12S Medicare Secondary Payer Statute

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I. MEDICARE AS A SECONDARY PAYER

A. [12S.1] Introduction

Add at the end of the last paragraph:

See CMS Memo (Oct. 15, 2004), Q & A 6 (available at www.cms.hhs.gov/WorkersCompAgency Services/Downloads/101504Memo.rtf).

C. [12S.2A] Statutory Authority

New section:

42 U.S.C. §1395y(b)(2) states:

> **(2) Medicare secondary payer.**
>
> **(A) In general. Payment under this title may not be made, except as provided in subparagraph (B), with respect to any item or service to the extent that —**
>
> **(i) payment has been made, or can reasonably be expected to be made, with respect to the item or service as required under paragraph (1), or**
>
> **(ii) payment has been made, or can reasonably be expected to be made under a workmen's compensation law or plan of the United States or a State or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance.**
>
> **In this subsection, the term "primary plan" means a group health plan or large group health plan, to the extent that clause (i) applies, and a workmen's compensation law or plan, an automobile or liability insurance policy or plan (including a self-insured plan) or no fault insurance, to the extent that clause (ii) applies. An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.**
>
> **(B) Conditional payment.**
>
> **(i) Authority to make conditional payment. The Secretary may make payment under this title with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.**

(ii) Repayment required. A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means. If reimbursement is not made to the appropriate Trust Fund before the expiration of the 60-day period that begins on the date notice of, or information related to, a primary plan's responsibility for such payment or other information is received, the Secretary may charge interest (beginning with the date on which the notice or other information is received) on the amount of the reimbursement until reimbursement is made (at a rate determined by the Secretary in accordance with regulations of the Secretary of the Treasury applicable to charges for late payments).

(iii) In order to recover payment made under this title 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. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity. The United States may not recover from a third-party administrator under this clause in cases where the third-party administrator would not be able to recover the amount at issue from the employer or group health plan and is not employed by or under contract with the employer or group health plan at the time the action for recovery is initiated by the United States or for whom it provides administrative services due to the insolvency or bankruptcy of the employer or plan.

(iv) Subrogation rights. The United States shall be subrogated (to the extent of payment made under this title for such an item or service) to any right under this subsection of an individual or any other entity to payment with respect to such item or service under a primary plan.

(v) Waiver of rights. The Secretary may waive (in whole or in part) the provisions of this subparagraph in the case of an individual claim if the Secretary determines that the waiver is in the best interests of the program established under this title.

(vi) Claims-filing period. Notwithstanding any other time limits that may exist for filing a claim under an employer group health plan, the United States may seek to recover conditional payments in accordance with this subparagraph where the request for payment is submitted to the entity required or responsible under this subsection to pay with respect to the item or service (or any portion thereof) under a primary plan within the 3-year period beginning on the date on which the item or service was furnished.

See 42 C.F.R. Part 411.

1. [12S.3] Medicare as Secondary Payer

Add at the end of the first paragraph:

See also 42 C.F.R. Part 411.

The last paragraph is deleted.

D. [12S.5] CMS Memoranda

The second sentence in the first paragraph is revised:

In furtherance of these efforts, the CMS has issued seven key memoranda setting forth its policy concerning its status as a secondary payer.

Add at the end of the carryover list on p. 12-5:

5. CMS Memo (Oct. 15, 2004), to all regional administrators from director of Financial Services Group Gerald Walters (available at www.cms.hhs.gov/WorkersCompAgencyServices/Downloads/101504Memo.rtf);

6. CMS Memo (July 11, 2005), to all regional administrators from director of Financial Services Group Gerald Walters (available at www.cms.hhs.gov/WorkersCompAgencyServices/Downloads/71105Memo.rtf); and

7. CMS Memo (Dec. 30, 2005), to all regional administrators from director of Financial Services Group Gerald Walters (available at www.medicareapproval.com/cmsmemos/CMS%2012-30-05%20Part%20D%20Memo.pdf).

