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Walking Through the Risk Analysis to Consider a Medicare Set-Aside Non-Submit Program

I) The Law Addressing a Burden Concerning Future Medical in Workers' Compensation Settlements is Not Well-Defined.

Statutory

There is currently no statutory authority requiring a Medicare Set-Aside. 42 U.S.C. 1395y(b)(2), commonly referred to as the Medicare Secondary Payer Act, spells out when Medicare can and cannot make payment for medical services. It also details the repayment burden that various parties have if Medicare makes payment conditioned upon reimbursement from a party, as defined in the statute. It does not mention any specific burdens concerning future medical when settling a workers' compensation claim.

Regulatory

The Code of Federal Regulations (C.F.R.) contains no requirement for a Medicare Set-Aside and spells out no penalties for a carrier or employer. However, 42 C.F.R. 411.46 spells out when Medicare will deny payment to a beneficiary for medical benefits as a result of a worker's compensation settlement and the extent of any denial of benefits. Specifically, 411.46(2) states, "*If a settlement appears to represent an attempt to shift to Medicare the responsibility for payment of medical expenses for the treatment of a work-related condition, the settlement will not be recognized*." The result articulated is that, "*Medicare will not pay for treatment of that condition*."

Center for Medicare & Medicaid Services (CMS) Workers' Compensation Medicare Set-Aside (WCMSA) Reference Guide

The February 2014 WCMSA Reference Guide Released by CMS states, in part, "*Any claimant who receives a WC settlement, judgment, or award that includes an amount for future medical expenses must take Medicare's interest with respect to future medicals into account. If Medicare's interests are not considered, CMS has a priority right of recovery against any entity that received any portion of a third-party payment either directly or indirectly. CMS also has a subrogation right with respect to any such third-party payment.*"

While this may be consistent with inferences in the regulatory authority, it is the first specific mention of a burden concerning "future medicals" in a settlement.

CMS' Medicare & Medicaid Services Secondary Payer Manual primarily intended for contractors

Chapter 10 of this manual deals with WC and the MSP, stating, "*Medicare is secondary to WC plans…Payment under Medicare may not be made for any items and services to the extent that payment has been made or can reasonably be expected to be made for such items or services under a workers' compensation law of plan…" §10.4* Further in the manual, CMS states, "*it is in the best interest of the individual to consider Medicare at the time of settlement. For this reason, CMS recommends that parties to a WC settlement set aside funds, knows as a WC Medicare Set-Aside." §10.4.1*

Case Law

There is no case law that identifies a burden to fund a Medicare Set-Aside outside of what the parties contracted for in a settlement agreement. Language in settlement agreements can be found to bind parties to a settlement where the law would not otherwise have required it.

State Law

There are some states, Nebraska is an example, where the state has required submission of an MSA to CMS for review as a condition of settlement, despite the fact that it is not required under federal law. Virginia is one state that allows settlement without pursuing submission of the MSA to CMS for review, but it requires the primary payer to indemnify the claimant from possible consequences. The state of Virginia has indemnification language it provides to settling parties.

II) **Consequences of Not Addressing Future Medical in a Workers' Compensation Settlement**

Consequences to Claimant

The identified consequences appear to fall squarely with the claimant, as spelled out in42 C.F.R. Sec. 411.47(a)(2).

> If a lump-sum compensation award stipulated that the amount paid is to compensate the individual 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.

Consequences to Carrier or Employer

Arguably, if the settlement is not recognized by the government, then conditional payment liability could continue to accrue and that could impose exposure for post-settlement conditional payment liability. There are no examples to provide of any case law proceeding in this theory, but it remains an arguable claim. This could also create exposure under the False Claims Act, discussed below.

As a practical settlement concern, if beneficiaries have trouble with Medicare coverage stemming from funding an unsubmitted MSA in a worker' compensation settlement, the state worker's compensation authority may become less likely to approve settlements. Most state authorities are charged with ensuring the settlement is in the best interest of the injured worker; the terms of the settlement must assure them that the claimant will suffer no undue harm by the settlement. Along the same lines, if a plaintiff attorney has a client who has issues with Medicare stemming from the adequacy of a Medicare Set-Aside funded, it will create practical stumbling blocks to future attempts with that attorney to fund an MSA without pursuing submission to CMS for review.

