MEDICARE IS A SECONDARY PAYER

Lessons Learned with Medicare Set-Aside Accounts in Workers' Compensation and How They Might Apply to Liability Settlements

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It is the summer of 2001 and the workers' compensation world is reasonably quiet. In most jurisdictions, the 1980s and 1990s were hotbeds of legislative change. The workers' compensation community struggled to adapt to the significant changes many legislatures made to benefit structures following the work of the National Commission on State Workmens' Compensation Laws. There was much discussion, heated debate, and proposed fixes designed to bring stability to a troubled insurance market. State systems seemed to be adjusting to doing what they were designed to do, providing oversight on benefits to those injured at work. Employers were being offered an opportunity to secure coverage at reasonable market rates and many elected to become self-insured.

While cases settled, few in the workers' compensation community were mindful of their obligation to protect Medicare's interests consistent with the Medicare Secondary Payors Act (MSPA) 42USC Sec 1395y(b) and 42USC sec1862(b) (2)(A)(ii). This legislation was enacted to ensure Medicare only paid bills that were their responsibility, not those of a "primary payer." In 2001 and even today, some would ask, "who is a primary payer?" The simple answer, in workers' compensation, is the insurance carriers, including self-insureds. The answer in a liability context is the liability carrier. One might have thought the bar had the MSPA front and center on their radar. They did not.

In July of 2001, a deputy in the Centers for Medicare and Medicaid Services (CMS), Parashar Patel, prepared a memo for CMS administrators addressing "workers' compensation situations" and their impact on Medicare as a secondary payer. The situations concerning Patel were settlements that did not protect Medicare from making inappropriate payments. In simple terms, cases were being settled by Medicare beneficiaries, or those soon to be, where future medical payments were an element of the settlement and Medicare's interests were not a concern. Patel provided examples of his observations.

Patel's memo changed the analysis cautious attorneys make when considering settling a claim for a client with actual or potential Medicare exposure. Medicare Set Aside Accounts (MSAs) are now a fixture when settlement is considered in workers' compensation. Although the MSPA is federal law, its impact on state workers' compensation systems is universal.

WORKERS' COMPENSATION SETTLEMENTS AND THE MSPA

The settlement process in workers' compensation varies widely from state to state. For example, some parties use an MSA vendor to calculate future medical exposure consistent with evolving CMS guidance documents. Some have the resources to do future projections in-house. Some submit proposals to CMS for review if the client fits within the work volume thresholds. Some rely on projections based on evidence-based medicine and believe a reasonable consideration of Medicare's interests is all that is needed. Time will tell if there is a superior approach.

Commentators observe workers' compensation as a pure creature of statute. The benefits claimants are entitled to are limited and found in the state statutory scheme. The same is true for claim procedures. These observations woefully understate how nuanced some jurisdictions' systems are. There are however a few universal principles applicable to all workers' compensation systems; one of which makes working with the MSPA straightforward. Compensable claims are entitled to have all reasonable and necessary medical bills paid.

This benefit structure allows for an uncomplicated calculation for future medical as an element in a settlement evaluation. Causally connected, reasonable and necessary bills with no policy limit make valuing this element doable for the seasoned practitioner. Added to this is the only other universal claim element, indemnity benefits. Again, valuing indemnity is not an exceedingly complex task for someone knowledgeable about the applicable statute, the worker's actuarial life expectancy, or any statutory limits and when appropriate, and reducing a future payment to present value. Protecting Medicare's interest in future medical treatment is another important consideration. This is accomplished by

having a skilled professional or team assess medical expenses associated with the claim and prognosticating about future medical needs. Settling parties must decide whether to submit the product of this calculation to CMS or not. Going through the settlement evaluation analysis is time consuming, a bit complex, but doable. Getting a client's understanding and authority is also fundamental.

Workers' compensation's rigid structure lends itself to a cookbook settlement evaluation process. One need only consider two damage elements, indemnity and medical. In workers' compensation there are no policy limits.

LIABILITY SETTLEMENTS AND THE MSPA

A liability settlement, however, considers the same two elements and depending on the nature of the claim, other damages. One must be sensitive to the fact that the exposure may exceed policy limits if insurance is all that is available to cover the loss. The complexity of a liability settlement complicates the analysis and the corresponding obligation to protect Medicare.