II. [12S.6] CLASSES OF CASES REQUIRING CONSULTATION WITH MEDICARE

The section is revised:

There are three types of cases in which contact with and approval by Medicare is required: (a) Medicare has made prior payment; (b) the claimant is eligible for Medicare and the settlement is

$10,000 or more; or (c) the settlement meets the 30-month/$250,000 threshold set forth by the Centers for Medicare and Medicaid Services. If a claim falls within any of these classes, special settlement arrangements must be made to ensure that Medicare's interests are protected, and Medicare must approve settlement of these cases.

As of July 11, 2005, the CMS considers these thresholds as part of its "workload review" and not substantive "safe harbor" thresholds. All settlements must be drafted to insure that Medicare is a secondary payer to Medicare. See CMS Memo (July 11, 2005), Q & A 1, 2 (available at www.cms.hhs.gov/WorkersCompAgencyServices/Downloads/71105Memo.rtf). Thus, even if the settlement does not fall within the thresholds set forth in §§12.7 – 12.9 and approval is not sought, an allocation of a portion of the settlement to reasonably anticipated future medical expenses is prudent.

It should be noted that the CMS considers the thresholds discussed in §§12.7 – 12.9 as subject to review and adjustment. Changes in the CMS thresholds will be published on its Web site at http://new.cms.hhs.gov/WorkersCompAgencyServices/04_wcsetaside.asp.

B. [12S.8] Claimant Is Medicare Eligible

The heading and section are revised:

B. [12S.8] Claimant Is Medicare Eligible and the Settlement is $10,000 or More

Claimants who are eligible for Medicare are

1. 65 or older;

2. on Social Security disability for 24 months or longer; or

3. suffering from a qualifying end stage renal disorder.

The Centers for Medicare and Medicaid Services refers to this type of beneficiary as a Class I beneficiary. In order to fall within this threshold, it is not necessary that medical bills have already been paid by Medicare, only that the claimant be eligible for Medicare benefits. Social security disability recipients are automatically eligible for Medicare benefits after receiving benefits for 24 months. In fact, social security will automatically enroll a social security disability recipient for Medicare benefits after the 24-month period expires.

Effective July 1, 2005, the CMS will no longer review workers' compensation settlement proposals when the total settlement is less than $10,000. It is important to note that the CMS now considers its thresholds as "workload review" thresholds and not "safe harbor" thresholds. Presumably, this means that despite the fact that it refuses to review such settlements, it does not waive any of its rights under the Medicare secondary payer statute.

In its July 11, 2005 memo, available at www.cms.hhs.gov/WorkersCompAgency Services/Downloads/71105Memo.rtf, the CMS states that the total settlement amount for

purposes of the thresholds includes, but is not limited to, wages, attorneys' fees, all future medical expenses, and repayment of any Medicare conditional payments. Further, payout totals for all annuities should be used rather than the cost or present value of the annuities. Finally, any previously settled portion of the workers' compensation claim must be included when computing the total settlement amount. Past medical expenses are not included.

In its December 30, 2005 memo, available at www.medicareapproval.com/cmsmemos/CMS%2012-30-05%20Part%20D%20Memo.pdf, the CMS announced that the total settlement amount for purposes of the thresholds must include amounts paid for prescription drugs paid as a part of the settlement and that may be prescribed in the future. The includable amount for prescription drugs is limited to those drugs that are for the treatment of the work-related injury that are covered by Medicare Part D as a result of the implementation of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub.L. No. 108-173, 117 Stat. 2066.

C. [12S.9] Claimant Meets $250,000/30-Month Threshold

Add at the end of the first paragraph:

The CMS refers to this type of beneficiary as a Class II beneficiary. Claimants who do not satisfy this threshold need not submit their settlements to the CMS for approval. However, the CMS made clear in its July 11, 2005 memo, available at www.cms.hhs.gov/WorkersCompAgencyServices/Downloads/71105Memo.rtf, that this threshold is a "workload threshold" and not a substantive "safe harbor" threshold. All settlements are required to set aside sufficient funds in the settlement to protect Medicare from reasonably anticipated Medicare covered medical expenses.

