The Medicare Secondary Payer Program and Recent Statutory Changes Effective July 1, 2009: The Days in Which Workers' Compensation Attorneys Can Ignore Medicare's Interests Have Ended

By Shiva Z. Kashani (May, 2009)

It is no secret that the federal government has been concerned for some time about the burden of its Medicare program. In fact, Medicare has long been a growing concern. As a result of increased health care costs and a shortage of funds, Congress continues to actively seek methods to recoup payments for medical treatment and prescription drugs that should not be paid by Medicare.

Workers' compensation attorneys have, for more than fifty (50) years, had the responsibility to consider liabilities imposed by the Medicare Secondary Payer program ("MSP"). The federal MSP statute is constantly changing and affects all workers' compensation parties, including claimants, insurers, attorneys, and even consultants. The laws are so encompassing that they impose liability on noncompliant insurers and attorneys representing both claimants and insurers.

The most recent amendment to the MSP statute imposes mandatory reporting requirements and accompanying penalties for noncompliance, effective July 1, 2009. These requirements now make it impossible to disregard Medicare's interests in the resolution of workers' compensation claims. Workers' compensation attorneys, representing either claimants or employers, can no longer afford to overlook Medicare's interests in the resolution of claims and must exhibit less eagerness to cost-shift liability for a claimant's future medical treatment onto Medicare.

The MSP statute provides the federal government with cost-cutting measures and heavy-handed collection tools to monitor claims made by Medicare beneficiaries and to determine

which of these beneficiaries remain entitled to medical treatment and prescription drug coverage first under workers' compensation insurance, also known as the "primary plan."

Workers' compensation insurance only becomes a primary payer when a Medicare beneficiary's medical treatment and prescription drug needs are causally related to a work-related injury or illness. This includes claimants who have received workers' compensation settlements, awards, judgments, or, as the regulations provide, "other payments."

All parties in workers' compensation cases, including claimants, insurers, attorneys, and consultants, continue to have significant responsibilities under the MSP statute to protect Medicare's interests when resolving cases that may include future medical expenses. The newly enacted amendments endeavor to enforce those responsibilities by imposing hefty penalties, at the astounding rate of $1,000.00 per day, for each claim involving an unreported Medicare beneficiary claimant. These new mandatory reporting provisions have effectively ended the days in which workers' compensation parties may have been able to afford non-compliance with the MSP program.

BACKGROUND OF THE MEDICARE SECONDARY PAYER PROGRAM

Congress established the Medicare program in 1965 by enacting Title XVIII of the Social Security Act to provide federal health insurance for hospital and medical coverage to persons age 65 and older, certain disabled individuals, and individuals with permanent kidney failure. *See* 42 U.S.C. § 1395, *et seq*.

Medicare has been a secondary payer to workers' compensation benefit payments since the inception of the Medicare program in 1965. The MSP provisions were enacted in the early 1980s and have been modified many times since. The Centers for Medicare and Medicaid Services ("CMS"), formerly known as the Health Care Financing Administration, is a federal

agency, which is part of the Department of Health and Human Services. CMS is responsible for the oversight of the Medicare program.

Due to the MSP statute's many and frequent changes since its inception, and the long road of exhausting administrative remedies, the federal appellate courts have not had many opportunities to interpret issues arising out of the statute. Most of the issues are resolved prior to appellate court review. Furthermore, the previously limited resources of CMS to completely enforce the provisions of the MSP statute have worked in the favor of noncompliant parties.

As granted by the MSP statute, Medicare can avoid disbursing payments that should be made under a primary insurance plan. Section 1862(b)(2) of the Social Security Act precludes Medicare from paying a beneficiary's medical expenses when payment has been made or can reasonably be expected to be made under a workers' compensation plan. 42 U.S.C. § 1395y(b)(2)(A)(ii).

Medicare may, however, pay for an expense when the availability of workers' compensation insurance is unknown or prompt payment under such coverage is not expected. In that case, Medicare may make "conditional payments" when prompt insurance payment is not expected. *See* 42 U.S.C. § 1395y(b)(2)(B)(i). A conditional payment is defined as a Medicare payment made due to lack of knowledge of other coverage. 42 C.F.R. § 411.22.

