

**MEDICARE & WORKERS' COMPENSATION
THE LEGAL FRAMEWORK**

AND

**MEDICARE SET ASIDES IN WORKERS'
COMPENSATION SETTLEMENTS**

PRESENTED AT:

WORKERS' COMPENSATION FOR THE GENERAL PRACTITIONER

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BY

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Medicare's inception as a secondary payer has its basis in § 1862 (b) of the Social Security Act [42 U.S.C. §1395]. With the enactment of the Medicare Secondary Payer Act (MSPA) on July 30, 1965, the Medicare program became effective. Initially Medicare was the primary payer for all beneficiaries except those with workers' compensation and Veterans Administration benefits. In 1980, in response to rising medical costs, § 953 of the Omnibus Budget Reconciliation Act (OBRA) was amended to significantly broaden the scope of the MSPA. Auto medical, no fault, or liability situations also became primary payers to Medicare under OBRA. With the enactment of the Deficit Reduction Act of 1984, Congress created the right to bring direct legislative action against any entity responsible for primary payment. This law also clarified that Medicare is subrogated to "any right of a worker or any other entity to payment". This act also enacted Medicare's right to recover for overpayments from any entity that would be responsible to make a primary payment and to provide a remedy of double damages. The Omnibus Budget Reconciliation Act of 1986 amended §1862(b) of the Social Security Act to create a private cause of action for damages "in law or plan, automobile or liability insurance policy or plan or no-fault insurance plan, group health plan, or large group health plan" which has been deemed primary and "fails to provide from primary payment (or appropriate reimbursement)..." 42U.S.C. §1395(b), 1985 (**Attachment 1**).

The MSPA has received little attention until recently, due in part to the passage of the "Medicare Integrity Program" Act of 1996. The MSPA requires that payment of medical expenses be withheld "to the extent that ...payment has been made or can

reasonably be expected to be made promptly under a work[ers'] compensation law or plan ... or under an automobile or general liability insurance policy or plan or under no fault insurance." 42 U.S.C. § 1395y(b)(2)(A)(ii). The Centers for Medicare and Medicaid Services (CMS), formerly HCFA, have issued three memos that further clarify the CMS policy regarding Medicare and Workers' Compensation settlements. (July 23, 2001 memo published by Deputy Director Patel, Center for Medicare Management and April 22, 2003 and May 23, 2003 All Regional Administrators (ARA) Memos published by Director Thomas Grissom. See **Attachment 2** May 23, 2003 ARA Memo.)

A series of regulations found at 42 C.F.R. §§ 411.20 – 411.52 give effect to the provisions of the MSPA. Tracking the language of the MSPA itself, federal regulations at 42 C.F.R. §411.26(a) state that Medicare is "subrogated to any worker, provider, supplier, physician, private insurer, State agency, attorney, or any other entity entitled to payment by a third party payer." Additionally, 42 C.F.R. § 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, private insurer, State agency, or private insurer that has received a third party payment." See Colonial Penn Ins. Co. v. Heckler, 721 F. 2d 432 (3rd Cir. 1983) and Abrams v. Heckler, 582 F. Supp 1155 (S.D. New York 1984) for case law decisions that establish Medicare as a residual rather than primary payer, and recognize that any State Law, which would interfere with this intent, would be superseded.

THRESHOLD FOR MEDICARE SECONDARY PAYER STATUTE

The Medicare directives are that a Medicare set-aside allocation **and** approval by the CMS is required with any settlement in which:

1. The claimant is a Medicare recipient at the time of settlement regardless of the amount of the settlement
2. The claimant is not yet receiving Medicare benefits but the following 2 prong test is met:
 - a) The total amount of the settlement is over \$250,000.00 **and**
 - b) It is reasonably expected that the claimant will become a Medicare recipient within 30 months of the settlement

Also see **Attachment 3** CMS notice that a CMS approved Medicare set aside arrangement is unnecessary unless this two prong test is met. What are the situations in which there may be a “reasonable expectation of Medicare enrollment within 30 months”? The April 22, 2003 ARA memo provides clarification. These situations include but are not limited to:

1. Worker is receiving Social Security Disability (SSDI) benefits at time of settlement.
2. Workers has applied for SSDI or has applied and been denied but anticipates appealing the decision.
3. Worker is in the process of appealing and/or re-filing for SSDI benefits.
4. Worker is 62.5 or greater at time of settlement.
5. Worker has End Stage Renal (ESRD) disease but does not qualify for Medicare based on ESRD.

What statutory law, regulations, or federal case law vests CMS with the authority to include for consideration, those injured workers who are not Medicare beneficiaries, but have a reasonable expectation of Medicare enrollment within 30-months of the settlement date and a total settlement amount of greater than \$250,000? Section 1862(b)(2) of the Social Security Act ("the Act") requires that Medicare payment may not be made for any item or service to the extent that payment has been made under a workers' compensation law or plan. 42 U.S.C. § 1395y(b)(2). Additionally, 42 C.F.R. § 411.46 requires the WC payer to be the primary payer when a worker receives a workers' compensation ("WC") settlement award that is intended to compensate the worker for future medical expenses required because of a work-related injury or disease. That is, Medicare must not pay for a worker's medical services when that worker received a WC settlement award that includes funds for future medical expenses. **Section 1862(b)(2) of the Act and 42 C.F.R. § 411.46 do not explicitly require workers who are not yet Medicare beneficiaries to consult with CMS prior to settling their WC cases.** However, once a worker becomes a Medicare beneficiary, §1862(b)(2) of the act and 42 C.F.R.§ 411.46 prohibit CMS from paying for items and services where a primary payment is available to pay. Medicare, therefore, has promulgated policy that at the time of settlement to give consideration whether the worker may become a Medicare beneficiary in the near future.

