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Protecting the Disabled Individual Through the Use of a Medicare Set-Aside Trust

In America it is preferable to become disabled as the result of the fault of another rather than to become disabled on the job, because the plaintiff in a tort settlement receives more benefits, including Medicare benefits, than the plaintiff in a workers' compensation case. But if a Medicare set-aside trust is properly set up and used, a disabled worker can be guaranteed that his or her Medicare benefits will be available, even after that person receives a workers' compensation settlement. The theory behind this type of trust is set forth below as well as the means for properly using it.

**By Susan G. Haines and
John J. Campbell**

When an individual is disabled on the job, he or she has two kinds of damages: financial and physical. The difference between an individual disabled on the job and an individual disabled through the fault of another is that the latter has a chance to start over. Most states provide that the disabled worker will receive up to two-thirds of his or her average weekly wage, as well as work-related medical expenses. In a tort settlement, plaintiffs often recover a lump sum intended to compensate them not only for lost income and medical bills but also for lost self-esteem, lost limb, and even lost marital relations. None of this is true for the individual who is disabled on the job.

The individual disabled on the job relies on the government's disability insurance—Social Security Disability Income (SSDI). In 32 states, receipt of workers' compensation benefits profoundly affects SSDI. Receipt of workers' compensation disability benefits in those states will directly reduce the SSDI payment on a dollar-for-dollar basis, to the extent that the claimant will receive no more than 80 percent of his or her gross income.¹ Although injured workers will also have all of their work-related medical expenses paid by the workers' compensa-

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tion carrier, their income will still be below the standard of living they enjoyed before the injury.

The vast majority of workers' compensation (WC) cases throughout the country are riddled with disputes about what constitutes "work-related" medical expenses. The carrier and the claimant are often in disagreement about whether the presenting medical symptoms are the result of the original accident, or a new illness, or some new stress in the claimant's life. Open an old workers' compensation file and you will find years of squabbling, bitter feelings, and even litigation. In this sense, every WC case is contested.

Even if the carrier and the claimant agree on the definition of work-related medical expenses and the carrier pays all medical bills, the claimant still lacks the necessary funds with which to restart his or her life.

In a tort settlement, the plaintiff may recover funds with which to purchase a handicapped-equipped van, renovate a home, enroll in special schooling or rehabilitation programs, or provide for outside-care management services. In a WC case, the claimant who receives even 100 percent medical coverage will still not have funds available to accomplish what a plaintiff can with substantial funds from a tort settlement.

The disabled plaintiff in a tort settlement does not lose his or her eligibility for coverage under group health insurance policy by virtue of having received the settlement for damages. The plaintiff can recover a lump-sum settlement and still qualify for health insurance benefits. The individual disabled at work does not recover a lump sum and is not awarded monies for loss of consortium or mental anguish, although his or her anguish may be just as great as that of the plaintiff in a tort case. Further, his or her group health insurance policy will have a clause excluding coverage for any work-related medical expenses. In America, it is preferable to become disabled as the result of the fault of another rather than to become disabled on the job.

In 1997, Congress provided for qualified assignments of structured settlements in WC cases. As a result, the structured-settlement industry began to target WC cases as possible candidates for structured settlements. In the last few years, there has been a dramatic rise in the number of WC cases settled with annuity products as opposed to lump sums.

Carriers compromise WC cases by cashing out the workers' entitlement to future medical benefits and lost wages. The compromise is paid as a lump sum and is less than the worker would have received had he or she not settled out the case but rather lived into old age continuing to receive benefits, both medical and wage replacement (indemnity) from the WC carrier. Disabled workers are motivated to settle out their benefits because they are anxious for money with which to restart their life.

The carrier wants to get the claimant "off the books" and the claimant wants to start life over. Both sides are anxious to separate. In the cynical, litigious atmosphere that has developed between the claimant and the carrier, both are motivated to settle.

Unlike the liability plaintiff, the WC claimant cannot get health insurance benefits once the case settles. That leaves Medicare as the only potential source of health insurance for the disabled worker. Within 24 months of receiving SSDI benefits, the claimant will be eligible for Medicare. However, Medicare is always secondary to WC and will not recognize or condone any attempt to shift the carrier's responsibility to pay for the injured workers' medical care.

