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NAMSAP news

National Alliance of Medicare Set-Aside Professionals

Webinar: The Impact of Senate Bill 2499 on Primary Payer Compliance with the MSP

Understanding the Requirements of Senate Bill 2499 and How the New Legislation Will Affect Primary Payers & Claims Handling

Updated Webinar Series
We are re-starting our Webinar Series in order to keep everyone updated on the latest developments within the Medicare Set-Aside Industry. Our first program is featured below, but stay tuned to upcoming announcements and check our website for new programs. If you would like to be a presenter, please submit your webinar idea and bio to our Education Committee, in care of Leslie Schumacher at Lschumacher@medallocators.com.

Date: April 1, 2008
Time: 2:00pm EST
Location: Webinar
Facilitator: Mark Popolizio, Esquire

On December 29, 2007, President Bush signed into law Senate Bill 2499 which makes significant amendments to the Medicare Secondary Payer Statute (MSP) affecting the obligations of workers' compensation, liability (including self-insurance), no-fault and group health insurance plans. Senate Bill 2499 places an affirmative obligation on all primary payers to (i) determine a claimant's Medicare entitlement status and (ii) to place Medicare on notice of said entitlement. The new amendments impose strict penalties for non-compliance -- $1,0000.00 per day, per claim in addition to all other available penalties under the MSP.

Senate Bill 2499 makes significant changes to primary payer's current obligations to protect Medicare's interests regarding conditional payments. This webinar addresses the impact Senate Bill 2499 will have on workers' compensation, liability (including self-insurance) and no-fault insurance plans and arrangements. The course will examine the key requirements and other main features of Senate Bill 2499 and how they all relate to primary payer compliance under the MSP. The course puts Senate Bill 2499 into perspective by also examining the current reimbursement and notice obligations of primary payers under the MSP.

The course will also outline practical considerations and approaches for primary payers to incorporate into their claims handling process to address their current obligations under the MSP, as well as in preparation of the forthcoming requirements under Senate Bill 2499.

Mark Popolizio, J.D. is a Senior Account Executive for NuQuest/Bridge Pointe.Prior to joining NuQuest/Bridge Pointe, Mark practiced law for ten years concentrating in the areas of workers' compensation defense and insurance defense litigation. Mark also developed a national Medicare practice that included Medicare Set-Asides and general compliance with the Medicare Secondary Payer Statute.

Mark is currently the Vice President of the National Alliance of Medicare Set-Aside Professionals (NAMSAP). He was also a featured instructor on Medicare and Life Care Planning issues with the former University of Florida/Medipro LLC program. Over the past several years, Mark has been a featured presenter at numerous seminars and other industry events across the country. His presentations have included Medicare Basics, Medicare Set-Asides and Medicare Part D (prescription drugs).

Member Cost: $60
Non-Member Cost: $80
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NAMSAP Annual Meeting • September 18, 2008

Summary of the New MSP Legislation

By: Collin McDonald, Esq., Crowe Paradis Services Corporation

On December 29, 2007, President George W. Bush signed and passed amendments to the Medicare Secondary Payer ("MSP") Statute entitled the "Medicare, Medicaid, and SCHIP Extension Act of 2007." This new legislation, effective for Group Health Plans on April 1, 2008, and for others as further set forth herein on July 1, 2009, amends the MSP and significantly impacts insurers, mandating new claim reporting requirements and instituting the first concrete, civil penalty for failure to comply with the MSP.

Specifically, the legislation under MSP Amendment, 42 U.S.C. § 1395y(b)(8), requires all liability, workers compensation, self-insured, and no fault insurers to report to Medicare all claims involving Medicare beneficiaries. That is, insurers will now need to determine the Medicare status of all claimants with whom they are engaged in litigation. If a claimant is, in fact, a Medicare beneficiary, an insurer, as of July 1, 2009, will be required to report such claims to Medicare when they are settled, whether resolved by settlement, judgment, or other payment or award. Under MSP Amendment, 42 U.S.C. § 1395y(b)(7), with respect to the impact on Group Health Plans, an entity serving as an insurer or third party administrator of a Group Plan will similarly be required to report all claims which are primary to Medicare, or face penalties discussed below. Reporting is subject to further instruction from the Secretary of Health and Human Services.