Decision Guide

| <i>Type of Claim</i> | <i>Worker's Status at Time of Settlement</i> | <i>MSPA Directive</i> |
|----------------------|---|-----------------------|
| Class I Claim | Any settlement amount Medicare beneficiary at time of settlement | Yes CMS approval |
| Class II Claim | Settlement over \$250,000 Yes to reasonable expectation of Medicare within 30 months of settlement | Yes CMS approval |
| Class III claim | Settlement equals or less than \$250,000* Not a Medicare beneficiary at time of settlement Yes to reasonable expectation of Medicare within 30 months of settlement. See Attachment 4 | No CMS approval |
| | Settlement equals or less than \$250,000* Not a Medicare beneficiary at time of settlement No reasonable expectation of Medicare within 30 months of settlement | No CMS approval |
| | Settlement over \$250,000* No Reasonable expectation of Medicare within 30 months of settlement | No CMS approval |
| | *(Note \$250,000 is for disability/lost wages & future medical expenses) | |

If an injured worker who is not a Medicare beneficiary at the time of settlement meets the review thresholds (i.e., the 30-month and \$250,000 figures) and fails to consider Medicare's interests, then Medicare may preclude its payments pursuant to 42 C.F.R. § 411.46 once the injured worker actually becomes a Medicare beneficiary. Medicare must not pay for a worker's medical services when that worker received a WC settlement award that includes funds for future medical expenses. If Medicare's

interests are not reasonably considered, Medicare may refuse to pay for services related to the WC injury that otherwise would be covered by Medicare until such time that the medical expenses related to the WC injury equal the amount of the entire WC settlement (not simply the stipulated future medical expenses portion of the settlement). CMS has a direct right of action to recover from any entity responsible for making primary payment. This includes an employer, an insurance carrier, plan, or program., and a third party administrator. CMS is subrogated to any right of a worker or any other entity to payment made under an insurance plan or policy. Refer to 42 U.S.C. § 1395y(b)(2)(B)(iii).CMS has a direct right of action and may collect double damages against a third party insurance policy or plan that fails to provide primary payment. See 42 U.S.C. § 1395y(b) and 42 CFR § 411.24(e).

REASONABLE CONSIDERATION OF MEDICARE'S INTERESTS

Although 42 CFR 411.46 requires that WC settlements must adequately consider Medicare's interests, the regulation does not mandate what type of arrangement must be used to set aside funds for Medicare. If an arrangement is self-administered, then the injured worker/beneficiary **must** adhere to the same rules/requirements as any other administrator of a set-aside arrangement.

In accord with 20 C.F.R. §404.408(d), the funds allocated to a set aside arrangement must be consonant with the applicable law or plan and reflect either the actual amount of expenses already incurred (based on a fee schedule) or a reasonable estimate of future expenses. Thus, the amounts to be set aside for future medical expenses may be based on the applicable WC fee schedule amounts, rather than on actual dollar amounts. However, the WC settlement must clarify that the amount

allocated to future medical expenses was calculated based upon applicable WC medical fee schedule amounts. The agreement creating the set-aside arrangement must also contain terms that address the provider's agreement to abide by the WC fee schedule reimbursement level.(e.g., providers will be reimbursed out of the set aside arrangement at the WC rate for medical services rather than the physicians regular full rate or the Medicare rate for covered services).(Attachment 5.)

The Patel memo outlines two methods for medical providers to obtain payment for WC covered services when funds are held in a set-aside arrangement. The memo clarifies that the payment method depends on two factors: 1.) How the set-aside arrangement is constructed and 2.) Whether the arrangement was constructed by contemplating full actual charge estimates or WC medical fee schedule.

The memo further states that there must be specific provisions in the settlement agreement that clarify the set aside arrangement will reimburse medical providers in accordance with the WC medical fee schedule. Once the CMS regional office has reviewed and approved the sufficiency of the arrangement based on the WC medical fee schedule, then medical providers will be paid based on what would normally be payable under the WC plan (i.e., under the WC medical fee schedule).

After the set aside funds are depleted, there must be a complete accounting to the Medicare contractor to ensure that the funds were used for medical services that would have been reimbursable by Medicare. Based on the acceptance by the Medicare contractor of documentation that justifies the depletion of the set aside funds, then Medicare can be billed for future medical services. Note that § 3416 "Effect of Lump Sum Compromise Payment" of the CMS Intermediary Manual directs the Medicare

contractor to retain a copy of the lump-sum agreement and flag any new claims for the condition for which the beneficiary received the lump-sum payment in order to assure accuracy of the payment on claims.

