



Single-Source Solution
for Workers' Compensation

Governmental Affairs Alert

January 21, 2008

The Medicare, Medicaid, SCHIP Extension Act of 2007

On December 29, 2007, President Bush signed into law the Medicare, Medicaid, SCHIP Extension Act of 2007 (S.2499). Section 111 stipulates the required submission of claimant status “by or on behalf of liability insurance (including self-insurance), No-Fault insurance, and workers’ compensation laws and plans” if a claimant is determined to be Medicare entitled.

During a discussion of this provision on the Senate floor, Senator Charles Grassley (R-IA) stated:

“As in previous legislation that Congress has passed, this legislation will continue to improve accountability in the Medicare Program. There are situations when Medicare is not the primary payer for a beneficiary's health care, but it is currently difficult to identify these situations. This legislation 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.”

In order to enforce the law, the Secretary of Health and Human Services is authorized to charge penalties of \$1,000 per day, per claim for Medicare-entitled cases not reported in accordance with the Secretary’s instructions. Implementation of penalties will commence July 1, 2009.

In the absence of procedural memoranda from CMS addressing the need for payers to consider Medicare’s interests in non-workers’ compensation settlements, the judiciary is upholding Medicare’s right of protection on liability settlements. Several appellate decisions in Federal Circuit Court Districts, including the 11th and the 4th, have upheld Medicare’s right of protection under Title 42 on non-workers’ compensation settlements.

It is important to understand that Medicare’s right of protection is statutory. It is not dependent upon lien notice. **If Medicare is forced to litigate to recover a lien, they are due double damages, plus interest.** Also, Medicare may seek recovery directly against a payer (liability or workers’ compensation) or any other responsible party such as the claimant, claimant attorney, defense attorney, treating doctor, and / or structured settlement broker. Also, Medicare has the option to terminate all benefits to a claimant if they are not protected as a secondary payer!

It is essential that stakeholders be cognizant of the Medicare Secondary Payer law when negotiating settlements—the consequences of ignoring this law can be disastrous and costly for all parties involved.

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The only way to be fully protected is by following these three steps:

1. Determine the claimant's Social Security Disability and Medicare status.
2. Report such status to the department of Health and Human Services (required information and method for submission below).
3. For cases in which a claimant is receiving Social Security Disability or Medicare, obtain a Medicare Set-Aside to be included in the settlement.
4. Verify and resolve outstanding injury-related Medicare liens and address such in the settlement.

For your reference, we have included below the text from this recent legislation.

SEC. 111. MEDICARE SECONDARY PAYOR.

(a) In General- Section 1862(b) of the Social Security Act (42 U.S.C. 1395y(b)) is amended by adding at the end the following new paragraphs:

“(7) REQUIRED SUBMISSION OF INFORMATION BY GROUP HEALTH PLANS-

“(A) REQUIREMENT- On and after the first day of the first calendar quarter beginning after the date that is 1 year after the date of the enactment of this paragraph, an entity serving as an insurer or third party administrator for a group health plan, as defined in paragraph (1)(A)(v), and, in the case of a group health plan that is self-insured and self-administered, a plan administrator or fiduciary, shall--

“(i) secure from the plan sponsor and plan participants such information as the Secretary shall specify for the purpose of identifying situations where the group health plan is or has been a primary plan to the program under this title; and
“(ii) submit such information to the Secretary in a form and manner (including frequency) specified by the Secretary.

“(B) ENFORCEMENT-

“(i) IN GENERAL- An entity, a plan administrator, or a fiduciary described in subparagraph (A) that fails to comply with the requirements under such subparagraph shall be subject to a civil money penalty of \$1,000 for each day of noncompliance for each individual for which the information under such subparagraph should have been submitted. The provisions of subsections (e) and (k) of section 1128A shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a). A civil money penalty under this clause shall be in addition to any other penalties prescribed by law and in addition to any Medicare secondary payer claim under this title with respect to an individual.

“(ii) DEPOSIT OF AMOUNTS COLLECTED- Any amounts collected pursuant to clause (i) shall be deposited in the Federal Hospital Insurance Trust Fund under section 1817.