The first paragraph on p. 12-7 is revised:

The $250,000 threshold includes, but is not limited to, wages, attorneys' fees, all future medical expenses, and repayment of any Medicare conditional payments. See CMS Memo (July 11, 2005), Q & A 2 (available at www.cms.hhs.gov/WorkersCompAgencyServices/Downloads/71105Memo.rtf). Payment of medical expenses is not included in the $250,000 threshold. If settlement is paid in a structured settlement and the total payments are greater than $250,000, then the threshold is met. This is true even if the cost of the structured settlement is less than $250,000. See CMS Memo (Apr. 22, 2003), Q & A 17 (available at www.cms.hhs.gov/WorkersCompAgencyServices/Downloads/42203Memo.rtf).

Add at the end of the second paragraph on p. 12-7:

In its memo of July 11, 2005, available at www.cms.hhs.gov/WorkersCompAgencyServices/Downloads/71105Memo.rtf, the CMS reversed this approach and stated that any funds from a workers' compensation settlement attributable to future medical expenses that are remaining at the time the claimant becomes Medicare eligible must be used to pay for Medicare-covered expenses. Only then will the CMS pay for Medicare-covered expenses.

The last paragraph is revised:

It is important to note that the CMS stated in its memo of May 23, 2003, available at www.cms.hhs.gov/WorkersCompAgencyServices/Downloads/52303Memo.rtf, that the thresholds are subject to change if it determines that Medicare's interests are not being protected. However, the CMS specifically stated that it would honor the thresholds in place at the time of the workers' compensation settlement. Further when the thresholds are not met, the CMS will not provide verification letters confirming that approval of a workers' compensation settlement is not necessary. This position was affirmed in CMS Memo (July 11, 2005), (available at www.cms.hhs.gov/WorkersCompAgencyServices/Downloads/71105Memo.rtf).

III. EXCEPTIONS AND SPECIAL SITUATIONS

A[1]. [12S.9A] Settlement Prior to CMS Approval

New section:

In its memo dated July 11, 2005, available at www.cms.hhs.gov/WorkersCompAgency Services/Downloads/71105Memo.rtf, the Centers for Medicare and Medicaid Services blessed the idea of settling a workers' compensation claim prior to CMS approval of a Medicare set-aside arrangement in order to end the continuation of indemnity payments while waiting for CMS approval. This is accomplished by closing out the indemnity portion of the settlement and leaving open the settlement of medical expenses pending a determination by the CMS on the proposed set-aside arrangement.

In the same memo, the CMS commented that settlement of a workers' compensation claim in its entirety prior to CMS approval is not binding on the CMS. Only the approval of a set-aside arrangement by the CMS and the submission of proof that the set-aside arrangement was funded in the approved amount would limit the denial of related claims to the amount in the set-aside arrangement.

E. [12S.13A] Coverage Through Group Health Plans, Managed Care Plans, and Veterans' Administration

New section:

Even though a claimant may have other health coverage through a group health plan, managed care plan, or Veterans' Administration coverage, the Centers for Medicare and Medicaid Services requires a Medicare set-aside arrangement. In its July 11, 2005 memo, available at www.cms.hhs.gov/WorkersCompAgencyServices/Downloads/71105Memo.rtf, the CMS stated that a set-aside arrangement is still appropriate because such other coverage could be canceled or reduced or the claimant might elect not to take advantage of the coverage.

IV. SET-ASIDE ARRANGEMENTS

A. [12S.14] Set-Aside Arrangements To Protect Medicare from Future Medical Payments

Add after the fourth sentence in the first paragraph:

The CMS has stated specifically that set-aside arrangements are used only in commutation settlements, not settlements that are solely compromise cases.

Add after the first sentence in the second paragraph:

See CMS Memo (Oct. 15, 2004), Q & A 5 (available at www.cms.hhs.gov/WorkersCompAgencyServices/Downloads/101504Memo.rtf).