To date, there are no instances identified where proper exhaustion of an unsubmitted MSA funded in a settlement has resulted in the denial of Medicare coverage to a beneficiary on the grounds that the MSA was insufficient. However, one bad experience by one state court or one plaintiff attorney could significantly impact the practice in any given state. Good faith, integrity and transparency in the settlement process are essential to maintaining the faith of state workers' compensation authorities and plaintiff attorneys that funding an MSA that was not submitted to CMS for review can be appropriate. Recall the indemnification language mentioned above that is required by practice in the State of Virginia.

Post-Settlement Conditional Payment Liability

As mentioned above, CMS' ability under the regulations to not recognize the settlement if it finds that medical costs shifted to Medicare creates the possibility of post-settlement conditional payments. Under the regulations, no workers' compensation settlement is final as to the federal government. The government's recovery is not limited to a lien on the settlement or a subrogation right, the government is afforded a direct right of recovery.

Per the statutory language addressing conditional payment recovery in 42 U.S.C. 1395y(b)(2)(B)(ii):

> A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment …. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not

there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means.

CMS is able to file a conditional payment recovery action against a large cast of characters, which should compel the parties to work together on an MSA that reasonably reflects the primary payer liability in the settlement. Under 42 U.S.C. 1395y(b)(2)(B)(iii):.

> In order to recover payment made under this title for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment... The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity.

Again, there is no identified instance of recoveries being pursued for post-settlement conditional payments, but it remains a legal possibility to consider. While submission of an MSA to CMS for review is not necessary to remove this risk, the parties must be able to defend the reasonableness of any MSA amount funded in a settlement.

The False Claims Act

The False Claims Act is a statute that potentially carries more exposure than the Medicare Secondary Payer (MSP) Act, but has not received as much discussion in the workers' compensation forum. While the MSP statute, regulations and CMS publications may place the future medical burden on the beneficiary with no direct consequences to the carrier or employer spelled out 31 U.S. Code § 3729 imposes liability on anyone who, "knowingly presents, or causes to be presented, a false or fraudulent claim for payment."

The False Claims act carries potential treble damages penalty plus civil penalties of a minimum of $10,781 and a maximum of $21,563 per claim. Failure to appropriately fund an MSA in a settlement can create exposure under the False Claims Act by causing claimant to present a claim for payment by Medicare that arguably should have been funded in the settlement.

III) There Are No Direct Consequences for Failure to Submit a Medicare Set-Aside to the Center for Medicare and Medicaid Services for Approval

As stated in CMS' Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) Reference Guide, January 5, 2015,COBR-Q1-2015-v2.3:

> *There are no statutory or regulatory provisions requiring that you submit a WCMSA amount proposal to CMS for review. If you choose to use CMS' WCMSA review process, the Agency requests that you comply with CMS' established policies and procedures.*

IV) Medicare's Interests May Be Protected Without Submitting a Medicare Set-Aside to the Center for Medicare and Medicaid Services for Approval.

Considerations When Calculating an MSA

When choosing not to submit the MSA to CMS for review, there can be different approaches to calculating a defensible primary payer allocation report. The purpose of the Medicare Secondary Payer law is to ensure that primary payers are not shifting their liability for medical coverage to Medicare. It can be a very reasonable argument that a primary payer's liability for medical coverage is defined by the workers' compensation laws of its particular jurisdiction. A Medicare Set-Aside report that properly reflects the primary payer liability may reflect jurisdictional limits on medical liability. For instance:

