000 lump sum. Big Problem!

Solution: Structure the MSA:  
MSA with annuity = \$4,000 seed + \$1,054/yr for life  
Cost of annuity: \$4,000 + \$16,063 = \$20,063

Result: \$70,000 Settlement (~~\$49,937~~ + \$20,063 MSA)  
Instead of  
\$70,000 lump sum Settlement (\$27,000 + \$43,000 MSA)  
Applicant receives additional \$22,937 non MSA dollars

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### Management of the Set-Aside Funds

- **Self Administration**
  - Subject to similar rules/regulations as the professional administrator
- **Professional Administration**
  - **Custodial Account**
  - Administrative fees/expenses cannot be charged to the set-aside allocation
- **Trust**
  - No requirement that set-aside funds be placed in a trust

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### Medicare Conditional Payments (Liens)

- Medicare conditional payments made on behalf of a Medicare beneficiary are conditioned on reimbursement to the Medicare trust fund.
- Coordination of Benefits contractor (COBC) is the source of Medicare Lien information.
- Receiving Medicare Lien status varies from two weeks to a year.
- A request should be made to the COBC ASAP when contemplating settlement
- The report received back from the COBC must be carefully reviewed by the client to be sure only items related to work injury are paid for.
- Conditional Payments provide the statutory teeth to MSA enforcement

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### Medicare's Available Recovery for Conditional Payments

- Anyone who received medical care for which Medicare paid and who later received payment from a "primary plan" ( ex. work comp, liability insurer) must, by stature and regulation, reimburse Medicare within 60 days from the beneficiary's receipt of payment from the primary plan (the settlement check). However, if the beneficiary doesn't reimburse Medicare, then the Government can recover from the primary plan (Insurer) and anyone who receives payment from that plan.
- Currently Insurer puts statement in settlement that "Claimant is responsible to reimburse Medicare". They are leaving themselves open to having to pay twice on this claim.

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### Consequences of failure to provide a WCMSA when needed affect All Parties

- Injured worker can lose Medicare benefits related to the WC claim
  - If no MSA allocation, entire settlement deemed the MSA
  - Without MSA, federal benefits may be withheld for repay
  - MSA permits applicant to receive Medicare coverage for industrial injury once MSA account is exhausted.
- CMS has a direct right of action to recover from Primary Payers including: an employer, an insurance carrier and a TPA. Double damages permitted if court action is necessary.
  - CMS approved MSA protects the insurer from future Medicare liability

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### When is a MSA Appropriate for Liability Cases?

- Currently, CMS has not issued any formal policy on how to consider Medicare's interest in liability cases.
- No requirement for creation or approval of MSAs in pure liability claims.
- A MSA is appropriate in situations that involve both a WC claim & a 3<sup>rd</sup> party liability claim (April 2003 memo)
- However, per the MSP, Medicare's interests must be taken into account in settlement of a liability claim
  - MSAs should focus on claims where plaintiff is already a Medicare beneficiary

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## Considering Medicare's Interests in Liability Claims

### 3 Options:

- Do Nothing. Wait until CMS creates protocols for liability claims.
- Determine future medical costs and include language in the settlement documents
- Prepare MSAs for liability claims and submit them to CMS
  - Consultation with your attorneys and development of internal policy is important. This is also a business decision

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## Considering Medicare's Interests in Liability Claims

### Option 1: Do Nothing and wait for CMS guidance.

- Considerations:
  - Won't delay settlements
  - Not complying with MSP statute
  - Primary Payer (carrier, tpa, employer) liable for potential reimbursement of costs to Medicare in the future

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## Considering Medicare's Interests in Liability Claims

### Option 2: Estimate future medical costs (using Life Care Plan or Medical Cost Projection) and indicate how these funds must be spent in the settlement document

- Considerations:
  - Proactively takes Medicare's interest into consideration
  - Plaintiff must agree to use these funds for future medical care
  - If Plaintiff does not use funds properly, CMS would still have right of action against primary payer

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### Considering Medicare's Interests in Liability Claims

**Option 3:** Create MSA allocations and submit them to CMS for approval

- Considerations:
  - Primary Payer protected from future claims by Medicare for reimbursement
  - Taken every step to comply with the MSP statute and clearly considered Medicare's interests.
  - CMS approval – maybe?
  - Cost involved for MSA preparation
  - Delay of the settlement

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### Medicare, Medicare & SCHIP Extension Act of 2007 (MMSEA)

- Mandatory Insurer Reporting - Section 111
- Impacts all primary payors: Workers' Comp, Liability (including Self-Insurance) and No Fault Insurance
- Requires the insurer to submit information for all claims involving a Medicare beneficiary as the injured party where the settlement, judgment, award or other payment date is on or after July 1, 2009.
- An insurer that fails to comply shall be subject to a penalty of \$1,000/day.

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### Medicare, Medicare & SCHIP Extension Act of 2007 (MMSEA)

- The Insurer or their Agent will electronically transmit a data file with the required information to the COBC.
- Important Dates:
  - May 1 – June 30, 2009. Registration with the COBC
  - July 1 – Sept. 30, 2009. Test period for data submission
  - October – December, 2009. Initial Input Claim Filing begins
- The Responsible Reporting Entity (RRE) must report regardless of whether or not there is an admission or determination of liability.
- Reports are required with either partial or full resolution of a claim
- <http://www.cms.hhs.gov/MandatoryInsRep/>

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# Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA)



## Information Update

The Centers for Medicare & Medicaid Services (CMS) has released additional information regarding the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA). All updates can be found at: <https://www.cms.hhs.gov/MandatoryInsRep/>

Per Section 111 of the MMSEA, workers' compensation, liability (including self-insurance) and no-fault insurance plans must report on all claims, where the injured party is/was a Medicare beneficiary, that are resolved (or partially resolved) through a settlement, judgment, award or other payment on or after July 1, 2009. Failure to report will result in a \$1000 penalty for each day of noncompliance with respect to each claimant. Complete instructions and requirements are still being compiled by CMS and will be published at a later date in a User Guide specific to liability insurance (including self-insurance), no-fault insurance, and workers' compensation plans (also known as non-group health plans [non-GHP]).

CMS has designated the Coordination of Benefits Contractor (the COBC) to manage the technical aspects of the Section 111 data submission process. The responsible reporting entity (RRE) must first register on-line via the COB secure web site (currently under development) as the initial step in complying with the "Mandatory Insurer Reporting" (MIR). Currently, registration is scheduled to take place from May 1, 2009 through June 30, 2009. The period from July 1, 2009 through September 30, 2009 will be used by the RRE and the COBC to fully test the data submission process. The RRE will then submit their initial Input Claim File during the fourth calendar quarter (October - December) of 2009 during their assigned submission timeframe. Input Claim Files must be submitted on a quarterly basis, four times a year.

The rationale behind the law is to improve accountability in the Medicare Program. Congress is aware that Medicare is not the primary payer for a beneficiary's health care in many instances but it has been difficult to identify these situations. CMS will use the information obtained from insurers to determine whether Medicare has made any conditional payments and, if so, promptly seek reimbursement.

A RRE may contract with an entity to act as its agent for purposes of the Section 111 data submission process. Agents will create and submit Section 111 files to the COBC on behalf of the RRE. Coventry Workers' Comp Services is available to work with our clients to assist in the creation and implementation of the needed preparations. We will continue to update our clients with information relating to the MMSEA as it becomes available.

**More Information?**

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