If such a conditional Medicare payment is made, CMS may seek reimbursement from the insurer or from one who receives payment from the insurer, if the insurer is responsible for the expense. *See* 42 U.S.C. § 1395y(b)(2)(A)(ii); 42 C.F.R. § 411.22. If reimbursement is not made, CMS has standing to bring action against the insurer or the recipient of a workers' compensation payment. *See* 42 U.S.C. § 1395y(b)(2)(A)(iii); 42 C.F.R. § 411.24.

CMS may waive its rights in the best interests of Medicare. *See* 42 U.S.C. § 1395y(b)(2)(A)(v); 42 C.F.R. § 411.28. CMS may waive reimbursement for conditional payments made, for example, if a third party liability insurer is also liable for a beneficiary's medical treatment and prescription drugs. However, this waiver can only be obtained through prior approval of a settlement from CMS.

When a worker makes a workers' compensation claim, doubt may exist regarding the compensability of the workers' compensation claim and the causal relationship of the claimed medical expenses. The workers' compensation insurer may question whether the worker's injury or illness arose out of and in the course of his employment or whether the medical expenses are a result of the injury or illness. Such questions may be litigated, but often they are settled. The resulting settlement is likely to affect Medicare's responsibility to pay for the worker's medical expenses.

Another important provision of the MSP statute is Medicare's disregard for an admission of liability. CMS considers a workers' compensation insurer a primary payer if and when the insurer disburses payment on a claim. This remains true regardless of language contained in the settlement agreement denying liability or coverage.

So long as a workers' compensation insurer continues to carry liability for medical benefits, Medicare is relieved of responsibility as a primary payer. But if the workers' compensation settlement limits or eliminates the duty of the workers' compensation insurer to pay future medical benefits, Medicare is becomes the primary payer and is responsible for the payments.

As a result of this shift of responsibility, claimants and insurers have always had a tempting incentive to structure their settlement agreements in a way that transfers liability from

the insurer to Medicare. Claimants consider this cost-shifting as an advantage because they can keep a greater amount of the settlement funds for themselves, rather than agreeing to have a portion of the funds set-aside to pay for future medical expenses. The lump sum settlement amount will be paid directly to the claimant, rather than held in a trust or annuity pending future medical treatment.

Insurers consider the cost-shifting as an advantage because once the workers' compensation plan is no longer liable for future medical benefits, Medicare's role will change from secondary payer to primary payer. This will lead to Medicare paying for a claimant beneficiary's future medical treatment. The costs of creating a trust or annuity are also avoided.

No matter the settlement amount, all parties to workers' compensation claims continue to carry the responsibility of considering Medicare's interests. The perceived incentive to shift the cost of future medical treatment onto Medicare can result in a settlement that is unfair to Medicare.

Another example of cost-shifting is if a portion of the settlement amount is allocated for lost wages and another portion is set aside to for future medical benefits. The claimant in this example seeks to divide the funds in a way so that he will not have to use the entire settlement amount for future medical benefits. Instead, when the allocated amount for future medical expenses set aside in the agreement are exhausted, the claimant will seek further medical treatment under Medicare.

CMS is aware of the different ways in which parties attempt to shift costs, and strives to limit its exposure for injuries or illnesses which are causally related to a workers' compensation claim. To avoid the resulting subsidization by Medicare in cases of cost-shifting, the provisions of the MSP statute permit CMS to refuse to recognize a workers' compensation settlement. *See* 42

C.F.R. § 411.46(b)(2). Medicare, in the case of an unrecognized settlement, would not pay for medical benefits that should have been covered by the workers' compensation insurance plan.

If and when Medicare pays for medical treatment causally related to a workers' compensation claim, prior to realizing a primary plan must cover the costs, CMS has standing to demand reimbursement for the conditional payments made. CMS has standing to demand reimbursement from either the workers' compensation insurer or from anyone who has received a portion of the settlement funds.

