

An Analysis of Workers' Compensation and Medicare

By

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1 Introduction

This paper will provide an analysis of some of the issues involved in the relationship between Medicare and workers' compensation. A separate paper, "Dealing with Medicare in Workers' Compensation Claims," which is found on the website of the Workers' Compensation Center at <http://www.lir.msu.edu/wcc/Medicare/Medicare.htm>, provides more specific information about the procedures involved.

This paper is divided into several sections:

Section 1, Introduction

Section 2, Background, will provide basic information about Medicare and workers' compensation and the problems that arise from their interaction.

Section 3, Problems, will point out some of the problems that this has created.

Section 4, Issues to be Considered. This section will discuss a number of issues that should be considered in relation to workers' compensation and Medicare. Some of them are simple facts worth mentioning. Some of them are warnings that should be kept in mind. And some discuss the legal weaknesses in the positions taken by CMS.

Section 5, Litigation. This brief section will discuss some potential litigation concerning these issues.

Section 6, Legislative Action. This section presents information about a legislative solution that has been proposed for these problems.

1.1 Sources and Information

- Statutes and Regulations

This paper will refer to various sources. The basic authority for all of this is the Social Security Act as amended by the Medicare as Secondary Payer Act and the Medicare Prescription Drug Improvement and Modernization Act of 2003. Pertinent sections can be found at 42 USC 1395y(b).

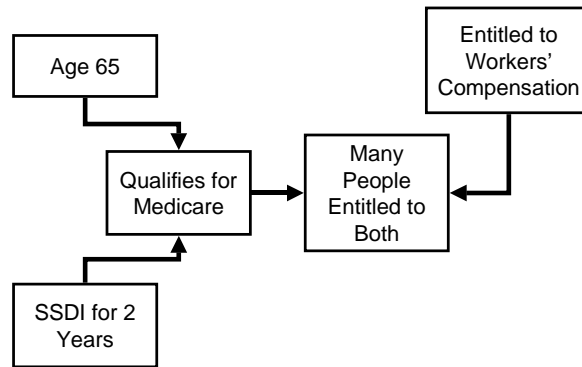
This is supplemented by regulations that have been adopted according to the government's rule-making process. These are found at 42 CFR 411.23 – 47.

- CMS Documents

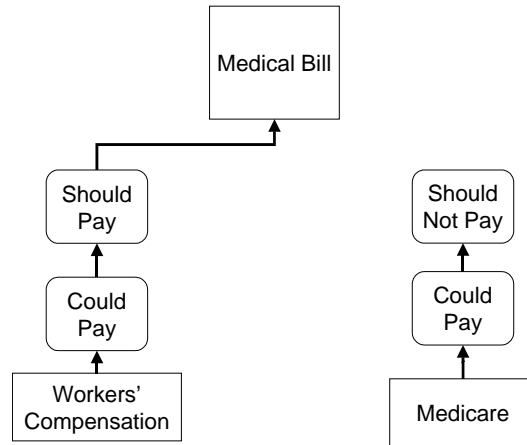
There is a series of memoranda issued by CMS, including the original "Patel Memo," that have played a key role in the development of these issues. (See Section 4.19 concerning the nature of these documents.) CMS publishes a detailed explanation of its positions concerning these issues on its website. The lead page for that is found at <http://www.cms.hhs.gov/WorkersCompAgencyServices/>. Links to a more detailed discussion of various topics are found on the left side of that page. Links to the published memoranda are found at the bottom of that page.

2 Background

2.1 Medicare



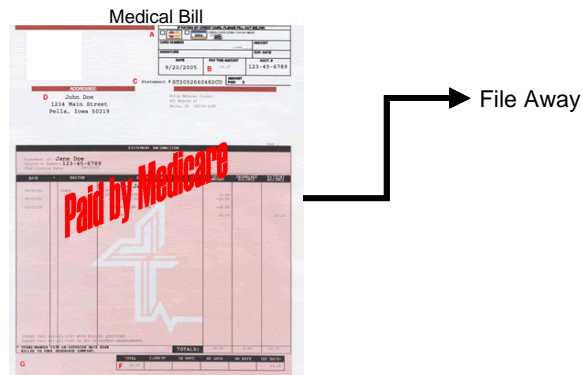
Medicare is a federally sponsored health care plan that is available to individuals who are age 65 or over and to individuals who have received Social Security Disability Insurance (SSDI) benefits for more than two years. This includes a significant number of workers' compensation claimants. Since the mid-1980s, the Medicare As Secondary Payer Act (42 USC 1395y(b)) has made clear that if medical expenses could be covered under either workers' compensation or Medicare, workers' compensation, and not Medicare, should pay. Workers' compensation is primary and Medicare is secondary.



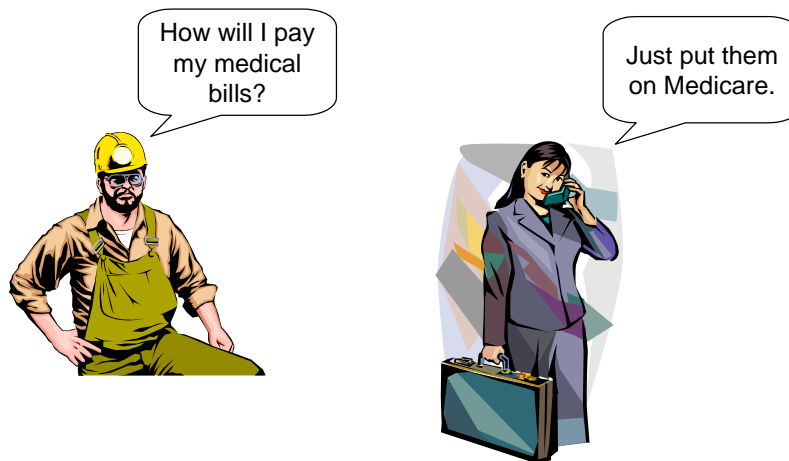
As part of the Medicare Prescription Drug Improvement and Modernization Act of 2003, additional language was inserted in the Medicare as Secondary Payer Act which strengthened the position of CMS with regard to these issues. This is discussed in more detail in Section 4.20.

Medicare is administered by the Centers for Medicare and Medicaid Services (CMS). CMS delegates some of its work, especially work dealing with the collection of overpayments, to private contractors that vary by region and state.

2.2 Past Abuses



It must be conceded that in the past, to at least some extent, workers, their attorneys, employers, and insurance companies have ignored or attempted to evade the fact that workers' compensation is primary. There were undoubtedly some instances in which a worker went into a hospital for treatment of a work-related problem and, as was his or her custom for other problems, showed a Medicare card, and the hospital billed Medicare. No one on behalf of the employer or its insurer went out of the way to tell the hospital that the bill should have been sent to workers' compensation or to reimburse Medicare after it had paid the bill.



There were also, undoubtedly, situations in which a worker and an employer agreed to settle a workers' compensation claim, and the worker asked, "What about my future medical expenses?" The employer, insurer, or attorney responded by saying, "Just charge them to Medicare."