Add at the end of the second paragraph:

Medical expenses are to be based on either the workers' compensation fee schedule (for states that have such schedules) or the full actual charges. See CMS Memo (Oct. 15, 2004), Q & A 1 (available at www.cms.hhs.gov/WorkersCompAgencyServices/Downloads/101504Memo.rtf). The CMS does not require that a Medicare set-aside arrangement be indexed for inflation nor may a set-aside arrangement be discounted to present value. See CMS Memo (Oct. 15, 2004), Q & A 4 (available at www.cms.hhs.gov/WorkersCompAgencyServices/Downloads/101504Memo.rtf).

Add after the second paragraph:

The CMS does not compromise or reduce future medical expenses. It asserts that the language in 42 C.F.R. §411.47 relates only to conditional (past) payments and not future medical expenses related to a workers' compensation injury. This position presumably applies to compromise settlements submitted for approval without a Medicare set-aside arrangement. See CMS Memo (July 11, 2005), Q & A 11 (available at www.cms.hhs.gov/WorkersCompAgencyServices/Downloads/71105Memo.rtf).

The first and second paragraph on p. 12-10 are replaced:

Initially the CMS stated that Medicare set-aside funds are not to be used to pay medical bills until the claimant actually becomes eligible for Medicare. Bills incurred prior to Medicare eligibility must be paid from another source. See CMS Memo (May 23, 2003), Q & A 4 (available at www.cms.hhs.gov/WorkersCompAgencyServices/Downloads/52303Memo.rtf). This policy changed in CMS Memo (July 11, 2005), Q & A 3, available at www.cms.hhs.gov/WorkersCompAgencyServices/Downloads/71105Memo.rtf. The CMS position is that funds from an approved set-aside arrangement may be used prior to the claimant becoming a Medicare beneficiary because the amount of the set-aside arrangement was priced based on the date of the expected settlement. However, the use of set-aside arrangement funds is limited to expenses that are related to the workers' compensation claim and that would be covered by Medicare if the claimant were a Medicare beneficiary. The same set-aside administration and reporting requirements apply to this use of the funds as if the claimant was a Medicare beneficiary.

A Medicare set-aside arrangement must be kept in an interest bearing account. See CMS Memo (July 23, 2001), Q & A 7 (available at www.cms.hhs.gov/WorkersCompAgencyServices/Downloads/72301Memo.rtf); CMS Memo (July 11, 2005), Q & A 6, 13 (available at www.cms.hhs.gov/WorkersCompAgencyServices/Downloads/71105Memo.rtf). Tax on this interest may be paid from the set-aside arrangement as a cost that is directly related to the account. Adequate documentation of the tax is required.

If a claimant looses his or her entitlement to Medicare after a set-aside arrangement has been approved and funded, the CMS will not release the set-aside arrangement funds but will allow the funds to be used for medical expenses related to the work injury that would be Medicare-covered if the claimant was a Medicare beneficiary. The same set-aside administration and reporting requirements apply to this use of the funds as if the claimant was a Medicare beneficiary. See CMS Memo (July 11, 2005), Q & A 9 (available at www.cms.hhs.gov/WorkersCompAgency Services/Downloads/71105Memo.rtf).

If the treating physician concludes that the beneficiary's medical condition has substantially improved, then the beneficiary may submit a new set-aside arrangement proposal covering future expected medical expenses. Such proposals must justify at least a 25-percent reduction in the outstanding set-aside arrangement funds. In addition, such proposals may not be submitted until at least five years after a previous CMS approval.

Beginning January 1, 2006, Medicare will begin its Part D prescription drug coverage due to the passage of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub.L. No. 108-173, 117 Stat. 2066. As set forth in CMS Memo (Dec. 30, 2005), available at www.medicareapproval.com/cmsmemos/CMS%2012-30-05%20Part%20D%20Memo.pdf, beginning January 1, 2006, all workers' compensation settlements must consider and protect Medicare's interest when future treatment includes prescription drugs along with future medical services that would otherwise be reimbursable by Medicare.

