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Will Medicare Rain on Your Parade?

by Thomas J. Misurek

As U.S. baby boomers trek their final decades to retirement, there's a clap of federal thunder announcing their arrival. Medicare, the medical program of insurance that has been an important umbrella for the aged, has less and less fabric to ward off the elements. As a result, some rain and some fury of the medical-cost storm is about to fall on the heads of industry and insurers. If you thought that Medicare was the medical bill-payer for retired Americans, well, that, in good part, remains true.

As Medicare has described itself, in 2009 and going forward, "Medicare is a federal program that pays for *certain* covered health provided to enrolled individuals, certain disabled individuals, and individuals with permanent kidney failure." Gone from Medicare's self-description is any emphasis of itself as *the* medical bill-payer for the elderly. And, there are a number of concerted federal efforts currently underway to help make sure that the "certain covered health" provided to the elderly does not outstrip the sums that the federal government can reasonably expect to collect from wage-earning taxpayers.

Limiting the federal government's exposure as the primary medical-expense payer—whenever possible—has grown in importance as health care expenses have swelled since the federal government's first foray into public health insurance programs. In 1950 Congress acted to improve access to medical care for needy persons who were receiving public assistance. In 1960 Congress had passed limited legislation, including legislation titled "Medical Assistance to the Aged," which provided medical assistance for aged persons who were less poor, yet still needed assistance with medical expenses. Following considerable national debate, Congress passed legislation in 1965 establishing the Medicare and Medicaid programs as Title XVIII and Title XIX of the Social Security Act. Medicare was established in response to the specific medical care needs of the elderly, with coverage added in 1973 for certain disabled persons and certain persons with kidney disease.

Overall health spending in the United States grew from $27.5 billion at the time that Congress first passed its limited "Medical Assistance to the Aging Act" in 1960 to $912.5 billion in 1993. By 2007 national health expenditures were up to $2.2 trillion.

A significant portion of public health spending can be attributed to the programs administered by the Centers for Medicare & Medicaid Services (CMS)—Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). Together, Medicare, Medicaid, and CHIP financed $769.6 billion in health care services in 2007—slightly more than one-third of the country's total health care expenditures.

According to projections of national health spending relied upon by Medicare administrators, national health expenditures will reach $4.4 trillion in 2018.

Medicare spending as a share of gross domestic product (GDP) is one of several measures reported by the Medicare Trustees in their annual report to Congress. This measure looks at expenditures over all parts of the Medicare program in the context of the U.S. economy as a whole. With the aging population and expected increases in overall health care costs, Medicare spending is projected to grow at a faster rate than the rate of growth for the overall economy. If current trends continue, Medicare expenditures as a share of GDP are projected to rise from 3.5 percent of GDP in 2010 to 6.4 percent of GDP in 2030.

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Defending Petitions to Vacate Workers' Compensation Settlements

by Matthew P. Bandt

Workers' compensation settlements can take many forms. Insurers prefer to settle on a full, final and complete basis to avoid what can seem like an endless stream of benefits. Unfortunately, the peace of mind provided by a full, final and complete settlement is limited. Pursuant to Minn. Stat. § 176.461, a party may file a Petition to Vacate an Award, including an Award on Stipulation for Settlement, where the party can show any of the following: 1) a mutual mistake of fact; 2) newly discovered evidence; 3) fraud; or 4) a substantial change in medical condition that was clearly not anticipated and could not reasonably have been anticipated at the time of the award.

The Workers' Compensation Court of Appeals (WCCA) reviews all Petitions to Vacate. From January 2008 through March 2010, the WCCA issued twenty-three decisions on Petitions to Vacate Settlements, all of which were filed by employees. In eighteen of those Petitions, the employee argued there was a substantial change in his or her medical condition, which is by far the most common basis for vacating a settlement. During that timeframe, the WCCA granted nine Petitions to Vacate Settlements and seven of those were due to a substantial change in medical condition. In addition, two Petitions to Vacate Settlements were referred for an evidentiary hearing on those issues.

From January 2008 through March 2010, the WCCA issued only four decisions on Petitions to Vacate filed by employers and insurers. In all of those cases, the employer and insurer were seeking to vacate a judicial order, not a settlement.