It makes sense that the disabled worker wants a cash settlement for injuries and also wants, as does the plaintiff in a tort settlement, to preserve eligibility for public benefits. In the case of the disabled worker, the most important of those public benefits will be Medicare and not Medicaid. Federal law already provides a means to preserve Medicaid benefits when the plaintiff recovers a tort settlement.²

The focus of this article will be on the preservation of different kinds of public benefits in the context of a different settlement—the workers' compensation settlement. The public benefits at issue here are an entitlement program—Medicare. Ironically, however, just like the corollary welfare benefits under the Medicaid program, those Medicare benefits are not available following the settlement of a WC case, but they are available following the settlement of a tort case. Just as a trust is necessary to preserve Medicaid benefits in a tort case (e.g., a disability trust under Title 42 of the United States Code, Section 1396p(d)(4)(A)), a trust is necessary to preserve Medicare benefits in a

WC settlement. This trust is known as a Medicare set-aside trust and was first proposed by our office in 1995. The Health Care Financing Administration (HCFA) has adopted this trust as a means of reasonably considering Medicare's interests and of preserving the claimant's entitlement to Medicare benefits after the receipt of a WC settlement. The purpose of this article is to set forth the theory behind the Medicare set-aside trust and help the reader understand the context in which it should be used. Provided that the Medicare set-aside trust is properly used, disabled workers can be guaranteed that their Medicare benefits will be available to them, even after they receive a WC settlement.

Understanding Definitions

Medicare is distinguishable from Medicaid. Unlike Medicare, Medicaid eligibility criteria and funding are provided partly by the states. Therefore, the rules on Medicaid liens and Medicaid eligibility vary from state to state. This variance is not true for Medicare, which is governed solely by federal law. Eligibility for Medicaid is based on an applicant's assets and income as they measure against federal poverty guidelines. Therefore, a personal injury recovery could disqualify a Medicaid recipient from Medicaid benefits. On the other hand, eligibility for Medicare is unrelated to financial need. A personal injury recovery will not affect the Medicare beneficiary's continued eligibility for Medicare benefits.

However, Medicare will have a claim against the personal injury recovery for its post-injury payment for services that reasonably could have been expected to be paid by WC insurance.³ A recovery deriving solely from a WC settlement will affect Medicare benefits.

The most valuable sources for understanding how the government monitors WC settlements and overpayments are the *Medicare Fiscal Intermediary Manual, Part 3 (MIM)* and the *Medicare Carrier's Manual, Part 3, (MCM)*. These manuals are promulgated by the HCFA, the federal agency that administers the Medicare program. They are written to guide the Part A fiscal intermediaries and the Part B carriers on how to recognize and reject claims for Medicare-covered services when WC benefits are involved. "Fiscal intermediaries" are insurance companies that contract with Medicare to administer Part A Medicare benefits in a particular region. "Carriers" are providers (e.g., doctors,

clinics, or labs) that have contracted through an insurance company to provide Part B Medicare benefits for a particular region.

Medicare Part A primarily covers hospitalization and pays partially for semiprivate room and board, general nursing, and miscellaneous services and supplies while a beneficiary is hospitalized. Medicare Part A also pays for home health care and hospice care for beneficiaries who qualify.

Medicare Part B pays partially for physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, and similar items, in or out of the hospital.

After employees are disabled on the job, they may apply for SSDI benefits. Within five months of applying, and assuming that they are totally disabled (so as to be unable to engage in any substantial, gainful employment), disabled workers qualify for SSDI. Once disabled workers have been receiving SSDI benefits for 24 months, they qualify for Medicare. However, provided that their medical expenses were covered under their WC policies, none of their medical bills are likely to have ever been paid by Medicare prior to settlement of the WC claim. That is, the WC carrier will always be primary and Medicare will always be secondary. (Medicare is not likely to make any secondary payments until all WC benefits are paid and the claimant has exhausted all remedies.⁴) Since Medicare is secondary, the government will not pay claims for medical bills for work-related injuries or illnesses unless the WC carrier contests liability and there is a long delay anticipated in coverage for the disabled workers. When this happens, Medicare may make secondary payments, subject to its right to recover those payments later on.⁵

When workers are totally and permanently disabled, Medicare will seldom make a primary payment. This is because under the laws of all 50 states, the WC carrier is responsible for lifetime medical expenses for a disabled worker. Thus, even if the WC case settles and the worker releases the carrier from liability for medical bills in exchange for a cash settlement, Medicare will remain secondary because the WC carrier had primary medical responsibility for the life of the disabled worker.

Settling the WC Case

A lump-sum settlement, whether that sum is a structure or up-front in cash, is deemed to be a WC

payment for Medicare purposes, regardless of the language in the settlement.⁶ The *MIM*, at Sections 3407.1 D and E, defines both a settlement that is a commutation and a settlement that is a compromise. The difference is meaningful.

