I. Introduction

Settlement of Minnesota workers’ compensation claims traditionally required solely an agreement between an employee and the employer’s insurer, with approval by a compensation judge. More recently, we have grown accustomed to delays in the settlement process as the result of intervention interests, primarily involving individual medical providers. Medicare, in many ways, has become a new stumbling block on the road towards voluntary resolution of certain claims brought by employees seeking workers’ compensation benefits in Minnesota and elsewhere.

The Medicare Secondary Payer statute of 1980 was created to assure that Medicare does not pay medical expenses that are the responsibility of a workers’ compensation insurer. The issue of Medicare Set-Aside accounts is not, however, a creature of statute, and the regulations and procedures remain fluid, essentially subject to the whim of Medicare, and generally announced through various regulations, memoranda, and Q&A forums.

More recent policy changes impact the process by which insurers, employees and attorneys administer workers’ compensation claims, keep Medicare apprised of developments and communicate with Medicare.

II. The Rise of the Medicare Interest

A. Why is this an issue?

Simply put, Medicare does not want to pay for medical expense benefits that should have been paid by a workers’ compensation carrier. This is true whether an injury was accepted but later settled or whether primary liability was denied from the outset, challenged through litigation, and ultimately settled without a formal decision.

Medicare regulations at 42 CFR 411.56 state the following:

If 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,
Medicare payments for such services are excluded until medical expenses related to the injury or disease equal the amount of the lump sum payment.

(emphasis added) This is highlighted further in Medicare manuals that 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 allocated to medical treatment.

In other words, unless the parties to an agreement that settles any or all future medical expenses take into consideration the role that Medicare might play, the likelihood of any Medicare conditional payments being made is reduced at such time as the employee may become eligible for Medicare.

III. When should parties take into account Medicare?

Medicare’s administrative arm, The Centers or Medicare and Medicaid Services (CMS) requires insurers to take Medicare’s potential interest into account in all cases. The extent to which any action must be taken is, however, dependent upon the individual claim.

A. Medicare Within the Claims Process

The claims process usually involves an employee who sustains a claimed injury, seeks treatment and the doctor attempts to get paid. In some cases, Medicare ends up paying the bill either because the claim was denied or the bill was erroneously submitted to Medicare.

Medicare’s interests should be considered either when Medicare has paid past medical bills that are part of the admitted or disputed workers’ compensation claim (so called “conditional” payments) or when the insurer intends to settle a claim that will close all or part of future admitted or disputed medical expenses, regardless of whether Medicare has paid any past medical bills.

In Minnesota, we have become accustomed to the idea that third parties who have paid medical bills need to be dealt with as part of the claims handling process. In simple terms, Medicare can be considered one of these potential “intervenors.” In reality, however, whereas the Minnesota Workers’ Compensation Statute places the burden on the intervenors to react when placed on notice of a right to intervene or be subject to possible exclusion from recovery, Medicare is unlikely to be subject to such an exclusion. As result, insurers must be aware of its obligation to deal with conditional payments as part of any resolution or on-going claims handling.

Section 111 of the Medicare Act of 2007 provided for mandatory reporting requirements for group health plan arrangements, liability insurance, no fault insurance and workers’ compensation. Insurers must report the identity of a Medicare beneficiary to the COBC electronically.
More recently, CMS has also announced policy changes regarding obtaining conditional payment information. These changes became effective October 1, 2009.

In order to obtain Medicare’s lien interest, it is first necessary to contact Medicare’s coordinator (COBC). In essence, after the employee has commenced his claim, the employee must notify Medicare of its right to intervene by contacting the COBC. This information can be submitted to COBC by phone (888-999-1118) or mail (P.O. Box 33847, Detroit, MI 48232-5847). Once notified, the COBC issues a “Rights and Responsibilities” letter to all individuals or entities. This will include a cover sheet, education brochure and Privacy Act enclosure. This initiates the retrieval process by which the MSPRC investigates the claim, determines what is related to the workers’ compensation claim and advises the parties of its “conditional” interest. It is estimated that this investigation process will take eight (8) weeks.

