

Medicare and Liability Settlements – A Fundamental Shift in Responsibility for the Self Insured or Insurance Carrier

By: Roy A. Franco, J.D.

INTRODUCTION:

Starting next July¹ to ensure Medicare is receiving all of its reimbursements, the Centers for Medicare and Medicaid Services (CMS) will require reporting to them all Settlements, Awards and Judgments that involve a Medicare recipient. Failure to do so may cost self insured entities and insurance carriers' penalties of \$1,000 per day for each claim not reported. The penalties and the complex claims administration problems will significantly increase the cost of these claims, without resulting in a better settlement for the injured party.

We are creating a coalition to help limit the exposure to penalties and to ease the administration of these kinds of claims. We would appreciate your participation and involvement in resolving this problem.

DISCUSSION:

Medicare does not need to take into account fault when making a demand for reimbursement on a liability claim. If a claim payment is made, the self insured or insurance carrier is deemed a primary payer under the law² and reimbursement is required to Medicare for past health care services provided to the injured party. There is also a requirement that the self insured or insurance carrier take into consideration Medicare's interest as to future medical payments; but there is no established process – like CMS created for workers' compensation³. This results in additional confusion for the self insured or insurance carrier when resolving a claim with an injured party that is also a Medicare Recipient.

Today, the self insured or insurance carrier satisfies its obligation under the Medicare Secondary Payer Law by requiring the injured party or his attorney (under the terms of the settlement agreement) to deal with Medicare. The settlement funds are disbursed and the claim closed. The new reporting requirement will bring change to this process. The settlement cannot be distributed to the injured party because the self insured or insurance carrier through reporting will be made primarily responsible to Medicare. This will increase the costs for liability claims – because of increased administrative process; lost opportunity to settle claims timely; additional funds that may be needed to satisfy Medicare; and the uncertainty caused by attempting to comply with making certain future Medicare benefits are covered by the settlement.

¹ SB2499

² 42 U.S.C. Section 1395y(b)(2)(A)(ii)(2002)

³ Workers' Compensation faced similar issues with regards to compromise of claims. However, a defined process was established by CMS which has helped with the administration of settlements, but far from perfect. As a result the Industry has put forth a bill³ to add further efficiency to that process.

The Medicare Secondary Payer Law requires amendment so that it may provide a fair and equitable process for a Self Insured or Insurance Carrier to reimburse Medicare its payment for services due to an alleged liability incident. Liability claims are fault based and require proof before legal liability attaches to the responsible party. Proof is established by a trier of fact in all jurisdictions in accordance with applicable law. The majority of liability claims are never decided by a trier of fact and instead compromised. Compromise requires both sides of the dispute to recognize their respective fault and make needed adjustments to avoid further litigation expense. In some cases, compromise is mostly for goodwill to preserve customer relations and liability is never accepted by either side. Present Federal law doesn't recognize fault concept for liability claims and treats it as another no fault program such as Group Health Plans and Worker's Compensation. The result is an inequitable requirement to reimburse Medicare for health care expenses that are not in proportion to the fault of the responsible party or in this case the Self Insured or Insurance Carrier.

The Self Insured or Insurance Carrier will carry a contingent liability, after July 1, 2009 when there is a Settlement, Award or Judgment that involves a Medicare recipient. The contingent liability would be triggered when any payment is made to the Medicare recipient. To protect itself from this exposure, the Self Insured or Insurance Carrier should not distribute any proceeds unless: 1) The Medicare Reimbursement Amount (MRA) is determined; 2) Medicare's interest is clearly taken into account as part of the resolution; and 3) SB2499 reporting requirements are complied with. Reform needs to occur because while the requirements are easily stated, they are difficult to execute as they upset the long established process of how liability claims are resolved.

The law will cause delay in settlements as administrative processes once absorbed by the Medicare Recipient or his attorney will now fall to the Self Insured or Insurance Carrier to process. The Self Insured or Insurance Carrier will not close its claim file expeditiously as it does today. They must wait for a final statement from Medicare, which will take several months⁴, and the settlement itself is precarious as no consideration can be exchanged. Consequently, when the final statement is received negotiations may need to be restarted adding additional cost or may ultimately breakdown altogether as there are not enough funds to satisfy both Medicare Recipient and Medicare.

The present rules require Medicare to be reimbursed for 100% of the expenses it has incurred related to the injuries that arose from the liability incident. Deductions are allowed only for economic hardship of the Medicare recipient or procurement costs of the

⁴ Presently, it takes three months to process a claim for settlement with Medicare. This assumes that Medicare was placed on notice of the loss through the Coordination of Benefits Office and therefore was able to segregate the data as health care services are provided. It takes longer – 6 to 8 months if notice was not provided as close in time to the occurrence of the loss. When SB2499 goes into effect Medicare estimates to receive 2.9M reported settlements with no planned staff increases. The added workload will increase the time it will take the self insured or insurance carrier to close files.