A commutation is a “settlement in which the beneficiary accepts a lump sum payment as compensation for all future medical expenses and disability benefits related to the work injury or disease.”⁷

A compromise is a “settlement which provides less in total compensation than the individual would have received if the claim had not been compromised.”⁸

Medicare will not pay for any *future* medical expenses *after* a lump-sum settlement is received until the total future medical expenses related to an employee’s injury equal the amount of the lump-sum settlement that was allocated to future medical expenses.⁹ If the settlement agreement does not make a reasonable allocation of a portion of the lump sum to future medical expenses, Medicare can make the allocation itself according to a formula set out in the regulations.¹⁰ The formula is carefully explained in the *MIM*, Section 3416.2, appropriately entitled “Apportionment of a Lump-Sum Compromise Settlement of Contested Worker’s Compensation Claim.” That section states:

If the settlement covers both medical care and disability benefits but does not apportion the sum granted between them and income replacement, or does not give reasonable recognition to both medical care and disability, calculate the amount of the award deemed to be payment of medical and hospital expenses as follows:

- Determine the ratio which the amount awarded (less the reasonable and necessary costs incurred in procuring the settlement) bears to the total amount which would have been payable under WC for both medical and hospital expenses (including expenses not covered under Medicare) *and* income replacement, if the claim had not been settled by compromise.
- Multiply this ratio by the total medical and hospital expenses incurred as a result of the injury or disease *up to the date of the settlement*. The product is deemed to be the amount of WC settlement intended as payment for medical and hospital expenses. Apply the latter amount to the medical and hospital expenses incurred due to the work-related injury.¹¹

While this formula is useful, it is *only* useful in those cases in which the liability of the carrier was contested, and Medicare made significant secondary payments that have not yet been reimbursed. The formula is used to determine which portion of the award is for future medical expenses and which portion of the award is for past, unreimbursed medical expenses.

Nevertheless, in either a commutation or a compromise, the release must allocate an amount roughly equal to the amount of the lump-sum settlement allocated to future medical expenses.¹² Not all future medical expenses allocated in the agreement need be set aside to cover skilled care. Only those medical expenses that Medicare would normally cover are required to be set aside. Thus, monies for custodial care, prescriptions, nursing home care, and other items not covered by Medicare need not be allocated, as well as those medical expenses not related to the work-related injury. This is because Medicare’s concern is that the carriers not shift liability to Medicare. If, for example, the claimant’s care is primarily custodial (Medicare does not pay for custodial care), there can be no argument that the carrier attempted to shift liability to Medicare.

The *MIM* provides, at Section 3407.7, that “if the beneficiary agrees to a compromise lump sum settlement, . . . which provides less . . . than the individual would have received if the claim had not been compromised . . . the settlement may be accepted. . . . If the individual signed a final release of all rights under WC, medical expenses incurred after the date of the final release are reimbursable under Medicare. . . .”¹³ However, regardless of the agreement between the disabled claimant and the carrier, Medicare regulations preclude an attempt to shift liability for the claimant’s future medical care and treatment to Medicare.¹⁴

From these regulations, it appears that Medicare has several objectives:

1. Medicare wants to make sure that its interests are considered and protected and there is no attempt to shift liability from the carrier to Medicare;
2. Medicare will require a compromise agreement and settlement;
3. The agreement and settlement must make a fair allocation between income replacement, future medical expenses, and attorney’s fees and costs; and

4. Of that portion related to future medical expenses, Medicare must know what portion is set aside to cover medical expenses that would normally be paid by Medicare.

Assuming that the carrier and the claimant have complied with all of the above conditions, the *MIM* requires yet one more step before a claimant can be assured that Medicare will be primary and available following the compromise and settlement of his or her WC claim. The last paragraph of Section 3407.7 of the *MIM* provides that “[W]here the settlement specifies that a portion of the settlement is for future medical expenses, Medicare may not pay for expenses until the beneficiary has submitted bills related to the injury or illness totaling the amount of the lump sum settlement allocated to medical treatment.”¹⁵ How does a disabled individual account to Medicare for that portion of the settlement allocated to consideration of Medicare’s interest—that is, how does he or she show Medicare that the amount allocated has been spent on the appropriate medical bills? The best way to accomplish all these objectives is through the use of a Medicare set-aside trust.¹⁶

A Medicare set-aside trust is funded with a lump sum specifically designated in the release and settlement as being for those medical bills that Medicare would otherwise be required to pay. The claimant may “submit bills related to the injury or illness” to the trustee. Each year, the trustee provides an accounting to Medicare. When the monies in the Medicare set-aside trust are exhausted, then pursuant to the *MIM*, the claimant is eligible for Medicare benefits for all covered medical expenses, whether work-related or not.