In *Fodness v. Standard Café*, 41 W.C.D. 1054, 1989 WL 251412 (1989), the WCCA outlined six factors to consider in determining whether there has been a substantial change in medical condition:
1) a change in diagnosis;
2) a change in employee's ability to work;
3) additional permanent partial disability;
4) necessity of more costly and extensive medical care/nursing services than initially anticipated;
5) causal relationship between the injury covered by the settlement and the employee's current worsened condition; and
6) contemplation of the parties at the time of the settlement.

The WCCA applies these factors by comparing the employee's condition at the time of the settlement to his condition at the time of the Petition to Vacate. *See Davis v. Scott Moeller Co.*, 524 N.W.2d 464, (Minn. 1994). According to the WCCA, the *Fodness* factors "must be applied in a manner consistent with Minn. Stat. § 176.461 which requires that the changes be ones which were 'clearly not anticipated and [which] could not be reasonably anticipated at the time of the award.'" *See Tudahl v. Beverly Enterprises d/b/a Greeley Healthcare Center*, 2010 WL 431911 (Jan. 11, 2010)

Typically, the WCCA relies solely on the *Fodness* factors. However, according to the Minnesota Supreme Court, the primary issue is one of fundamental fairness:

> Under Minn. Stat. § 176.461 and Minn. Stat. § 176.521, subd. 3, "the basic concern in determining whether sufficient cause exists to set aside an award is to assure a compensation proportionate to the degree and duration of the disability." *See Landon v. Donovan Construction Co.*, 270 N.W.2d 15, (Minn. 1978) (per curiam); *Eigen v. Food Producers, Inc.*, 240 N.W.2d 559, (1976) (per curiam); and *Bohnhoff v. Allan Engineering Co.*, 231 N.W.2d 554 (1975) (per curiam). This basic concern, together with the nature of the four types of good cause, indicate that fairness is the overriding principle. (*Krebsbach*, 350 N.W. 349 (Minn. 1984)).

The WCCA has reiterated: "While these [*Fodness*] factors are a useful guide…, we also remain mindful that the primary purpose of allowing a vacation of an award is to assure compensation proportionate to the degree and duration of disability." *See Bell v. Flower City*, 2009 WL 5064793, (WCCA Dec 14, 2009), citing *Monson v. White Bear Mitsubishi*, 663 N.W.2d 534 (Minn. 2003).

In addition to relying on the *Fodness* factors, when defending a Petition to Vacate a Settlement due to an alleged substantial change in medical condition, an employer and insurer may have a strong fairness argument that should not be overlooked.

If a settlement is vacated, in theory, the parties are placed in the same position they were prior to the settlement. The employee can claim any benefits available at the time of the settlement, while the employer and insurer can rely on any defenses that existed at that time. The claim must be decided without any deference to the conclusions reached in the decision vacating the settlement. However, in reality, the employee is almost always better off and the employer and insurer worse off. That is because the employee has already received the benefit of the settlement proceeds. This is unfair to the employer and insurer for two reasons. First, the vacated settlement is like an interest free loan to the employee. Second, and more importantly, the employer and insurer's ability to offset the settlement proceeds from past and future benefits is severely limited.

After a settlement is vacated, pursuant to Minn. Stat. § 176.179, the employer and insurer can only claim a 20% credit from any benefits owed following the settlement. *See Bernard v. Marvin Lumber and Cedar*, 43 W.C.D. 399, 1990 WL 291784 (WCCA June 22, 1990); and *Rehn v. Hoffman Engineering*, 1995 WL 83000 (WCCA Feb. 8, 1995), Footnote 4. That includes past benefits owed up until and after the petition to vacate.

As an illustration, consider a settlement of $100,000 reached in 2000 and then vacated in 2010. Not only will the credit for future benefits be limited to 20%, so will the credit for any past benefits that accrued during those ten years. The employee will have to be awarded $500,000 in indemnity benefits before the employer and insurer will fully recover. Excluding benefits that may have accrued prior to the settlement, the ratio of recovery will always be five to one.

After a Stipulation for Settlement is vacated, to the extent the employer and insurer cannot recover the proceeds of the settlement, the employee will be overcompensated. Therefore, even when there has been a clear substantial change in the medical condition, the employer and insurer should still object to vacating a settlement, if it appears the employee was nonetheless fairly compensated.