On the other hand, if the workers' compensation settlement agreement is sent to CMS and CMS approves it in advance, all parties are relieved of liability for medical expenses beyond what is provided for in the agreement. Clearly, obtaining CMS approval prior to a settlement is the most favorable course of action, save the resulting costs of obtaining the approval and the associated delays in the settlement process.

The new legislation affecting workers' compensation insurers, as of July 1, 2009, will equip CMS with the information it needs to seek reimbursement for many claims not previously reported or approved. CMS will have notice of all primary payers who continue to carry responsibility for current Medicare beneficiaries' medical benefits.

CMS will presumably compare the electronic data submitted by the primary payers to its own information regarding each beneficiary's current treatment status. The medical diagnosis and treatment codes will be compared and CMS will easily and quickly have the capability to determine if it is disbursing payments from Medicare funds for medical benefits that should be made by the workers' compensation insurer.

The most controversial effect of the MSP statute, some attorneys contend, is the liability imposed upon the attorneys who have not protected Medicare's interests in the past. CMS has

indicated the reporting requirements will be retroactive. Workers' compensation attorneys on both sides of workers' compensation cases will be well-advised to seriously consider both the liabilities imposed upon themselves and their clients by the MSP statute. And, these attorneys should then take the initiative to review cases in which they may have overlooked Medicare's interests and determine their clients' treatment or payment status.

TWO TYPES OF SETTLEMENT AGREEMENTS

To understand the liability imposed by the MSP statute, we must first understand the difference between the two types of settlement agreements recognized by CMS. It is important to note a settlement may have characteristics of both types of agreements, and liability exists, as always under contract law, based on the contents of the agreement and the circumstances surrounding it, rather than by the agreement's title. The two types of settlement agreements are as follows.

(1) Commutation. A commutation settlement is a full-and-final or conditional settlement that sets aside settlement funds for future medical expenses and prescription drugs. Medicare payments for medical services for the work-related injury or illness will not be made by the federal government until the medical expenses disbursed by the primary payer related to the injury or illness are equal to the amount of the lump-sum payment.

Attorneys should always keep in mind that unless the commutation agreement specifically sets aside an amount for medical expenses, prescription drugs, lost wages, attorney's fees, and other expenses, and CMS approves the amount set aside in advance of the settlement, the entire lump sum amount may be deemed the liability of the primary payer for medical expenses. This exposure creates "double liability" for the primary payer if CMS or the Medicare beneficiary files suit in federal court against the primary payer, as permitted by the MSP statute.

(2) Compromise. A compromise settlement agreement is one in which a lump sum of money is given in settlement of a workers' compensation claim. It does not admit liability by the insurer for a legally compensable injury.

As stated above, the MSP statute does not require an admission of liability by an insurer to impose liability for future medical benefits or grant CMS the authority to demand reimbursement for conditional payments. The insurer's settlement payment is the action which creates liability under the MSP statute. Payment of a settlement by an insurer automatically establishes liability as a primary payer.

Again, CMS realizes workers' compensation parties may seek to shift the costs of future medical benefits onto Medicare. As a result, if a settlement agreement allocates liability to an insurer only for past medical treatment, parties should be aware CMS will not automatically assume it is a compromise agreement.

If the facts of the case are such that it is clear the claimant will continue to seek medical treatment after the date of the settlement, the workers' compensation insurer will remain the primary payer. This is true even when the settlement agreement specifically attempts to terminate the insurer's liability for future medical treatment and the agreement does not provide for an insurer's liability for future medical expenses.

If it is clear at the time of settlement that the work-related injury or illness will create a continued need for medical care, then the agreement will not be a compromise settlement; it will be considered a commutation settlement. The workers' compensation insurer will remain the primary payer on the claim.

Furthermore, unless CMS approves of the allocation of indemnity benefits or attorney's fees, the entire settlement amount may be deemed available for payment of past or future

Medicare-covered services related to the injury. The primary payer should not attempt to shift costs onto Medicare by closing medicals or transferring the burden onto Medicare, as CMS would then assert liens for double the amount of CMS's estimation of the appropriate amount that should have been set aside.