Theoretically, the monies in the Medicare set-aside trust could be spent down in one year or 10 years. What matters is that Medicare approved the amount allocated toward future medical expenses (medical expenses that Medicare *would* pay) *before* the case is settled. In this way, the claimant is assured that the monies set aside in the Medicare set-aside trust will be sufficient to satisfy Medicare that its interests have been reasonably considered.

It is not a good idea to fund a Medicare set-aside trust with a structured settlement. The monies in the trust must be readily available to the beneficiary and they must be such that they can be expended, concluded, and depleted. When the monies are gone, the claimant is eligible for

Medicare coverage of his or her work-related medical expenses. If the trust is funded with a structure, the amount of the structure payment may be insufficient, in any one year, to cover unanticipated skilled medical expenses. Further, the payout period on the structure may be arbitrary or unrealistic. It is far better to fund the Medicare set-aside trust with a lump sum calculated to cover the claimant’s skilled medical expenses for a future period of time and to structure the balance of the settlement.

Reopening the WC Settlement

Carriers are often skeptical that Medicare must be involved in a compromise settlement *before* the settlement is final. Generally speaking, the practice throughout the United States is to settle WC claims, having the claimant sign a settlement agreement in which the claimant acknowledges that his or her right to future Social Security and Medicare benefits is not guaranteed and the carrier is released from all claims. This is a mistake—both for the carrier and the claimant.

Section 2370.6 of the *MCM* provides that

[a] decision by a state WC agency on a . . . compromise settlement which has been approved by the agency should be accepted as a basis for applying the WC exclusion, except where the settlement did not make reasonable provision for payment under WC of all work-related medical expenses. Thus, where an individual has been denied WC benefits for a particular illness or injury, allow claims for treatment of that condition, unless the settlement is clearly inconsistent with the medical facts . . . and has the effect of shifting to the Medicare program, liability for medical expenses which are the responsibility of the state WC program. Where it is clear that an attempt was made to shift responsibility to the Medicare program, deny the Medicare claim. Explain your conclusions in detail in the denial notice and state that the beneficiary may wish to request a reopening under the WC law.¹⁷

Claimants whose cases represent attempts to shift responsibility to the Medicare program will find that the settlement is insufficient to cover their future skilled medical expenses. They will also find that they are unable to secure group health insurance coverage. The claimant’s only secure source of catastrophic health insurance coverage is Medicare. When Medicare denies coverage for

work-related medical expenses, claimants will be without adequate health insurance coverage and will be required to use their own resources to for their medical expenses.

If it is later represented to the WC board that the claimant believed or the board was led to believe that the claimant would retain his or her Social Security and Medicare benefits, but did not, the claimant will be persuaded to reopen his or her WC case. If Medicare has then sent the claimant a letter encouraging the claimant to reopen his or her WC case because the settlement represented an unlawful attempt to shift responsibility to Medicare for medical expenses that were the responsibility of the state WC program, the WC board may also be persuaded to reopen the claimant's case.

Provided that the release allocates the settlement monies appropriately, as discussed above, and provided that the settlement agreement establishes a Medicare set-aside trust with monies earmarked for work-related skilled medical expenses, and provided that the compromise agreement has been approved by a WC agency, HCFA will approve the settlement. Section 3407.6 of the *MIM* admonishes the intermediaries that they should accept a decision by a state WC agency: "In general, accept a decision by a state WC agency on a contested claim, or a compromise settlement that has been approved by a WC agency, as a basis for applying the WC limitation, except where the settlement did not make reasonable provision for payment under WC of all work-related medical expenses."¹⁸

The regulations envision that carriers are likely to negotiate a settlement, whether that settlement is a commutation or a compromise.¹⁹ Therefore, the amount allocated to the Medicare set-aside trust may reflect that negotiation. That is, the monies allocated to the Medicare set-aside trust need not equal the claimant's calculated medical expenses for life. Otherwise, why should the parties settle at all? Further, the claimant may die within a year or less of the settlement. The amount allocated to the Medicare set-aside trust reflects a compromise on the part of the carrier and the claimant, but must be sufficient to demonstrate that Medicare's interests have been reasonably considered and must be reflective of the overall settlement and the particular facts and circumstances of the case.

Medicare's Secondary Payer Claim

The disabled worker will usually become eligible for Medicare and SSDI, but often will receive little or no benefit under either program. Instead, the WC carrier pays a portion of the indemnity (SSDI) and almost all of the medical bills. Nevertheless, the disabled worker is *eligible* for both programs of public benefits, even though he or she may not be receiving full benefits from either SSDI or Medicare.

