In This Issue:

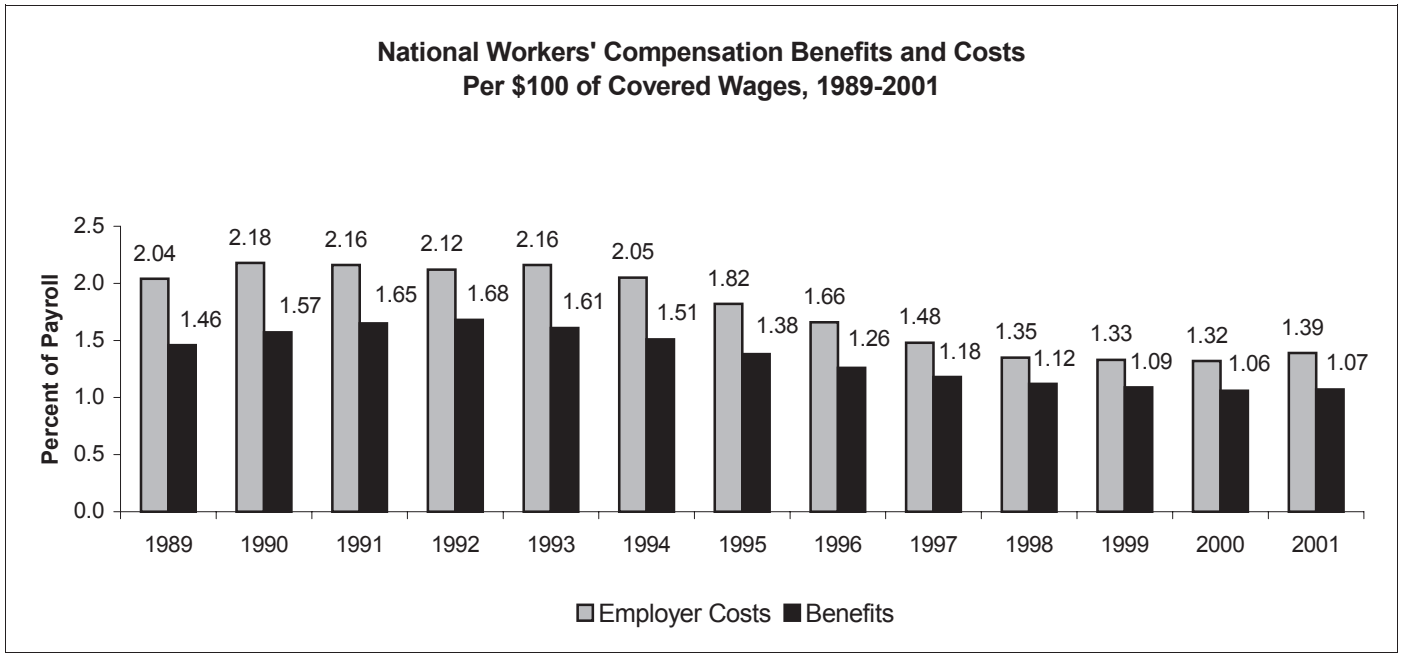
FEATURED TOPICS

This issue is being distributed in September 2003. Readers should expect a continuing deluge of issues in the next few months.

Summary of the Contents

Workers' compensation is only one of the programs in the workers' disability income system in the U.S. that provide cash benefits, medical care, or rehabilitation services to employees who are disabled by work-related injuries and diseases. Some of the other programs provide benefits both to persons disabled by work-related sources as well as by nonwork-related sources. For example, some of the recipients of cash benefits from the Disability Insurance component of the Social Security program are former workers who were disabled by work-related sources, while other beneficiaries were disabled by non-occupational causes. Another example is Medicare, which provides medical benefits to beneficiaries, some (but not all) of whose medical conditions are due to work-related factors. A particularly vexing current problem concerns the efforts by the Medicare program to ensure that workers' compensation is the primary source of medical care for workers disabled by workplace injuries or diseases. Edward Welch does a masterful job of clarifying the relationships between Medicare and workers' compensation in the lead article.

The latest release from the National Academy of Social Insurance of the most comprehensive national data on the benefits, costs, and coverage of the workers' compensation program is examined in the other article. Among the most interesting findings (as shown below) is that both worker benefits and employer costs as a percent of payroll increased in 2001, thus reversing declines in these measures that began in the early 1990s. Despite the increases in 2001, benefits and costs relative to payroll remained well below their levels of a decade ago. Employer costs, for example, were 1.39 percent of payroll in 2001, well below the peak of 2.18 percent of payroll in 1990.



Advisory Board Members

(Membership on the Advisory Board does not constitute an endorsement of the contents of the *Workers' Compensation Policy Review.*)

Please note change of address and phone numbers for the *Workers' Compensation Policy Review,* effective 8/1/03:

Workers' Compensation Policy Review
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Mark T. Sumwalt and Richard B. Harper.
- "Medicare as a Secondary Payor and Workers' Compensation Settlements" by Kathleen Shannon Glancy

Updates:

- From time to time we may post updates.

1.2 A Caution

A few words of caution are in order here. This is a relatively new area in which there is little experience. The statute and regulations being interpreted have rarely been litigated. Unlike workers' compensation, where there may be dozens of decisions by the courts and an appellate body interpreting provisions of the statute, there are only a few court decisions interpreting these provisions. And, finally, the situation is hard to explain because CMS has declined to explicitly state its position on some of these issues. A memo of July 2001 is helpful in some regards, but it is confusing in others, and there are many points it does not cover. A set of frequently asked questions released in April of 2003 is helpful in some areas but only to a limited extent.

What I offer here is my view of this topic. Others may disagree. Readers may wish to examine some of the articles listed in the preceding section. I would encourage readers to be a bit critical about this and not to take for granted one view, either that of the government or of one attorney.

Claims managers should review this themselves and seek advice from their own or an independent attorney. By "independent" attorney I mean one who is not selling services related to this issue. It is true that some of the vendors were aware of these problems before any of the rest of us. It is also true that they may be keeping better informed than anyone else but, like everyone else (including people who teach classes for universities), their views may be colored by the services they have to offer. This should be kept in mind by those receiving advice from them.

Attorneys should read this and other papers, do the necessary research, and make up their own minds about these issues.

1.3 The Problem

Certain individuals qualify to have their health care expenses paid for by both workers' compensation and Medicare. When there is such a choice, the law is clear that workers' compensation is primary. Workers' compensation should pay and Medicare should not.

In the past, workers' compensation practitioners have not always respected the rights of Medicare. They would either intentionally or fortuitously arrange for or allow Medicare to pay for health care services that should have been covered under workers' compensation. Medicare is now taking aggressive steps to prevent this from happening.

It is clear that workers' compensation can no longer shift its health care costs to Medicare. Problems have arisen, however, involving settlements of workers' compensation cases. In such settlements, it is generally assumed that part of the money is a replacement for future cash benefits and part of it is for future medical expenses. Medicare should only pay for medical bills for the work-related condition after the part of the settlement for future medical expenses has been exhausted.

The Centers for Medicare and Medicaid Services (CMS) that administers Medicare has made it clear that it will require an accounting of the settlement before it begins paying for healthcare under Medicare. A number of vendors now offer to help set up life care plans and Medicare set aside trusts that will justify the amount set aside for future medical expenses and keep track of the expenditures. CMS seems also to have asserted that parties should obtain preapproval of workers' compensation settlements in two categories of cases: (1) cases in which the worker is currently entitled to Medicare and (2) cases in which the settlement is over $250,000 and there is a reasonable expectation of a Medicare entitlement within 30 months. By this it means that before a workers' compensation case is settled the parties should submit it to CMS and CMS will indicate if it believes the allocation to future medical expenses is appropriate.

The situation is complicated by several factors. The position of Medicare on many of these issues remains unclear. Sometimes, its position is stated in memos and policy statements that seem to differ from the statute or the formal published regulations. The situation is made worse by the fact that some of the predictions of the worst possible consequences come from vendors who are offering to help deal with these situations in return for a fee. It is not entirely clear whether these vendors are foresighted saviors who can protect us from impeding doom or whether they are scaring us about problems that do not exist in order to make a profit. Numerous individuals and organizations have asked Medicare to clarify its position and to take a more reasonable approach, but they have met with only limited success. It may be that this problem will have to be resolved through Congressional action. See section 5.

1.4 A Summary

This paper will discuss this situation in some detail. For those looking for a quick review of the current situation we offer the following summary.

Admitted liability

When there is no dispute that a bill could be covered under workers' compensation, workers' compensation and not Medicare should pay. See section 3.1.1.

Disputed liability, no settlement

When there is a dispute over whether a bill should be covered under workers' compensation, it would seem most appropriate for it to be resolved by the state workers' compensation agency.

Disputed past bills in a settlement

The regulations provide a formula by which the settlement is apportioned to cover part of the past bills. See section 6.3.12. It is not clear that CMS accepts this position.

Settlement with no dispute

If there is a settlement of a case in which the carrier *admits liability* but intends to settle by a lump-sum payment, the regulations give Medicare substantial leverage. See 6.3.9. Accordingly, in those cases, it would seem best to obtain preapproval from CMS. (See question 4.5 for information about how to find out if there are any potential liens from Medicare.)

Don't try to cheat

The regulations give CMS substantial rights if the parties are entering into a settlement in an attempt to inappropriately shift costs to Medicare. See section 3.1.2. Accordingly, parties should avoid even the appearance that they are trying to do this. If there is any doubt, it would seem best to obtain preapproval.

Settlement with a dispute

In settlements in which there is a dispute about liability under workers' compensation, the regulations provide that CMS is bound by an allocation to future medical expenses that was made by the workers' compensation agency. CMS seems to dispute this but it is quite clearly stated in their regulations. See section 3.2.5.

We have attempted to summarize this situation in the flow chart that follows. It attempts to illustrate graphically how decisions about these topics might be made.

