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Workers' Compensation Settlements with Medicare Set-Aside Arrangements: Problem Solving the Issues

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Introduction

Although enacted in 1980, the Medicare Secondary Payer (MSP) statute has received little attention until recently. This is due in part to the passage of the "Medicare Integrity Program" of 1996. The MSP requires that payment of medical expenses be withheld "to the extent that …payment has been made or can reasonably be expected to be made promptly under a work[ers'] compensation law or plan … or under an automobile or general liability insurance policy or plan or under no fault insurance" (42 USC § 1395y(b)(2)(A)(ii)). On July 23, 2001, the Centers for Medicare and Medicaid Services (CMS), formerly HCFA (Health Care Finance Administration), issued a memorandum that further clarifies CMS policy regarding Medicare and Workers' Compensation settlements (Patel, 2001).

A series of regulations found at 42 CFR § 411.20 – 411.52 gives effect to the provisions of the MSP. Tracking the language of the MSP itself, federal regulations at 42 CFR §411.26(a) state that Medicare is "subrogated to any worker, provider, supplier, physician, private insurer, State agency, attorney, or any other entity entitled to payment by a third party payer." Additionally, 42 CFR § 411.24(g) states that Medicare "has a right of action to recover its payments from any entity, including a beneficiary, provider, supplier, physician, attorney, private insurer, State agency, or private insurer that has received a third party payment."

The Medicare Secondary Payer (MSP) claim arises in the following contexts:
When providers are mistaken about who is the primary payer and bills Medicare in compensable workers' compensation (WC) claims. The "overpayments" subsequently become a MSP claim in any WC settlement.

A WC claim is contested and the employee is without any health insurance benefits during the period of delay. Section 3407.6(B) of the Medicare Fiscal Intermediary Manual (MIM) provides for conditional Medicare payments to avoid imposing a hardship pending a decision on compensability.

When a WC payer pays an amount for Medicare-covered services that is less than the provider's charges and less then the gross amount payable by Medicare, and the provider does not accept and is not required to accept the payment as payment in full under WC law.

Threshold for Medicare Secondary Payer Statute

Not all workers' compensation settlements must be submitted to the CMS Regional Office for review. If the worker is not eligible for Medicare, CMS is not interested, unless the worker has a reasonable expectation of qualifying for Medicare within 30 months and the future medical expenses and indemnity being offered in the settlement (less expenses) exceed $250,000. To determine whether an injured worker is within 30 months of Medicare enrollment, note that Medicare eligibility is based on one of two methods: attainment of age 65 or receipt of 24 months of Social Security Disability Income (SSDI) regardless of age.

However, if the injured worker is already eligible for Medicare, Medicare's interests must always be considered, regardless of the amount of settlement. Where Medicare's interests must be considered, CMS Regional Offices can issue written opinions on which the worker and attorney can rely regarding whether Medicare's interests are being adequately considered in a particular settlement. Provided Medicare's interests are being adequately considered, the carrier is given a full release and, once the funds in the Medicare Set-Aside Trust or other approved set-aside arrangement are exhausted on injury-related medical expenses, the worker is eligible for Medicare coverage for future medical expenses.

Compromised vs. Commutation Claim

Medicare's regulations (42 CFR 411.46) and the Medicare Fiscal Intermediary Manual, Part 3 §§ 3407.7&3407.8 and Medicare Carrier's Manual (MCM) §§ 2370.7 & 2370.8, make a distinction between lump sum settlements that are commutations of future benefits and those that are due to a compromise between the workers' compensation carrier and the injured worker. The CMS defines a commutation as a settlement in which the beneficiary accepts a lump sum payment as compensation for all future medical expenses and disability benefits related to the work injury or disease (Patel, 2001). There is clearly intent to compensate for future medical expenses. Compromise claims are those in which liability is contested and often, although not necessarily, involve claims that have been controverted. Therefore, compromised settlements provide less in total compensation than the worker would have received if the claim had not been compromised and are intended to compensate the worker for current or past medical expenses. However, a settlement may be considered a commutation regardless of whether the parties admit or deny liability. Designation of the claim as a compromised or commutation settlement depends solely on whether the settlement involves future medical expenses.