CMS RECOMMENDS OBTAINING APPROVAL PRIOR TO SETTLEMENT

A Workers' Compensation Medicare Set-Aside Arrangement ("WCMSA") is an allocation of funds from a final workers' compensation settlement used to pay for a claimant's future medical expenses and future prescription drug costs causally related to the work injury or illness. A WCMSA is not necessary when resolution of the workers' compensation claim leaves the medical aspects of the claim open because the primary payer continues to have liability for future medical expenses and Medicare's interests will remain protected as a secondary payer.

A WCMSA may be submitted to CMS for review in the following situations:

(1) The claimant is currently a Medicare beneficiary AND the total settlement amount is greater than $25,000.00; OR

(2) The claimant has a "reasonable expectation" of Medicare enrollment within 30 months of the settlement date and the anticipated total settlement amount for future medical expenses and disability/lost wages over the life or duration of the settlement agreement is expected to be greater than $250,000.00. Existence of any of the five following factors is sufficient to establish "reasonable expectation":

   (a) the claimant has applied for Social Security Disability Benefits;

   (b) the claimant has been denied Social Security Disability Benefits but anticipates appealing the decision;

(c) the individual is in the process of appealing and/or re-filing for Social Security Disability Benefits;

(d) The claimant is sixty-two (62) years and six (6) months old (because then in thirty (30) months he will be eligible for Medicare based on the sixty-five (65) year age requirement); or

(e) the claimant has an End Stage Renal Disease ("ESRD") condition but does not yet qualify for Medicare based upon ESRD.

MANDATORY REPORTING REQUIREMENT EFFECTIVE JULY 1, 2009

The most recent legislation passed by Congress is the implementation of the MSP Mandatory Reporting Provisions in Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 ("MMSEA").

Section 111 of the MMSEA adds new mandatory reporting requirements for group health plan ("GHP") arrangements and for non-GHP plans, including liability insurance, no-fault insurance, and workers' compensation insurance. The insurer's reports are to be submitted with respect to only Medicare beneficiaries (including a deceased beneficiary if the claimant was deceased at the time of the settlement, award, judgment, or other payment).

As it applies to workers' compensation claims, these changes only add reporting rules and do not eliminate any existing statutory provisions or regulations. They also include penalties for non-compliance. The penalty imposed by CMS for each Medicare beneficiary claimant whose workers' compensation claim is not reported will be $1,000.00 a day.

Reports will be due in a specific form and manner, due after the claim is resolved, and in electronic format. The testing period for workers' compensation reporting begins July 1, 2009 and ends September 30, 2009. The first production files will be due between October 1, 2009 and

December 31, 2009. All liability/no-fault/workers' compensation Responsible Reporting Entitles ("RREs") will be required to submit production files by January 1, 2010.

RISKS ALL PARTIES TO A WORKERS' COMPENSATION CLAIM INVOLVING A MEDICARE BENEFICIARY SHOULD CONSIDER

In addition to the specific requirements set forth by CMS, all parties involved in workers' compensation claims should be aware that other issues have arisen as a result of this constantly changing area of law. These risks are discussed in depth below and include (1) the double liability of the primary payer if a claimant fails to reimburse Medicare for conditional payments made prior to the settlement, (2) the double liability of the primary payer if the expenditure for medical treatment has not been properly documented, (3) issues arising from the ambiguity in the law, (4) long delays and increased costs, (5) ambiguity in setting reserves, and (6) the risk of inflated settlement demands or a claimant's unwillingness to resolve his workers' compensation claim.

First, parties to workers' compensation claims must always manage their records properly and keep track of conditional payments made by Medicare prior to the date of the settlement or other payment. Conditional payment amounts can be requested directly from CMS. However, it is a more efficient rule of thumb if claimants and workers' compensation insurers work together to identify the payments disbursed for medical treatment and prescription drugs causally related to the work injury or illness.