While these abuses took place in the past they are no longer acceptable. Indeed, although many people in the workers' compensation community have trouble with some of the positions taken by CMS, they all agree that these past abuses are no longer acceptable.

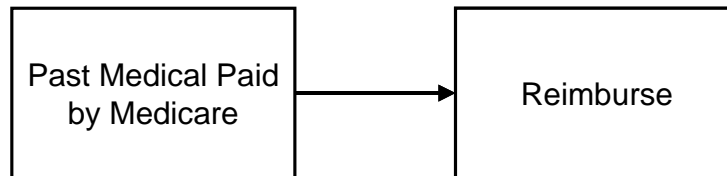
2.3 Cost Control

Medicare represents a very substantial portion of the federal budget. There is tremendous pressure to reduce Medicare expenses. On several occasions in the last few years, Medicare has, for example, arbitrarily reduced the amount it pays doctors by four percent

or more. Medicare has been searching for every way it can to control its costs. In 2000 and 2001, studies by the General Accounting Office pointed out that Medicare was losing money by paying for services that should have been covered under workers' compensation. At about the same time (perhaps in response to the GAO), CMS began to more aggressively enforce its right to have workers' compensation pay when it should.

2.4 Open Claims

Today it is abundantly clear that if a bill could be paid under either workers' compensation or Medicare it should be paid under workers' compensation. Any worker faced with a choice of where to submit such a bill should submit it to the workers' compensation carrier. Any claims manager faced with a choice of paying such a bill or shifting it to Medicare should pay the bill.



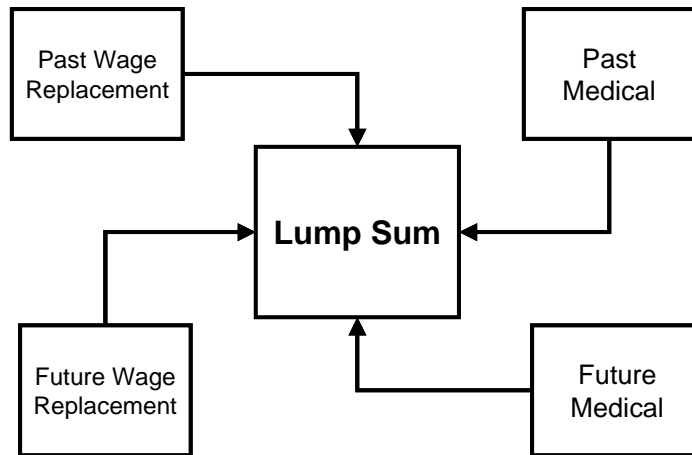
It nevertheless happens sometimes that the bills are submitted to and paid by Medicare. Perhaps the medical service was rendered before the case was accepted as compensable. Perhaps the worker submitted it to Medicare without realizing that he or she should have submitted it to workers' compensation. The Medicare as Secondary Payer Act views these as "conditional payments." They are, in theory, paid by Medicare on the condition that the workers' compensation carrier will make reimbursement. Assuming the condition could be covered under workers' compensation, there is no question that Medicare is entitled to reimbursement and claims managers should arrange to make reimbursement promptly.

As discussed in Section 4.1, the statute provides that if a civil action must be brought to recover the reimbursement, Medicare is entitled to *double damages*.

2.5 Settlements

When a workers' compensation case is settled, the settlement often involves four elements.

- Past cash benefits
- Past medical expenses
- Future cash benefits
- Future medical expenses



Past Medical Expenses

If there are any past medical expenses that have been paid by Medicare and should have been paid under workers’ compensation, arrangements must be made to reimburse Medicare.

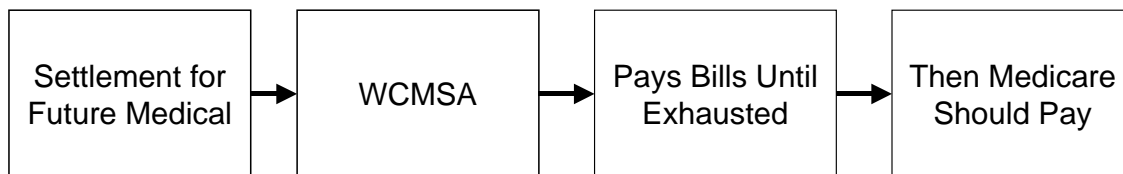
Future Medical Expenses

If money has been set aside to pay future medical expenses, then Medicare should not be expected to pay those expenses until after those funds have been exhausted. Most of the problems we will discuss here relate to how this is implemented.



Workers’ Compensation Medicare Set-Aside Arrangements

CMS takes the position that under certain circumstances the parties to a workers’ compensation settlement should create what CMS calls a Workers’ Compensation Medicare Set-Aside Arrangement (WCMSA). The parties to the settlement should place in this arrangement the funds from the settlement that are for future medical expenses. These expenses should then be paid out of the WCMSA until it is exhausted. Thereafter, Medicare will begin to pay for medical expenses related to the compensable injury.

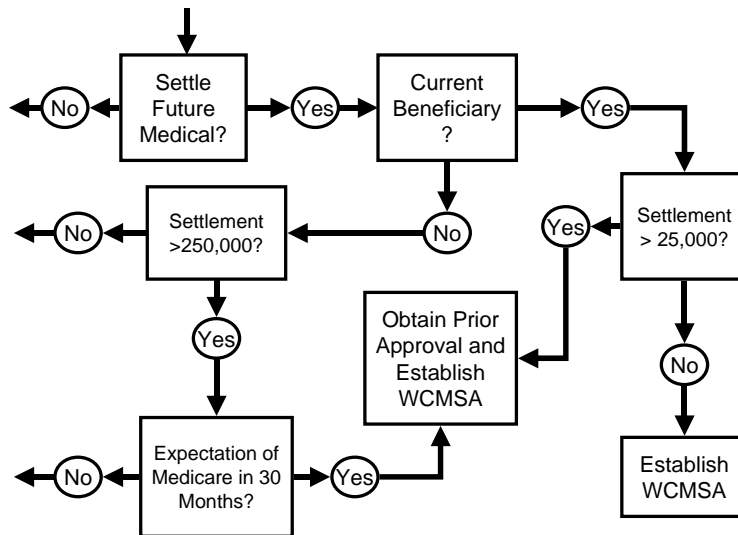


Pre-approval

In July 2001 CMS issued a memo to its regional offices (July 23, 2001 Memorandum). It suggests that under certain circumstances parties to workers' compensation claims should not settle those cases until after CMS has had an opportunity to review the settlement and

approve the allocation to future medical expenses. The memo discusses the circumstances under which the regional offices will preapprove such an allocation.

- Cases in which the workers' compensation claimant is currently entitled to Medicare benefits (July 23, 2001 Memorandum).
- Cases in which the injured individual has a "reasonable expectation" of Medicare entitlement within 30 months of the settlement date and the settlement is over \$250,000 (July 23, 2001 Memorandum).
- More recently, CMS has said that for current beneficiaries in which the settlement is less than \$25,000, it will not pre-approve the settlement, but does expect the parties to create a WCMSA. (April 25, 2006 Memorandum)



Difficulties with Pre-Approval

The requirement for pre-approval of workers' compensation settlements has caused considerable difficulty for the workers' compensation system. If a case is settled for more than \$250,000, it is reasonable to devote the time and resources necessary to obtain pre-approval and create some form of set-aside arrangement. However, the vast majority of workers' compensation claims are settled for much smaller amounts. In these cases, the time and effort that pre-approval and set-asides require is very substantial when compared to the amounts involved.