The Patel Memo states at pages 9, 14 and footnote 2 that there must be some reasonable and verifiable additional sources outside the agreement of the basis for arriving at the allocation amount. Reasonableness can be demonstrated by a provider report documenting necessity of future care, injured worker's claims history in the 2 to 2 year period after the condition has stabilized, and/or a life care plan. Note that a life care plan that is completed for litigation purposes is very different from one that establishes a realistic MSA cost allocation of future medical expenses for purposes of settling a claim. In fact, when litigating a claim, there are usually life care plans completed by each side. Life care plans completed for litigation purposes may project twice as much cost allocations that are completed for purposes of settling a claim. CMS has addressed this inconsistency in its April 21, 2003 ARA memo that states on page 6 that a "life care plan" or similar evaluation is not automatically conclusive. That is, if there is contrary evidence, internal conflicts or if the plan is not credible on its face, then CMS will not accept the plan.

Practice Tips: See Barrett v. Massanari, 2001 WL 1193716, 2001 U. S. Dist. LEXIS 16232. Reasonableness can be demonstrated by a treating provider report and prognosis documenting frequency and duration of future care, an independent medical exam, and/or a functional capacity evaluation. See **Attachment 6** for sample medical provider questionnaire (MPQ). When future care recommendations from treating providers can be obtained, that is the most defensible and consistent approach with life

care planning methodology to be followed in the calculation of the set aside allocation. Retrospective reviews of the past medical records and medical billing summary may be used to establish the future MSA cost allocation. CMS accepts this type of analysis. But see the decision in Norwest Bank and Kenneth Frick vs. K-Mart Corporation, U. S. District Court, Northern District of Indiana, Case No. 3:94-CV-78RM, found at 1997 U. S. Dist LEXIS 3426, decided January 29, 1997 (**Attachment 7**), that excluded a life care plan with an analysis of future medical needs based upon a retrospective review of medical records as inadmissible under Federal Rules of Evidence 702.

As an example of how the provider recommendations can impact the set aside amount, the following case study illustrates this point. A cost projection completed by a Medicare health care consultant using a rated age of 54 and a retrospective review of the medical records and billing summary recommended a set aside allocation of \$101,396.00. Using the same medical records, same medical billing summary, and same rated age but obtaining treating provider recommendations, the recommendation for the set aside allocation was \$55,735.00. The cost savings came from the provider recommendations. In response to treating provider questionnaires, the psychologist recommended only two years of psychotherapy and the physical therapist recommended a gym membership and in home therapy exercises with no further treatment at the clinic. The psychiatrist recommended a total of 9 office visits for first two years and semiannually thereafter for medication management. See chart below for details of comparison.

Case Study Comparison of IW Debbie

Chronological age 44 Rated age 54 LE 27.22 years

Using Provider Questionnaires

Retrospective Review Using Medical
Records & Payout Screens

| | | | |
|---|------------------|--|-------------------|
| Office visits(Pain mgment; Drug mgment) | \$14,361. | Office visits(annual neurological & ortho) | 2,156 |
| Therapeutic intervention | \$2,286. | Pain Mgmt (monthly) | \$25,872. |
| Diagnostic &Lab work | \$14,318. | Psychiatric-Drug mgment | \$8,400. |
| TENS unit & supplies | \$14,127. | Psychotherapy (monthly) | \$37,968. |
| Orthopedic needs | \$6,533. | Lab work | \$2,800. |
| One time trial spinal cord stimulator | \$4,110. | Diagnostic x-rays & MRI | \$7,000. |
| | | TENS unit & supplies | \$17,200. |
| TOTAL | \$55,735. | TOTAL | \$101,396. |

DETERMINATION OF LIFE EXPECTANCY

The life expectancy of the injured worker for whom the need for a Medicare Set-aside Arrangement is being evaluated, will impact components of the settlement process in addition to the period of time into the future for which provision must be made for medical care costs related to the compensable work injury which are subject to reimbursement/payment by Medicare. For example, in the "case study" of "Debbie," a 45-year-old while female, born 12/08/58, the adjuster requested a "rated age" to be provided to a Florida company that was employed to prepare a proposed MSA allocation using the "retrospective review of utilization costs" methodology. The letter

from the annuity broker communicating to the adjuster the "rated age" of 54 states: "we received the rated age information from our life markets, and the *best* rated ages from [the workers' compensation insurer's] approved life companies are" **Attachment 8**, obtained nearly one year later contains the "rated" ages provided by seventeen (17) different life companies. The "rated age" to which "Debbie's" chronological age was advanced, with the sole exception of a "rated age" of forty-six (46), provided a "rated age" for every year between "Debbie's" chronological age of forty-five (45) and the "rated age" which advanced "Debbie's" chronological age by the most years!

Life expectancy will impact how the Social Security "offset" of workers' compensation periodic income benefits will be determined and will be a factor in settlement negotiations concerning the amount of income benefits and medical care costs not subject to Medicare reimbursement/payment would be paid by the Employer/Insurer in the years between the true chronological age and the "rated age."

CMS Methodology for Determination of Life Expectancy

In an apparent effort to create nationwide uniformity in the determination of the life expectancy of injured employees, CMS has specified three methods for the determination of the life expectancy of an injured worker for whom a Medicare Set-aside Arrangement is being formulated. Unless,

1. documentation supporting use of a "rated" age for like injuries/illnesses is obtained from a life insurance company and submitted with the MSA to CMS; or,
2. documentation from a medical professional which provides justification for an alternative projection,

3. CMS will " . . . project the cost of the claimant's future treatment over the claimant's life expectancy, using the CDC Life Tables which may be accessed directly through the URL website imbedded in the CMS "check list", the most recent edition of which is attached as **Attachment No. 12**.