2 BACKGROUND

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

Medicare is administered by the Centers for Medicare and Medicaid Services (CMS). This agency was previously known as the Health Care Finance Administration. CMS delegates some of its work, especially work dealing with the collection of overpayments, to private contractors that vary by region and state.

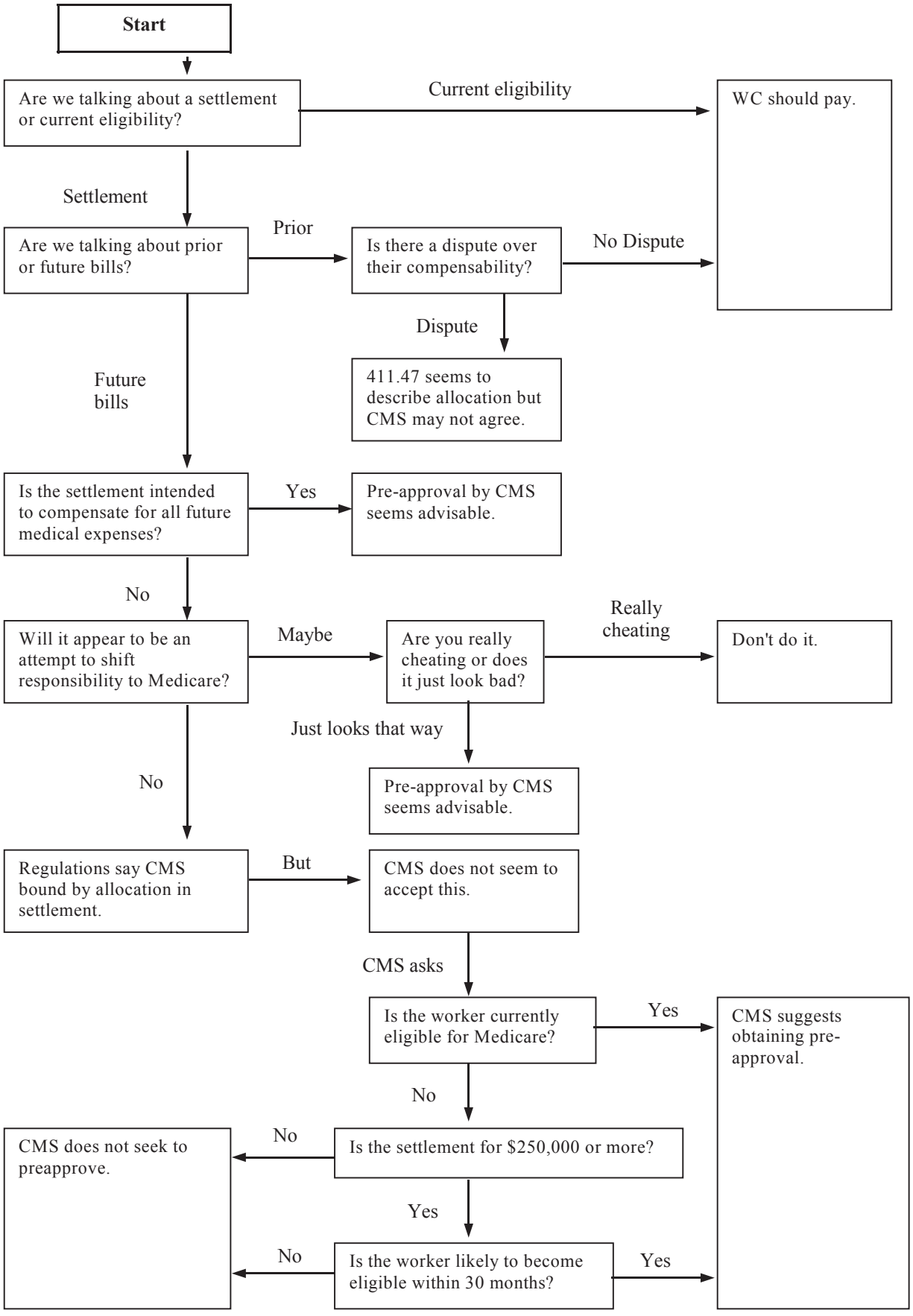
It must be conceded that, in the past, to at least some extent, workers, their attorneys, employers, and insurance companies have ignored or attempted to evade the fact that workers' compensation is primary. There were undoubtedly some instances in which a worker would go into the hospital for treatment of a work-related problem and, as was his or her custom for other problems, would simply show a Medicare card, and the hospital would bill 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 been paid. There were also 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 the attorney responded by saying, "Just charge them to Medicare."

Medicare represents about 25 percent of the budget of the federal government. 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 (GAO) pointed out that Medicare was losing money by paying for certain services that should have been covered under workers' compensation. At about the same time (perhaps in response to the GAO), CSM began to more aggressively enforce its right to have workers' compensation pay when it should.

With regard to ongoing care when a worker is currently entitled to workers' compensation, the situation is fairly straightforward. Workers' compensation should pay and Medicare should not. The situation becomes much more complicated with regard to settlements. When a worker receives a lump sum and an employer is relieved of its liability for future benefits, in most cases, some of the lump sum is for the payment of future medical benefits. When that amount is exhausted, Medicare should begin paying for health care related to this condition. The problems concern how to determine how much of a settlement should be allocated for future medical expenses and how to know when that amount has been exhausted.

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 Medicare has any past liens against the workers' compensation claim. 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.


Start
Are we talking about a settlement or current eligibility?
Current eligibility
WC should pay.
Settlement
Are we talking about prior or future bills?
Prior
Is there a dispute over their compensability?
No Dispute
Dispute
411.47 seems to describe allocation but CMS may not agree.
Future bills
Is the settlement intended to compensate for all future medical expenses?
Yes
Pre-approval by CMS seems advisable.
No
Will it appear to be an attempt to shift responsibility to Medicare?
Maybe
Are you really cheating or does it just look bad?
Really cheating
Don't do it.
Just looks that way
Pre-approval by CMS seems advisable.
No
Regulations say CMS bound by allocation in settlement.
But
CMS does not seem to accept this.
CMS asks
Is the worker currently eligible for Medicare?
Yes
CMS suggests obtaining pre-approval.
No
Is the settlement for $250,000 or more?
No
CMS does not seek to preapprove.
Yes
Is the worker likely to become eligible within 30 months?
No
Yes

- 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 preapproval from CMS of the amount of the settlement that will be allocated to future medical expenses.
- Create a *Medicare 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.
- Assist in purchasing an annuity to fund the trust.

In July 2001, CMS issued a memo to its regional offices. (A copy is available on our web site at http://www.lir.msu.edu/wcc/Medicare/Medicare.htm.) 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. It discusses preapproval in two categories of cases:

- Cases in which the workers' compensation claimant is currently entitled to Medicare benefits.
- Cases in which there is a "reasonable expectation" of a Medicare entitlement within 30 months of the settlement date, and in which the settlement is over $250,000.

Many people have interpreted this memo as a demand or a requirement by CMS that parties obtain preapproval of all workers' compensation settlements that fall into either of these categories. Implicit in this interpretation is a threat that the parties to a workers' compensation settlement who do not comply with this requirement will somehow be punished.

A careful reading of the memo, however, allows another interpretation. The language seems to suggest that CMS *is willing to* review workers' compensation settlements that fall into these categories but no other workers' compensation settlements. In other words, CMS is not demanding a requirement of preapproval but offering the helpful service of preapproval for claims that fall into these categories. As will be discussed subsequently, there is nothing in the statute or regulations that gives CMS authority to demand preapproval, much less a provision that allows CMS to somehow punish parties if they do not obtain preapproval. There are circumstances, however, in which it is to the advantage of the parties to obtain preapproval from CMS.

In response to the memo and other publicity, many participants in the workers' compensation system have contacted the regional offices of CMS in an attempt to obtain preapproval of workers' compensation settlements. The reports of the results are varied. Some parties report that they can obtain approval from the regional office within a few weeks. Others report that when they call, there is no one available to assist them. Others report that they submit cases for approval and never hear back or only hear back after many months. Some have found vendors who can expeditiously assist them in dealing with CMS. Others are able to do this on their own without assistance from vendors. Recently, the situation seems to have improved. As this is being written in early 2003, most people tell me that they hear back from CMS in a few months.

Several individuals and organizations have approached CMS in Washington asking it to clarify its position on several issues. In April of 2003 CMS released a set of frequently asked questions. (There is a link to them on our website.) They are helpful in some areas but only to a limited extent. Nonetheless, some people are now looking for help from Congress to clarify this issue. See section 5.

The participants of the workers' compensation system are at something of a loss concerning how to deal with this. If they settle a case for $250,000, it is reasonable to devote the time and resources necessary to obtain preapproval and create some form of set-aside agreement. However, the vast majority of workers' compensation claims are settled for much smaller amounts. It is questionable whether it is practical to set up such agreements in these cases. It would also create a serious burden on the workers' compensation system in most states if these settlements had to be delayed for a significant time, waiting for preapproval from CMS.

When we settle workers' compensation cases, it is clear we can no longer tell the worker, "Don't worry. Medicare will pay your bills." If this happens, it is now very realistic to expect that this worker will be denied health care coverage by Medicare in the future. Some claimants' attorneys are concerned that if they do not adequately protect the interest of Medicare, CMS may attempt to hold them personally responsible. If an attorney is a party to a situation like this, he or she may be liable for such benefits as a result of legal malpractice. On the other hand, if the attorney properly advises the client of all the risks and proceeds appropriately according to state workers' compensation law, it is questionable whether that attorney would have any obligation to Medicare. See question 4.33.

From the point of view of an employer or insurer, the worst-case scenario is the following situation: It will enter into a settlement of a workers' compensation claim, which under state law seems to completely relieve it of all future liability for workers' compensation benefits. At some time in the future, perhaps years later, the worker will go to the hospital and give someone his or her Medicare card, Medicare will pay for the procedure, and CMS will then seek reimbursement from the employer. Some parties suggest that this is a realistic

possibility. CMS has never clearly claimed its right to do this and it is very questionable whether there is any legal basis for it to do so. See section 3.3.1.