2.6 Vendors

A number of vendors have come along in the last few years, including law firms and others. They offer to do one or more of the following things:

- Determine if there have been any "conditional payments" by Medicare. In other words, determine if there were any instances in the past in which Medicare paid for health care coverage that should have been paid for by workers' compensation. More traditionally, we might say, determine if Medicare has any liens against the workers' compensation settlement.

- Review the medical situation and prepare a defensible estimate of how much of a lump-sum settlement should be allocated to future medical expenses. This is sometimes called a *life care plan*.
- Obtain pre-approval from CMS of the amount of the settlement that will be allocated to future medical expenses.
- Create a Medicare Workers' Compensation Set-aside Arrangement. These are sometimes formal trusts, sometimes less formal agreements, that pay or keep track of the expenditure of the portion of the settlement that is allocated to future medical expenses.

These vendors have played a significant role in the situation. They have often been the ones who have alerted parties to the potential problems involved in settling cases without first dealing with CMS. At the same time it is possible that some vendors are exaggerating the problems, that they are describing the situation as worse than it really is in order to scare parties into using their services.

Some claims managers and attorneys report that they have vendors who are very helpful. Others suggest that the vendors do not do anything that they could not do themselves. Still others report great variation in the quality of the service received from various vendors.

2.7 Attempts at Cooperation and Legislative Action

Many participants in the workers' compensation system incurred considerable difficulty in attempting to comply with the requirements of CMS. Although the situation has varied from time to time and region to region, many practitioners report long delays and a lack of cooperation from CMS. These problems are discussed in more detail in Section 3.

Approaches were made to CMS suggesting adjustments to its policy that would result in less interference in the workers' compensation system. Most of the representatives of the workers' compensation community reported that CMS simply turned a deaf ear to the proposed discussions.

When the discussions of CMS proved unsuccessful, many people in the workers' compensation community turned to possible legislative action. See Section 6.

2.8 Contested Liability in Workers' Compensation Claims

There is an aspect to workers' compensation settlements that must be kept in mind in reviewing this situation.

Sometimes even though a carrier admits liability for a workers' compensation claim, cases are settled because the parties want to close the file and "put it all behind them." The carrier agrees to make and the worker agrees to accept a single lump sum payment up front, which is intended to represent all the carrier's future liability.

Much more often, however, workers' compensation cases settle because there is a dispute over the liability of the carrier. The dispute might involve whether or not the whole case is compensable. For example, a worker might have suffered an injury while fooling around on the employer's parking lot. Depending upon the laws in a given state and the

particular circumstances surrounding the incident, such an injury may or may not be compensable. Often, such injuries result in ambiguous situations where it is not clear whether the carrier has liability.

In other cases the question might involve whether the employer has continuing liability for cash benefits or medical expenses. For example, a 50 year-old worker might have degenerative arthritis which is aggravated by a work-related incident. The carrier might admit that it is responsible for the medical treatment immediately following the work-related incident, but take the position that any long-term care is related to the aging process, not to the compensable event.

Very often cases such as these are resolved by a compromised settlement. In negotiating the amount of the settlement the potential cost of future medical care is a factor, but an equally important consideration is the estimate by the parties as to the outcome if the case goes to trial before a judge. If the case is tried, the result is likely to be one of two extremes. Either the judge will order that the carrier is responsible for all future medical care or the judge will hold that the carrier has no further liability at all. When a compromise settlement is negotiated, the amount of the settlement depends in part on the total potential medical expense, but also on the likelihood that the carrier will have any liability at all.

As discussed in Section 4.18, the positions taken by Medicare do not seem to deal with these situations in a realistic way.

2.9 Reporting Requirements

Late in 2007 Congress amended the Social Security Act to add requirements that under various circumstances plans, including workers' compensation plans, submit to CMS information about individuals who are entitled to Medicare. These will become effective in June of 2009. There are severe penalties for failure to comply.

3 Problems

A number of problems have arisen as a result of the policy of CMS. Their severity has varied over time and varies from state to state and region to region. Since the problems usually involve the settlement of workers' compensation cases, they do not arise in states like Washington or Texas where settlements are not allowed. The regional variations seem to relate to the efficiency or lack of efficiency in the regional CMS offices.

3.1 Delay

The most immediate frustration for parties to the workers' compensation system has been the delays in obtaining approval from CMS. Seeking approval has added considerably to the time that elapses between the point at which the parties to a workers' compensation case reach agreement on a settlement and the point at which the settlement can be submitted for approval, benefits paid and the case closed. In some cases this means that a carrier must continue to pay benefits for many months during which it would otherwise have been able to stop paying and close its claim. In other cases it means that a disabled worker goes without any income while waiting for the agreed upon settlement to be approved and finalized.

In 2006 the Michigan Workers' Compensation Agency reported that there were over 900 cases in which a settlement had been agreed upon by the parties but which could not be submitted to the agency because they were waiting for pre-approval from CMS.

3.2 *Lack of Understanding*

Many attorneys and claims managers report that the people dealing with workers' compensation on behalf of Medicare do not have an understanding of various aspects of the workers' compensation system, in particular, the question of liability of the workers' compensation carrier discussed in Section 2.8.

3.3 *Accounting*

As discussed in Section 4.14, the policies of CMS place on workers an accounting burden that in some cases is extremely heavy and may be totally unrealistic.

3.4 *The Possible Re-Opening of Workers' Compensation Cases*

When offering their services to carriers, some vendors have suggested the possibility that if these matters are not handled appropriately CMS could force carriers to reopen workers' compensation claims that the carrier thought it had closed. As discussed in Section 4.20, the 2003 amendments give at least some credibility to this claim.

3.5 *The Cost in the Average Case*

The pre-approval requirements that CMS is attempting to impose involve considerable delay and costs for the workers' compensation system. If the case is being settled for \$250,000 or more, the amount of dollars involved justifies the time and expense required. The vast majority of workers' compensation cases, however, are much smaller.

The requirements of CMS impose a significant burden in estimating future medical expenses, submitting all the documents for pre-approval, waiting for pre-approval, negotiating pre-approval in some cases, and then keeping track of all future payments. For the most part this burden is the same for small cases as it is for big ones. In 2006 CMS to some extent reduced the burden for cases involving current Medicare beneficiaries in which the workers' compensation settlement was less than \$25,000. This nevertheless leaves a large number of workers' compensation settlements in which the burden resulting from the CMS policies is extreme when compared to the amount of money involved.

3.6 *No Appeal*

CMS takes the position that there is no appeal from the determinations it makes on set-asides that are submitted to it. This is discussed further in Section 4.10.

3.7 *Ambiguities and Contradictions*

As will be discussed throughout this paper, there are many ambiguities and contradictions in the positions taken by CMS. These range from very specific instructions about accounting to questions about the basic principles of what CMS is trying to do.