During the eight-week investigation period, it is recommended that insurers confirm that the employee has completed and sent to MSPRC the Proof of Representation and Consent to Release forms. Although this is the responsibility of the employee, if such forms are not completed, the information will only be provided to the insurer and the employee. Prompt resolution of claims should include notification of all lien interests to the employee’s attorney. The Consent to Release allows the attorney to gather information from MSPRC but not act on behalf of the employee. The Proof of Representation takes things a step further, allowing the employee’s attorney to make requests, dispute the claim, correct the nature of the injury or file an appeal.

Once an initial investigation is completed by MSPRC, a Conditional Payment Letter (CPL) will be issued. It is important to recognize that this is an “interim” amount. Medicare recognizes that it may continue to pay payments. The CPL will automatically be generated once a claim is commenced. It will be updated every 90 days until such time as a final settlement is reached. If a settlement is reached, the parties should provide to MSPRC further information to include the date of the settlement, amount of settlement, attorney’s fees, itemized costs and a copy of the Stipulation for Settlement and Award. This will generate a final demand letter, following which payment is to be made to Medicare within 60 days to avoid interest. Payments not timely issued will be referred by MSPRC to the Department of the Treasury.

B. Medicare Within the Settlement Process

The possibility for Medicare’s involvement should be taken into consideration as part of any and all settlements involving the closure of any, or all, future medical expenses. However, under current Medicare regulations, not all cases require Medicare’s involvement. When involvement is required, it is recommended that a Medicare Set-Aside (MSA) account be created.

An MSA arrangement most often will be used in those claims in which the employee has reached maximum medical improvement (i.e., his condition has stabilized) so that “it can be determined, based on past experience, what future medical expenses may be”. Regardless, an MSA is mandatory when:
1. There is a settlement of future medical claims; and
   a. The employee is currently a Medicare beneficiary and the total settlement proceeds are in excess of $25,000, or
   b. The employee is not currently a Medicare beneficiary but:
      i. The settlement in total exceeds $250,000; and
      ii. There is a “reasonable expectation” that the employee will enroll in Medicare within 30 months of the settlement date.

Important definitions to be applied to the above guidelines include:

1. “Medicare beneficiary” means:
   a. The employee has been receiving Social Security Disability for more than two years; or
   b. The employee is 65 years of age.

2. “Reasonable expectation” means:
   a. Employee has applied for Social Security; or
   b. Employee has been denied Social Security benefits but anticipates appealing that decision; or
   c. Employee is 62 years 6 months of age; or
   d. Employee has end stage renal disease.

Therefore, an insurer who pays any amount to an employee as part of a full and final settlement agreement that includes a closeout of some or all of that employee’s future medical benefits must create an MSA if that employee is already a Medicare beneficiary and the settlement is in excess of $25,000. If the employee is not a Medicare beneficiary but the cumulative settlement (amount paid to the employee and all intervenors, for example) totals more than $250,000, an MSA must be created if the employee is 62 years and 6 months of age, has applied for Social Security, has end stage renal disease, or has been denied Social Security benefits but anticipates appealing that decision.

IV. What is the role of the Medicare Set-Aside Agreement?

Although Medicare does not have a claim against a lump sum payment made as part of a workers’ compensation agreement until the employee becomes eligible for Medicare benefits, once that entitlement exists the purpose of the MSA is to prevent a complete or total offset of the lump sum by those medical benefits that otherwise would have been paid by Medicare.

In order to prevent an offset, CMS has agreed to review proposed settlements including a set-aside arrangement and give a written opinion on which the employee, his or her attorney, and the insurer can rely. This review by CMS is ultimately to determine whether the settlement agreement has adequately considered Medicare’s interests pursuant to 42 CFR 411.56. This review agreement is an effort by CMS to balance Medicare’s interest in avoiding the payment of medical expenses otherwise the liability of the workers’ compensation carriers and the desire of employees and insurers to reach amicable settlement agreements that close future medical expenses.