The consequence to insurers for failure to comply with the required reporting of such claims is severe and will result in a civil penalty to insurers of $1,000.00 per day, per beneficiary for non-compliance. Though a timeframe to report settled claims is not set forth or referred to in this legislation, this most likely will be subsequently addressed in the Code of Federal Regulations. In addition, it is likewise expected that further instruction regarding specifics for the processing of settlement information will be forthcoming from Medicare and the Secretary of Health and Human Services.

With the passage of this legislation, the onus indeed falls upon the insurance carriers to implement protocols to determine a claimant's Medicare status and to report settled claims involving a Medicare beneficiary—or face steep penalties for non-compliance. This amendment essentially forces insurers to address the conditional payment aspect of MSP compliance, by introducing strict civil penalties for failure to report final settlement information for all Medicare beneficiaries—which triggers a final lien demand from Medicare with respect to its recovery of conditional payments made by Medicare on a claimant's behalf. It should be noted that settlement reporting for claims involving all Medicare beneficiaries is required under this legislation, regardless of whether or not Medicare has actually made any conditional payments on a claimant's behalf.

The Act is undoubtedly intended to continue to preserve the Medicare trust fund, to encourage accountability to Medicare, and to implement stricter compliance with the MSP, the overall objective of which is to ensure that Medicare is a secondary, and not a primary payer, with respect to claims for which insurers are primarily responsible. Iowa Senator Charles Grassley, a co-sponsor of the bill, stated that the amendment "will improve the Secretary's ability to identify beneficiaries for whom Medicare is the secondary payer by requiring group health plans and liability insurers to submit data to the Secretary." (http://www.govtrack.us/congress/record.xpd?=110-s20071218-25)

Medicare's Approval Held to be Condition Precedent to Parties' Agreement

By: Collin McDonald, Esq., Crowe Paradis Services Corporation

In Miller v. Workers' Compensation Appeal Board, 2007 WL 4615440, a decision dated January 4, 2008, the Commonwealth Court of Pennsylvania affirmed the denial of a Widow Petitioner's request to enforce a Compromise and Release Agreement ("C&R" or "C&R Agreement"). The Court held that Medicare's approval of the C&R was a condition precedent to the parties' Agreement. The Employer refused to finalize the C&R Agreement without first ascertaining the Claimant's Medicare status and ensuring that Medicare's interests were considered, so as to guard against potential liability under 42 U.S.C. 1395y(b)(2)(A)(ii), the Medicare Secondary Payer Act ("MSP").

The facts of the case were such that on June 15, 1989, the Claimant-Employee sustained a work-related injury to his right ankle while employed by Electrolux ("Employer"). By letter dated March 24, 2004, Claimant's Counsel accepted Employer's January 16, 2004 offer to settle the claim in full for a lump sum of $25,000.00. The Employer confirmed the Claimant's acceptance of the offer by letter dated April 1, 2004, in which the Employer additionally requested that Claimant's Counsel confirm Claimant's Medicare status for purposes of Medicare approval of the C&R Agreement. On November 25, 2005, the Claimant died of causes unrelated to his work injury, at which time the proposed C&R Agreement was neither executed nor submitted to the Workers' Compensation Judge ("WCJ").