Having walked through the settlement process in workers' compensation, let us look at the analysis process in a typical liability case, an automobile liability claim. The plaintiff operated his vehicle with due care. He was struck by the defendant who was negligent. Negligence and liability, therefore, are a given and not important to this discussion.

The plaintiff's vehicle is a total loss. The plaintiff, a 65-year-old married business executive, sustained severe injuries requiring surgery, extended hospitalization, months of rehabilitation, and costly pharmaceuticals. His doctors believe he will need more surgery in the future. The accident significantly disrupted his family life.
A negligence suit has been filed. Discovery is complete and a trial date is set. The defendant has no tangible assets. He has had accidents in the past and as a result he is insured above his state's minimum requirements. He has $300,000 in bodily injury and property damage coverage.

The plaintiff's damages include, but are not limited to, lost wages, medical expenses to date, the vehicle, pain and suffering, loss of consortium, projected future lost wages, and future medical related to the accident. He had medical insurance up until recently, when, due to business necessity, he was terminated. There is a lien being negotiated for incurred medical expenses.

One need not have a great deal of experience nor economic insight to quickly understand the plaintiff's damages exceed the defendant's policy limits. The facts also inform that the plaintiff is Medicare eligible due to his age. The defendant's liability insurance is a primary payer. Medicare is secondary.

Given the example, how can the parties involved in the settlement "protect" Medicare's interests? Unlike workers' compensation, liability has no guidance documents from CMS. Additionally, CMS has not established a system for submitting proposed future liability medical for review. The CMS position seems to be, "we expect you to protect our interests, but we will not guide you on how to meet our expectations."

How can attorneys comply with this expectation while protecting their client when the funds available will not begin to cover the value of incurred damages? There is no black and white answer. In smaller cases, often language in the release may suffice or a rather arbitrary amount can be allocated for future medical. In larger cases, like this example, one common approach is to assess the full value of the damages, including the fair value of all future medical expenses, and determine the percentage attributable to each – a process often referred to as apportionment. The parties involved take the settlement proceeds available, the defendants' $300,000, and apply the percentages to that figure.

In this example, if the case settles for a compromise figure of $300,000, from that fees and expenses are deducted. The balance, for instance $185,000, is the funding available to satisfy the damage obligations. If future medicals represented 17% of the incurred and projected damages, then 17% of our $185,000, or $31,450, would be set aside to protect Medicare's interests. This apportionment approach finds support in *Arkansas Department of Human Services v. Ahlborn*, 547 US 268. (2006)

Where would these funds be placed? Drawing parallels from the workers' compensation guidelines, a professional administrator could assist the plaintiff in ensuring the funds are used properly. In the WCMSA Reference Guide, Medicare states that it "highly recommends" the use of professional administration. The funds would be placed into a dedicated interest-bearing checking account, and all bills associated with treatment connected to the injury would be paid out of the account. Corresponding records and annual reporting would be maintained. Professional administration would further demonstrate an effort by all parties to protect Medicare's interests.

Would CMS accept the methodology described above to protect Medicare's interests? What we know is the methodology demonstrates a logical effort to ensure Medicare is fairly represented at the settlement table and its interests are protected post-settlement. Without guidance from CMS, one cannot be certain, but an approach like this shows good faith efforts to satisfy their protection expectations.
As this article is being written, the industry is awaiting updated settlement guidance from CMS. In 2020, announcements were made by CMS suggesting they were working on guidance for the liability community on MSAs (LMSAs). In 2020, COVID-19 turned our world upside down. The pandemic impacted governmental agencies, disrupting work plans. Most recently, CMS reported an announcement to be coming in March 2021. Just what to expect is unclear. It may be guidance solely limited to LMSAs or it may have a broader impact on Medicare Set Aside accounts in both liability and workers' compensation settlements.

The obligation to protect Medicare's interests has been with us since 1980. During most of that time, the obligation was ignored more than honored. Times are changing; CMS is continually refining its guidelines for workers' compensation with updates to its reference guide every few months. And CMS continues to advise of upcoming regulations for liability cases. Although this area of the law is not a model of clarity, it appears that might change. When settling a case, it's important to be up to date on CMS's directives and the methodologies practitioners are using to address them. Consulting with those in our legal community who actively work with CMS can help make sure a prudent approach is taken.

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[1] There are a number of MSA vendors available. Ametros is not one. Ametros is a post-settlement professional administration company that manages settled medical funds, including Medicare Set Asides from both workers' compensation and liability cases.