A couple of notes are in order here. When we talk about a *settlement* or *lump-sum settlement*, we are talking about a situation in which, under state workers' compensation law, the employer is completely relieved of all liability for future medical expenses.

Finally, all of this is about preventing cost shifting from workers' compensation to Medicare. There is also cost shifting from Medicare to workers' compensation. The reimbursement rates at which Medicare pays doctors and hospitals are quite low. Some would argue that they are sometimes below the costs of these providers. The providers make up for this by charging higher fees to non-Medicare patients including those covered by workers' compensation.

3 Apparent Liabilities, Overreaching by CMS and Exaggerated Threats

One of the reasons we are all having problems with this issue is that the discussions are being driven by threats and demands rather than by a careful analysis of the rights and powers given to Medicare under the law. The situation is made worse because much of the available information is coming from providers who stand to profit by helping us deal with these problems and who will profit more if the problems appear to be worse than they are.

This section will attempt to deal with this situation by focusing on the statute and the officially published regulations. In some cases, the regulations seem to claim for Medicare more authority than it has under the statute. (For a further discussion of this see the paper "Medicare, Medicare, and More Medicare" by Vernon Sumwalt, Mark T. Sumwalt and Richard B. Harper. a copy of which is posted on our web site.) If, however, we accept the general validity of the regulations, the situation can be divided into three areas:

- Areas in which the parties to a workers' compensation claim appear to have a potential liability.
- Areas in which CMS appears to be overreaching, that is, asserting more power and control than is given to it by its own regulations.
- Areas in which vendors (and the workers' compensation rumor mill) are telling us that the threats are worse than they really appear to be.

3.1 Apparent Liabilities

The Medicare as a Secondary Payer Act imposes obligations on the parties to a workers' compensation claim. While CMS may be overreaching in some areas and the threats may be exaggerated in others, we cannot ignore the liabilities that are there.

3.1.1 Admitted Liability Under Workers' Compensation

When a workers' compensation carrier admits it is responsible for the health care involved, there is no question that it should pay and Medicare should not, 42 USC 1395y(b)(2)(A). This applies to a variety of situations.

- If it is an open ongoing claim, workers' compensation should pay.
- If the parties are approaching a settlement and there are medical bills from a prior time and it is not disputed that they should have been covered under workers' compensation, the carrier should pay them or at least the parties should reach an agreement with CMS concerning the situation.
- If there is no dispute that the carrier is responsible for future medical expenses but the parties are settling a case anyway, they probably should obtain preapproval of the allocation to future medical expenses from CMS. See 42 CFR 411.46(a) discussed in section 6.3.90.

3.1.2 Don't Try To Cheat

In discussing this with attorneys, I sometimes get the impression that they feel it appropriate to manipulate the situation to the disadvantage of Medicare. Of course it is an attorney's duty to advocate for his or her client, but there are appropriate limits to this advocacy. 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." (See section 6.3.10.) This is potentially a regulation in which CMS is asserting more power than the statute gives it. If, however, this is interpreted to apply to situations in which the parties *inappropriately* attempt to shift responsibility to Medicare, it is probably a valid provision and should serve as a caution against people who would go too far.

We hear talk of situations in which a carrier has set medical reserves at $500,000 but tells CMS that only $200,000 of a settlement is for future medical expenses. This may be asking for trouble. If the parties deal fairly and honestly with CMS and obtain an agreement to the amount of future medical expenses, they are probably all right. On the other hand, if they settle without approval and the settlement "appears to represent an attempt to shift to Medicare the responsibility for payment of medical expenses," CMS may be able to use this regulation to overrule an allocation made by a state agency. Also, if the parties obtain approval from CMS without fully disclosing all the facts, this section may come into play or, worse yet, they may be accused of fraud.

3.1.3 The Worker's Requirement To Document Future Medical Expenses

If a worker who settles a workers' compensation case ever expects Medicare to pay for medical care related to the disability involved, he or she will have to document the expen-

diture of the amount of money allocated to future medical expenses. At a variety of points this paper questions the right of CMS to demand preapproval of an allocation and the need to set up a formal trust or any trust at all, but there can be no doubt that a worker will have to find some way to document the expenditure of the funds before Medicare will begin paying.

3.1.4 Report And Cooperate

42 CFR 411.25 requires that a third party (such as a workers' compensation carrier) who learns that Medicare has made a payment that it should not have made must notify Medicare.

42 CFR 411.23 provides that the beneficiary (for our purposes, the 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.

3.1.5 Double Damages

If CMS is required to resort to litigation to recover payments that should have been paid by workers' compensation, it is entitled to double damages, 42 USC 1395y(b)(2)(B)(ii) and 42 CFR 411.24(c)(2). This is of course a severe penalty and should cause us to be cautious. However, it does not enlarge the rights of CMS in any way.

3.1.6 A Worker's Right To Enforce A Medicare Lien

If a carrier does not honor its liabilities, the worker may be able to file an action seeking reimbursement for Medicare and a double recovery. See 6.2.7.

3.2 Overreaching By CMS

There are several areas in which CMS appears to be making claims that are not supported by or are contrary to the statute and published regulations.

3.2.1 "Consider The Interests" of Medicare

CMS bases many of its assertions on the obligation of parties to "consider the interests" of Medicare in settling a workers' compensation case. First of all this is a very ambiguous term. If we think for a while about whether we have to take care of Medicare, haven't we "considered their interests"? Moreover, the statute and regulations do not make this requirement.

3.2.2 Requirement Of Preapproval Of A Settlement

There is nothing in the statute or regulations that gives CMS the authority to require preapproval of an allocation, that allows CMS to punish parties that do not obtain preapproval, or that gives any official status to a preapproval granted by CMS. CMS finally seems to have admitted this in its answer to Question 1 of the April 2003 Frequently Asked Questions, but in other answers in that document and elsewhere CMS seems to give the impression that there is such a requirement.

Note that while there is not such a requirement in the statute and regulations, there are many situations in which obtaining such an agreement may be a good idea.

3.2.3 Meaning Of Approval Or Disapproval Of A Settlement

In answer to Question 14 of the April 2003 FAQs CMS asserts that there is no appeal from its decision to approve or not approve a settlement allocation. This is probably true. It is true because this is not an official action of a government agency. This of course has implications beyond the right to appeal.

Is an approval binding on CMS? It is not a formal action of the agency. It may be a binding agreement (a contract) but it will probably be difficult to enforce.

Is a refusal to approve an allocation or an assertion that a different allocation is appropriate binding? Since neither the statute nor the regulations give CMS the authority to do this, it would not seem to be binding. It is certainly an indication that CMS is likely to contest the allocation if the worker seeks payment for medical expenses from Medicare in the future. At that point, however, CMS would have to make a formal refusal to pay benefits. This determination would then be subject to appeal and review. Of course there are many circumstances in which it would be better to work things out in advance rather that settle a case with the possibility of future litigation. CMS should not, however, be giving the impression that this is a final binding determination by the agency.

3.2.4 Commutations and Compromise Settlements

The regulations give CMS much more power to deny future coverage in what it terms a "commutation" than in a "compromise settlement." CMS seems to be taking the position that if any part of a settlement is for future medical expenses, it is a commutation. That is not what the regulations say. 42 CFR 411.46(a) provides:

> Lump-sum commutation of future benefits. 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 would seem to apply to situations in which a carrier acknowledges liability for future medical expenses, but the parties nevertheless agree to a lump-sum payment. It does not describe the situation in which a carrier disputes its liability, and the worker agrees to accept an amount that is less than the total ex-

pected future medical expenses. The latter situation would be a compromise settlement. [See also section 6.3.9.]

3.2.5 CMS Is Bound By Workers' Compensation Allocations

By expecting parties to come to it for preapproval of allocations in settlements, CMS is at least implying that it is not bound by allocations to future medical expenses made by state workers' compensation agencies. The regulations, however, seem to state that Medicare is bound by such determinations of both past and future medical expenses in disputed cases.

42 CFR 411.46(d) provides:

> Lump-sum compromise settlement: Effect on payment for services furnished after the date of settlement—
>
> (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 agreement 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.
>
> [See also section 6.3.11.]

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. [See also section 6.3.12.]

The situations discussed in sections 3.1.1 and 3.2.4, in which the carrier admits liability and is intending to reimburse the claimant for *all* future medical expenses, and those discussed in section 3.1.2, in which the parties are attempting to shift responsibility to Medicare, are apparently exceptions. Otherwise the above regulations would seem to say that CMS is bound by the allocations of a state agency.

The position of CMS on this is confusing. The April 2003 FAQs include the following:

5) When a state WC judge approves a WC settlement, will Medicare accept the terms of that settlement?

Answer: 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.

However, a distinction must be made where a court or other adjudicator is only approving a settlement that incorporates the parties' settlement agreements. Medicare cannot accept the terms of the settlement as to an allocation of funds of any type if the settlement does not adequately address Medicare's interests. If Medicare's interests are not reasonably considered, Medicare will refuse to pay for services related to the WC injury (and otherwise reimbursable by Medicare) until such expenses have exhausted the amount of the entire WC settlement. Medicare will also assert a recovery claim, if appropriate. [Emphasis in original.]

CMS rightly makes a distinction between situations in which a workers' compensation judge makes a determination of an allocation and those in which the judge simply rubber stamps an agreement between parties. Setting aside the "rubber stamp" situation CMS seems to be saying here that it "will generally honor judicial decisions." As indicated above this is appropriate because regulations appear to require it. It seems, however, to be in conflict with the other positions taken by CMS. If the agency will honor a determination by a judge, why should the parties seek preapproval from CMS?

Whatever the position of CMS, the regulations seem to require it to accept the allocation of state workers' compensation agencies.