In some circumstances one has to wonder if CMS is being deliberately vague. As discussed below, there are some situations in which the position of CMS seems to have no foundation in the statutes or regulations, or may in fact be contrary to positions taken by CMS in its formal regulations. Sometimes one has the impression that CMS is attempting to avoid a confrontation with these facts by being deliberately vague or ambiguous.

We will briefly mention here some of these ambiguities and discuss them in more detail elsewhere.

- Is a worker required to file an annual accounting for a self-administered WCMSA? See “Dealing with Medicare” at <http://www.lir.msu.edu/wcc/Medicare/Medicare.htm>.
- To what extent does CMS grant deference to determinations made by state workers’ compensation agencies? See Section 4.16.
- To what extent is CMS willing to consider the fact that most workers’ compensation settlements involve a dispute over liability? See Section 4.18.
- When CMS reviews a settlement, is it asking whether there is enough money in the settlement to cover all the worker’s future medical expenses, or is it asking whether an appropriate portion of the settlement is set aside for this purpose? See Section 4.12.
- Is the suggestion that CMS will pre-approve some workers’ compensation settlements a friendly offer of assistance or a demand coupled with a threat of punishment? See Section 4.17.

3.8 Negotiations in Workers’ Compensation Cases

This process is having a significant effect on the negotiation of settlements in workers’ compensation claims. Frequently, CMS or a vendor hired by one of the parties will conclude that the set-aside for future medical should be larger than the amount the parties have negotiated. How does this affect the final outcome? The worker’s attorney will argue that the settlement should be increased to cover the additional amount. The carrier will argue that it negotiated a single “bottom line” and that the increased allocation to future medical expense should come by reducing the amount of the indemnity settlement.

Some claimant’s attorneys are trying to deal with this situation by negotiating with the carrier a settlement of the indemnity portion of the case. They want this to be agreed upon first and to protect it from the results of any negotiation with CMS. Carriers of course would prefer to begin with a negotiation of the bottom line payment they will have to make.

Who deals with CMS? In some cases, it is the claimant’s attorney that takes the lead. In other cases, it is the defense attorney. Some large carriers have established requirements that their attorneys use certain vendors in these situations.

Finally, it is possible that all of these requirements will result in the settlement of fewer workers’ compensation cases. There may be some observers of the system who think this would not be a bad idea. However, the workers’ compensation systems in many states

depend very heavily on the fact that a majority of disputes over workers' compensation claims are resolved by a compromise. To take away this option could substantially cripple the operation of many state workers' compensation programs.

4 Issues to be Considered

This section will discuss a number of issues that should be considered in relation to workers' compensation and Medicare. Some of them are simple facts worth mentioning. Some of them are warnings that should be kept in mind. And some discuss the legal weaknesses in the positions taken by CMS.

4.1 Double Damages

If CMS is required to resort to litigation to recover payments that should have been made by workers' compensation, it is entitled to double damages (42 USCS § 1395y(b)(2)(B)(iii)). In *Manning v Utilities Mut Ins Co*, No 98 Civ 4790 (RCC), 2004 us Dist LEXIS 1674 (SDNY Feb5, 2004), there were medical bills totaling over \$200,000 that could have been covered under either workers' compensation or Medicare. They were paid by Medicare. The workers' compensation insurance carrier did not reimburse Medicare. The injured worker, through his attorney, filed an action against the workers' compensation carrier and was awarded double damages.

With regard to open claims in which there is no dispute or settlement, this should make it quite clear that it is foolish for a workers' compensation carrier to attempt to shift medical costs to Medicare. If either Medicare or workers' compensation could pay the bill, workers' compensation should pay. If a claims manager discovers that sometime in the past Medicare has paid a bill that workers' compensation could have paid, the claims manager should immediately take steps to reimburse Medicare.

4.2 Report and Cooperate

CMS takes the position that parties must "consider the interest of Medicare" in workers' compensation claims. As we discuss in Section 4.19, this requirement is not found in either the statute or the regulations. This assertion by CMS goes too far. That is not to say, however, that the parties to a workers' compensation case have no responsibility whatever. The regulations do require that a third party (such as a workers' compensation carrier) who learns that Medicare has made a payment which it should not have made, must notify Medicare. They also provide that a beneficiary (for our purposes, a workers' compensation claimant) must cooperate with the government in any attempt to recover overpayments and that a beneficiary who does not cooperate may be held responsible for the benefits (42 CFR 411.25 and .43).

4.3 Threats to Attorneys

Some statements from CMS and from some vendors have suggested or implied that attorneys, particularly claimant's attorneys, might be personally liable under some circumstances.

CMS has said that if its interests are ignored, it "has a direct priority right of recovery against any entity, including a beneficiary, provider, supplier, physician, attorney, state

agency, or private insurer that has received any portion of a third party payment directly or indirectly” (Grissom April 2003, Question 13). Until the 2003 amendments there was little statutory support for this position but 42 USC 1395y(b)(2)(B)(ii) now provides for recovery from “an entity that receives payment from a primary plan.” It is far from clear that this results in personal liability for attorneys, but it is possible that this could be given that interpretation. (See Section 4.20.)

4.4 *Don't Try to Cheat*

Although many of the positions asserted by CMS are not supported in the statute or regulations, there is a provision in the regulations which appears to give CMS certain powers if the parties treat Medicare unfairly. Regulation 42 CFR 411.46(b)(2) appears to give CMS the power to disregard a settlement if it “appears to represent an attempt to shift to Medicare the responsibility for payment of medical expenses.” Of course attorneys have a duty to be advocates for their clients but going too far may jeopardize their position.

4.5 *Majority Approved*

Reports that we receive from attorneys and claims managers indicate that in the majority of cases, when a settlement and set-aside is submitted, CMS approves the allocation. There may be some delay, and there may be a need for some negotiation or explanation, but in the majority of cases, agreement is reached on the amount of the set-aside.

4.6 *Cost Shifting*

All of this, of course, concerns the possibility that some medical bills will be paid by Medicare which could have been paid under workers' compensation. In other words, there is cost shifting from workers' compensation to Medicare. It should be pointed out, however, that there is considerable cost shifting in the other direction, from Medicare to workers' compensation. Congress regulates the fees that Medicare pays to doctors and hospitals. In most circumstances they are substantially lower than the fees paid by other payers, including workers' compensation. Some would argue that Medicare often pays fees that are less than the actual costs incurred in providing the services. When providers take losses on services offered to Medicare beneficiaries, they make up for the loss by charging higher fees to other groups of people, including workers' compensation claimants. In this way, there is probably substantial cost shifting from Medicare to workers' compensation.

4.7 *Retroactivity*

By their terms, the 2003 amendments are retroactive to 1980. Will CMS seek to apply them to bills that occurred many years ago or to settlements that were agreed to many years ago? At this point, we do not know. There may be some constitutional limits on the power of Congress to invalidate prior contracts. There is also a question of what Congress intended in granting this retroactivity.