Medicare set aside arrangements submitted to the CMS should include separate allocations for: (1) future medical treatment and (2) future drug prescription treatment. The cover letter should include an explanation as to how the amount allocated to future prescriptions was calculated. If the cover letter does not include an amount for future prescription drug treatment, and the treatment records show that the claimant has been prescribed drugs and/or may need drugs related to the work injury in the future, then the CMS will conclude that the parties to the settlement have not adequately considered Medicare's interests. If there is no indication in the records that the claimant will need future treatment with prescription drugs, then the CMS will accept that Medicare's interests have been adequately protected. CMS Memo (Dec. 30, 2005), Q & A 1, 2 (available at www.medicareapproval.com/cmsmemos/CMS%2012-30-05%20Part%20D%20Memo.pdf).

Beginning January 1, 2007, the CMS will begin to independently price for future prescription drug treatment for set aside arrangements it receives after January 1, 2007. Set aside arrangements submitted after that date must include separate allocations for future medical treatment and future drug prescription treatment as described above. In addition, the submission must include a payment history of payments made by the workers' compensation carrier for

prescription drugs. If the injury occurred less than two years prior to the date of the submission, the history should include payments from the date of the injury to the date of the submission. If the injury occurred more than two years prior to the date of the submission, the history should include the last two years of payments. CMS Memo (Dec. 30, 2005), Q & A 5 (available at www.medicareapproval.com/cmsmemos/CMS%2012-30-05%20Part%20D%20Memo.pdf).

Set aside arrangements that have already been approved by or submitted to the CMS prior to January 1, 2006, do not have to be resubmitted due to Part D coverage. CMS Memo (Dec. 30, 2005), Q & A 7 (available at www.medicareapproval.com/cmsmemos/CMS%2012-30-05%20Part%20D%20Memo.pdf).

B. [12S.15] Set-Aside Administration

The address for AdminaStar Federal on p. 12-10 is revised:

AdminaStar Federal
225 N. Michigan Ave.
22nd Floor
P.O. Box 812912
Chicago, IL 60618
Phone: 312/297-4618
www.adminastar.com

Add after the second full paragraph on p. 12-11:

Set-aside arrangements must be administered by a competent administrator. When an individual has a designated payee, appointed guardian, or otherwise has been declared incompetent, the settlement parties must include that information in their set-aside arrangement proposal. See the CMS Memo (Oct. 15, 2004), Q & A 2 (available at www.cms.hhs.gov/WorkersCompAgencyServices/Downloads/101504Memo.rtf).

C. [12S.16] Submission of Settlement to Medicare for Approval

The address for CMS on p. 12-12 is revised:

CMS
c/o Coordination of Benefits Contractor
P.O. Box 660
New York, NY 10274-0660
Attention: WCMSA

G. [12S.20] Appeals

The section is revised:

The CMS memo of July 11, 2005, available at www.cms.hhs.gov/WorkersCompAgency Services/Downloads/71105Memo.rtf, makes clear that the CMS has no formal appeals process

for rejection of a Medicare set-aside arrangement. However, if the claimant or submitter believes that there is additional evidence not previously considered by the CMS that would warrant a change in the CMS determination, the claimant or the submitter may resubmit the case with the additional evidence and request a re-evaluation. If the additional information does not convince the CMS to approve the set-aside arrangement and the parties proceed to settle the case despite the objections, then Medicare will not recognize the settlement. Medicare will exclude its payments for the medical expenses related to the injury or illness until such time as settlement funds expended for services otherwise reimbursable by Medicare exhaust the entire settlement. When Medicare denies a particular beneficiary's claim, the beneficiary may appeal that particular claim denial through Medicare's regular administrative appeals process. See CMS Memo (Apr. 22, 2003), Q & A 14 (available at www.cms.hhs.gov/WorkersCompAgencyServices/Downloads/42203Memo.rtf).