Note that **Attachments 9(a) and 9(b)** are the 2001 CDC Life Tables for all males and all females, respectively; however, where it would be helpful to your client, you may want to use one of the CDC life tables which are race and gender specific. The complete CDC Life Tables provide categorical divisions as follows:

- Life Table - total population;
- Life Table - "white" population (M & F);
- Life Table - all males;
- Life Table - black males;
- Life Table - all females;
- Life Table - white females;
- Life Tables - black females.

Life Expectancy And "The Pro-ration" Formula

Obviously, a Medicare Set-aside Arrangement only becomes a factor to be considered in settlement of a claim because the injured worker is receiving either Social Security Disability Insurance Benefits or Social Security Retirement Benefits. If the injured worker is receiving Social Security Disability Insurance Benefits (DIB) and is receiving workers' compensation income benefits there is a good chance that the DIB will be reduced by an offset. A simple rule of thumb is this: Social Security Disability

Insurance Benefits will be reduced by the amount by which those benefits, when added to the workers' compensation income benefits, exceeds eighty (80%) percent of the average current earnings of the injured worker. 20 CFR §404.1500 et seq. In the case study of "Debbie," her average current earnings were \$783.00. Her ACEH; that is, the sum which represents eighty (80%) percent of the greatest sum that "Debbie" earned in a year during the five-year period preceding her date of onset of disability is \$626.40.¹

Since "Debbie's" workers' compensation weekly income benefit is \$147.67, her monthly workers' compensation income benefit of \$630.28 ($\147.67×4.3) results in "Debbie" being totally offset, meaning that she receives no Social Security Disability Insurance Benefits. However, because the cost of living adjustments awarded annually apply to the full monthly SSDIB benefits to which "Debbie" was entitled - but for the total offset - "Debbie" does receive a Social Security DIB check in the amount of \$128.00 per month which represents only COLA increases. The "net" after deduction of Medicare premium of \$58.70 for actual total COLA adjustments to date totaling \$186.70.

Until "Debbie's" claim is settled, she will continue to experience a total offset until she reaches the age of sixty-two (62). 42 U.S.C.A. §424(a). However, if "Debbie" does not settle her claim and elects "early retirement" at age sixty-two (62) in order to

¹ To avoid confusing the issue - and the reasons for which "Debbie's" case was selected, mention must be made of primary insurance amount (PIA). Suffice it to say that PIA is based on an individual's taxable earnings averaged over the working lifetime to yield a monthly benefit that partially replaces the earned income lost because of retirement, disability, or death. There are two methods of averaging earnings. In "Debbie's" case, the second method of determining her "first eligibility" would be used; that is, her period of disability began before she attained the age of sixty-two (62) and "first eligibility" occurred after 1979. Thus, "Debbie's" PIA is based on average indexed monthly earnings for years following 1951 and are indexed, ie. adjusted to put them in proportion to the earnings level of all workers for those years.

eliminate the affect of the offset, she will be forced to accept a twenty (20%) percent reduction in retirement benefits. 42 U.S.C.A. §402(q). Note that recent changes to 20 CFR §404.317 provide that the "penalty" for early retirement at age sixty-two (62) will be gradually increased to thirty (30%) percent for retirees and thirty-five (35%) for spouses.

Thus, in settling "Debbie's" case, effort should be made to reduce to the greatest extent possible, the affect of the offset. Since "Debbie" is currently forty-five (45), if her offset could be completely eliminated, she stands to recover \$133,368.00 in SSDIB by the time she is eligible to retire with "full" retirement benefits at age sixty-six (66) years and eight (8) months when her "retirement" benefit will be \$555.70 - the same as her "PIA."² But, note that even though "Debbie" would not be eligible for a full Social Security retirement benefit until she reaches sixty-six (66) years and eight (8) months; nevertheless her offset still ends the day she becomes sixty-five (65). See 20 CFR §404.317, 68 Fed. Reg. 4700.

Thus, in settlement of "Debbie's" claim, care must be given to the life expectancy used. The 7/23/01 ("Patel memo") permits, but not require, that a "rated age" be used for determining the length of time an injured worker would continue to live and require medical care for the work-related injury. In response to question No. 5, regarding the criteria that Medicare uses to determine whether the amount of a lump sum or structured settlement has sufficiently taken the interest of Medicare into account, one of the criteria stated is "age of beneficiary - Acquire an evaluation of whether his/her

²The \$133,368 is based upon the monthly PIA of \$555.70 x 12 x 20 rather than the ACE of \$626.40.

condition would shorten the life span." Question 10 and its answer is even more specific:

"Question 10: Are there documentation requirements that must be satisfied before the RO can provide a written opinion on the sufficiency of a Set-aside Arrangement?"

Answer: Yes. At a minimum, the following documentation must be obtained by the RO prior to the approval of any arrangement:

A copy of the settlement agreement, or proposed settlement agreement, a copy of the life care plan (if there is one), and, if a life care plan does not contain an estimate of the injured individual's estimated life span, then a "rated age" may be obtainable from life insurance companies for injuries/illnesses sustained by other similarly situated individuals. (Emphasis supplied).