4.8 Future Changes in the Threshold Amounts

Do parties need to worry that CMS may lower the threshold amounts in the future? CMS has repeatedly taken the position that the thresholds are subject to change but it has said that “CMS will honor threshold levels that are in effect as of the date of a WC settlement” (Grissom May 2003, Question 2).

4.9 Set-aside for Only Medicare Expenses

CMS takes the position that there should be a set-aside for only the medical expenses that would have been covered under Medicare. Why is that appropriate? Wouldn't it be more appropriate for the set-aside to cover all the expenses that would have been covered under the workers' compensation law, which generated the settlement? Assume Ms. A settles a workers' compensation case, sets aside an appropriate amount to cover future medical expenses and then spends all of that amount on such expenses. Shouldn't Medicare then begin covering her medical expenses even if some of the past expenses would not have been covered under Medicare?

One of CMS's own regulations raises some questions in this regard. Section 42 CFR 411.47(b) deals with the situation in which Medicare is entitled to recover for benefits it has paid in the past from a compromise settlement. It provides that the monies from a settlement will first be allocated to cover medical care that is not covered under Medicare and that only the remainder may then be recovered by CMS.

4.10 Appeal and Finality

CMS takes the position that there is no appeal from its determination of what would be an appropriate allocation to future medical expenses (Grissom April 2003, Question 14).¹ Generally, the law guarantees an appeal from every final decision of an administrative agency. How can CMS do this? How can it issue a binding decision without allowing the parties any avenue of appeal? It apparently does this by taking the position that this is not a final and binding determination. But if it is not final and binding, can the parties be assured that it will stick to its commitment to accept the approved allocation? If not, why bother going through all of this?²

It is possible that when a settlement proposal is submitted to CMS and it refuses to approve it, the parties might file an action in federal district court challenging the rejection. Ordinarily, federal courts would not hear such an action against administrative agencies because the parties are required to exhaust their administrative remedies. In this case, however, CMS takes the position that there is no appeal, and accordingly there are no administrative remedies to exhaust.

¹ CMS takes the position that the parties will eventually have an appeal. At some point in the future, CMS will refuse to pay for a medical bill that is submitted to it and the parties can appeal that decision. This potential appeal, which may not be available until many years after the parties have entered into a binding workers' compensation settlement, is hardly an effective remedy.

² CMS has said that the parties “can rely” on these approvals (Patel 2001, Question 1) and that once CMS agrees, they “can be certain” that they have appropriately protected Medicare's interest (Grissom April 2003, Question 1) but questions remain as to whether it is a final determination of the agency. This is of course related to the question discussed in Section 4.17, of whether this is simply a helpful service that CMS is offering or whether it is a requirement it is imposing.

4.11 “Subrogation”

CMS notes that it has a right of subrogation in these cases. This usually means that a party such as CMS has a right to intervene in the lawsuit and to assert that if the worker wins an award from an employer or an insurer it is entitled to some of the proceeds. If that was all CMS was trying to do, there would be many fewer problems. The difficulties arise because CMS asserts many more rights than simple subrogation.

One solution to this whole problem would be to make it clear that CMS has a right to subrogation and may intervene in individual workers’ compensation cases but has no special powers beyond that.

4.12 How Does CMS Analyze Settlements?

When CMS reviews a workers’ compensation settlement to determine if the set-aside for future medical is appropriate, what is CMS doing?

1. Is it reviewing the settlement to determine whether the net amount for future medical expenses is enough under the circumstances of the case?

Or,

2. Is it taking as a given the total amount of the workers’ compensation settlement and reviewing it to determine if an appropriate portion has been allocated to future medical expenses?

This is one of those areas in which the position of CMS is ambiguous. If CMS is deferring to state workers’ compensation systems concerning the appropriate total amount of a settlement but is protecting its own interest concerning how much of this is set aside for future medical, the position of CMS may be acceptable. If, however, CMS is making a determination as to what the total settlement should be, this has a couple of important implications.

- The people at CMS who have little or no experience in workers' compensation are second guessing experienced workers' compensation people concerning liability under state workers' compensation laws.
- The federal government is now preempting the authority of state agencies in an area of workers’ compensation.

4.13 Which Bills and What Amounts?

Which medical bills and which payments are we considering?

We are considering only medical bills related to the compensable condition. Within that group, which are we considering? Some procedures are covered by Medicare, but a few are not. Workers’ compensation covers virtually all medical procedures.

Medical bills are paid for at a variety of different rates. There is the face amount from the medical bill, often called the “charges.” There is the amount that would be paid under a workers’ compensation fee schedule, and there is the amount that would be paid under Medicare.

Although it is not absolutely certain, it appears that CMS wants the Medicare set-aside arrangement to cover medical bills related to the compensable condition for procedures that would have been covered under Medicare, and they may be calculated at either the charges or under a workers' compensation fee schedule. See "Dealing with Medicare" at <http://www.lir.msu.edu/wcc/Medicare/Medicare.htm>.

4.14 Accounting

It is clear that Medicare should only begin paying after the worker has exhausted the amount of the workers' compensation settlement which is attributable to future medical expenses. If a WCMSA has been created, then it should be exhausted before Medicare is expected to pay. It is clear that the worker must in some way document that these funds have been expended before he or she can expect Medicare to begin paying future bills. This can, however, be a complicated task. Consider, for example, the complicated structure of the Medicare prescription drug program.

In very large cases it is appropriate and feasible to hire an outside administrator to keep track of these calculations, to make these payments and to document them. Most workers' compensation settlements, however, are not large enough to justify this expense. Accordingly, this places on the shoulders of ordinary workers a very heavy accounting burden.

The proposed legislation discussed in Section 6 includes an arrangement under which the parties would be able to make a payment directly to Medicare. Instead of setting up a set-aside arrangement, the parties along with CMS would agree upon the amount that should be allocated to future medical covered under Medicare. They would pay that amount directly to CMS immediately after the settlement. Medicare would then immediately assume responsibility for coverage. This would greatly reduce the virtually impossible accounting responsibilities that are otherwise imposed on workers.

4.15 Costs to Medicare

Sections 3.5 and 3.8 discuss the costs of this to the individuals involved and to the workers' compensation system. One must also wonder about the cost to Medicare. In very large cases, the amount of the possible recovery undoubtedly justifies the efforts. Under the present system, however, CMS must be expending very substantial costs on a great many cases in which the potential recovery is relatively small. One must wonder whether the cost of administering these cases exceeds the potential recovery.

4.16 Preemption of State Workers' Compensation Laws

Workers' compensation has always been a state system. The federal government has kept its hands off. There are portions of the formal published regulations adopted by CMS which seem to indicate quite clearly that CMS will grant deference to determinations made by state workers' compensation systems³.

³ 42 CFR 411.46(d) provides:

Lump-sum compromise settlement: Effect on payment for services furnished after the date of settlement—

In addition, the April 23, 2003 memorandum provides, “Medicare will generally honor judicial decisions issued after a hearing on the merits of a WC case by a court of competent jurisdiction. If a court or other adjudicator of the merits specifically designates funds to a portion of a settlement that is not related to medical services (e.g., lost wages), then Medicare will accept that designation.”