It is anticipated that once an MSA has been approved by CMS, the responsible Medicare office will “check on a monthly basis” Medicare’s enrollment database to determine whether an employee has
ultimately been accepted into Medicare. Once that determination is confirmed, a benefits coordinator is assigned within Medicare for monitoring of the employee’s case according to the employee’s residence.

Following necessary internal paper shuffling at Medicare, the designated MSA administrator for the particular claim is required to maintain contact with the coordinator, including providing annual accounting summaries concerning expenditures of the arrangement. The coordinator is charged with verifying that the listed expenditures related to services that Medicare would otherwise cover and credit the account accordingly. If all goes according to plan, Medicare should not make any payments related to the work injury until the MSA is exhausted.

CMS requires that the MSA lump sum be placed in an interest-bearing account indexed to account for inflation consistent with how Medicare calculates its growth for spending.

V. How much is enough to put in the MSA?

In evaluating the amount to be placed into an MSA, CMS is generally interested in determining whether the amount allocated is “reasonable”. A July 23, 2001, memorandum from CMS outlines the following criteria for evaluating the amount of a proposed settlement to determine where there has been an attempt to shift liability for the cost of a work-related injury or illness to Medicare:

1. Date of entitlement to Medicare;
2. Basis for Medicare entitlement (disability, end stage renal disease, or age);
3. Type and severity of injury or illness and whether additional recovery is expected;
4. Age;
5. Extent of disability under WC (TTD, TPD, PTD);
6. Amount of prior medical expenses paid by WC (as this would suggest that it is a partial compromise claim, as opposed to a commutation claim);
7. Amount of the lump sum or structure and any allocation within the settlement agreement;
8. Whether this is a specific time or lifetime commutation of the employee’s benefits;
9. Whether the employee is living at home, in a nursing home, or receiving assisted living care;
10. Whether the expenses for Medicare covered items and services are appropriate in light of the employee’s condition. Although determined on a case-by-case basis, CMS may refer to the average annual amounts of Part A and Part B spending for a disabled person in Minnesota. The amount is determined on the basis of the employee’s expected life expectancy.

On December 30, 2005, CMS issued a new memorandum regarding the Medicare Secondary Payer Statute. Simply put, the new rules require that any workers’ compensation settlement must protect Medicare’s interest with regard to prescription medication.[6]

Once the amount is determined by CMS and placed into an MSA, it remains in the account except in those circumstances where it can be shown through a written treating physician’s opinion that the employee’s condition has “substantially improved”. In that case, an employee may request that funds be released to him or her. If CMS disagrees, the funds remain in the MSA. In any event, they are not returned to the insurer. This apparently provides an incentive for the employee to work towards health improvement post-settlement and avoid the possibility that he or she will ever dip into Medicare funds.
VI. Will Medicare settle with the parties to avoid an MSA?

Medicare has been willing to settle a potential intervention interest in those cases where Medicare has paid medical bills arguably related to a work injury. However, according to department memoranda issued in July 2001 and July 2005, they are unwilling to simply accept a lump sum to avoid an MSA as part of a settlement agreement that closed future medical benefits. They take the position that Medicare cannot pay any benefits on behalf of the employee until the medical expenses related to the injury or disease equal the amount of the settlement allocated to future medical expenses or the amount included for medical expenses in the set-aside arrangement have been exhausted.

Medicare has previously been willing to discuss a reduction in the total allocation in those cases involving a denial of primary liability. The amount being offered to Medicare needed to be clearly outlined within the confines of the proposed Stipulation for Settlement and discussed with CMS early in the settlement process. More recent practice calls into question the willingness of CMS to continue this practice. CMS has, however, been willing to waive the necessity for an MSA altogether (essentially creating a “zero allocation”) in those cases where primary liability has been denied and a clear defense exists.