If a "rated age" which advances an injured workers' chronological age is used resulting in a reduced MSA, one should not assume that Social Security would accept that same "rated age" for the purpose of calculating the offset. For example, if use of a "rated age" advanced the chronological age of an injured worker from fifty-eight (58) to sixty-five (65), resulting in the potential elimination of seven (7) years of medical care costs that would have been included in an MSA, one should not assume that Social Security would accept that "rated age" of sixty-five (65) and upon receiving a copy of the settlement agreement would simply eliminate the application of the offset.

Next, and returning to the "case study" of "Debbie," utilizing a "rated age" of fifty-four (54), a Florida company recommended that a Set-aside allocation be established in the amount of \$101,396.00. Experience teaches that the Insurer would also attempt to reduce its settlement "exposure" by insisting that certain health conditions "documented" in "Debbie's" medical records amply support the Insurer's contention that

"Debbie" has a nine-year shorter life expectancy;³ therefore, income benefits and medical care expenses, not reimbursable by Medicare, that would have been incurred during the nine-year period between "Debbie's" actual chronological age of forty-five (45) and the "rated age" of fifty-four (54) should not be considered for settlement purposes. But, acceptance of the validity of the basis for the "rated age" of fifty-four (54) would result in "factoring out" of settlement value \$57,094.48 in income benefits for temporary total disability at \$147.67 per week reduced to present value for that nine-year period and \$136,132.00 in medical care costs not reimbursed/covered by Medicare. But, in using "Debbie's" chronological age life expectancy, determined from the Annuity Mortality Table for 1949, Ultimate, the MSA calculated by Beverly Manley only increased from \$55,735 to \$74,430. Thus, use of the "rated age" of fifty-four (54) in "Debbie's" case would have "taken off the table" exposure totaling \$174,531.48. (Income benefit of \$57,094.48 plus medical care costs not reimbursed by Medicare of \$136,132.00 less \$18,695.00 - the difference between the chronological age MSA of \$74,430 and the "rated age" MSA of \$55,735.)

So, in "Debbie's" case study, not using a "rated age" is not only consistent with the medical "facts" in her case; but also allows her to argue that her claim has much greater settlement value by including the income benefit and medical care costs not reimbursed by Medicare in the exposure of the Employer/Insurer.

³ In fact, the "consulting" group that examined the medical records stated in its report: "there is mention in the medical reports of a cervical (!) uterine cancer - treated in 1993, scoliosis, diabetes and hypercholesterolemia (sic)." Yes, there were "mentions" of all these conditions; but only diagnoses of scoliosis (resulting from the work related back injury) and uterine cancer successfully treated years ago exist.

SETTLEMENT METHODOLOGY

"Debbie" is experiencing a complete offset. Although the amount allocated to the MSA is not subject to the offset, the settlement combining the Employer/Insurer's future exposure for any form of income benefits and un-segregated future medical care costs not subject to reimbursement/payment by Medicare is subject to the offset. Thus, in "Debbie's" case could her claim be settled - exclusive of the amount to be allocated to an MSA - in a way that recovers all or most of the Social Security Disability Benefits that she is currently losing to the offset? If "Debbie" chooses to settle her claim, the principal settlement sum, exclusive of the amount to be set-aside in an MSA, is to be reduced for offset purposes by the amount of legal expenses; rehabilitation expenses; past and future medical expenses; payments to dependents and payments for specific loss such as permanent partial anatomical loss. Davidson v. Sullivan, 942 F. 2d 90. After deducting for the foregoing expenses, the "net" sum due the injured worker may still be subject to offset if the injured worker was already experiencing an offset. In order to reduce as much as possible the amount of workers' compensation benefits against which the offset will be applied, the lump sum settlement is pro-rated. There are three different methods for pro-rating the lump sum:

1. The excludable expenses are first totaled and then divided by the weekly income benefit rate. This method delays the application of the offset until the number of weeks produced by the division of the total excludable expenses by the weekly income benefit has been consumed.

This pro-ration method is particularly useful if the injured worker is approaching sixty-five (65) when the offset would end, anyway.

2. The second method involves dividing the net amount of benefits, after deducting excludable expenses, by the gross amount of benefits (gross settlement before deduction of expenses) and then the resulting percentage is multiplied by the weekly rate to get a reduced weekly rate to apply in computing the offset.

3. The third method is what is commonly called "the Hartman method." This method involves dividing the Claimant's portion of the settlement, after having deducted all excludable expenses, by the number of weeks (or months) remaining in the injured worker's life expectancy. If this pro-ration method is selected, the mortality table that produces the longest life expectancy should be used.

Lump Sum Or Structured Settlement?

If the injured worker was already subject to an offset, a lump sum or structure such as an annuity is likely to result in continuation of the offset; albeit at a reduced rate. Social Security Ruling 81-32 considers the applicability of the offset provisions of Section 224 of the Act when annuities are used in a workers' compensation settlement.

The Ruling:

"it is the position of the Social Security Administration (SSA) that where the W/C award gives the worker an option of receiving a cash lump-sum payment or having the employer or insurer purchase an annuity, the worker's exercise of that option constitutes his or her receipt of the lump-sum or purchase price. Thus, a worker who chooses to receive a lump-sum amount is considered to have been paid that amount regardless of whether he or she uses it to purchase an annuity. Where the worker exercises an option to have an employer or insurer purchase an annuity, it

is the purchase price of the annuity which he or she is considered to have been 'paid' within the meaning of Section 224(a) of the Act."