If Medicare makes a conditional payment, and later believes a settlement agreement did not properly protect its interests, CMS may demand reimbursement for the conditional payment from the claimant, or if the claimant already spent the funds, from the primary payer, even if the

primary payer had already paid that amount once to the claimant. This double liability imposed upon the primary payer is a serious risk for insurers.

Second, the primary payer can again have double liability related to the mismanagement of funds and documentation. If CMS approves a settlement arrangement and the funds set aside by the arrangement are exhausted, Medicare will then cover the costs of the claimant's future medical treatment and prescription drugs.

The primary payer's expenditures for causally related medical treatment and prescription drugs should be well documented because Medicare will not pay for any services directly related to the injury or illness until the beneficiary presents medical invoice amounts, in accordance with the Maryland Fee Schedule, that total the amount of the lump sum payment in a commutation settlement.

Third, another risk to consider is the ambiguity of the law. Due to the relatively recent enactment of many of these laws, CMS' past inability to pursue every claim in a timely and effective manner, and the long process of exhausting administrative remedies, many issues that workers' compensation parties have tried to resolve have yet to be addressed by the federal courts.

One example of an ambiguity in the law that has not yet been addressed by federal appellate courts is the seemingly contradictory fact that CMS will not recognize a settlement that shifts the cost from the primary payer to Medicare, but CMS may approve a lump sum compromise settlement arrangement, which relieves the primary payer of all medical expenses incurred after the date of the settlement. The argument is that any settlement with closed medicals may be considered cost-shifting from the primary payer to Medicare.

Fourth, there is a risk that there are long delays associated with the settlement of workers' compensation claims created by the CMS approval process. Both the approval process and the new mandatory reporting requirements also lead to increased costs associated with compliance with the MSP statute.

Workers' compensation is a system specifically structured to allow speedy payment to injured workers, and Maryland has one of the most efficient systems in the country. As such, the longer the delay in obtaining approval of a settlement arrangement, the longer a claimant must wait for compensation benefits. This, in turn, also amounts to increased litigation costs for the primary payer.

The multi-step process requiring CMS' review of settlement arrangements threatens the efficient functioning of the workers' compensation system. The delay is caused by the collection of medical records and invoices, determination of Medicare lien amounts, cost estimation and allocation, review by the recovery contractor assigned by CMS, and determination of the existence of prior liens.

The mandatory reporting requirements effective July 1, 2009 create a new burden for the workers' compensation insurers who can only file their reports electronically. The electronic submission requirements increase the costs associated with all workers' compensation claims involving Medicare beneficiaries. These costs are irrespective of whether the claim is ever resolved. The only requirement is that the claimant must also be currently entitled to Medicare benefits.

Fifth, the ambiguity of laws creates risk. The potential for an insurer's double liability, and the new but steep penalty liability will make it difficult for primary payers to effectively set

reserves and properly plan for future liability on workers' compensation claims. Accordingly, insurers are faced with the difficult task of setting reserves on these types of cases.

CMS both has the option and lacks the resources to make a demand for reimbursement of conditional payments in all workers' compensation cases. If CMS does make a demand, no formula for reimbursement exists. As such, it is not clear what method of calculation is employed by CMS to determine the amount of its anticipated demands for reimbursement.

Yet another obstacle is created in the reimbursement demand process by the relatively long federal statute of limitations period. The primary payer must wait up to six years to determine if CMS will ever issue a reimbursement demand letter on a claim. And, the only way to determine the amount of the reimbursement liability to CMS is by receiving the demand letter.

Furthermore, the federal courts have held that they will not order CMS to provide a final reimbursement demand because a claimant must first exhaust his administrative remedies. This means the insurer must remain waiting for up to six years to determine if CMS will issue a demand letter at all, and if so, for what amount.

The primary payer's liability exposure to Medicare remains open on a claim if future medical treatment has not been closed in the settlement agreement. In Maryland, there is no limitations period for future medical treatment on a workers' compensation claim. So, although an insurer effectively deems a claim closed, the potential liability for future medical treatment remains open until a full and final settlement has been approved by the Maryland Workers' Compensation Commission.