In most cases, it is wise to obtain CMS approval of a settlement proposal prior to seeking approval of a compensation judge at the Office of Administrative Hearings. However, CMS has made clear that it is also acceptable to obtain approval and closure of the claim by a compensation judge in advance of CMS approval.[7]

VII. What CMS needs to provide an opinion in a proposed MSA

CMS will provide a written opinion concerning the sufficiency of an MSA but, at a minimum, they must first be provided with copies of the proposed settlement agreement, a copy of the life care plan, if any, an estimate of the employee’s life expectancy and/or rated age opinion. Documentation also needs to be provided as to the basis for the projected amounts, including letters from doctors and providers documenting the necessity of continued care. The detail should separately outline the specific amount being set aside for future prescription medication and that which is set aside for medical treatment.

Once the proper documentation is submitted, CMS has a goal of responding to requests for approval within 45 to 60 days. To assist in reaching this goal within its ten regional offices, CMS has hired an outside contractor to reduce caseloads. More recent experience has shown that the approval wait time has ranged from a matter of a few weeks to many months. Current estimates are approximately four to five months.

CMS generally will not provide verification letters to parties to a claim when the claim does not meet the criteria necessary for the creation of an MSA. The parties are left to determine which cases fall within the review category or risk indeterminate delay.

VIII. Handling Claims Not Meeting the Review Thresholds
CMS requires that all cases in which medical is to be closed must take into account Medicare’s interest, regardless of the “working” or “review” threshold established by CMS. That is, even if a claim does not meet the requirements for an MSA and CMS involvement, Medicare’s interest must be taken into account in all settlements where medical is closed.

One favored option to ensure that Medicare’s interests are taken into account is to set up a Medicare custodial account, similar to an MSA but not requiring CMS approval. Ultimately, a decision will need to be made among the parties as to whether the costs of an MSA or custodial account is justified by the desire to close medical under the terms of a settlement agreement. It is generally anticipated that insurers may opt to keep future medical benefits open subject to all defenses to avoid the inherent potential exposure for such accounts.

[1] “Commutation” is defined elsewhere in Medicare materials as generally involving those cases where there is an absence of controversy over whether a WC carrier is liable; however, the manuals further state that “[a]n absence of controversy over whether a WC carrier is liable to make payments is not the only distinction that Medicare’s manuals and regulations make between a compromise and commutation cases”. It appears clear that any settlement agreement that intends to “compensate an individual for any medical expenses after the date of settlement, (i.e., future medical expenses) are commutation cases”.

[2] The initial letter to COBC should include: Employee’s name, Medicare insurance number, gender, date of birth, phone number, date of injury, description of the injury, the insurer’s name and address and attorney contact information.

[3] Payments issued to Medicare should include the name of the employee, Medicare number, notification that it was a workers’ compensation claim and the date of injury. Payments should be sent to MSP WC Recovery: P.o. Box 33831, Detroit, MI 48232-5831.

[4] The $25,000 “review threshold” is subject to periodic adjustment by Medicare. The increase from $10,000 to $25,000 is effective with the release of the April 25, 2006, CMS memorandum.

[5] The $250,000 figure is fluid and there have been suggestions made that even settlements less than this amount may require consideration of medical savings account, even if not reviewed or specifically approved by CMS. Medicare statements and footnotes to articles have merely stated that “it is not in Medicare’s best interests to review every WC settlement nationwide in order to protect Medicare’s interests per 42 CFR 411.56”. Therefore, at this point, the $250,000 figure is only a minimum review “threshold” which “will be subject to adjustment once CMS has experience reviewing these matters…”

[6] It is not necessary to include prescription allocations for those settlements reached prior to January 1, 2006, but not approved by CMS until after that date. Current MSAs must include an allocation for anticipated future prescription medication costs.

[7] This obviously requires some degree of confidence that the proposed MSA was properly submitted and will be found satisfactory to CMS. The documents must also provide for an agreed-upon contingency should the MSA not be approved.