The following example is used in SSR 81-32:

"A workers' W/C award consisted of a lump-sum of \$10,000.00 and an annuity to be purchased by the employer and insurer to provide the worker a lifetime income of \$500.00 per month for the first year with an increase in the monthly amount after that under a 5% compounded interest escalator schedule the insurer advised that the lump-sum settlement and the annuity are completely separate; the worker did not have the option to receive the lump-sum settlement only; the worker did not determine the amount of the monthly payment from the annuity; and the monthly payment from the annuity was payable immediately. Although the annuity was part of the W/C settlement award agreed to by the worker, he did not have the option of converting the purchase price of the annuity into a lump sum."

Thus, in the example given by Social Security, because the worker did not have the option of taking a lump sum in lieu of the annuity, the worker did not have the dominion and control over the time and manner of the annuity payments. Assuming there was no option and the annuity created a stream of periodic payments, Social Security would determine whether receipt of the annuity payments would cause an offset, applying the offset computation at the time the annuity payments are actually paid to the worker. In applying the offset, if the worker did not have the option to elect an annuity and it was a mandatory term of the agreement, Social Security will use the monthly payment amount received at the time it is paid for the purposes of offset calculations. On the other hand, if the worker was given an option which was elected, the Social Security Administration will consider the amount paid up-front which will allow the application of the lifetime pro-rata method for offset calculations to be used so long as those provisions are contained within the Settlement Agreement.

Because "Debbie" is completely "offset," a settlement method that restores as much of her Social Security Disability Benefit award as possible should be explored. Examples are furnished in the "slides" which accompany this presentation.

Some Thoughts About Use Of Annuities "To Fund" An MSA

At the point in time that an MSA is established, it could be "funded" in a number of ways. If the Set-aside Arrangement is to be self-administered, there is no need to "build in" additional sums for administration of the Arrangement by a third party. Moreover, if the Arrangement is based upon the employee having attained maximum medical improvement with future medical costs generally limited to periodic office visits, occasional diagnostic testing and issuance of prescriptions for medication, the arrangement can be calculated very accurately. **Attachment 10** is a sample Medicare Questionnaire and report upon which specific calculations were based in a claim that required use of an "IME" physician. This "sample" questionnaire combines the questions that would be propounded to the treating physician and the "special" questions that must be propounded to an "IME" physician in order to comply with the directive of Q & A 15, page 6 of the 4/22/03 ARA Memo. **Attachment 11** is a sample stipulation which contains a self-administered Arrangement.

As the amount "set aside" increases as annual medical care costs expected to be incurred increase, the funding mechanism becomes more complex with greater potential for error when the Arrangement is established. An annuity can be purchased to fund the MSA provided that it has escalator provisions to account for increases in inflation, as well as possible periodic "bubbles" to provide funding for unexpected medical care costs. Provision must be made for disposition of any sums remaining in

the MSA arrangement if the employee dies before the MSA has been exhausted. In the July 23, 2001, "Patel memo," CMS points out that structured set-aside arrangements generally apportion settlement money over fixed or defined periods of time. For example, a structured arrangement may be designed to disburse \$20,000 per year over the next ten (10) years for an employee's Medicare covered services. If the \$20,000 allocated on January 1, for Year One was exhausted by August 31, of that year, Medicare may make payments for the services performed after August 31, once the contractor responsible for monitoring the employee's case verifies that the entire \$20,000 (plus interest, if applicable) was exhausted. However, when the structured arrangement allocates money for the start of Year Two (i.e. on January 1) Medicare would not make any payments for services performed until year two's allocation was completely exhausted. Another approach to consider would be to use sequential annuities that are limited in the amount and duration to five-year increments. This approach would allow adjustment for unexpected medical care costs in later years that could not have been reasonably anticipated when the Arrangement was initially established. This approach might involve the purchase of annuities sequentially in the fourth year of each five-year incremental period which would allow adjustments to be made periodically if medical care costs increased or decreased over the original projections. Another funding method that is worthy of exploration would be the use of U.S. Treasury "strips" or zero coupon Treasury Bonds that are purchased at a steep discount and can be purchased to mature annually on a specific date. If using this approach, it might be wise to consider "blending" an annuity or even a one-time "cash" payment in the early years with Treasury "strips" that accumulate interest for at least ten

years before maturity, since U. S. Treasury "strips" or zero coupon Treasury Bonds can be purchased at a significant "discount."

OTHER ISSUES TO CONSIDER

Inclusion Of Prescription Medication Cost In The MSA

Even before the passage of The Medicare Prescription Drug Improvement and Modernization Act of 2003 (Public Law 108-173), "The Patel Memo", in answer to question 7 had stated in part:

"provision should also be made in the Settlement and Agreement to provide for a mechanism so that items or services that were not covered by Medicare at the time, but later become covered, are transferred from the commutation specified for non-Medicare covered items and services to the Set-aside Arrangement. (For example, if outpatient prescription drugs become more widely covered.)"

Prior to passage of Pub. L. 108-173, it would have been much easier to calculate the cost of future medications since the workers' compensation medical fee schedule provides a workable formula for both patent and generic medications. However, the passage of Pub. L. 108-173 has created a gordian knot that - in truth - no one, including this writer, can untie. Tables 1, 2 and 3 attached as **Attachment No. 13**, provide a superficial explanation of an extremely complex, 600-page Bill.