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Medicare *continued from page 1*

Medicare is administered under Center for Medicare and Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. U.S. taxpayers contribute to the funds available to Medicare, in part, through those infamous "FICA" initials (Federal Insurance Contributions Act) that you see in tax-withheld sums on your paycheck stubs. (Part of your FICA deductions supports Social Security, part supports Medicare).

Clearly, unless U.S. wage earners were ready to see FICA deductions on their paychecks grow by multiples, Medicare administrators and Congress saw the need to limit Medicare payouts and to increase Medicare's recoveries under the Medicare Secondary Payer Act.

Therefore, it was not too long in the institutional existence of Medicare that the federal government tracked with demographers the boomers' population bulge moving in step toward retirement and toward Medicare eligibility. The Medicare Secondary Payer Act of 1980 refined prior Medicare legislation to try to assure that Medicare was neither the program nor the insurer of first resort for the elderly and the disabled; if there was any other insurer whose liability was able to stand in line ahead of it, Medicare was going to try to assure that it paid bills only after potential Medicare recipients first exhausted the dollars available from other insurers, including from workers' compensation insurers and from liability insurers.

In the first decade or two following the passage of the Medicare Secondary Payer Act there were not a lot of bite marks from that 1980 legislation on workers' compensation insurers or on liability insurers. However, the "bite here" maps were on the drawing table. In only the last half-dozen years have workers' compensation insurers started seeing the reach and bite of Medicare "super liens" on the closing of some number of claimants' future medical claims; Medicare coordination of benefits administrators began sharpening their collection teeth; and the issue of Medicare Set-Aside agreements wedged uncertainties into full, final and complete settlements of workers' compensation claims.

And now, under Medicare Secondary Payer Mandatory Reporting Provisions in Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 ["MMSEA," 42 U.S.C. 1395y(b)(7)&(b)(8)], the federal government has launched a means of collecting the very information which Medicare administrators will use to take their next bites out of liability and no-fault insurers.

These new rules under the MMSEA are requiring a whole raft of parties—known as RREs ("Responsible Reporting Entities," ranging from group health insurance plans to liability insurers, no-fault insurers and workers' compensation insurers)—to report certain information by often shifting deadlines. Certain MMSEA reporting deadlines were supposed to take effect for insurers on January 1, 2010 and were next delayed until April 1, 2010. Now the reporting deadline for liability insurers, no-fault insurers and workers' compensation insurers to submit "initial Section 111 Claim Input production files" has been pushed to January 1, 2011.

There may have been some initial confusion surrounding the MMSEA, its deadlines, and whether it was indeed implementing requirements for Medicare set-aside agreements for proceeds from liability claims. However, the MMSEA presents only reporting requirements for RREs, and does not even mention any need for set-aside agreements in liability cases. Section 111 establishes separate mandatory reporting requirements for group health plans as well as for liability insurance (including self-insurance), no-fault insurance, and workers' compensation.

Medicare explains that the purpose of collection of information under the MMSEA is for "coordination of benefits." This is Medicare's normal description of saying how it protects Medicare's right to stand in line only as a payor of last resort, classifying its payments as soon as possible as "conditional," and seeking recovery for all of its "conditional" payments if it can find an insurer or entity with any other possible responsibility to make the medical payments. The detailed reporting requirements under Section 111 of MMSEA are "necessary for both pre-payment and post-payment coordination of benefit purposes, including necessary recovery actions."

Medicare explains that pre-payment activities are generally designed to stop mistaken primary payments in situations where Medicare should be only the secondary payer. Post-payment activities are designed to recover mistaken payments or conditional payments made by Medicare where there is a contested liability insurance (including self-insurance), no-fault insurance, or workers' compensation which has resulted in a settlement, judgment, award, or other payment.

While Medicare pours oil to calm the roiling waters and rumors that MMSEA is already requiring set-aside agreements on liability cases, it makes no bones about the fact that MMSEA is the information-setup stage that will increase the opportunities for the federal government to limit both its initial unconditional payments of medical bills under Medicare and/or to point its lien collectors at all possible payors for reimbursement of the conditional medical payments it makes.

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Coming in the Summer 2010 Issue...

Legislative Update

Coverage (Coverage B v. GL)

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