If CMS would abide by these commitments we would not be having the problems that are discussed here. In practice, CMS disregards these and takes the position that it should have the final say on whether sufficient funds have been set aside for future medical expenses.

See also sections 4.12 and 4.20 for examples of other situations in which CMS appears to be usurping the authority of state workers’ compensation agencies.

4.17 An Offer or a Requirement?

It is not clear what position CMS is taking with regard to the pre-approval of workers’ compensation settlements. Is it offering this as a helpful service or is it announcing a requirement and threatening a penalty for lack of compliance?

Up to a certain point it seems as if CMS is saying it simply wants to be helpful. There may be a problem for the parties to the settlement of a workers’ compensation case. The parties would like to have an assurance that after a specified amount is spent on future medical expenses, Medicare will be paying for medical expenses related to the compensable injury. Because of the workload and staffing of CMS it cannot review every single workers’ compensation case so it will set down certain criteria for the cases it is willing to review.⁴

(1) Basic rule. Except as specified in paragraph (d)(2) of this section, if a lump-sum compromise settlement forecloses the possibility of future payment of workers’ compensation benefits, medical expenses incurred after the date of the settlement are payable under Medicare.

(2) Exception. If the settlement arrangement allocates certain amounts for specific future medical services, Medicare does not pay for those services until medical expenses related to the injury or disease equal the amount of the lump-sum settlement allocated to future medical expenses.

42 CFR 411.47 begins as follows:

Apportionment of a lump-sum compromise settlement of a workers’ compensation claim.

(a) Determining amount of compromise settlement considered as a payment for medical expenses.

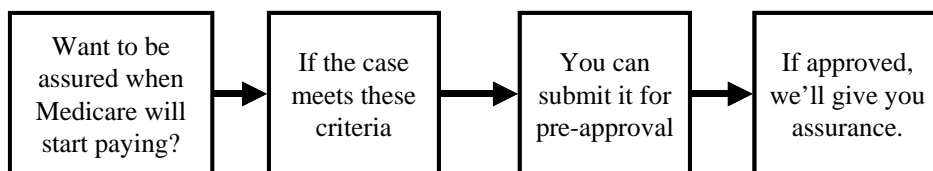
(1) If a compromise settlement allocates a portion of the payment for medical expenses and also gives reasonable recognition to the income replacement element, that apportionment may be accepted as a basis for determining Medicare payments.

(2) If the settlement does not give reasonable recognition to both elements of a workers’ compensation award or does not apportion the sum granted, the portion to be considered as payment for medical expenses is computed as follows:

(i) Determine the ratio of the amount awarded (less the reasonable and necessary costs incurred in procuring the settlement) to the total amount that would have been payable under workers’ compensation if the claim had not been compromised.

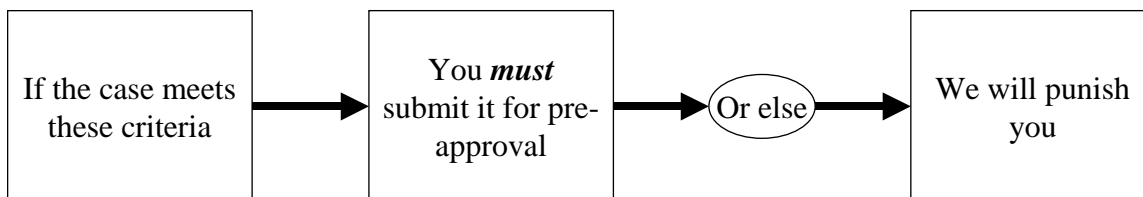
(ii) Multiply that ratio by the total medical expenses incurred as a result of the injury or disease up to the date of the settlement. The product is the amount of the workers’ compensation settlement to be considered as payment for medical expenses.

⁴ The Patel memo says that CMS “can give a written opinion on which the potential beneficiary and the attorney can rely...” (July 23, 2001 Memorandum, Question 1). In more recent publications, CMS explains that the Patel memo was intended to “prioritize workloads” of the regional offices (May 23, 2003 Memorandum).



If this were all CMS was doing it would not be a problem.

In other places, however, CMS seems to be saying that if a case meets the criteria for review the parties must submit it for pre-approval, and if they do not it will punish the parties by treating the entire settlement as if it were for future medical expenses even though that was not the intent of the parties or the determination of the state workers' compensation agency.⁵



It is this approach that has caused problems.

4.18 Compromise v Commutation

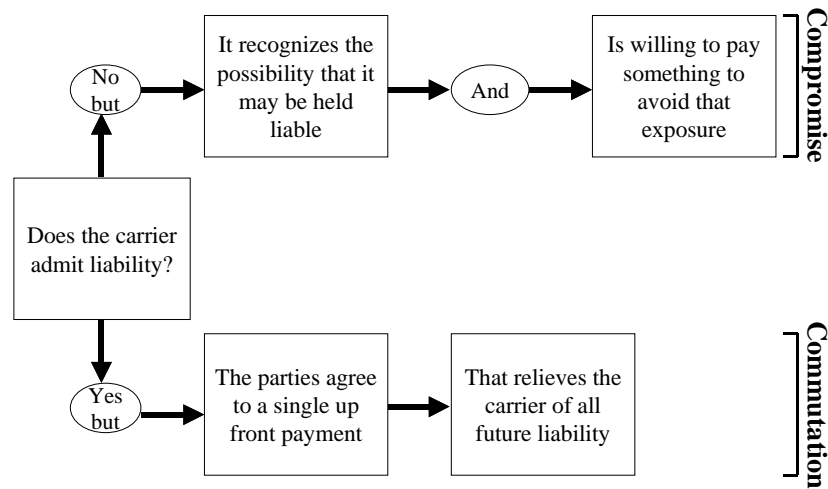
CMS uses the terms *compromise* and *commutation*. Although commutation is not a term that is frequently used in most workers' compensation systems, there are some places in which CMS uses these terms in ways that seem logical and that fit with the common understandings of how workers' compensation claims are resolved.

As discussed in Section 2.8 there are often disputes as to whether a carrier is liable for continuing medical benefits. Rather than go to a trial and have this decided by a judge, the parties often enter into a settlement in which the carrier pays an agreed upon amount. This is a compromise because the amount, while substantial, is less than the carrier would have to pay if a judge were to determine that it was in fact liable for future medical care. In some places the CMS memo refers to this situation as a compromise.⁶ The parties agree to this compromise because there is some possibility that the judge will find that the employer is not responsible for any future medical expenses. The amount of the

⁵ CMS says that if the parties settle a case over its objections or if its interest are not adequately considered in any settlement, "Medicare will not recognize the settlement" and will not pay until reimbursable Medicare expenses "have exhausted the amount of the entire WC settlement" (Grissom April 2003, Questions 14 and 22). It encourages parties to a workers' compensation settlement to report to it a party who is "uncooperative" and promises to send him or her a nasty letter "by certified mail" (Grissom April 2003, Question 22). Finally it threatens to come after anyone who ignores the interest of Medicare. The CMS has a direct priority right of recovery against any entity, including a beneficiary, provider, supplier, physician, attorney, state agency, or private insurer that has received any portion of a third party payment directly or indirectly. (Grissom April 2003, Question 13)

⁶ The Patel memo says in part: "Lump sum compromise settlements represent an agreement between the WC carrier and the injured individual to accept less than the injured individual would have received if he or she had received full reimbursement for lost wages and life long medical treatment for the injury or illness" (July 23, 2001 Memorandum, Page 2).

settlement is dependent in part on the total possible medical expenses but also on the likelihood that the judge will rule that the carrier is or is not responsible for any or all of the expenses.