- Some jurisdictions only recognize treatment recommendations from the authorized treating physician. Treatment recommended by a treating physician who is not authorized under the claim would not be covered under the laws of those jurisdictions and should not be included in an MSA.
- Some jurisdictions have a rebuttable presumption of treatment termination at a finding of maximum medical improvement (MMI). If there has been a finding of MMI and claimant has not presented medical information to rebut the termination of medical by the time of settlement, there would be no ongoing liability.
- Some states have limits on medical liability. For instance, Georgia has a 400 week cap on medical liability, with a few exceptions. If the claim fits the definition of a claim where the cap would be applied, the MSA could be capped at 400 weeks.
- An MSA written to reflect appropriate primary payer liability could consider evidence based medicine standards in those jurisdictions that recognize that as a standard for providing medical care under the workers' compensation laws of that jurisdiction.
- Any other jurisdictional legal defense could be considered, as well.

Additionally, many states allow carriers or employers to contract with pharmacy benefit managers to provide pharmacy services. Often, the contracted pharmacy rates are significantly below average wholesale price (AWP), which is the pharmacy pricing that CMS uses when calculating an approved MSA. This AWP pricing can result in an MSA amount that greatly exceeds the primary payer liability on a claim. Many of these pharmacy benefit managers are willing to offer indefinite post-settlement pharmacy access to claimants at the carrier's negotiated rates. This could make it reasonable for a carrier to utilize its pharmacy pricing in the MSA calculation in an unsubmitted MSA.

In the end, calculating a primary payer's liability in an MSA is a complex look at an individual claim in light of the laws and practices of those jurisdictions.

An Experienced Medicare Set-Aside Vendor Can Offer Options Outside Submission

When choosing an MSA vendor to calculate MSAs that are not prepared for submission, it is important to ensure that the vendor can calculate an amount that accurately reflects

the primary payer liability and protects the risk. Industry experience can be one indicator. It is important to investigate the vendor's reputation in the industry and experience accurately forecasting future medical care expenses.

The legal expertise of the vendor is also important. Do they have the ability to educate and explain to the settling parties the approach and key concepts of the non-submit program? Do they have legal staff who can explain the concept, walk through the process and articulate the protections in place for an injured worker and employer to feel comfortable with this approach? Do they have the ability to get on the phone for a live discussion with defense counsel who is at a Board trying to get a judge's approval? While having an MSA non-submit program may allow the parties to more accurately fund the primary payer liability, it may also require greater attention to the details.

V) Post-settlement Services Can Be an Effective Tool to Protect Medicare's Interests

Annuities

Once parties are comfortable that they have properly calculated the primary payer exposure in an MSA allocation report and funded a defensible amount, there are additional measures that can be taken to further protect Medicare's interests. While not mandated in any way, funding an MSA via annuity can provide a steady annual MSA stream of funds to a claimant and help protect the MSA from improper expenditure. It can be tempting to misspend a large MSA lump sum amount. As an additional benefit, it reduces the settlement cost.

Professional Administration

Professional administration can also be used to administer MSA funds. Self-administering an MSA can be very burdensome. Beneficiaries have the burden of ensuring they are only paying for treatment from the MSA that Medicare would otherwise cover. Additionally, they must maintain an annual accounting of all amount spent and be prepared to present that accounting to CMS. These are all tasks that an administrator could perform.

Good administrators have access to pharmacy benefit managers and other care opportunities to allow for cost-savings for the MSA account to maximize the funds. This is beneficial for both claimant and Medicare. If the MSA is exhausted, either in its entirety or in any given annuity year, the professional administrator would provide the proofs to Medicare so that the beneficiary could continue treatment with medical services provided by Medicare.

VI) Indemnification Can be a Tool to Facilitate Settlement Without Submission to CMS

Vendor Could Indemnify Employer or Carrier

Some vendors will agree to provide indemnification to the employer or carrier for a non-submitted MSA that they calculate. There is an insurance policy that could be purchased to protect against potential financial consequences of an unsubmitted MSA.

Carrier or Employer Indemnifying Claimant

The carrier or employer could agree to provide indemnification in the settlement agreement to create the same assurances that the parties would get from submission. While the possible benefits of submission are debatable, some state approving bodies expect to see the claimant protected in the settlement in some fashion.