3.2.6 Only Expenses Covered Under Medicare

There are certain medical expenses that are covered under workers' compensation but not under Medicare. It appears to be the position of CMS that a set-aside arrangement should only pay for expenses that would be covered under Medicare. This does not seem logical. If a case is settled for $90,000 and $30,000 is for future medical expenses, when the $30,000 is gone then, in the terms of the statute, payment can no longer "reasonably be expected to be made ... under a workers' compensation program." If the money was used for medical expenses for the work-related condition, it should not matter whether the services would have been covered under Medicare.

It would seem to be more beneficial to both the worker and Medicare if the set-aside limited payments to the amounts that would have been payable under the state workers' compensation fee schedule. See question 4.23.

3.3 Exaggerated Threats

There are many rumors about all of this circulating in the workers' compensation community. To some extent they may be encouraged by providers who can profit by helping carriers and their attorneys deal with the problems that have been created. Some of the worries seem to go well beyond even the most strongly stated claims of CMS.

In some of these circumstances CMS is aggravating the situation by not clearly stating its position on the record. In these situations, vendors tell the parties about exaggerated threats that go beyond anything CMS has asserted. However, instead of disclaiming these extreme positions, CMS allows them to go uncorrected and takes advantage of the fear it creates in order to obtain compliance with its wishes. I will discuss a few of these situations here.

3.3.1 Reopening Of Settlements For Future Medical Expenses

The worst-case scenario for a carrier would be for CMS to try to reopen a settled case and expect the carrier to pay for medical expenses for treatment that occurred after the settlement. While many people seem to be concerned about this possibility, no one has pointed to any situation in which CMS has asserted a claim that it could do this. There have been cases in which CMS sought reimbursement for expenses that were incurred *before* the settlement, but I am not aware of any situation in which CMS has even claimed that it could require a carrier to reopen a settlement and pay for expenses that occurred *after* the settlement. CMS, however, has not disavowed assertions that it may do this.

3.3.2 Required Preapproval

It is widely suggested that certain workers' compensation settlements must be preapproved by CMS. As discussed in section 3.2.2, CMS seems now to admit that it does not have authority to demand such preapproval or to punish parties who do not obtain it. There appear to be many circumstances in which obtaining preapproval seems like a good idea, but that is quite different from having situations in which it is required.

3.3.3 You Do Not Need A Trust

CMS has never said that a formal trust is required, and it is not clear that it takes the position that even a set-aside agreement is necessary. After a settlement Medicare will not pay until the amount allocated to future medical is exhausted, and the worker must somehow document those expenditures. In many circumstances some form of set-aside may be the best way to do that, but this is a very different situation from a legal requirement that such an arrangement be created.

3.3.4 State Agency Allocations

It is widely believed that CMS will not be bound by state agency allocations for future medical expenses unless it preapproves the settlement. As indicated in section 3.2.5, the regulations seem to say that under many circumstances CMS is indeed bound by these allocations. The position of CMS on this issue is not clear.

3.4 Now And In The Future

For the moment it seems clear that all parties involved in workers' compensation cases must be cautious of the situations described in the Apparent Liabilities section above. They might, however, consider challenging CMS in the areas in which it appears to be overreaching, and they should be skeptical of exaggerated threats.

In the long run it may be necessary for the workers' compensation community to seek a remedy from Congress. See section 5.

4 Frequently Asked Questions

This section will attempt to give practical answers to some frequently asked questions and to perhaps raise some questions that are not asked frequently but should be.

4.1 If a worker is eligible for both workers' compensation and Medicare, is it all right to let Medicare pay for some bills that might be covered under workers' compensation?

Absolutely not. You are asking for trouble if you do this.

4.2 If, accidentally or inadvertently, some bills have been paid for by Medicare that should have been covered under workers' compensation, is it all right if the parties to the workers' compensation case "just let this go"?

No, you are asking for trouble if you do this. See 6.3.5.

4.3 If I am settling a workers' compensation case, and there are some bills from the past that have been paid for by Medicare, but should have been covered under workers' compensation, do I need to resolve these issues before I settle the workers' compensation case?

Yes. If there is any potential past lien, you should resolve it before you settle the case.

4.4 Is the answer to question 4.3 different if there is a dispute about whether or not the services were related to a compensable injury?

If there is a dispute as to whether the bill should be covered under Medicare, then it would seem that section 42 CFR 411.47 applies, and the proceeds of the settlement should be allocated as it describes. See 6.3.12. Practically speaking, however, it may be most appropriate in these circumstances to obtain an agreement from Medicare before the settlement is concluded.

4.5 Is there any way I can find out if there are any potential liens from Medicare?

I posed this question to CMS and received the following answer (Ashkenaz 2003):

> Any question (that an attorney may have) about potential liens should be directed to CMS's Coordination of Benefits (COB) Contractor promptly upon entering into an agreement to represent a Medicare beneficiary for an accident or injury that may involve health care claims. The COB Contractor can be reached Monday through Friday, 8am-8pm Eastern Time (except holidays); the toll-free number is 1-800-999-1118.
>
> The COB Contractor will send the attorney a "Medicare right of recovery" letter and a "release of information" form for beneficiary signature. The COB Contractor will advise the attorney as to the lead Medicare recovery contractor and create a Medicare Secondary Payer record in the CMS database used in the claims adjudication process to prevent mistaken Medicare primary payment for affected claims.
>
> The COB Contractor will notify the lead recovery contractor (usually the Part A Fiscal Intermediary in the beneficiary's state of residence) of the attorney's representation. The lead recovery contractor will attempt to identify Medicare's claim (i.e., claims paid by Medicare which were as a result of the incident or injury). The lead Medicare recovery contractor identifies these claims by communicating with all other local contractors that may have paid claims on the beneficiary's behalf. The timeframe to obtain this information varies depending on the accessibility of the claims data. If there is a delay in the notification of a potential recovery case, the claims data may not be readily available within the contractor's processing systems. There is not one single database utilized to obtain the claims data. In the event a beneficiary had claims paid by four different contractors (i.e., hospital services, doctor visits, DME or home health care), the time to ascertain and obtain the information is dependent on the affected contractors' processing systems and claims data availability.
>
> CMS standards require contractors to respond to all correspondence (including the requests you mentioned) within 45 days from receipt.

4.6 If there is a settlement of a workers' compensation case, and it allocates certain sums to future medical expenses, is CMS bound by that allocation?

The regulations seem to say the answer is yes; CMS is bound by the allocations. See 3.2.5. CMS, however, does not seem to accept this interpretation. As a result, there are circumstances in which it would seem wise to obtain preapproval from CMS before a case is settled.

4.7 Under what circumstances is anyone required to obtain preapproval from CMS before settling a workers' compensation case?

The statute and regulations do not include any provision requiring preapproval of the settlement of workers' compensation cases. See 3.2.2. Nevertheless, there may be many circumstances in which it is beneficial to obtain preapproval.

4.8 Are there any cases in which the parties do not need to worry about this at all?

Yes. This only concerns cases in which the worker is entitled to, or is likely to become entitled to, Medicare benefits. If the worker is under the age of 65 years, and the disability is clearly not severe enough to result in entitlement to SSDI benefits, you can forget about all of this.

4.9 When do we need to worry about getting CMS involved in the settlement of workers' compensation cases?

If there are any bills for *past* medical services that were paid by Medicare you may wish to consider involving CMS. See questions 4.3 and 4.4 above. The following questions will attempt to deal with *settlements* in which there are no past medical expenses paid by Medicare.

4.10 In which cases does CMS seek to preapprove settlements?

CMS seeks to preapprove workers' compensation settlements in two categories of cases:

(1) cases in which the worker is currently entitled to Medicare and

4.20 Under what circumstances will Medicare cover health care expenses for a work-related injury after the settlement of a workers' compensation claim?

If a workers' compensation claim is settled, a specific amount is allocated for future medical expenses, and Medicare accepts that amount as an appropriate allocation. Medicare will begin paying after the allocated funds have been exhausted.

4.21 How do you decide how much should be set aside for future medical expenditures?

This is a matter of some debate. In a small simple case a report from a treating physician may be enough. In a more complicated case with a large settlement you probably will want to have vendor create a "life care plan."

4.22 Are there any particular problems involved in calculating when the expenditures equal the amount set aside?

Yes. There are a great many complications involved here. Workers' compensation covers almost all medical expenses, while Medicare is more limited (for example, it does not cover prescription drugs). Furthermore, each state has a set of regulations concerning the amount it pays for various medical services under workers' compensation. Medicare has its own such set of regulations. A detailed exploration of these issues is beyond the scope of this section. It is discussed, to some extent, in Patel (2001).

4.23 If a worker settles a workers' compensation case, and allocates certain amounts to future medical expenses, are health care providers still required to abide by state workers' compensation regulations concerning payment levels?

This, too, is a very difficult question. Once the case is settled, the state workers' compensation agency is out of the picture, and thus there would not seem to be any entity that can enforce the payment restrictions. One possible approach to this situation is to create a trust, and provide in the terms of that trust, that the funds are only available to pay health care expenses that would have been payable under the state workers' compensation law. It is not clear how formal the trust must be in order to enforce these provisions.

4.24 If I set aside an amount for future medical expenses, am I required to create a trust?

There is no requirement in the statute or regulations for the creation of a trust. CMS does not take the position that a trust is required. It does appear, however, that some CMS offices are using forms that appear to require that at least a separate banking account be set up. It is not clear whether this is simply a form letter it has been using, or whether it believes this is a requirement. See question 4.27.

Even if it is not a requirement, there may be circumstances under which it is desirable to set up a trust.

4.25 When is it desirable to set up a trust?

The short answer to this would seem to be that a trust is desirable in big cases where the amount of money justifies the time and expenses involved in setting up a trust. The purpose of the trust is to be able to document to CMS when the money set aside has been fully expended. If the case is simple enough, or the individuals involved are sophisticated enough to keep accurate records, then a trust would not seem to be necessary.