Sixth, the new liabilities of claimants, primary payers, and attorneys create another risk: inflated settlement demands from claimants or the plain unwillingness to settle. Medicare does not recognize medical and non-medical portions of settlement arrangements. In cases of

compromise of liability, this system allows claimants to push for unjustified settlement amounts. This may occur because employers will agree to a settle in a case where liability has not been fully established.

As a result, the amount of future medical expenses may be greater than the amount the primary payer offers to settle. Although a primary payer's liability for a settlement arrangement approved in advance by CMS is capped at the amount specifically allocated for future causally related medical expenses, attorneys on both sides of the workers' compensation claim will have to confront this issue head-on during settlement negotiations. This potential future liability is another obstacle to settlement created by the MSP statute and may prolong and deter negotiations all together.

It is also important to note another hindrance to the settlement of a workers' compensation claim. CMS will not participate in pre-settlement negotiations. This will probably further delay or prevent an agreement. Attorneys may wish to avoid all of the ambiguities and difficulties with this system and choose not to settle the case.

But, parties should keep in mind that Medicare may still have interests in any award, judgment, or other payment besides a final agreement of compromise and settlement. Additionally, as a result of the new mandatory reporting requirements, CMS will have notice of which primary payers continue to have primary payer liability for future medical treatment as a result of a work-related injury or illness sustained by current Medicare beneficiaries.

FEDERAL HOLDINGS

The MSP statute casts Medicare as the secondary payer in virtually all situations if any other insurance coverage exists. This creates a cause of action for Medicare to seek reimbursement from primary payer insurance funds. The federal government has standing to

intervene in litigation between the beneficiaries and primary payers when the primary payer is disputing the beneficiary's claim. Several of the holdings of federal appellate courts involving issues related to the MSP statute follow.

MEDICARE HAS NO RIGHT OF REIMBURSEMENT FROM AN UNINSURED EMPLOYER THAT SETTLES A WORKERS' COMPENSATION CLAIM

The United States Court of Appeals for the Fifth Circuit held a party that settles a Medicare recipient's claim against it is not, *ipso facto*, a "self-insurer" under the MSP statute. *See Thompson v. Goetzmann*, 337 F.3d 489 (5th Cir. 2003). The payment by the primary payer must be made under a "primary plan" of self-insurance, which requires both an arrangement for (1) a source of funds, and (2) procedures for disbursing these funds when claims are made against the employer. *Id*. at 498.

The employer therefore, to be liable for reimbursement to Medicare, "would have to engage in the same sorts of underwriting procedures that insurance companies employ; estimating likely losses during the period, setting up a mechanism for creating sufficient reserves to meet those losses as they occur, and, usually, arranging for commercial insurance for losses in excess of some stated amount." *Id*. A plan must be in place as an arrangement to provide health benefits or assume legal liability. *Id*.

Accordingly, an uninsured employer that settles a Medicare beneficiary's workers' compensation claim would not be liable to Medicare for reimbursement of prior conditional payments or future medical expenses. The primary payer identified under the federal statutes must be an insurance company or a self-insurer structured like an insurance company.

An uninsured employer, that under Maryland law would be liable to a claimant for an accidental injury or occupational disease, would not be liable for reimbursement to Medicare.

CMS does not have the reach to demand reimbursement from any party in a workers' compensation case if the payment to the claimant was not made under a "primary plan." *Id*. at 503. The claimant and the attorneys in the case would also, as a result, have no reimbursement liability to Medicare.

It is important to note, however, *Goetzmann* applauded the federal government for its motive in seeking to recoup funds it had disbursed for Medicare treatment and services. *Id*. It also advised that the desire to expand the list of those responsible for reimbursement should be directed to Congress rather than the courts. *Id*. In light of the many changes to the MSP program in the past several years, this is a change which may be fast approaching fruition.

MEDICARE IS NOT ENTITLED TO DOUBLE DAMAGES AGAINST RECIPIENT OR HIS ATTORNEY

Workers' compensation attorneys should be relieved to know that although they are liable for protecting Medicare's interests, they are not liable for double damages to Medicare. Payment by Medicare is conditional when payment has been or can reasonably be expected to be made under an insurance policy.