While the WC carrier is responsible for all work-related medical expenses, the WC carrier and HCFA may later disagree on what is a work-related medical expense. The Medicare secondary payer statute²⁰ provides that Medicare may recover directly from the claimant or the WC carrier any benefits Medicare paid for services that are reimbursable under WC.²¹

While in the vast majority of cases involving disabled workers this right of Medicare to recover directly does not arise, it *does* arise when the worker enters into either a commutation or a compromise and the individual is awarded WC benefits. Hence, when the claimant cashes out his or her benefits, any monies Medicare may have paid for work-related medical expenses give rise to a claim against the claimant's settlement. This claim is known as the "Medicare secondary payer" (MSP) claim. The MSP claim will arise in three different contexts.

The first context in which the MSP claim will arise is when providers (e.g., hospitals, physicians, free-standing clinics) are mistaken about who is the primary payer. When this happens, the provider mistakenly bills Medicare, and Medicare mistakenly pays, not knowing that a WC carrier is primarily responsible. The "overpayments" subsequently become an MSP claim in any WC settlement.

The second way in which the MSP claim develops is that the WC claim is contested and the worker is without any health insurance benefits during the period of delay. Section 3407.6(B) of the *MIM* provides that

[t]here is frequently a long delay between an injury and the decision by the State WC agency in cases where compensability is contested. A denial of Medicare benefits pending the outcome of the final decision means that beneficiaries might use their own funds for expenses that are eventually borne by either

WC or Medicare. To avoid imposing a hardship pending a decision, conditional Medicare payments may be made. They are conditioned upon reimbursement to the trust fund if it is determined that the services are covered by WC.²²

The third way in which an MSP claim arises is when the WC carrier pays an amount for Medicare-covered services that is less than the provider's charges and less than the gross amount payable by Medicare, and the provider does not accept and is not required to accept the payment as payment in full under WC law.

In any one of these three situations, the MSP claim arises and must be paid before the individual worker is awarded benefits in any WC settlement. Unless and until claimants cash out their benefits, the question of an MSP claim does not arise. It is only when claimants receive an award or enter into a compromise settlement wherein they exchange their right to benefits for a sum of money that Medicare is first entitled to be reimbursed. This is because the MSP statute provides that all Medicare payments are conditioned on reimbursement to the Medicare program, if Medicare is or should have been the secondary payer.²³

The concept of Medicare's right to recover is succinctly stated in the introduction to Section 3407 of the *MIM*. That section provides in part:

Payment under Medicare may not be made for any items and services if payment has been made or can reasonably be expected to be made for them under a WC law or plan of the United States. . . . If Medicare has paid for . . . services which can be, or could have been paid for under WC, the Medicare payment constitutes an overpayment.²⁴

Medicare is equally secondary to the Federal Employees' Compensation Act, the Longshoremen's and Harbor Workers' Compensation Act, and the Federal Coal Mine Health and Safety Act of 1969 as amended (the Federal Black Lung Program). *Not* covered under the MSP program is the Federal Employer's Liability Act that covers merchant seamen and employees of interstate railroads.

Medicare's right to recover its secondary payments is superior to any other claim for subrogation in the country,²⁵ including that of Medicaid. Medicare's superiority as a subrogee stems directly

from the MSP statute, which provides that:

1. Medicare's right to recover is superior to that of *any entity*;
2. Medicare may recover directly from the employer or the employer's WC carrier; and
3. Medicare may recover any overpayment directly from any entity that has been paid under WC.²⁶

Compromise of Medicare's Secondary Payer Claim

The Medicare program is administered nationally through regional offices. There are 10 regions. These regions are directly under the U.S. Department of Health and Human Services and its subagency, HCFA. HCFA is responsible for administering both the Medicare and the Medicaid programs nationally. The regional offices that administer the Medicare program are known as HCFA regional offices.

Each regional office has authority to administer the MSP program, including the collection, enforcement, and compromise of Medicare's claims. In addition, each regional office has the authority for determining the validity of the Medicare set-aside trust and the reasonableness of the amount set aside in the trust. Furthermore, the annual accounting for each Medicare set-aside trust is sent to the HCFA regional offices.

The authority to compromise the MSP claim was not always vested in the HCFA regional offices. Prior to 1995, that authority was vested exclusively in the central office in Baltimore, Maryland. Compromising an MSP claim took months. It was not unusual for claimants to settle out their case, discover that Medicare was owed a third of the recovery, and then wait months to seek a compromise of the claim.