Medicare recipient's attorney – none for the apportionment of fault. Hence if a settlement is proposed of \$100 and the MRA is greater than the settlement amount, Medicare expects to receive the entire amount. Unless Medicare considers fault principles that are presented in the liability claim and is willing to adjust the MRA, the settlement will not occur unless the Self Insured or Insurance Carrier increases the proposed offer. If we settle the liability claim under these conditions, **the average cost per claim will increase.**

Furthermore, the penalties for non-compliance for reporting by the Self Insured or Insurance Carrier are significant. Failure to report a claim results in a \$1,000 a day penalty for each claim and each day the report is delayed. Failure to confirm that the Government was reimbursed may lead to a recovery action that could result in the Self Insured or Insurance Carrier or insurance carrier to pay twice the amount of the reimbursement in addition to the penalty for delayed reporting. There are no defenses to these claims.

We also expect to see greater number of liability claims involving Medicare Recipients. The Baby Boomers are retiring at an alarming rate and Medicare rolls are increasing at a rate of 10,000 people per week. Medicare expects the number of Medicare Recipients to almost double in the next couple of years to 78M or a little more than 25% of Country's population. As liability claims usually reflect the landscape of the population, it is not unrealistic to assume that 25% of liability claims could involve Medicare Recipients and be subject to the Medicare Secondary Payer Laws.

In fact, Medicare expects to receive 2.9M claims⁵ each year as a result of the reporting requirements under SB2499.⁶ To understand the potential dollars that may be involved here we can make some reasonable assumptions to arrive at the MRA associated with those claims. If the average settlement is \$1,200⁷ and multiplier (ratio of medical bills to total settlement dollars) is about 2, then by conducting some simple math ($[2.9M \times \$1,200] / 2.0$) should provide the estimated MRA or \$1.740B annually. This represents a significant amount of money that will move from the control of the Medicare Recipient to Medicare. The resulting shortfall in expectation of the Medicare Recipient during the settlement process will result in settlement issues, delay and more than likely increased litigation. Unless Medicare is authorized to compromise for fault a great deal of settlements will be frustrated and increase litigation will inevitably occur. This is not a "win" for anyone as it was concluded in a recent study.⁸

⁵ CMS provides no insight as to how this number was derived. We estimate about 40M liability claims are filed each year, and the number selected by CMS represents 7%. The current Medicare population is about 15% of the U.S. Population. It may very well be that CMS has underestimated the potential number to be reported.

⁶ Supporting Statement for the Medicare Secondary payer (MS) Mandatory Insurer Reporting Requirements of Section 111 of the Medicare medicated, and SCHIP Extension Act of 2007 at page 10 – Published August 1, 2008.

⁷ The average cost per claim is a conservative estimate for the retail/wholesale industry.

⁸ NY Times Article – *Study Finds Settling Is Better than Going to Trial*, published August 1, 2008.

A coalition was formed on June 12, 2008 to bring about legislative change to remedy the inequities currently in place for the Self Insured or Insurance Carrier. The Medicare Advocacy Recovery Coalition (MARC) purpose is promote legislative change that promotes efficiency in the recovery process and removes barriers that result in unnecessary delay and litigation.

CONCLUSION:

Join the coalition. Failure to do so will result in an increased cost for your liability program starting next year. It will be difficult to curb Medicare's appetite once it believes it has an unfettered right to a no fault recovery process for the MRA in liability claims. We need your financial support to bring about legislative change and awareness. You can reach me at 925.216.5727 or via e-mail at roy.franco@safeway.com and look forward to hearing from you.

About the Author

Roy A. Franco, J.D. is the Director of Casualty Claims for Safeway Inc. responsible for the self-administration of general liability claims for the entire Company. Prior to joining Safeway, Roy engaged in a general liability practice for over 10 years. In recent years he has identified Medicare and the process it employs to seek reimbursement as counterintuitive to long established liability methods that promote the efficient administration of liability claims. He has worked to educate and promote the issue amongst industry members which has culminated into the formation of the Medicare Advocacy Recovery Coalition (MARC) whose purpose is to promote legislation that will improve the efficiency of the Medicare reimbursement process. The coalition is presently seeking contributions to fund the effort to draft legislation and promote legislative awareness and support.

Roy has been involved with a grass roots task force to promote these issues for the last two years and has presented for several organizations to raise awareness. The task force was successful in publishing an article in the DRI in February 2008 (Medicare Reimbursement Problems). That organization has now merged into MARC to support the effort to reform the Medicare Secondary Payer Laws.

Contributions to this Article were made by Tito Melara, Sandra Dodich Paul Cryar and Jim Cole.