“(C) SHARING OF INFORMATION- Notwithstanding any other provision of law, under terms and conditions established by the Secretary, the Secretary--

“(i) shall share information on entitlement under Part A and enrollment under Part B under this title with entities, plan administrators, and fiduciaries described in subparagraph (A);

“(ii) may share the entitlement and enrollment information described in clause (i) with entities and persons not described in such clause; and

“(iii) may share information collected under this paragraph as necessary for purposes of the proper coordination of benefits.

“(D) IMPLEMENTATION- Notwithstanding any other provision of law, the Secretary may implement this paragraph by program instruction or otherwise.

“(8) REQUIRED SUBMISSION OF INFORMATION BY OR ON BEHALF OF LIABILITY INSURANCE (INCLUDING SELF-INSURANCE), NO FAULT INSURANCE, AND WORKERS' COMPENSATION LAWS AND PLANS-



`(A) REQUIREMENT- On and after the first day of the first calendar quarter beginning after the date that is 18 months after the date of the enactment of this paragraph, an applicable plan shall--

`(i) determine whether a claimant (including an individual whose claim is unresolved) is entitled to benefits under the program under this title on any basis; and

`(ii) if the claimant is determined to be so entitled, submit the information described in subparagraph (B) with respect to the claimant to the Secretary in a form and manner (including frequency) specified by the Secretary.

`(B) REQUIRED INFORMATION- The information described in this subparagraph is--

`(i) the identity of the claimant for which the determination under subparagraph (A) was made; and

`(ii) such other information as the Secretary shall specify in order to enable the Secretary to make an appropriate determination concerning coordination of benefits, including any applicable recovery claim.

`(C) TIMING- Information shall be submitted under subparagraph (A)(ii) within a time specified by the Secretary after the claim is resolved through a settlement, judgment, award, or other payment (regardless of whether or not there is a determination or admission of liability).

`(D) CLAIMANT- For purposes of subparagraph (A), the term `claimant' includes--

`(i) an individual filing a claim directly against the applicable plan; and

`(ii) an individual filing a claim against an individual or entity insured or covered by the applicable plan.

`(E) ENFORCEMENT-

`(i) IN GENERAL- An applicable plan that fails to comply with the requirements under subparagraph (A) with respect to any claimant shall be subject to a civil money penalty of \$1,000 for each day of noncompliance with respect to each claimant. The provisions of subsections (e) and (k) of section 1128A shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a). A civil money penalty under this clause shall be in addition to any other penalties prescribed by law and in addition to any Medicare secondary payer claim under this title with respect to an individual.

`(ii) DEPOSIT OF AMOUNTS COLLECTED- Any amounts collected pursuant to clause (i) shall be deposited in the Federal Hospital Insurance Trust Fund.

`(F) APPLICABLE PLAN- In this paragraph, the term `applicable plan' means the following laws, plans, or other arrangements, including the fiduciary or administrator for such law, plan, or arrangement:

`(i) Liability insurance (including self-insurance).

`(ii) No fault insurance.

`(iii) Workers' compensation laws or plans.

`(G) SHARING OF INFORMATION- The Secretary may share information collected under this paragraph as necessary for purposes of the proper coordination of benefits.

`(H) IMPLEMENTATION- Notwithstanding any other provision of law, the Secretary may implement this paragraph by program instruction or otherwise.'

(b) Rule of Construction- Nothing in the amendments made by this section shall be construed to limit the authority of the Secretary of Health and Human Services to collect information to carry out Medicare secondary payer provisions under title XVIII of the Social Security Act, including under parts C and D of such title.

(c) Implementation- For purposes of implementing paragraphs (7) and (8) of section 1862(b) of the Social Security Act, as added by subsection (a), to ensure appropriate payments under title XVIII of such Act, the Secretary of Health and Human Services shall provide for the transfer, from the Federal Hospital Insurance Trust Fund established under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of such Act (42 U.S.C. 1395t), in such proportions as the Secretary determines appropriate, of \$35,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for the period of fiscal years 2008, 2009, and 2010.