Since 1995, resolution of the MSP claim has been expedited. The claimant must sign an Appointment of Representative Form (HCFA Form 1696—available from HCFA or any regional office), which is then forwarded to the HCFA regional office for the region in which the claimant lives. This form allows the claimant's attorney or counsel for the carrier to ascertain whether there is indeed an MSP claim.

The HCFA regional office first ascertains whether Medicare is owed any monies. Assuming Medicare is owed monies, the representative for the claimant is notified. The representative has the

right to request an audit of the claim and should do so. That audit is nothing more than a printout of all the Medicare payments to date.

The MSP claim can be either compromised or waived, pursuant to the Federal Claims Collection Act (FCCA),²⁷ under the MSP statute,²⁸ or under Title 42 of the United States Code, Section 1395gg(c). These federal statutes apply equally to the compromise or waiver of the MSP claim in tort settlements, and the HCFA regional offices are authorized to address those as well.

Since 1995, either the regional offices or the lead contractor, usually the Part A fiscal intermediary, may negotiate directly with the claimant or the claimant's representative. While the negotiations to compromise the MSP claim must be done in an approved manner, on approved forms, the process is nevertheless greatly expedited, and a compromise can now be reached in weeks, sometimes days, when before it took months.

The bases for a compromise under the FCCA are:

1. The claimant does not have the money to repay the claim within a reasonable period of time;
2. HCFA would find it difficult to prevail on the claim in a court of law; or
3. The costs to HCFA of collecting the claim exceed the value of the claim.²⁹

Under Title 42 of the United States Code, Section 1395gg, claims can be compromised for economic hardship, for equity and good conscience, and for reasons beyond the fault of the claimant—that is, the claimant was not responsible for the overpayment.³⁰

Under the MSP statute, claims can be waived, in whole or in part, if waiver is determined to be in the best interests of the MSP program.³¹ A denial of a waiver request under this provision is *not* appealable.³²

Generally, HCFA will compromise claims on the basis of economic hardship, good sense, and fairness. The claimant should never be expected to compromise his or her own MSP claim. It takes skilled lawyering to maneuver the compromise of an MSP claim through the system.

The Duty to Notify Medicare

Often before a case settles, the parties assume that because no one has *heard* from Medicare,

Medicare is not involved, and it is therefore “safe” to proceed and close the file without contacting Medicare. If the claimant is or has been eligible for Medicare, then Medicare should always be informed before the case is settled.

The duty to notify Medicare rests on the third-party payer who is primary to Medicare; in this context, that third-party payer is the employer or its WC carrier. While the duty to notify Medicare rests on the third-party payer, and while Medicare will seek recovery of its claim *first* from the third-party payer, Medicare may also recover from the provider, the employer, the attorney, and the carrier. In short, Medicare may recover from all parties that have been paid any WC benefits or who have derived any benefit from the WC settlement.

Whose Duty Is It?

Section 411.21 of the Code of Federal Regulations (C.F.R.) defines a third-party payer as any “insurance policy, plan, or program that is primary to Medicare.”³³ The same section further defines a third-party payment as a “payment by a third party payer for services that are also covered under Medicare.”³⁴

Who is the third-party payer? Section 1395y(b)(2)(A)(ii) of the United States Code states that Medicare may make a conditional or secondary payment provided that repayment cannot reasonably be expected from a workers' compensation plan, an automobile plan, a liability insurance plan (including homeowners' insurance), a self-insured plan, or a no-fault insurance plan.³⁵ Any payment Medicare makes is conditioned on reimbursement by one of these plans.

These plans are the third-party payers. Whenever one of these payers makes a payment for services that are covered by Medicare, the third-party payer may be required to reimburse Medicare. From where does this duty to reimburse Medicare derive? The MSP statute provides that the “United States shall be subrogated to any right under this subsection of an individual or any other entity to payment with respect to such item or service under a primary plan.”³⁶

What makes a plan primary? Possibly a court order, a legally approved settlement, established liability, or some variance of all three. For Medicare to recover, the primary plan—that is, the third-party payer—does not need to be the entity responsible for causing the physical damages. It is

sufficient that Medicare contractors (i.e., the intermediaries or carriers) had to pay Medicare providers for medical services for the physically injured person. The Medicare claim is not like the Medicaid lien. In the case of the Medicaid lien, the state can only recover against the actual tortfeasor who caused the injuries.

In the context of Medicare, Medicare is looking only for an insurance plan that is required to make a payment for services that are also covered by Medicare. If there is a third-party payment and Medicare has also made a payment, then Medicare is entitled to recover from the third-party payer, provided Medicare is secondary and the third-party payer is primary. Medicare will always be a secondary payer in any case involving liability or workers' compensation insurance.