Although it is less common, there are cases in which the carrier admits liability for future medical expenses but the parties desire to “close the book” on the workers’ compensation claim and agree that if the carrier pays a specific amount “up front” it will be relieved of all future liability. Some CMS statements seemed to define this as a commutation.⁷

This seems like a logical distinction and fits in with the way workers’ compensation systems actually operate. It is especially hopeful when considered along with suggestions in some of the CMS statements that pre-approval and WCMSAs are only required in cases involving a commutation, not in cases involving a compromise.⁸

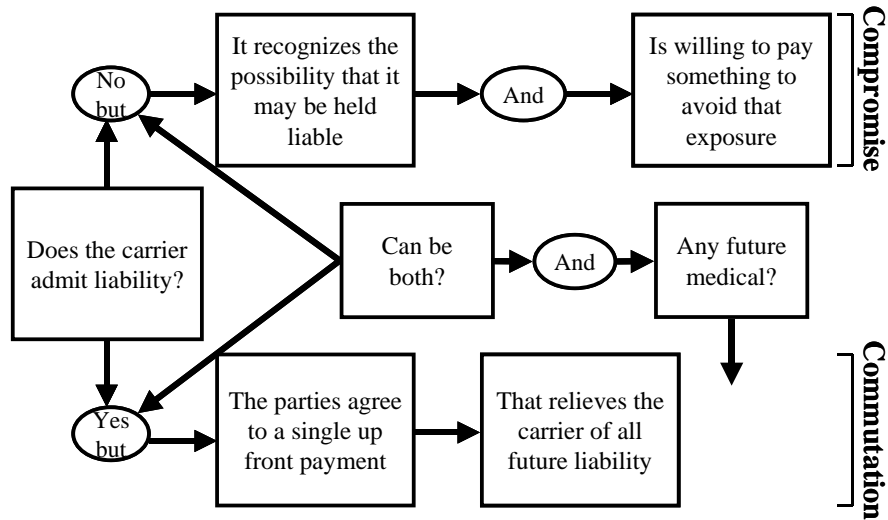
Problems arise, however, because CMS is not consistent in how it uses these terms. As used above, compromise and commutation should be mutually exclusive categories. Either the carrier admits liability or it does not.⁹ In some places, however, CMS seems to take the position that some, or perhaps most, settlements involve aspects of both a commutation and a compromise. Given the definitions above it is hard to understand how this would happen. Either the carrier admits liability or it does not.

⁷It describes commutations as cases in which “there is no controversy between the injured individual and the WC carrier over whether the WC carrier is actually liable to make payments” (Page 2). The regulations describe a commutation as a case in which “a lump-sum compensation award stipulates that the amount paid is intended to compensate the individual for *all future medical expenses* required because of the work-related injury or disease” (42 CFR 411.46(a)). (Emphasis added.)

⁸ “It is important to note that set-aside arrangements are **only** used in WC cases that possess a commutation aspect; they are not used in WC cases that are strictly or solely compromise cases.” (Patel 2001 page 2) (Emphasis in original.)

⁹ A possible exception would be cases of multiple injuries in which, for example, the carrier admitted liability for a back injury but disputed liability for a leg injury.

In other statements CMS seems to use an entirely different definition of commutation. It defines as a commutation any case that involves a settlement of future medical expenses.¹⁰

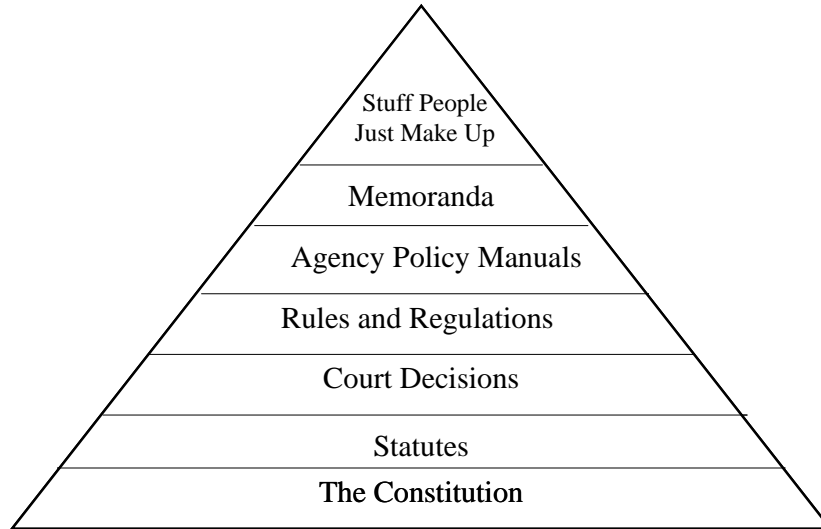


The ambiguities and contradictions in positions taken by CMS make it difficult for the parties to comply with their requests and lead to questions about the underlying authority for its positions.

4.19 No Foundation for the Positions of CMS

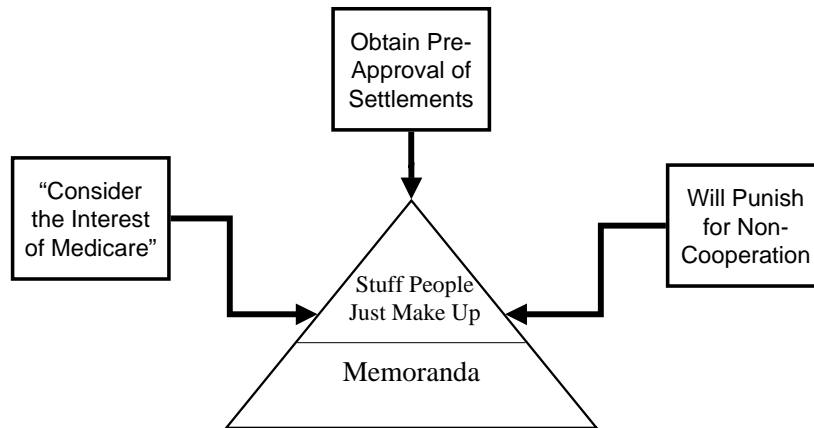
In the United States we believe in the rule of law. That is to say that we believe that the actions of government must be based on the laws of the land. Furthermore, we believe that there is a hierarchy to such laws.

¹⁰ “WC commutation cases are settlement awards intended to compensate individuals for **future** medical expenses required because of a work-related injury or disease. In contrast, WC compromise cases are settlement awards for an individual’s current or past medical expenses that were incurred because of a work-related injury or disease. Therefore, settlement awards or agreements that intend to compensate an individual for any medical expenses after the date of settlement (i.e., future medical expenses) are commutation cases.” (July 23, 2001 Memorandum, page 3) (Emphasis in original.) (See also April 21, 2003 Memorandum, Question 4.)