Compromised Settlement

It is the intent of CMS that in all WC compromise cases, all pre-settlement and post-settlement requests to compromise **any** Medicare recovery claim amounts be submitted to the CMS Regional Office for appropriate action. The Patel memorandum (Patel, 2001) further advises that set-aside arrangements are not used in WC compromised claims.

Lump sum compromise settlements represent an agreement between the WC carrier and the injured worker to accept less than the injured worker would have received if he or she had received full reimbursement for lost wages and life long medical treatment for the injury or illness. In a typical lump sum compromise case between a WC carrier and an injured worker, the WC carrier disputes liability and usually will not have voluntarily paid for all the medical

bills relating to the accident. Generally, settlement offers in these cases are relatively low and allocations for income replacement and medical costs may not be separately listed. Such agreements, rather than being based on permanent impairment rating, life expectancy and cost of medicals, are based on factors such as whether there was a preexisting condition, whether the accident was really work related, or whether the worker was acting as an employee, or performing work-related duties at the time the accident occurred.

Commutation Settlement

WC commutation cases are settlement awards intended to compensate workers for **future** medical expenses required because of a work-related injury or disease. Medicare will not pay for any future medical expenses after a lump-sum settlement is received until the total future medical expenses related to an worker's injury equal the amount of the lump-sum settlement that was allocated to future medical expenses (See 42 CFR § 411.46(d)(2)).

A commutation settlement must allocate an amount toward medical expenses that "reasonably considers" Medicare interests. When a claim is commuted and the settlement is intended to compensate the injured worker for all future medical expenses in connection with the work injury, some set-aside arrangement, allocation, annuity, or Medicare Set-Aside Trust should be considered. It is important to note that set-aside arrangements are **only** used in WC cases that possess a commutation aspect.

A single WC lump-sum settlement agreement can possess both WC compromise and commutation aspects. That is, some single lump-sum settlement agreements can designate part of a settlement for an injured worker's future medical expenses and simultaneously designate another part of the settlement for all of the injured worker's medical expenses up to the date of settlement. This means that a commutation case may possess a compromise aspect to it when a settlement agreement also stipulates to pay for all medical expenses up to the date of settlement. Conversely, a compromise case may possess a commutation aspect to it when a settlement agreement also stipulates to pay for future medical expenses. Therefore, it is possible for a WC lump-sum settlement agreement to be both a WC compromise case and a WC commutation case.

The amount of the lump sum may be established by using a set-aside arrangement or a life care plan that makes allowance for future medical services. Medicare regulations at 42 CFR 411.46 state that:

"If a lump-sum compensation award stipulates that the amount paid is intended to compensate the worker for all future medical expenses required because of the work-related injury or disease, Medicare payments for such services are excluded until medical expenses related to the injury or disease equal the amount of the lump-sum payment."

In addition, the Medicare manuals (§3407.8 of the MIM, §2370.8 of the MCM) state:

"When a beneficiary accepts a lump-sum payment that represents a commutation of all future medical expenses and disability benefits, and the lump-sum amount is reasonable considering the future medical services that can be anticipated for the condition, Medicare does not pay for any items or services directly related to the injury or illness for which the commutation lump-sum is made, until the beneficiary presents medical bills related to the injury equal to the total amount of the lump-sum settlement allocated to medical treatment."

Enforcement Provisions

Even in compromise settlements, failure to designate an amount allocated toward medical expenses as being in payment of past medical expenses incurred will result in CMS withholding payment of future medical expenses up to the amount of such allocation (see 42 CFR § 411.46(d)(2)). If no allocation is made, 42 CFR § 411.47(a) provides a formula by which CMS will decide what portion will be attributed toward "future medicals," and may choose to treat the entire lump sum amount as a payment toward future medicals.

If an injured worker has been a SSDI beneficiary for some time before retaining an attorney for representation and has an open claim for workers' compensation, there is a likelihood that Medicare may have made payments that the workers' compensation payer should have paid. CMS has a direct right of action against the insurer, employer, or any entity required or responsible to pay for recovery of its payments (see 42 CFR §411.24(d)). This direct action may include injured workers, attorneys, and providers who have received payment from the primary payer (see 42 CFR § 411.24(e) & (g)). When an injured worker, attorney, or medical provider receives a third party payment, they are under an obligation to reimburse Medicare within 60 days (42 CFR 411.24(h)). Thus reimbursement must be made to Medicare within 60 days of the day the injured worker receives the settlement check following State Board approval of the agreement. There is a private cause of action (double add–on to the recoverable amount) against the employer/insurer that fails to reimburse Medicare (42 USC § 1395(y)(b)(3)(A)).