Readers of this paper should be aware that the political firestorm that has been created by Pub. L. 108-173 could result in significant changes and potentially even the same fate that the 1988 Medicare Catastrophic bill suffered. Objections to the new Medicare Law are legion; however, four provisions, in particular, have attracted the most vocal opposition:

- The law forbids the Secretary of Health and Human Services to use its enormous economic bargaining power to negotiate with pharmaceutical

manufacturers to obtain the lowest prices for medications purchased in bulk as the Veterans Administration is permitted to do;

- Despite the House Bill passing with overwhelming support for re-importation from a number of countries including Canada, the conference committee version which ultimately passed and was signed into law by the President did not include any provision to facilitate re-importation of much lower cost medications;
- Even though the law created a gap in coverage which is referred to as the "doughnut hole", the law forbids the purchase of Medigap policies that would provide coverage for those Medicare beneficiaries who have drug expenses between \$2,250 and \$5,100;
- The law diverts financial resources to subsidize HMO's and appears to have been designed to encourage the shifting of Medicare beneficiaries out of traditional Medicare and into HMO's.

Most political observers have been intrigued by the last minute, middle of the night, machinations that resulted in the narrow passage of the Conference Committee substitute. By now, most are aware that Richard Foster, Chief Actuary at CMS has gone public with his claim that he had been ordered not to reveal that CMS' actuarial estimates performed before the final vote on the Bill was taken had placed the true cost of the Bill in the \$540 billion range despite the Administration's representations that the cost could be held to the \$400 billion limit that the President had placed upon the cost over a ten-year period.

Since that public revelation by Richard Foster, a cascade of more bad news has followed. It is now reported that the Medicare Trust Fund will be depleted by the year 2019. On Thursday, March 25, 2004, CMS Chief Actuary, Richard Foster, projected a 17% premium increase beginning next year; that is, an average increase of \$11.50 per month per Medicare beneficiary, increasing the average monthly premium from \$66.60 to \$78.10. In even more bad news for America's seniors and disabled, Mr. Foster also projected that premiums will have to continue to increase and projected that the monthly premium would rise to \$80.00 in 2006; \$82.00 in 2007; and, \$85.60 in 2008. Many that have examined the provisions of Pub. L. 108-173, believe that those premium increases are understated and that the full affect of the bill will not be realized until 2008 or later.

The stunning revelations by Richard Foster about his having been pressured not to report his actuarial estimates until after the final vote on the Medicare Bill, the disquieting report by Michigan Representative, Nick Smith, about threats made to him to coerce a favorable vote and the after-passage discovery of many of the implications of the Bill have caused AARP, the support of which was crucial to the narrow passage of the Bill, to announce its support for immediate amendments to the Bill. On January 6, 2004, AARP CEO William D. Novelli, announced that AARP now supports several immediate amendments. Many of those amendments appear in S 1992, introduced by Senator Kennedy, D Mass. on 12/09/03. That Senate Bill, pointedly entitled "Defense of Medicare and Real Medicare Prescription Drug Benefit Act" would make numerous substantive changes to Pub. L. 108-173 such as:

- Repealing the premium support program;
- Eliminating the coverage gap (the doughnut hole);

- Allowing Medicaid wrap;
- Elimination of the assets test;
- Requiring the Secretary of HHS (rather than HMO participants) to define classes and categories under any drug formulary;
- Provision of wrap-around prescription drug coverage through use of Medigap policies;
- Re-importation of prescription drugs;
- Negotiation by the Secretary of HHS with pharmaceutical manufacturers to achieve the best prices through bulk purchasing;
- Repeal of health savings accounts.

Several other bills offered to amend Pub. L. 108-173 have also been introduced in the Senate and/or the House. S. 2053 (Snowe, Wyden and Feinstein); S. 2130 (Graham, R. SC; Sessions, R. ALA; McCain, R. ARIZ); HR 1340 (Stark and sixteen others).

Recent polls indicate widespread dissatisfaction with both the process and the provisions of Pub. L. 108-173 - particularly among the large voting bloc of those 65 and older. It would be wise to anticipate that Pub. L. 108-173 will be amended, requiring that CMS adapt the guidelines currently being drafted for the Bill that actually passed. Currently CMS is not requiring that an MSA include an allocation for the cost of future medication. In December, 2003, shortly after the passage of Pub. L. 108-173, CMS officials reported that guidelines would not be written for several months; and, until CMS created guidelines for inclusion of prescription medication in MSAs, it would be "business as usual." Given the political climate, it is reasonable to predict that CMS

may adopt a "wait and see" approach before creating guidelines that may have to be changed more than once during the next two years.