4.26 How formal does the trust have to be?

The most important requirement of any trust is that there be an accurate accounting of how money was spent on medical bills for the work-related problem. This accounting is crucial regardless of the form of the trust. As indicated above, it can be argued that no formal trust is required so long as the accounting is there.

When there is a trust, the degree of formality will depend on the circumstances and the amount involved. If the settlement contemplates the payment of medical bills amounting to $1 million during the remaining lifetime of an injured worker, it would probably be appropriate to create a formal legal trust and appoint a corporate trustee. There may be other circumstances, however, in which it is sufficient to put the money in a separate bank account and pay the medical bills out of that without actually creating a legal trust.

See also question 4.23 concerning fee limitations under state workers' compensation laws.

4.27 Is there a form that can be used for an informal trust?

There is a form that is recommended by at least one CMS office. While this might be acceptable to CMS, it may not be best for the parties. For example it does not limit payment to the workers' compensation fee schedule. See 4.23. A copy of the form is available on our website.

4.28 Can you use an annuity to fund a trust?

Yes and this is often the best way to do it. You may need the assistance of a vendor to do this.

4.29 Is it necessary to use an outside vendor to deal with these situations?

No, but some people have found it to be helpful. Section 2 lists some of the services that vendors provide.

4.30 What are the risks to a worker if he or she enters into a workers' compensation settlement without arranging for reimbursement for past medical care that was paid for by Medicare?

The risks under these circumstances are very great. It is quite possible that Medicare will attempt to recoup the prior expenditure by refusing to pay for future health care services, both those related to the compensable disability and those related to other future health care needs.

4.31 What are the risks to a worker if he or she fails to set aside funds for future medical care in a way that is satisfactory to CMS?

The primary risk is that Medicare will refuse to pay for medical expenses related to the disability involved. As discussed above, it would appear that if there is an allocation in the settlement, Medicare is bound by it, even though CMS did not preapprove the settlement. CMS, however, does not seem to accept this position. If CMS is correct, then it is likely to refuse to pay for benefits until the expenditure on health care exceeds the total of the workers' compensation settlement.

If the settlement appears to represent an attempt to shift to Medicare the responsibility for medical expenses, which should have been covered under workers' compensation, it would seem that section 42 CFR 411.46(b)(2) will apply, and Medicare may not pay for treatment of the work-related condition at any point in the future.

4.32 Wouldn't it be extremely harsh for Medicare to deny future health care under some of these circumstances?

It certainly would. Both the statute and regulations allow Medicare to waive these provisions under appropriate circumstances. See 6.2.4. However, it would be very foolish for anyone to ignore these issues assuming that Medicare will grant a waiver.

4.33 What are the risks for an attorney if CMS believes he or she has not handled these situations appropriately?

First of all, there is a risk of legal malpractice. If an attorney has not properly advised his or her client, the attorney may be subject to a malpractice action.

In situations in which Medicare has paid for *past* services that should have been covered under workers' compensation, and an attorney for either side has not dealt with this situation, Medicare may attempt to hold the attorney responsible for reimbursement of the medical expenses involved. It is not entirely clear that it has statutory authority to do this, but there are cases in which it has tried.

It is much less clear whether CMS will take any action when an attorney has failed to take appropriate steps to deal with *future* medical expenses. Under these circumstances, Medicare can simply refuse to pay for the future medical expenses. It would seem that the attorney may have failed in his or her duty to the client, but CMS does not seem to be the appropriate agency to enforce that duty.

4.34 What are the risks for a carrier (an employer or insurance company) if it lets Medicare pay bills that could be covered under workers' compensation?

This would be a bad idea. It is very likely that CMS will seek recovery. If it has to litigate to get the recovery, it is entitled to double damages. See 6.2.3 and 6.3.3. It is also possible that the worker could file an action forcing the carrier to reimburse Medicare under 42 USC 1395y (b)(3)(A) and (b)(2)(B). See 6.2.7 and 6.5.

4.35 What are the risks for a carrier if there are prior bills that were paid by Medicare and it settles a case without having resolved these to the satisfaction of CMS?

It can be argued that this is the responsibility of the worker and not the carrier, and that once the workers' compensation case is settled, the carrier is relieved of responsibility under state law. It can also be argued that even if there is some responsibility, then the payment for past due medical expenses should be accomplished out of the settlement in accordance with section 42 CFR 411.47. See 6.3.12. This section would seem to indicate that it is the responsibility of the worker, not the carrier, to pay the money out of the settlement. However, there is some risk that CMS will assert a right to recovery of these amounts from the carrier. Whether it can succeed legally is still an outstanding question. It is also possible that the worker could take some action as indicated in the previous question.

4.36 What are the risks for a carrier that enters into a settlement of future responsibility in a manner that CMS deems is inappropriate?

There are individuals who suggest that if a worker seeks treatment for the work-related disability in the future and it is paid by Medicare, then at that point CMS may seek reimbursement from the carrier. I am not aware of any case in which CMS has attempted to do this. I am not aware of any claim by CMS that it has the right to do this; and as indicated above, there does not appear to be statutory authority for CMS to do it. Of course, that does not guarantee that CMS will not try to do it in the future.

4.37 Can CMS make a carrier pay more than it would have been required to pay under the state workers' compensation laws?

This may sound like a restatement of the previous question, but it is an important way to look at the matter. These provisions were put in place by Congress to protect against unfairly shifting costs to Medicare. It is not logical to suggest that they were intended to broaden anyone's coverage under workers' compensation. Accordingly, this outcome would seem unlikely.

The exception to this may be the provisions that Medicare is entitled to a double recovery if it must file a lawsuit in order to obtain reimburse-

ment. The double recovery would appear to be a penalty under the Social Security Act rather than an expansion of rights under state workers' compensation law.

4.38 Are there any special concerns for health care providers?

So far, CMS has concentrated its efforts primarily on employers and insurers. However, health care providers such as doctors and hospitals may be in the most vulnerable position. Subsection 42 USC 1395y(2)(b)(ii) of the statute would seem to give CMS the power to hold a provider responsible if it has submitted a bill under Medicare that should have been submitted under workers' compensation. Providers are more vulnerable because they must continue to deal with Medicare. If Medicare pays a bill that it should not have paid, it can try to collect from the injured worker, but it is unlikely that the injured worker will have sufficient assets to pay the bill. A doctor or hospital, however, is continually dealing with Medicare, and subsection 42 CFR 411.24(l) of the regulations would appear to give CMS the power to recover these amounts by withholding future payments from providers for other services.

4.39 Is there a statute of limitations that limits the amount of time CMS may seek reimbursement for past medical bills it has paid?

This is not entirely clear. It would appear that 42 USC 1395y42 USC 1395y(b)(2)(B)(v) provides a three-year statute of limitations, beginning on the date when the item or service was furnished. See section 6.2.5, but others have suggested that different statutes may apply. See Sumwalt, Sumwalt and Harper (2003) and Glancy (2002).

4.40 Does it help if I give notice to CMS, even if I do not wait for approval?

There is nothing in the statute, regulations, or statements so far from CMS that says a party is protected by simply giving notice. Nevertheless, there seem to be some practitioners who take this approach. In smaller cases, they write to CMS seeking approval and describing the proposed workers' compensation settlement, but they do not delay the settlement to wait for approval. There are both legal and practical reasons why giving notice should have an effect.

In general, courts hold that a party that is put on notice must take some action to protect its interest. As indicated above, there appear to be a number of areas in which CMS has a relatively weak legal position. If, in addition to these, it has ignored notice and an opportunity to participate in the proceedings, that position will be even weaker.

There are also practical reasons why notice should be considered important. There has been some speculation that what CMS "really wants" is a database of everyone who is entitled to workers' compensation. This would, in fact, seem like a very logical approach. All of the matters discussed here become much more complicated if Medicare first pays and then must attempt to seek reimbursement. If there were some way for CMS to check whether a patient was eligible for workers' compensation before payment was made, the whole system might run more effectively and many of these problems might be avoided. Recently, some state workers' compensation agencies have entered into agreements with the Social Security Administration to share information about individuals who are receiving both workers' compensation and Social Security Disability Insurance. An approach such as this might be a much more effective way for CMS to reduce Medicare costs.

4.41 Does all of this have an affect on the cash benefits a worker receives in Social Security Disability Insurance?

Yes. In most states SSDI is reduced based on the receipt of workers' compensation benefits. When there is a settlement of a workers' compensation case, the settlement amount is prorated over future months and SSDI benefits continue to be reduced until the settlement is exhausted. In the past, attorneys attempted to allocate as much as possible of a settlement towards future medical expenses. This reduced, or shortened, the offset to cash benefits. With the new concern about Medicare, the temptation is to minimize the amount allocated to future medical expenses. Doing this, however, may increase the offset to cash benefits.

It would seem that all parties should be consistent here. If the worker agrees to a certain allocation for the purpose of the SSDI offset, then he or she should expect the same allocation to be applied when considering the Medicare allocation. Similarly if the Federal Government agrees to a certain allocation for SSDI it should apply the same allocation when considering Medicare benefits.

5 How Will All of This Get Resolved?

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.

There are, in fact, similar procedures in place for resolving issues concerning Medicare. 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.

There are some practical considerations that come into play. In smaller cases, the parties seem willing to take risks. In larger cases, they are much more cautious. Claims managers sometimes acknowledge that they might have legal grounds to challenge CMS but say, "I don't want to be the

> Action by United States. In order to recover payment under this title [42 USCS §§ 1395 et seq.] for such an item or service, the United States may bring an action against any entity which is required or responsible (directly, as a third-party administrator, or otherwise) to make payment with respect to such item or service (or any portion thereof) under a primary plan (and may, in accordance with paragraph (3)(A) collect double damages against that entity), or against any other entity (including any physician or provider) that has received payment from that entity with respect to the item or service, and may join or intervene in any action related to the events that gave rise to the need for the item or service.