- The basic foundation of all laws is the Constitution. Neither the Congress nor administrative agencies can pass any law which is not founded upon or which violates the provisions of the Constitution.
- Next come statutes, or laws, that are adopted by the Congress or state legislators.
- This is followed by court decisions. The decisions of the courts can interpret the laws passed by Congress. The court decisions, however, must be based on the laws or statutes and the Constitution.
- On top of this are formal regulations that are adopted by administrative agencies. The Administrative Procedures Act spells out procedures by which agencies can adopt regulations. The procedures involve a publication of the proposed regulations, a period for comments, and then a formal adoption of the regulations. When they are adopted, these become part of the Code of Federal Regulations. The regulations must be based on and authorized by statutes passed by Congress.
- Sometimes courts will grant some deference to policy memos or opinions that are issued by state agencies. These cannot exceed or contradict formal regulations and must be based on statutory authority.
- Finally, there are informal memoranda and what I call “stuff people just make up.” These have no official standing.

A problem with the issues we are talking about here is that in many cases the position of CMS is based simply on informal memoranda or stuff people just make up.



Consider the Interest of Medicare

CMS takes the position that the parties to a workers' compensation claim must "consider the interest of Medicare." There is nothing in the law that requires the parties to do this. Why shouldn't Medicare be treated as an adversary? Adversaries have certain rights, they must be given notice and an opportunity to protect their interest but why should other parties be expected to protect their interest, especially since Congress has not seen fit to require this in the law?

No Requirement for Pre-approval or a Set-Aside

There is nothing in the law or the published regulations that requires the parties to seek pre-approval of settlements or that requires a set-aside. It is of course logical that CMS should be able to require an accounting before it begins to pay after a settlement and it is logical that in many cases a set-aside is the best way to do that but that is very different from saying that it is a requirement that the government has imposed on us.

Penalty for Not Seeking Pre-Approval

As discussed in Section 4.17, CMS takes the position that if the parties do not obtain pre-approval under certain circumstances it can penalize them by treating the settlement as if the entire amount were for future medical expenses. There is nothing in the statutes or regulations that authorizes it to do this.

In fact, a recent Supreme Court case raises considerable questions about the power of CMS. *Arkansas HHS v Ahlborn*, 126 S. Ct. 1752; 164 L. Ed. 2d 459; 2006 U.S. LEXIS 3455 (2006) involved Medicaid rather than Medicare, but also involved a claim by CMS that it could treat an entire settlement as if it were all for future medical expenses. The Supreme Court rejected this and held that it could not do so. While the Medicaid statute is somewhat different from the Medicare as Secondary Payer Act, the principles are the same.

4.20 The 2003 Amendments

The Medicare Prescription Drug Improvement and Modernization Act of 2003 is the bill that was discussed and debated for more than a year and added prescription drug coverage to Medicare. With virtually no notice, discussion or hearings, CMS added to

that bill amendments to the Medicare As Secondary Payer Act which greatly strengthened the position of CMS.

The most critical changes involve 42 USCS § 1395y(b)(2)(B)(ii). Previously this section had provided that payments were “conditioned on reimbursement to the appropriate Trust Fund.” This language provided a very weak basis for all the claims made by CMS. The amendments changed that language to provide:

A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. 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.

All of the implications of the new language are not entirely clear but it could be interpreted to mean that if Medicare pays a bill that could have been paid under workers’ compensation:

- A primary plan that was responsible to make the payment must reimburse Medicare.
- Any entity that receives payment from a primary plan is responsible to reimburse Medicare.
- Responsibility to make payment may be demonstrated by any payment, even one conditioned upon a recipient’s compromise, waiver or release.
- This is true whether or not the compromise was a determination or admission of liability.
- The United States may bring an action against any and all entities that were required or responsible to make payment.
- In such an action, the United States may be entitled to double damages.
- This may apply to both medical bills incurred before the settlement and those incurred after the settlement.

Consider the following example. Ms. A is 66 years old and thus covered by Medicare. In 2004, she settles a workers’ compensation claim for a back injury for \$80,000 in a state that allows the complete release of an employer. The parties to the settlement do not seek or obtain pre-approval from CMS. The insurance carrier reduces the reserves to zero and closes its file. Three years later, Ms. A goes into a hospital for back surgery. As is her custom for other medical problems, she hands them her red, white, and blue Medicare card and Medicare pays the bill. A year after that, a contractor discovers that Medicare has paid a bill that might have been covered under workers’ compensation. It is possible to interpret the new language to allow Medicare to demand that the insurance carrier reopen the workers’ compensation claim and repay it for that medical bill.

This is clearly the worst-case scenario. It is not even clear that CMS asserts the power to do this, but it is possible that the 2003 amendments could be given this interpretation.

4.21 A Question for Workers' Compensation

The process has raised an important question about the workers' compensation system. It would appear that when outside parties not familiar with the system look at the settlements, they find that a substantial portion of the settlements do not actually include sufficient funds to cover future medical expenses. It may be that we have all been kidding ourselves and that in fact workers' compensation really does not cover all the medical expenses related to workplace injuries.

5 Litigation

If these were purely workers' compensation issues, they would be resolved through litigation. The parties would take different positions, the cases would be brought before hearing officers and appealed, and eventually we would be given answers. Somewhat surprisingly, however, parties who never hesitate to litigate workers' compensation issues are quite reticent to challenge the federal government over Medicare. In fact, the parties seem quite intimidated by the federal government in this situation.

6 Legislative Action

It would seem that at least some of these problems could be solved if the people from CMS and some people who understand workers' compensation would sit down together and try to deal with their mutual problems. It is sometimes difficult to decide who can speak for "workers' compensation," but it should be possible to put together a representative group through some organization such as the National Academy of Social Insurance.

Some workers' compensation groups have tried to talk with CMS and have had little or no success. Others who have tried to deal with CMS on different issues suggest that this is a waste of time. Accordingly many in the workers' compensation community are coming to feel that legislative action will be necessary. They have introduced a bill which provides:

- Exempt settlements where it does not make sense to establish a set-aside
- Use a single \$250,000 threshold for future and current Medicare beneficiaries
- Clarify how to calculate the \$250,000
- Provide for Medicare to share the costs of reviewing a set-aside proposal as well as set-aside administration
- Clarify that the amount of the primary payment obligation is established by the applicable workers' compensation law
- Provide safe harbors in establishing set-asides
- Permit the parties to pay a set-aside directly to Medicare

- Provide reasonable deadlines for Medicare to (i) notify the parties of any conditional Medicare payments and (ii) complete its review of a set-aside proposal
- Establish an appeal process
- Grandfather in prior settlement agreements

The bill has support from employers, insurers, trial lawyers, and to some extent organized labor. The lead organization in supporting the bill is UWC—Strategic Services on Unemployment and Workers’ Compensation (UWC) (<http://www.uwcstrategy.org>). Its president is Doug Holmes. He can be reached at holmesd@UWCstrategy.org.