Full Disclosure

Some Employers and Insurers have refused to share with an attorney representing an Employee all of the report containing a Medicare Set-aside allocation recommendation made by the consultant hired by the Employer or Insurer. In some instances, Employers or Insurers have apparently instructed consultants to evaluate only the cost of medical care that is subject to Medicare reimbursement/payment, omitting from the report the medical care costs which are not reimbursed by Medicare. There are also reports of instances in which an Employer, Insurer or defense attorney have refused to share with an Employee's attorney any part of the report except the MSA "bottom line." Yet, these same Employers and Insurers, recognizing their own potential liability, have insisted that the Employee execute a Social Security Release so that determination can be made whether any conditional payments have been made by Medicare. Recognizing that the goal should be the determination whether an MSA in any amount is necessary; and, if so, in what amount, and recognizing that the parties to the claim, their attorneys and even the medical providers have potential liability, these factors would seem to suggest that full disclosure of the reports containing cost projection for Medicare and non-Medicare covered future medical expenses should be made by both sides. The Employee seeks to establish an MSA that is sufficient "to consider the interests of Medicare"; but not a penny more. Employers and Insurers, on the other hand, recognize that the larger the MSA the less likely it will ever be that any "downstream" liability would attach. Moreover, both the Employer and the Employee

want to be certain that the Stipulation and Agreement is approved by the State Board of Workers' Compensation, either before "approval" by CMS or after. Because all of the parties to the claim, their attorneys and the medical providers - usually "panel" physicians - have a vested interest in the calculation of an accurate MSA, full disclosure increases the likelihood of the establishment of an MSA that would be reviewed and approved by CMS whether or not the Stipulation and Agreement had been first sent to and approved by the State Board of Workers' Compensation. If all parties are "working off" the same information, neither "side" will be making decisions, will be negotiating "in the dark."

Review of Adverse Determinations by CMS

CMS takes the remarkable position that no review is available directly from its determination that an MSA submitted for review is inadequately funded. Since it would be difficult to envision a situation in which an Employee would complain if CMS determined that an MSA had been overfunded, consideration of the availability of a right of review is limited to those situations in which CMS has determined that an MSA was underfunded, failed to include an allocation for specific medical care deemed to be necessary by CMS or any other factor that caused CMS not to approve an MSA as submitted.

CMS takes the position that if an MSA is rejected by CMS; or, is conditionally approved subject to acquiescence by the Employee in a demand for supplementation, the Employee has no avenue for dispute resolution. CMS takes the position that, if the MSA is rejected and the Employee refuses to accept CMS' demand for supplementation

or other change in the MSA, the entire settlement proceeds available to the Employee will be deemed to be for future medical care (even where the stipulation specifically allocates a sum certain to future income benefits) and that the entire settlement available to the Employee must be used for payment for future medical care expenses and the settlement exhausted before any medical treatment will be paid by Medicare. CMS takes the position that if the Employee does not acquiesce in the changes/supplementation demanded by CMS, the settlement will not be recognized and the only recourse is for the Employee to obtain treatment, submit the cost of medical care to CMS upon a procedure by procedure basis and then to seek review of CMS' determination on each separate bill submitted. Clearly, that "solution" never addresses the question whether the original determination by CMS of the adequacy of the entire MSA was correct or incorrect. CMS appears to interpret 42 U.S.C. 405(g) to be applicable to determinations made concerning the sufficiency of an MSA. 42 U.S.C. 405(g) essentially provides that judicial review of a claim under the Medicare Act is available only after the Secretary of HHS has rendered a "final decision" on the claim in the same manner as is provided in that code section for old-age and disability claims arising under Title II of the Social Security Act. Title 42 U.S.C. 405(h), to the exclusion of 28 U.S.C. 1331(Federal-question jurisdiction), makes 405(g) the sole avenue for judicial review of all "claims arising under" the Medicare Act. But, this writer postulates that a determination of the sufficiency - or lack thereof - of an MSA is not a "final decision" on a claim. See, for example, Bowen v. Michigan Academy of Family Physicians, 476 U.S. 667(1986).

The Best Solution Is Never Having To Seek Review

We should remember that the present hysteria over Medicare's right to demand repayment (plus a 100% penalty) of any bill paid by Medicare that should have been paid by an Employer or Insurer followed quickly after the issuance of "The Patel Memo" in July, 2001. Employers and Insurers, fearing "downstream" liability on many claims that had been settled without "considering the interest of Medicare" began demanding CMS approval of even meager MSAs amounting to no more than a couple thousand dollars. Many of these Employers and Insurers refused to obtain approval of a settlement agreement from the State Board first before seeking CMS approval; consequently, Employers and Insurers have been continuing to pay benefits for temporary total disability and all medical care costs during the ten months (and more) that it takes to obtain CMS approval. Thus, in many instances, Employers and Insurers have been paying twenty thousand dollars and more during the ten month approval period even where their own consultants indicated that an MSA was adequately funded at less than ten thousand dollars. Slowly a better approach has emerged. Many Employers and Insurers now agree to obtain Board approval of a settlement agreement incorporating an MSA; and then, after payment of the sums provided for within the settlement agreement the MSA is submitted to CMS for approval with a provision having been included in the settlement agreement that the Employer or Insurer will supplement the MSA if found to be inadequately funded. In the long run this approach will save Employers and Insurers hundreds of thousands - perhaps millions - of dollars since liability is "fixed" as of the date of approval of the stipulation and agreement by the State Board and the treacherous ten-month period during which an Employee's medical

condition can change and worsen, dramatically increasing medical care costs, can be avoided. Similarly, the Employee and his attorney favor the approach of obtaining Board approval first, paying the sums due under that agreement and then obtaining CMS approval with the understanding that an underfunded MSA will be supplemented by the Employer or Insurer since the Employee and his attorney want their money quickly after a settlement has been negotiated.