Liability stipulations are not exempt from the MSP Act. In congruence with 42 CFR 411.46(b)(1), a lump sum compromise settlement is deemed to be a workers' compensation payment for Medicare purposes, even if it is stipulated that there is no liability.

Reasonable Consideration of Medicare's Interests

Although 42 CFR 411.46 requires that all WC settlements must adequately consider Medicare's interests, the regulation does not mandate what type of arrangement must be used to set-aside funds for Medicare. Of course, if an arrangement is self-administered, then the injured worker/beneficiary **must** adhere to the same rules/requirements as any other administrator of a set-aside arrangement.

In accord with 20 CFR §404.408(d), the funds allocated to a set-aside arrangement must be consonant with the applicable law or plan and reflect either the actual amount of expenses already incurred (based on a fee schedule) or a reasonable estimate of future expenses. Thus, the amounts to be set-aside for future medical expenses may be based on the applicable WC fee schedule amounts, rather than on actual dollar amounts. However, the WC settlement must clarify that the amount allocated to future medical expenses was calculated based upon applicable WC medical fee schedule amounts. The agreement creating the set-aside arrangement must also contain terms that address the provider's agreement to abide by the WC fee schedule reimbursement level. (e.g., providers will be reimbursed out of the set-aside arrangement at the WC rate for medical services rather than the physicians regular full rate or the Medicare rate for covered services).

The Patel memorandum (Patel, 2001) outlines two methods for medical providers to obtain payment for WC covered services when funds are held in a set-aside arrangement. The memorandum clarifies that the payment method depends on two factors: 1) How the set-aside arrangement is constructed and 2) Whether the arrangement was constructed by contemplating

full actual charge estimates or WC medical fee schedule. The memorandum further states that there must be specific provisions in the settlement agreement that clarify the set-aside arrangement will reimburse medical providers in accordance with the WC medical fee schedule. Once the CMS Regional Office has reviewed and approved the sufficiency of the arrangement based on the WC medical fee schedule, then medical providers will be paid based on what would normally be payable under the WC plan (i.e., under the WC medical fee schedule). The settlement agreement should include five separate categories in order to safeguard the workers' Medicare benefits and Social Security Disability Insurance payments:

1. past medicals (a lien only can be asserted against that portion allocated to past medicals);
2. future medicals (not including skilled care);
3. future medicals (intended for skilled care);
4. indemnity (life-time lost wages); and
5. attorney's fees and costs.

After the set-aside funds are depleted, there must be a complete accounting to the Medicare contractor to ensure that the funds were used for medical services that would have been reimbursable by Medicare. Based on the acceptance by the Medicare contractor of documentation that justifies the depletion of the set-aside funds, then Medicare can be billed for future medical services.

CMS Criteria to Determine if Allocation if Reasonable

The Patel memorandum (2001) also outlines what must be submitted to the CMS Regional Office in order to make a determination that a set-aside arrangement reasonably considers Medicare's interests. This documentation includes

1. Date of Medicare entitlement;
2. Basis for Medicare entitlement;
3. Type and severity of injury or illness:
4. Beneficiary's age, rated age and life expectancy;
5. WC classification of beneficiary as permanently or partially disabled;
6. Prior medical expenses;
7. Amount of settlement and allocations to indemnity and future medical expenses with an explanation of the basis for the amounts of projected expenses for Medicare covered services and services not covered by Medicare (this could be a copy of letters from doctors/providers documenting the extent, duration, and necessity of continued care);
8. Whether commutation is for the worker's lifetime or some other period;
9. The beneficiary's living arrangements (e.g., at home, nursing home, etc.); and
10. Whether expected future medical expenses are appropriate in light of the worker's condition.