If Medicare is not reimbursed for conditional payments by the beneficiary, the primary payer must reimburse Medicare even though it has already reimbursed the beneficiary or other party. *U.S. v. Sosnowski*, 822 F.Supp. 570, 573, 41 Soc.Sec.Rep.Serv. 312, Med & Med GD (CCH) P 41,068 (W.D. Wisc. 1993). The Court held double damages were not appropriate in that case because neither the Medicare beneficiary nor his attorney were a "primary plan" and double damages are only available when a primary plan fails.

CMS MAY RECOVER UP TO THE FULL AMOUNT OF CONDITIONAL MEDICARE PAYMENTS EVEN WHEN THE BENEFICIARY RECEIVES A DISCOUNTED THIRD PARTY SETTLEMENT

Often another issue in workers' compensation settlements is the workers' compensation insurer's subrogation lien against a third party liability insurer. This occurs when a claimant is entitled to workers' compensation benefits under Maryland workers' compensation law, but is also entitled to damages as a result of a third party tortfeasor's negligence. In Maryland, workers' compensation insurers have an automatic lien against those third party liability insurers for the amount of medical and indemnity payments made on the claim.

The subrogation provisions of the MSP statute give the federal government the right to be put in the legal position of the Medicare beneficiary in order to recover from third parties who are legally responsible for the beneficiary for a loss. *Zinman v. Shalala*, 67 F.3d 841, 844, 49 Soc.Sec.Rep.Serv. 128, Med & Med GD (CCH) P 43,653 (9th Cir. 1995). *Zinman* rejects the principle that because the right of subrogation is equitable in nature, a subrogated right holder is limited to recovery of the proportion of its loss for which third-party reimbursement is actually received.

Instead, *Zinman* holds the MSP statute allows full reimbursement of conditional Medicare payments even though a beneficiary receives a discounted settlement from a third party. *Id*. at 845. "The transformation of Medicare from the primary payer to the secondary payer with a right of reimbursement reflects the overarching statutory purpose of reducing Medicare costs." *Id*.

The Court made a point to reject an equitable apportionment of third party settlements because, it opined, workers' compensation cases are different than tort cases. *Id*. at 846.

Workers' compensation schemes generally determine recovery on the basis of a rigid formula, often with a statutory maximum. *Id*. Apportionment in workers' compensation settlements is relatively simple to calculate. *Id*.

"Tort cases, in contrast, involve noneconomic damages not available in workers' compensation cases, and a victim's damages are not determined by an established formula." *Id*. The Court refused to find that Medicare's recovery amount from a tort liability settlement should require a factfinding process or be "at the mercy of a victim's or personal injury attorney's estimate of damages." *Id*.

A THIRD PARTY LIABILITY INSURER SATISFYING A WORKERS' COMPENSATION SUBROGATION LIEN MAY BE LIABLE FOR DOUBLE DAMAGES

The MSP statutory provisions also apply if a third party payer makes its payment to an entity other than Medicare when it is, or should be, aware that Medicare has made a conditional primary payment. *Sosnowski*, 822 F.Supp. at 573. This holding is especially relevant to workers' compensation claims that involve third party liability. CMS, in that type of case, would be entitled to demand reimbursement for payments from the third party liability insurer, even if the third party had satisfied the workers' compensation insurer for the full amount of the subrogation lien.

A PRIVATE CITIZEN MAY COLLECT DOUBLE DAMAGES BY BRINGING CLAIMS AGAINST PRIMARY PAYERS TO RECOVER MONEY OWED

A noteworthy case involving an accepted claim for an occupational disease under Maryland workers' compensation law visits a provision of the MSP statute which allows private citizens to collect double damages by bringing claims against primary payers to recover money owed to Medicare. *O'Connor v. Mayor and City Council of Baltimore*, 494 F.Supp.2d 372, Med

& Med GD (CCH) P 302,166 (D. Md. 2007). The district court held the claimant had standing to bring the claim for double damages because an injury in fact had occurred, a causal connection had been established between his disease and his employment, and a decision in his favor would redress his injury. *Id*. at 374.