So, the first answer to the question of whose duty it is to notify Medicare of a third-party payment is simple; it is the affirmative duty of the third-party payer. The MSP regulations provide that if a third-party payer learns that a Medicare intermediary or carrier has made a Medicare payment "for services for which the third party payer has made or should have made primary payment," the third-party payer must give notice to the Medicare intermediary or carrier that paid the claim.³⁷

In the context of Medicare, however, the third-party payer may not rely on anyone to ascertain the existence of a Medicare claim. This is because Medicare may initiate recovery as soon as it learns of a third-party payment. The MSP regulations provide that "HCFA has a direct right of action to recover from any entity responsible for making primary payment."³⁸ This includes an employer; an insurance carrier, plan, or program; and a third-party administrator. What's more, if the primary payer, the third-party payer, or the insurance plan (all names for the same thing) fails to reimburse Medicare, then "the third party payer must reimburse Medicare even though it has already reimbursed the beneficiary or other party."³⁹

This is only part of the story. The Medicare contractor also has an affirmative duty to notify and/or reimburse Medicare. The regulations provide that "[i]f a Medicare contractor, including an intermediary or carrier who also insures, underwrites, or administers as a third party administrator, a program or plan that is primary to Medicare, and does not reimburse Medicare, HCFA may offset the

amount owed against any funds due the intermediary or carrier. . . ."⁴⁰

Plaintiff's counsel reading this article is breathing a huge sigh of relief. The relief is an illusion. Medicare's claim is a superclaim. It is true that there is nothing in the rules or the statute that requires plaintiff's counsel, or the beneficiary, to notify Medicare that he or she is commencing a claim for which Medicare may have made conditional payments. But what comfort is this when C.F.R. Section 411.26 states that Medicare is "subrogated to any individual, provider, supplier, physician, private insurer, State agency, attorney, or any other entity entitled to payment by a third party payer"?⁴¹ What comfort is it when C.F.R. Section 411.24(g) states that Medicare "has a right of action to recover its payments from any entity, including a beneficiary, provider, supplier, physician, attorney, State agency, or private insurer that has received a third party payment"?⁴²

What Kind of Notice Is Required?

The MSP regulations require that a third-party payer must give notice that describes "the specific situation and the circumstances (including the particular type of insurance coverage) . . . and, if appropriate, the time period during which the insurer is primary to Medicare."⁴³

Once the third-party payer gives notice, Medicare will immediately contact plaintiff's counsel. Ironically, neither plaintiff's counsel nor counsel for the defendant third-party payer are entitled to information *about* the claim, unless the beneficiary receiving Medicare, who is now the plaintiff, consents to the release of information on the Appointment of Representative Form provided by Medicare. Sometimes the claimant or his or her attorney is reluctant to sign this form. The MSP regulations state that the beneficiary must cooperate.⁴⁴ Failure to cooperate means that Medicare may recover directly from the beneficiary.⁴⁵

Medicare benefits are secondary to benefits payable by a third-party payer even if state law or the third-party payer states that its benefits are secondary to Medicare benefits. In short, the Medicare claim supersedes state law, insurance contracts, and the Medicaid lien.

Section 411.24(f)(1) of the MSP regulations provides that Medicare "may recover without regard to any claims filing requirement that the insurance program or plan imposes on the benefi-

ciary or other claimant such as a time limit for filing a claim or a time limit for notifying the plan or program. . . .”⁴⁶

Therefore, while the Medicare claim is often the “silent” claim, once the claim is opened up, it tends to rip cases apart. Ignorance will not excuse the third-party payer (or its counsel) when it should have taken steps to ascertain Medicare’s claim.⁴⁷ Further, Medicare is granted the right to intervene in the plaintiff’s third-party liability action, if it so desires.⁴⁸ The moral of this story is that no WC case should be settled and the file closed without first ascertaining whether Medicare has a secondary payer claim.

Conclusion

It is tragic when an individual becomes permanently disabled on the job. However, there is no reason why settlement of his or her WC claim should *compound* the tragedy. Through the proper treatment of Medicare’s interests regarding both past and future medical expenses, the use of a Medicare set-aside trust tailored to the specific needs of the case, and comprehensive medical benefit planning, future coverage for necessary medical care can be ensured. Absent this necessary medical care, the individual will be forced to resort to welfare for payment of his or her medical bills. Both the government and the claimant have an interest in seeing that this does not occur.⁴⁹