Section 3416 of the CMS Medicare Intermediary Manual directs the Medicare contractor to retain a copy of the lump-sum agreement and flag any new claims for the condition for which the beneficiary received the lump-sum payment in order to assure accuracy of the payment on claims. Thus, it would appear that the same results could be achieved through a

process of notification and production of settlement terms as through the use of a Medicare Set-Aside Trust.

Additionally, CMS makes clear that the Regional Office will be looking for some detail as to an investment policy and return on the set-aside funds. Also, CMS states that a set-aside arrangement may be self-administered. Note that it is not considered reasonable to fund a set-aside arrangement with a set number of years of anticipated medical expenses. However, the funds allocated to the set-aside arrangement need not necessarily equal the worker's calculated medical expenses for life.

Practice Tips

Provision in the settlement agreement for both Medicare covered and non-covered medical services can be made based on a reasonable and supportable basis. The future medical expenses that would not otherwise qualify for Medicare shall not be allocated to the set-aside arrangement as long as they are listed in the settlement agreement. CMS will evaluate the allocation to determine whether it is sufficient to "reasonably consider" Medicare's interest. Note that an allocation solely for non-covered services, in the face of WC-related needs for covered services, will not demonstrate that Medicare's interests have been reasonably considered. There must be some reasonable and verifiable additional sources outside the agreement of the basis for arriving at the allocation amount. Reasonableness can be demonstrated by a treating provider report and prognosis documenting frequency and duration of future care, injured worker's claims history, and/or a life care plan. Other documents required by CMS to determine "reasonableness" may include a copy of the settlement agreement, rated age, and letters from providers establishing the need and agreement to WC fee schedule reimbursement for future medical care.

CMS has mandated that all cases involving a Medicare beneficiary must have a set-aside arrangement. This means that set asides for future medical care could be as low as five to twenty thousand dollars. Smaller set-aside arrangements do not justify or require use of a government approved trust agreement. From a practical standpoint, a trust funded with a minimal sum does not make sense and would be more appropriate as a self-administered set-aside arrangement. Separate medical annuities may be used as a Medicare set-aside arrangement; however, if the trust is funded with the annuity, the amount of the structured periodic payment may be insufficient, in a given year, to cover unanticipated expenses. Either self-administered (by the injured worker) or custodial account arrangements are an alternative for these arrangements that have minimal sums.

Conclusion

The objective of the MSP is to ensure that workers' compensation primary payers do not shift the responsibility for payment of medical services to Medicare. If an injured worker is under 65 years of age and does not qualify for Social Security Disability Insurance, then there is no exposure. In these cases, consideration of the MSP Act is not necessary when you are drafting settlement agreements.

Medicare applies a set of criteria to any WC settlement on a case-by-case basis in order to determine whether Medicare has an obligation for services provided after the settlement that originally was the responsibility of WC. Because an arrangement's purpose is to pay for all services related to the worker's on-the-job injury or disease, Medicare will not make any

payments (as a primary, secondary or tertiary payer) for any services related to the work-related injury or disease until all funds in the set-aside arrangement have been depleted. It is incumbent on the injured worker's attorney to properly inform his/her client, prior to settlement of his/her claim, of the possible consequences the settlement can have on his/her Medicare entitlement for future medical care.

When proposed medical care for the injured worker is very costly, the only way to guarantee eligibility coverage by Medicare once the set-aside funds are depleted is to obtain CMS pre-approval of the proposed settlement allocation. Future entitlement to Medicare is an integral element in these settlement evaluations and recommendations as to future medical care from the treating physicians are needed with negotiated costs calculated. A life care plan with a cost analysis of future medical needs is a necessary part of allocating appropriate funds for recommended future medical services. Looking at the claims history and cost is not sufficient and Medicare set-aside trusts based on a life care plan are appropriate for these high dollar settlements. However, when the injured worker is at or near MMI and the proposed medical care is palliative in nature, self-administered or custodial set-aside arrangements are more appropriate. These can be submitted to CMS for approval before or after the settlement is negotiated.

References

20 CFR §404.408(d).

42 USC § 1395y(b)(2)(A)(ii).

42 CFR § 411.20 – 411.52.

Medicare Carrier's Manual, Sections 2370.7 & 2370.8. Available at http://cms.hhs.gov/manuals/14_car/3b2336.asp.

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About the Author

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