Unfortunately, like many other issues created by the MSP statutes, no other opinion has been drafted by any Federal court regarding the issues raised by Medicare beneficiary and workers' compensation claimant O'Connor. However, the *O'Connor* opinion, through dicta, indicates that the federal courts in our jurisdiction will not hesitate to enforce the MSP provisions imposing liability upon primary payers.

CONSULTANTS THAT ASSIST IN STRUCTURING WORKERS' COMPENSATION SETTLEMENT ARRANGEMENTS MAY HAVE STANDING TO BRING SUIT AGAINST THE FEDERAL GOVERNMENT

Consulting companies often assist parties to workers' compensation claims in structuring settlement arrangements that comply with CMS regulations designed to assure that Medicare's interests are considered when the claimants are persons eligible for Medicare benefits. These consulting companies typically receive a fee from the settlement proceeds. *Protocols, LLC v. Leavitt*, 549 F.3d 1294, Med & Med GD (CCH) P 302, 685 (10th Cir. 2008).

Protocols filed suit against the Secretary of the Department of Health and Human Services and the Acting Administrator of CMS alleging that a memorandum issued by CMS misinterpreted the MSP statute and regulations and exposed Protocols to unexpected liabilities arising out of settlements it had structured in the past. *Id*. at 1294.

Protocols alleged a change in the law by CMS would create liability for the company as a result of CMS' potential refusal to recognize prior settlements. This, Protocols alleged, would

lead to a decrease in the company's value, uncertainty of how much revenue it must not use for capital or operating costs in case of future exposure, and postponed discussions with potential investors awaiting the outcome of the lawsuit.

The Court found that these reasons did amount to injury in fact, and therefore Protocols had standing to bring suit against the federal government. This case reaffirms that the liabilities imposed by the MSP statute affect all parties to workers' compensation claims, not just claimants and insurers.

A CLAIMANT MUST EXHAUST HIS ADMINISTRATIVE REMEDIES TO RECOVER ON ANY CLAIM ARISING OUT OF THE MEDICARE ACT

The Medicare statute requires that any lawsuit which seeks to recover on any claim arising under it must first be brought through the Department of Health and Human Services administrative appeals process before it can be filed in federal court. *See Walters v. Leavitt*, 376 F.Supp.2d 746, Med & Med GD (CCH) P 301,666 (E.D. Mich. 2005). The Medicare beneficiaries in this case filed suit to compel CMS to produce the itemized list of federal Medicare benefits paid on their behalf, including the reimbursement amount Medicare will seek. *Id*. at 749.

The district court held the beneficiaries had made no attempt to exhaust their administrative remedies and they can obtain precisely the information they seek by following the administrative process outlined by CMS. *Id*. at 755.

The administrative process begins with a request to CMS. *Id*. at 756. If CMS denies the request, the party would then seek review of that denial at a hearing before an administrative law judge. *Id*. If still unsatisfied, the party should request review of the administrative law judge

decision by the Department of Health and Human Services Appeals Board. *Id*. If the party again receives an unfavorable decision, filing a claim in Federal court is then proper. *Id*.

This long line of administrative procedures acts as a deterrent for litigation of issues raised by enactment of the MSP statute. The associated litigation costs are another serious risk to consider when determining liability arising from a workers' compensation claim.

CONCLUSION

In light of the evolving federal laws involving Medicare beneficiaries entitled to future medical treatment and prescription drugs under a workers' compensation primary payer insurance plan, no party to a workers' compensation claim can afford to ignore the liabilities imposed.

The newly enacted penalties for the failure to report Medicare beneficiaries entitled to continued medical treatment under a primary payer plan to CMS have effectively ended the days in which all parties to workers' compensation claims may have been able to afford non-compliance with the MSP program. CMS will soon have the ability to determine if a workers' compensation insurer is liable for payments for a Medicare beneficiary's medical payments. The anticipated result is an increase in the number of demands for reimbursement for conditional payments made by Medicare.