This is the only section that can possibly be interpreted to allow CMS to bring an action in federal court to pay benefits. However, it clearly relates to benefits that are payable "under a primary plan." In the case of workers' compensation, the primary plan would be the state workers' compensation law. The determination of what benefits are covered under state law should be left to the state workers' compensation agency. If an employer or insurer settles its obligation under the state plan, does this section allow it to be reopened? Was this provision, in federal law, intended to expand liability under state workers' compensation plans? That seems doubtful.

6.2.7

42 USC 1395y (b)(3)(A) and (b)(2)(B) provide that an individual, such as an injured worker, may bring an action when an insurer allows Medicare to pay bills it should have paid, and to recover the double damages provided for in 42 USC 1395y(b)(2)(B)(ii). This would seem to apply when a worker was denied workers' compensation benefits, and had to resort to Medicare to pay his or her bills while awaiting a determination of the workers' compensation case. If the worker later won the workers' compensation case, and received a determination that the insurer should have paid, the worker might then file a federal action against the insurer seeking the double damages. This argument was made in *Manning v. Utilities Mutual Insurance Co., Inc.*, 254 F.3d 387 (2001) which is discussed in section 6.5.

6.3 Code of Federal Regulations

6.3.1

42 CFR 411.23 provides that the beneficiary (for our purposes, the workers' compensation claimant) must cooperate with the government in any attempt to recover overpayments and that a beneficiary who does not may be held responsible for the benefits.

> (a) If CMS takes action to recover conditional payments, the beneficiary must cooperate in the action.
>
> (b) If CMS's recovery action is unsuccessful because the beneficiary does not cooperate, CMS may recover from the beneficiary.

6.3.2

42 CFR 411.24(c)(1) seems to provide that Medicare will recover the lesser of the amount that Medicare would pay or the amount paid by workers' compensation. It states:

> (1) If it is not necessary for CMS to take legal action to recover, CMS recovers the lesser of the following:
>
> (i) The amount of the Medicare primary payment.
>
> (ii) The full primary payment amount that the primary payer is obligated to pay under this part without regard to any payment, other than a full primary payment that the primary payer has paid or will make, or, in the case of a third party payment recipient, the amount of the third party payment.

6.3.3

42 CFR 411.24(c)(2) restates the statutory provision that CMS is entitled to a double recovery if it must use litigation.

6.3.4

42 CFR 411.24(f) provides:

> (f) Claims filing requirements.
>
> (1) CMS may recover without regard to any claims filing requirements that the insurance program or plan imposes on the beneficiary or other claimant such as a time limit for filing a claim or a time limit for notifying the plan or program about the need for or receipt of services.
>
> (2) However, CMS will not recover its payment for particular services in the face of a claims filing requirement unless it has filed a claim for recovery by the end of the year following the year in which the Medicare intermediary or carrier that paid the claim has notice that the third party is primary to Medicare for those particular services. (A notice received during the last three months of a year is considered received during the following year.)

This provision would seem to say that CMS is not bound by claim filing limitations found in other health plans. It would be possible to interpret it to mean that if a claimant loses a workers' compensation case because he or she did not file a claim in a timely manner and receives health care through Medicare, CMS may recover from the workers' compensation carrier. However, subsection (2) appears to limit subsection (1) and provides that CMS will not assert a right to ignore time limits except under the circumstances provided in subsection (2). Note that the time frames laid out here are extremely complicated.

It might be argued that subsection (2) could be read as extending

the limitation period for recovery by Medicare found in 42 USC 1395y(b)(2)(B)(v) of the statute (discussed above in 6.2.5). This seems unlikely, however. It is more likely that subsection (2) applies only to subsection (1) that precedes it. Furthermore, the principles of statutory construction would ordinarily not allow the regulation to overrule the statute.

6.3.5

Section 42 CFR 411.25 requires that any third party who learns that Medicare has made a payment, which it should not have made, must notify Medicare.

6.3.6

Section 42 CFR 411.26 provides for subrogation and the right to intervene. Clearly, under this provision, Medicare would have a right to file an action with a workers' compensation agency to recover from an employer or an insurer. At the same time, the principle of subrogation implies that Medicare only has the same rights that the worker would have under the state workers' compensation law.

6.3.7

Section 42 CFR 411.43 provides that a beneficiary (for our purposes, a workers' compensation claimant) must take appropriate steps to recover payment for medical benefits through workers' compensation.

6.3.8

Section 42 CFR 411.45 provides that Medicare may make conditional payments if the workers' compensation carrier will not pay promptly.

6.3.9

Section 42 CFR 411.46 deals with lump-sum payments and attempts to distinguish between a "commutation" and a "compromise settlement." The July 2001 memorandum attempts to expand further on this distinction. The memorandum is, however, quite confusing and does not draw a clear line between these two categories. The regulations, in fact, seem clearer than the memorandum, which tries to explain them. In any conflict, the formal regulations should control over memorandums.

42 CFR 411.46(a) provides:

> Lump-sum commutation of future benefits. 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.

This is an important but confusing provision. It is important because it is the source of much of the authority CMS asserts over settlements. It is confusing because its application has been interpreted in several different ways, and also because it seems to overreach the statutory authority behind it.

CMS seems to interpret this as if it applies to all settlements intended to compensate the worker for any future medical expenses. Others have suggested that it applies when the settlement is intended to relieve the carrier of all future liability for medical expenses. It seems to me that the language is quite clear; it applies if the settlement "is intended to compensate the individual for *all future* medical expenses" (Emphasis added). This would be a situation in which the employer does not contest its obligation to pay benefits to the worker, but has reached an agreement to relieve itself of future liability by making a single lump-sum payment.

The language of the regulation suggests that under these circumstances, Medicare is not responsible to pay medical expenses until after the amount of such expenses equals the total amount of the lump-sum payment, including the amount set aside for medical benefits *and the amount for indemnity benefits*. It is not at all clear that the statute gives CMS the authority to offset the amount of a settlement that is for indemnity benefits. When cases are submitted to CMS for preapproval, it will acknowledge its responsibility to pay after the amount set aside for future medical expenses is exhausted. It seems, however, to be reserving the right to demand that the entire settlement be exhausted if the parties do not submit a claim for preapproval. Its authority to do this is questionable.

Note that this section deals with situations in which a "compensation award *stipulates* that the amount paid is intended to compensate the individual for all future medical expenses" (emphasis added). If this is the intention of the parties, but it is not stipulated in the award, does this section apply? One could certainly argue that it does not, and that in those circumstances Medicare must immediately assume responsibility for medical benefits. This may, however, be an overly technical point.

6.3.10

42 CFR 411.46(b)(2) provides:

> 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. For example, if the parties to a settlement attempt to maximize the amount of disability benefits paid under workers' compensation by releasing the workers' compensation carrier from liability for medical expenses for a particular condition even though the facts show that the condition is work-related, Medicare will not pay for treatment of that condition.

Clearly, one is ill-advised to attempt to cheat Medicare or even to enter into arrangements in which it might appear that one is trying to

cheat Medicare. There is a difficulty in this for attorneys. It is their duty to attempt to maximize the recovery of their clients. Presumably, this provision should be read to mean an *illegal* or *inappropriate* attempt to maximize the amount of benefits. In this area, however, parties must proceed with great caution. Clearly, they need to be able to justify and document the positions they take. See also section 3.1.2.

Note that the language here says, "[T]he settlement will not be recognized." What does that mean? Taken literally, it might mean that the case is not settled and that the employer or insurance company is still liable. This would seem a strange and unusual expansion of state workers' compensation laws by the federal government. The example in the last sentence of the subsection suggests a more reasonable explanation. It suggests that CMS will not recognize the settlement from the point of view that "Medicare will not pay for treatment of that condition" at any time in the future.

6.3.11

42 CFR 411.46(d) provides:

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

The regulations do not define a "lump-sum compromise settlement." The structure of the regulations, however, would seem to indicate that this is the alternative to a "lump-sum commutation of future benefits" discussed in subsection 42 CFR 411.46 (a). See (0.) That subsection describes the situation in which "the amount paid is intended to compensate the individual for all future medical expenses." This section would then appear to apply to cases in which there is a dispute about the continuing need for medical care and/or a dispute as to whether or not the continuing need for medical care is still related to the compensable injury. This, of course, includes the vast majority of all lump-sum settlements of workers' compensation cases.

Taken together, subsections (1) and (2) would appear to say that if the settlement "forecloses the possibility of future payment of workers' compensation benefits" and "the settlement agreement allocates certain amounts for specific future medical services," then Medicare does not pay for services until medical expenses related to the injury equal the amount allocated to future medical expenses. This would also clearly imply that after that, Medicare would pay for those expenses.

Taken literally, this section would also seem to say that if the agreement forecloses the possibility of future workers' compensation benefits, and does not allocate amounts for future medical services, then Medicare will pay for all future medical expenses. Clearly, CMS does not accept this interpretation of the regulation. It is, however, its regulation, and it would seem to be bound by it.

Note also that subsection (2) speaks of the amount that the "agreement allocates" for future medical services. This would certainly suggest that CMS is bound by its own regulations to accept the allocation set forth in the lump-sum settlement. This says nothing about prior approval by CMS and would appear to take away from CMS any right to dispute the allocation in the workers' compensation settlement. (As discussed above, exceptions would of course occur when there was "an attempt to shift to Medicare the responsibility for payment" (6.3.10) and claims in which the settlement was "intended to compensate the individual for all future medical expenses" (6.3.9).)

6.3.12

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 settle-

ment to be considered as payment for medical expenses.

It is not entirely clear whether this section is intended to apply only to services furnished before the settlement, or to both those services and future services. Section 42 CFR 411.46 (c) provides: "Medicare pays for medical expenses incurred before the lump-sum compromise settlement only to the extent specified in Sec. 411.47." This would seem to suggest that section 42 CFR 411.47 refers to the expenses incurred before a settlement.