Endnotes

1. See 42 U.S.C. § 424a. Eighteen states and the District of Columbia have elected to avail themselves of the relief granted under 42 U.S.C. § 424a(d). Under that exception, a reduction of benefits is made from the state WC benefits and SSDI is unaffected by the receipt of such reduced state benefits. Those states are Alaska, California, Colorado, District of Columbia, Florida, Louisiana, Maine, Michigan, Minnesota, Montana, New Hampshire, New Jersey, New York, North Dakota, Ohio, Oregon, Utah, Washington, and Wisconsin.
2. See generally 42 U.S.C. § 1396p(d)(4).
3. See 42 U.S.C. § 1395y(b)(2)(A)(ii).
4. See 42 C.F.R. § 411.43(b).
5. See 42 U.S.C. § 1395y(b)(2)(B).
6. See 42 C.F.R. § 411.46(b)(1).
7. MEDICARE FISCAL INTERMEDIARY MANUAL, pt. 3, § 3407.1D.
8. MEDICARE FISCAL INTERMEDIARY MANUAL, pt. 3, § 3407.1E.
9. See 42 C.F.R. § 411.46(d)(2).
10. See 42 C.F.R. § 411.47(a).
11. MEDICARE FISCAL INTERMEDIARY MANUAL, pt. 3, § 3416.2.
12. See 42 C.F.R. § 411.46(d)(2).
13. MEDICARE FISCAL INTERMEDIARY MANUAL, pt. 3, § 3407.7.
14. “If a settlement appears to represent an attempt to shift to Medicare the responsibility for payment of medical expenses for treatment of a work-related condition, the settlement will not be recognized.” 42 C.F.R. § 411.46(b)(2).
15. MEDICARE FISCAL INTERMEDIARY MANUAL, pt. 3, § 3407.7.
16. The authors first developed the concept of the Medicare set-aside trust in 1995 and has continued to develop the concept with the office of general counsel for HCFA ever since. In the intervening years, the procedures for establishing and maintaining the trust have grown more sophisticated, more complex, and more refined as the private bar and HCFA have negotiated, on a case-by-case basis, what is a reasonable consideration of Medicare’s interests.
17. MEDICARE CARRIER’S MANUAL, pt. 3, § 2370.6.
18. MEDICARE FISCAL INTERMEDIARY MANUAL, pt. 3, § 3407.6.
19. See 42 C.F.R. §§ 411.46, 411.47.
20. See generally 42 U.S.C. § 1395y(b).
21. See 42 U.S.C. § 1395y(b)(2)(B).
22. MEDICARE FISCAL INTERMEDIARY MANUAL, pt. 3, § 3407.6(B).

23. *See* 42 U.S.C. § 1395y(b)(2).
24. MEDICARE FISCAL INTERMEDIARY MANUAL, pt. 3, § 3407.
25. *See* 42 U.S.C. § 1395y(b)(2)(B)(iii).
26. *See* 42 U.S.C. § 1395y(b)(2)(B).
27. *See* 31 U.S.C. § 3711.
28. *See* 42 U.S.C. § 1395y(b)(2)(B)(iv).
29. *See* 31 U.S.C. § 3711.
30. 42 U.S.C. § 1395gg(c).
31. *See* 42 U.S.C. § 1395y(b)(2)(B)(iv).
32. *See* MEDICARE FISCAL INTERMEDIARY MANUAL, pt. 3, § 3418.15.
33. 42 C.F.R. § 411.21.
34. *Id.*
35. 42 U.S.C. § 1395y(b)(2)(A)(ii).
36. 42 U.S.C. § 1395y(b)(2)(B)(iii).
37. 42 C.F.R. § 411.25(a).
38. 42 C.F.R. § 411.24(e).
39. 42 C.F.R. § 411.24(i)(1).
40. 42 C.F.R. § 411.24(k).
41. 42 C.F.R. § 411.26(a).
42. 42 C.F.R. § 411.24(g).
43. 42 C.F.R. § 411.25(b).
44. *See* 42 C.F.R. § 411.23(a).
45. *See* 42 C.F.R. § 411.23(b).
46. 42 C.F.R. § 411.24(f)(1).
47. *See* 42 C.F.R. § 411.24(l).
48. *See* 42 U.S.C. § 1395y(b)(2)(B)(ii).
49. For those wishing to read further, the authors recommend *The White Paper*, a newsletter published by the authors and directed primarily to personal injury and workers' compensation attorneys and structured settlement professionals. In particular, the authors recommend the following articles: "The Use of Medicare Set-Aside Trusts in Workers' Compensation Cases," appearing in the Fall/Winter 1998 issue; and "The Crocodile: Medicare's Big Bite in Physical Injury Cases," appearing in the Spring/Summer 1998 issue.