Subsequently, Rochelle Miller, the Claimant's widow ("Widow Petitioner"), petitioned the WCJ for enforcement of the C&R Agreement. The WCJ denied her petition and dismissed the claim, on the basis that the C&R Agreement did not meet the requirements of Section 449 of the Workers' Compensation Act ("Act"). That is, the WCJ found that the C&R did not satisfy the subparts of the Act requiring that a compromise and release agreement be signed by both parties and notarized or attested by two witnesses. In addition, the Act's required resolution hearing, during which a claimant confirms his or her comprehension of the legal significance of a C&R Agreement, never occurred in this case. The WCJ also determined that because the Claimant's death was unrelated to his work injury, the Widow Petitioner was not authorized to execute the C&R on the Claimant's behalf.

The Widow Petitioner appealed the WCJ decision to the Board, maintaining that the delay in filing the C&R was due to the Employer's mistaken belief that Medicare approval of the proposed Agreement was a necessary condition precedent. The Board rejected this argument and held that a decision to seek Medicare approval did not exempt the Claimant from the requirements of Section 449 of the Act. Further, the Board concluded that no evidence established Employer's actions as deliberately intended to delay approval of the Agreement.

The Commonwealth Court of Pennsylvania, to which the Widow Petitioner ultimately appealed, affirmed the decisions of both the Board and the WCJ. The Court looked to the plain language of the Act, noting that death is not recognized as providing exception to Section 449's statutory requirements of signatures, notarization, and a hearing. The Court additionally cited relevant case law, specifically referring to Blessing v. Workers' Compensation Appeal Board, 737 A.2d 820 (1999). In Blessing, a C&R Agreement was found invalid, where a claimant had signed and submitted the agreement, but died of unrelated causes prior to his employer's

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execution of same and before the required hearing. Similarly, in Lebid v. Worker's Compensation Appeal Board, 771 A.2d 79 (2001), the Court noted that it would have been erroneous for the WCJ to approve an agreement that had not been a signed writing submitted by an employer.

The Widow Petitioner herein set forth several arguments in her appeal seeking approval of the C&R Agreement, all of which were rejected by the Court. The Widow Petitioner maintained that the traditional analysis under Section 449 of the Act was inapplicable; specifically, she asserted that no statute or regulation authorizes Medicare's approval of the Agreement, that the insurer's refusal to file the Agreement after a confirmation in writing was unconstitutional, and that the Claimant's hearing before the WCJ had been deterred due to the Employer's erroneous position that Medicare approval of the Agreement was necessary.

The Court concluded that the Employer in this case proposed the $25,000.00 settlement amount for future indemnity and medical benefits, clearly not intending to remain responsible for the Claimant's future medical expenses. The Court held that Medicare's approval of the C&R was a condition of the parties' Agreement—that is, the Employer refused to finalize the C&R Agreement without first ascertaining the Claimant's Medicare status and ensuring that Medicare's interests were considered, so as to guard against potential liability under 42 U.S.C. 1395y(b)(2)(A)(ii), the Medicare Secondary Payer Act ("MSP"). As the Court discussed, the MSP clearly requires that whenever future medical expenses are relative to a C&R Agreement, Medicare's interests must be adequately considered; otherwise, pursuant to policy memoranda, the Center for Medicare and Medicaid Services ("CMS") has a right to recovery against any entity that received a portion of a third party payment. The Court therefore did not address the Widow Petitioner's argument as to whether Medicare's approval of the C&R Agreement was necessary, as it was irrelevant where there was never an underlying agreement in existence. Here, the Court held that the parties did not have the essential, contractual meeting of the minds with respect to the issue of protecting Medicare's interests, and as a result, there was never a finalized C&R Agreement for WCJ approval.

Finally, the Court noted that it additionally rejected the Widow Petitioner's contention that the Employer's requirement of Medicare approval violated due process. The Court cited Fratta v. Workers' Compensation Appeal Board, 892 A.2d 888, 894 (2006), a case in which the Board decision to deny a widow participation in the compromise and release process was upheld, with the conclusion that the "compromise and release of workers' compensation claims is [not] a constitutionally protected interest."

If you have an article or idea for the newsletter, please contact our Membership Committee in care of Ann at Ann_Major@corvel.com. We really would appreciate any articles, stories, or items of interest.

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