In either case, it is difficult to see authority for CMS's position that it is not bound by fair allocations in a workers' compensation settlement. For services furnished before the date of the settlement, the language is clear that the formula in this section applies. For services furnished after the settlement, either this language applies or 42 CFR 411.46(d) applies (6.3.11). If 42 CFR 411.46(d) applies, then as discussed above, CMS is bound by the allocation found in the settlement. If there is no allocation, then that section suggests that Medicare is not entitled to any offset at all.

6.3.13

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 the 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.

6.4 What Is Not In The Statute?

The above discussion focuses on statements that are contained in the statute and formally adopted regulations. It is perhaps just as important to note that there are several things that are not mentioned in either the statute or these regulations. They include the following:

- There is nothing in the statute or regulations that gives CMS the authority to require preapproval of workers' compensation settlements. (That is not to say that it is not a good idea to take advantage of their willingness to do this in certain circumstances.)
- There is nothing in the statute or regulations that gives CMS the authority to somehow punish parties who do not obtain preapproval of a settlement.

6.5 Cases

We will discuss a few of the cases that deal with these issues. Some other cases are discussed in the papers posted on our website.

Thompson v Goetzmann, 315 F3d 457 (5th Cir 2002), involved not workers' compensation but a product liability claim. The parties settled, and plaintiff received payment without having reimbursed Medicare for medical expenses it had paid in the past. In this action, the secretary of Health and Human Services sought reimbursement from defendant manufacturer, plaintiff, and plaintiff's attorney. The Court of Appeals for the Fifth Circuit affirmed a dismissal by the district court. In this case, the claim for Medicare was based on 42 USC 1395y(b)(2)(A), which allows recovery from a "liability insurance policy or plan (including a self-insurance plan)." The court of appeals held that the payment by the manufacturer did not amount to a self-insurance plan and dismissed the case.

While this does not provide much guidance for workers' compensation, it does illustrate the tenacity with which CMS is pursuing these matters. It may also indicate the skepticism with which the courts will view the situation. At one point, the court of appeals observed, "Notably, the government's prior efforts have proved uniformly feckless—every court that has heard its argument on this issue, including the district court in the instant case, has rejected the government's expansive interpretation of the ... statute." 315 F3d at 459.

In *Brown v Thompson*, 2003 U.S. Dist. Lexis 4307, the district court reached a result different from that in *Goetzmann.* In *Brown* the court found that the self-insured health care provider did have a "primary plan" as defined in the regulation.

Manning v. Utilities Mutual Insurance Co., Inc., 254 F.3d 387 (2001) is the only case so far to reach the courts of appeals that involves workers' compensation. The workers' compensation carrier refused to pay medical benefits after the proceeds of a third party case had been exhausted. The worker attempted to recover from the carrier under 42 USC 1395y (b)(3)(A) and (b)(2)(B), which is discussed above. This case is not very instructive, however, because the court only dealt with an issue concerning the statute of limitation.

Note that none of these cases deal with a question of future liability after a claim has been settled.

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- An extensive list of international, national, and state or provincial conferences and meetings pertaining to workers' compensation and other programs in the workers' disability system.
- News updates of current events in workers' compensation.
- Posting of Job Opportunities and Resumes for those seeking candidates or employment in workers' compensation or related fields.
- The full text of the *Report of the National Commission on State Workmen's Compensation Laws.* The report was submitted to the President and the Congress in 1972 and has long been out of print.

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Workers' Compensation Benefits and Costs in 2001

by John F. Burton, Jr.

The National Academy of Social Insurance (NASI) released the 2001 data on the national costs of workers' compensation to employers and on the benefits paid to workers in July 2003 (Williams, Reno, and Burton 2003). The NASI report is the most comprehensive source of data on national benefits and costs, as well as data on benefit payments by individual states. This article focuses on the national data included in the latest NASI report.

The 2001 Developments in Perspective

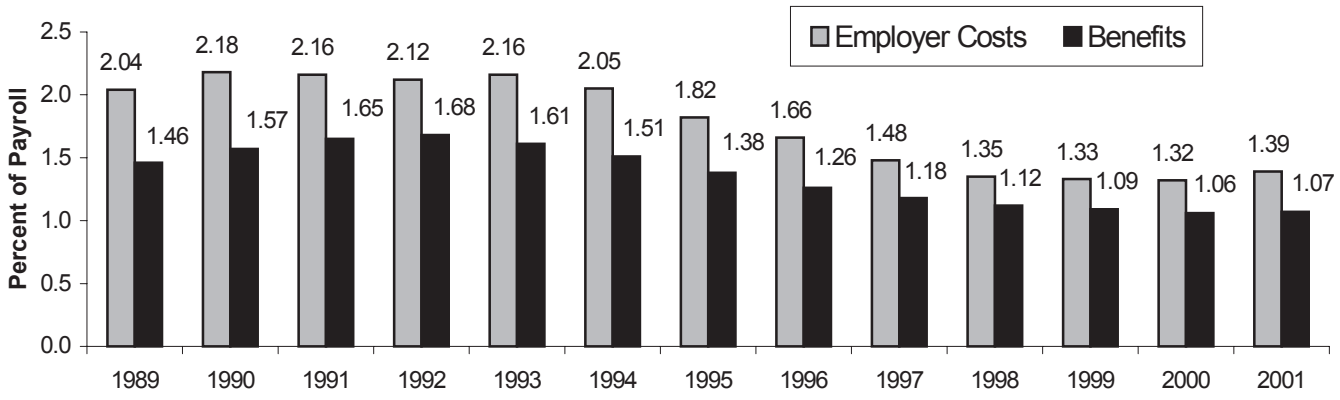
Benefits Paid to Workers. The benefits paid to workers in selected years between 1960 and 2001 are shown in Table 1. Benefits in current dollars in 2001 were $49,354 million (or $49.354 billion), which is the fifth year that benefits in current dollars have increased. Benefits in current dollars increased every year from 1980 to 1992, when the total payments reached $45.668 billion. Then benefits dropped for several years, before bottoming out at $41.837 billion in 1996. Benefits paid to workers then began to increase, and reached a record amount in 2001.

A somewhat different story emerges when benefits are measured in constant dollars (adjusted for changes in the consumer price index since 1982-84), also shown in Table 1. Benefits in constant dollars increased modestly from $27.691 billion in 2000 to $27.868 billion in 2001. However, the 2001 figure is well below the peak figure of $32.550 billion of benefits in constant dollars that were paid to workers in 1992.

Still another way to assess developments in benefits paid to workers is to compare the benefits to the wages paid to workers covered by the workers' compensation program. This comparison not only reflects (at least roughly) changes in the general level of prices and average wages, but also the changes in the total wage payments resulting from increases (or decreases) in employment. The increases in the dollars of benefits paid to workers did not keep up with the increases in wages between 1992 and 2000. As shown in Table 1 and Figure A, workers' compensation benefits as a percentage of wages peaked at 1.68 percent in 1992 and then declined every year until 2000, when benefits were equal to 1.06 percent of wages. This eight-year decline in benefits paid relative to wages is the longest stretch of dropping benefits at least since 1946 (when annual data for the program are first available) and brought benefit payments relative to wages to a level not seen since the 1970s. Benefits paid to workers as a percent of payroll then increased modestly to 1.07 of payroll in 2001, reflecting in part the decline in total wages resulting from the slowdown of the economy.

Costs to Employers. The employers' costs of workers' compensation for selected years between 1960 and 2001 are shown in Table 2. Costs in current dollars were $63,931 mil-

Figure A - National Workers' Compensation Benefits and Costs Per $100 of Covered Wages, 1989-2001



Source: Williams, Reno, and Burton (2003), Figure 1.

lion (or $63.931 billion) in 2001, which is the third consecutive year that benefits in current dollars have increased. The previous peak of employers' costs in current dollars occurred in 1993, when the costs were $60.819 billion.

An alternative measure of employers' costs, namely expenditures measured in constant dollars (adjusted for changes in the consumer price index since 1982-84) increased from $34.381 billion in 2000 to $36.099 billion in 2001, as shown in Table 2. The real costs of the program to employers thus increased for the third consecutive year. However, the costs in 2001 in constant dollars were lower than the costs in every year from 1988 to 1995.

A third measure of the costs of workers' compensation relates employers' expenditures on the program to the wages received by the workers covered by the program. There was an extraordinarily pronounced decline in this measure of employers' costs during the 1990s, as shown in Figure A and Table 2. Employer costs peaked at 2.18 percent of payroll in 1990, and then declined almost every year during the decade before reaching a low of 1.32 percent of payroll in 2000. This multi-year decline in the employers' costs of workers' compensation as a percent of payroll was unprecedented in magnitude and duration since at least 1946. In 2001, workers' compensation costs as a percent of payroll increased to 1.39 percent of payroll. This is the highest percent of payroll devoted to workers' compensation since 1997, but this figure is below the proportion of payroll devoted to workers' compensation by employers between 1980 (or earlier) and 1997.

Table 1
Workers' Compensation Benefits

Year	Benefits in Current Dollars (Millions)	Consumer Price Index (1982-84=100)	Benefits in 1982-84 Dollars (Millions)	Benefits as Percent of Covered Payroll
1960	1,295	29.6	4,375	0.59
1970	3,031	38.8	7,812	0.66
1980	13,618	82.4	16,527	1.07
1981	15,054	90.9	16,561	1.08
1982	16,407	96.5	17,002	1.16
1983	17,575	99.6	17,646	1.17
1984	19,685	103.9	18,946	1.21
1985	22,217	107.6	20,648	1.30
1986	24,613	109.6	22,457	1.37
1987	27,317	113.6	24,047	1.43
1988	30,703	118.3	25,954	1.49
1989	34,316	124.0	27,674	1.46
1990	38,238	130.7	29,256	1.57
1991	42,169	136.2	30,961	1.65
1992	45,668	140.3	32,550	1.68
1993	45,330	144.5	31,370	1.61
1994	44,586	148.2	30,085	1.51
1995	43,373	152.4	28,460	1.38
1996	41,837	156.9	26,665	1.26
1997	42,313	160.5	26,363	1.18
1998	43,355	163.0	26,598	1.12
1999	45,197	166.6	27,129	1.09
2000	47,684	172.2	27,691	1.06
2001	49,354	177.1	27,868	1.07

Sources:

Benefits in Current Dollars (column 1): 1960-86 data from Nelson (1992), Table 2; 1987-2001 data from Williams, Reno, and Burton (2003), Table 4.

