Beware of the Language Used in Your Settlement Agreements: Medicare Is Watching

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In the summer of 1996, a collective feeling of relief reverberated through the Pennsylvania workers' compensation bar. Finally, the concept of a full and final settlement of all liability was approved and in its nascency. In years prior, cases seemed to drone on forever and the complicated process to close out a claim (or at least indemnity liability) was limited to the "commutation" method—theoretical stipulations as to future earning capacity in order to arrive at a commuted present-day payment. The math alone was impetus enough to move to another area of law.

The compromise and release settlement is the most profound change in Pennsylvania's workers' compensation history. But the winds of change carry with it pitfalls and stumbling blocks that leave even the most venerable workers' compensation litigator trembling in the shadow of perceived dereliction. The pressure can be unbearable as every paragraph of the settlement agreement will impact the parties forever. Looming somewhat unseen in the background is the oft overlooked and dastardly duty of considering the interests of the U.S. Treasury's Medicare trust funds, aka "protecting Medicare's interests."

Most attorneys would rather suffer an eye infection than study the law surrounding Medicare as a "secondary payer." In truth, more attorneys are worried about being chronically under-dressed at video hearings as opposed to the actual language they use in a settlement agreement as it relates to Medicare. This is a dangerous game as the Centers for Medicare and Medicaid Services (CMS) are ever-evolving in their relentless pursuit to preserve their secondary payer status. The workers' compensation practitioner has now become a forced bedfellow of CMS, like it or not. If you fail to "issue spot" in relevant settlements, you will have problems.

The natural starting point for any resolution in the workers' compensation system involves a determination as to which settlements (and more specifically which claimants) are subject to the long arm of Medicare. The secondary payer statute points to two classes of individuals that require attention. The traditional Medicare beneficiary—normally a claimant who has reached 65 years of age or otherwise qual-

ifies through collecting Social Security disability or the clauses surrounding end stage renal disease or ALS—is the primary class of claimant subject to review. A secondary class of claimants involve those who are not yet Medicare beneficiaries but have a "reasonable expectation" of Medicare enrollment within 30 months of the date of settlement. Settlements involving these two classes of claimants must consider (protect) Medicare's interests if the resolution involves medical liability.

Herein lies the first error to which many attorneys fall victim. CMS has issued "thresholds" by which they will review proposed Medicare set aside allocations. Most attorneys who practice in the workers' compensation field are familiar with these threshold amounts:

- The claimant is a Medicare beneficiary and the total settlement amount is greater than $25,000; or
- The claimant has a reasonable expectation of Medicare enrollment within 30 months of the settlement date and the anticipated total settlement amount for future medical expenses and disability or lost wages over the life duration of the settlement agreement is expected to be greater than $250,000.

Many attorneys mistakenly view these thresholds as creating a safe harbor such that those settlements involving these classes of claimants falling below the threshold are immune from Medicare's purview. That is incorrect. The review thresholds are for workload purposes only and do not alleviate the parties' collective responsibility to maintain Medicare's secondary payer status as part of the settlement agreement. Failure to consider/protect Medicare's interests (even in cases that fall below the thresholds) run the risk of CMS refusing to pay for Medicare covered medical services into the future until the claimant can prove that the entire workers' compensation net settlement has been exhausted.

After identifying claimants who fall within the class of individuals contemplated by the statute, the next step is to determine whether a workers' compensation Medicare set aside arrangement (WCMSA) should be employed. The government lets us know through the statute and CMS guidance publications that a WCMSA is not required in any case. But then they go on to threaten, cajole and otherwise bully claimants and employers/insurers to use such a tool or face negative consequences.

We are reminded constantly that the WCMSA is the only method by which CMS will approve a set aside arrangement. This is floated to us against a backdrop that the use of non-CMS-approved "products," or even nonsubmit products to assess future medical care, could be instantly rejected. We are cautioned that if CMS decides that a non-submitted WCMSA or other product was not funded or utilized appropriately, the claimant will need to demonstrate complete exhaustion of the net settlement amount rather than a CMS approved WCMSA amount (if such a product had been properly submitted and approved). So how much stock can one really put in the statement that a WCMSA submission is not required? Sure, you can do a nonsubmitter or an evidence-based

WCMSA but the parties need to understand the risks over the reward.

Some practitioners fail to appropriately determine whether the case falls within the threshold requirements for the submission of the WCMSA from the inception. In order to assess whether a WCMSA can even be submitted to CMS requires knowledge of the total settlement amount (TSA) and how to calculate the same. The TSA is calculated to include (among other things), wages, attorney fees/expenses, settlement advances and conditional payments to be reimbursed. Therefore, the settlement that you undertook with no WCMSA for $24,999 "plus costs and lien waiver" to avoid the threshold may actually have been a case that fell above the threshold. These issues can come back to haunt you no matter what side of the fence you practice.

Whether a qualified class of claimant has a TSA above or below the review threshold does not make a difference as to the obligations of the parties to, at the very least, consider Medicare's interests as part of the settlement. Obviously, settlements above threshold inherit the ability to submit a WCMSA, obtain approval from CMS and retain the knowledge and peace of mind on the amount that must be appropriately exhausted before Medicare will begin to pay for care related to the work injury. Those cases falling below threshold, while still possessing the obligation to consider Medicare's interests, are given no vehicle to successfully complete this task. This is true even with those non-beneficiaries who have a reasonable expectation and settled their workers' compensation claims below the $250,000 threshold.

Unfortunately, the most predominant action we see taken in Pennsylvania workers' compensation settlements is to do nothing. The settlement agreement may state that the case is "below threshold" and does not require review or approval from CMS—nothing else. To be clear, this is an incorrect method to use when settling non-threshold cases involving beneficiaries and nonbeneficiaries with reasonable expectation of Medicare enrollment defined by the statute. At the very least, the parties should undertake an analysis as to proposed future medical expenses that would be covered by Medicare and note such a voluntary set aside as part of the settlement documents. The preferred method is to still undertake a nonsubmit WCMSA, which by definition cannot be submitted for approval, but is nonetheless relied upon by the parties as a reasonable means for agreeing to consider and protect Medicare's interests in below-threshold cases.

There is yet another area of concern when settling a claim involving specifically Medicare beneficiaries (as opposed to non-beneficiaries with a reasonable expectation of enrollment). When a beneficiary obtains a settlement, judgement, award or other payment, Medicare is required by statute to seek reimbursement for conditional payments made that arose from the work injury. Under the statute, if responsibility for a workers' compensation claim is in dispute and medical expenses are not paid promptly, Medicare will pay conditionally subject to later recovery. Many practitioners get bogged down with issues involving the set aside and either have no clear understanding of conditional payments that are due and owing or even fail to address the concept. Make no mis-

take—conditional payments must be accounted for before any settlement or the results can be devastating to the claimant, the employer/insurer and their counsel.

The protection of Medicare's interests is but one of the myriad of issues that the workers' compensation practitioner must affirmatively address in relevant settlement agreements. Be mindful, however, that this issue must not be brushed aside or made the subject of vague "cut and paste" excerpts inserted between a sea of word salad. While the infamous paragraph 14 of the standard Pennsylvania workers' compensation settlement agreement may be something you traditionally gloss over, be aware that Medicare is watching.

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