Consumer Price Index (1982-84=100) (column 2): 1960-1999 data from *Economic Report of the President* (2001), Table B-60; 2000-01 data from Table 34, *Monthly Labor Review*, Vol. 126, No. 4 (April 2003).

Benefits in 1982-84 Dollars (column 3) = (column 1) / (column 2).

Benefits as Percent of Covered Payroll (column 4): 1960-88 data from Nelson (1992), Table 6; 1989-2001 data from Williams, Reno, and Burton (2003), Table 12.

Sources of Workers' Compensation Insurance

Workers' compensation insurance is provided by three sources, and the relative importance of those sources has varied in recent years as shown in Table 3 and Figure B. Private carriers are permitted to sell workers' compensation in all but five states that have exclusive state funds – Ohio, North Dakota, Washington, West Virginia and Wyoming. The share of all benefit payments accounted for by private carriers dropped from 58.1 percent in 1990 and 1991 to 48.7 percent in 1996, but has since rebounded to 55.8 percent in 2000 and 54.8 percent in 2001.

Table 2
Workers' Compensation Costs

Year	Costs in Current Dollars (Millions)	Consumer Price Index (1982-84=100)	Costs in 1982-84 Dollars (Millions)	Costs as Percent of Covered Payroll
1960	2,055	29.6	6,943	0.93
1970	4,898	38.8	12,624	1.11
1980	22,256	82.4	27,010	1.96
1981	23,014	90.9	25,318	1.85
1982	22,765	96.5	23,591	1.75
1983	23,048	99.6	23,141	1.67
1984	25,122	103.9	24,179	1.66
1985	29,185	107.6	27,124	1.82
1986	33,964	109.6	30,989	1.99
1987	38,095	113.6	33,534	2.07
1988	43,284	118.3	36,588	2.16
1989	47,955	124.0	38,673	2.04
1990	53,123	130.7	40,645	2.18
1991	55,216	136.2	40,540	2.16
1992	57,395	140.3	40,909	2.12
1993	60,819	144.5	42,089	2.16
1994	60,517	148.2	40,835	2.05
1995	57,089	152.4	37,460	1.82
1996	55,293	156.9	35,241	1.66
1997	53,053	160.5	33,055	1.48
1998	52,635	163.0	32,291	1.35
1999	55,173	166.6	33,117	1.33
2000	59,204	172.2	34,381	1.32
2001	63,931	177.1	36,099	1.39

Sources:

Costs in Current Dollars (column 1): 1960-86 data from Nelson (1992), Table 7; 1987-2001 data from Williams, Reno, and Burton (2003), Table 11.

Consumer Price Index (1982-84=100) (column 2): 1960-1999 data from *Economic Report of the President* (2001), Table B-60; 2000-01 data from Table 34, *Monthly Labor Review*, Vol. 126, No. 4 (April 2003).

Costs in 1982-84 Dollars (column 3) = (column 1) / (column 2).

Costs as Percent of Covered Payroll (column 4): 1960-88 data from Nelson (1992), Table 7; 1989-2001 data from Williams, Reno, and Burton (2003), Table 12.

In addition to the five states with exclusive state funds, there are 21 other states that operate state insurance funds that compete with private carriers. The combination of exclusive and competitive state funds accounted for 15.4 percent of all benefit payments in 1990, then increased to a peak of 18.2 percent in 1995 and 1996 before declining to 15.6 percent in 2000 and 16.1 percent in 2001. In addition to funds operated by the states, the federal government also pays benefits to civilian employees and certain other workers. The federal share of benefit payments has slowly declined from 7.6 percent in 1990 to 6.2 percent in 2001.

The third source of benefits is self-insuring employers, an option that is available to qualifying employers in all states but North Dakota and Wyoming. Self-insuring employers increased their share of benefit payments from 19.0 percent in 1990 to 25.9 percent in 1995. Since then, the relative importance of self-insurance has declined in most years, although there was a slight rebound in 2001 that increased the share to 22.9 of all benefit payments.

An Overview of Costs and Benefits Since 1985

Terry Thomason, Tim Schmidle, and I wrote a book (Thomason, Schmidle, and Burton 2001) that provides an overview of workers' compensation costs and benefits since 1960, and divides 1960 to 1998 into five subperiods. An updated version of a portion of the book is Burton (2001). I summarize here the analysis of the two most recent subperiods, since they are interrelated.

The Seeds for Neo-Reform Are Sown: 1985-91. Workers' compensation medical benefit payments increased at 14.6 percent per year between 1985 and 1991, more rapidly than both the annual increases of 11.0 percent in cash benefits and the generally high rate of medical cost inflation elsewhere in the economy. A partial explanation for the high rate of medical cost increases in workers' compensation was the relatively limited use of managed care (such as HMOs and PPOs) in workers' compensation.

The rapid increase in benefit payments was the major contributor to the increasing costs of workers' compensation to employers, which rose from 1.66 percent of payroll in 1984 to 2.18 percent in 1990 (Table 2).

Table 3
Sources of Workers' Compensation Insurance

Year	Private Carriers	State Funds	Federal	Self-Insured Employers	Total
1990	58.1	15.4	7.6	19.0	100.0
1991	58.1	15.9	7.1	18.8	100.0
1992	55.4	16.4	6.9	21.3	100.0
1993	53.2	16.3	7.0	23.4	100.0
1994	50.0	17.0	7.1	25.9	100.0
1995	48.8	18.2	7.2	25.9	100.0
1996	48.7	18.2	7.3	25.8	100.0
1997	51.2	17.2	6.6	25.1	100.0
1998	53.2	16.7	6.6	23.5	100.0
1999	54.5	16.1	6.3	23.1	100.0
2000	55.8	15.6	6.2	22.4	100.0
2001	54.8	16.1	6.2	22.9	100.0

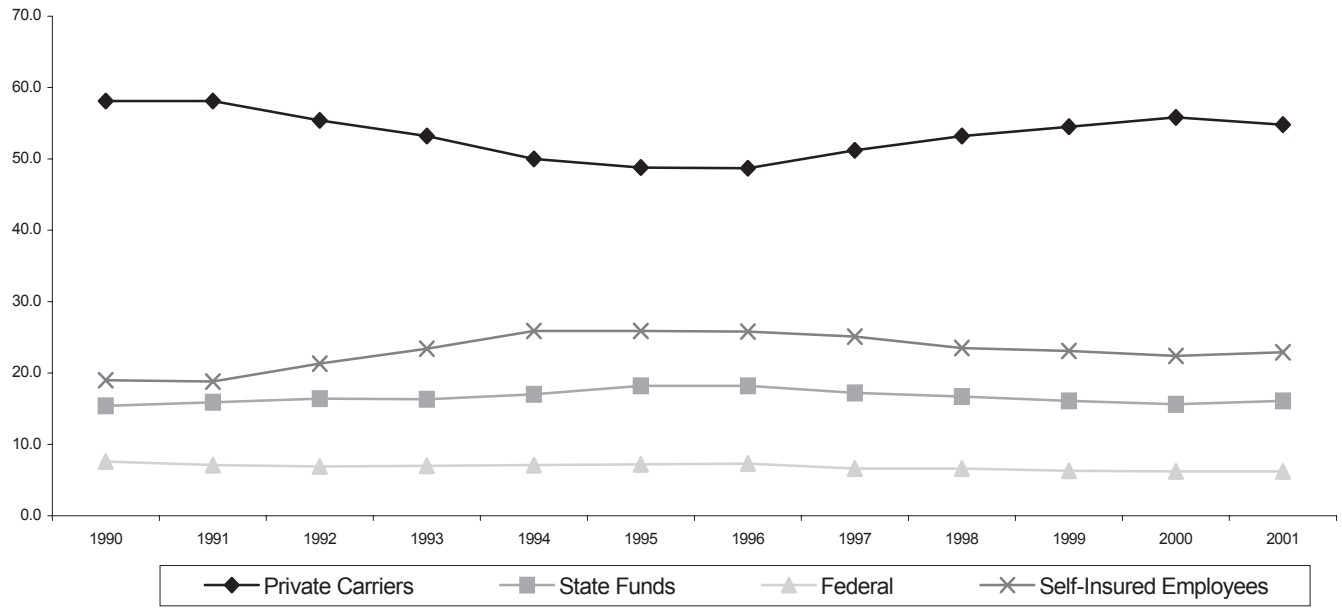
Source: Williams, Reno, and Burton (2003), Table 5.

As this period progressed, the workers' compensation insurance industry declared itself in a crisis mode. Several factors contributed to the industry's problems. Benefit payments increased rapidly, but in many states, insurance carriers were unable to gain approval from regulators for rate filings with significant premium increases that the industry felt were justified. As a result, the industry lost money in every year between 1984 and 1991, even considering investment income.

The Neo-Reform Era: 1992-2000. As previously discussed, the multi-year decline in benefits relative to payroll since 1992 is unprecedented in duration and magnitude since at least 1946. Also, the employers' costs of workers' compensation declined sharply between 1990 and 2000. As benefits and costs declined in the 1990s, insurer profitability quickly improved. The period from 1994 to 1997 was the most profitable period in at least twenty years for workers' compensation insurance.

The developments since 1992 can best be understood as a reaction to the escalating costs in the period from 1985 to 1991, which galvanized political opposition from employers and insurers to compensation programs that had been liberalized in the 1970s and 1980s.

Figure B - Sources of Workers' Compensation Insurance



Source: Table 3.

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