

**Recovering for Personal Injury:
Successful End or Just the Beginning?
Medicare's Interest in a Personal Injury Settlement?**

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Center for Medicare Services

Medicare is administered through the Center for Medicare Services (CMS). The Medicare Secondary Payer (MSP) statute 42 U.S.C §1395y, and regulations at 42 C.F.R §411.20 et. seq. make Medicare a secondary payer for any medical services for which payments have been made, or can reasonably be expected to be made promptly under a workers' compensation law or insurance plan. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 expanded Medicare's recovery and enforcement powers.

CMS has an interest in the portion of the settlement intended to cover future medical benefits since, prior to the settlement, the workers' compensation carrier was the responsible party for paying the injured party's medical expenses for his or her lifetime. Once the settlement is complete, CMS does not want the injured person looking to Medicare as the primary payer of the injured party's medical expenses related to his or her injury unless the injured party has exhausted proceeds from the settlement on his or her medical care.

Review Criteria in Workers' Compensation Cases

CMS protects its interests in workers' compensation settlements by requiring a certain amount of a settlement be specifically be set aside for payment of future medical benefits that Medicare otherwise would pay.

If no amount of the settlement is set aside from the settlement, or too little of the settlement is set aside, CMS may refuse to provide any Medicare-covered services related to the injury until the entire amount of the settlement is exhausted.

On July 23, 2001, the Central Office of CMS issued written guidelines in an attempt to provide some form of uniform guidance on the application of the MSP regulations. CMS has published eight additional memoranda defining and refining CMS's policies and procedures for the use, submission, approval and administration of Medicare Set-asides related to workers' compensation cases. All CMS memoranda can be found at <http://www.cms.hhs.gov/WorkersCompAgencyServices>.

For a worker's compensation case, the minimum review criteria for a Medicare Set-aside review are as follows: The claimant is currently eligible for Medicare and total uncommuted value of the workers' compensation settlement exceeds \$25,000; or the claimant is reasonably expected to become eligible for Medicare within 30 months of a workers' compensation settlement with total uncommuted value of more than \$250,000. For Medicare purposes, the total value of a settlement includes past and future medicals, indemnity, attorney's fees and costs, and Medicare overpayments.

Calculating the Set-Aside Amount

The set aside amount is determined by evaluating the claimant's past course of medical treatment, current condition, the reasonable probability of future medical needs, and other factors. For example, the amount includes future medical expenses that Medicare would pay for and that are related to the injury including prescription drug

expenses. To calculate this amount, one must determine the claimant's life expectancy (based on the claimant's actual or rated age). Then, evaluate the claimant's medical history, life care plan, and physician statement. The set aside amount is not reduced by the costs of determining that amount. Medicare set-asides are submitted through the Coordination of Benefits Contractor (COBC).

Medicare Set-Aside Options

Various options are available to comply with Medicare's requirements. These options include: Creation of a formal trust, Medicare set-aside custodial accounts, and self-administered accounts. Medicare set-aside trusts require the creation of formal trusts, which impose fiduciary obligations on the trustee. The trust may authorize the trustee to hire third party administrators. These formal trusts are usually used for large accounts or used in combination with a special needs trust.

By contrast, if the amount of money is insufficient to justify creation of a formal trust, custodial bank accounts may be established. Those accounts could be administered by a non-trustee custodian, who could authorize payment of injury-related expenses that would otherwise be covered by Medicare.

Lastly, a claimant can self-administer an account. But unless the claimant is willing and able to follow Medicare's rules and account for payments made from the account, there is a substantial risk of claimant non-compliance.

Working with MSAs

To avoid noncompliance, attorneys settling personal injury or workers' compensation cases may handle these set-aside accounts in the following manner: they are initially funded with a qualified structured annuity; they are controlled by a third party administrator; the account must be funded for the life of the beneficiary; funds from the account are used to pay medical expenses related to the injury that Medicare ordinarily would reimburse; the account must cover prescription drugs; the administrator must provide accountings to CMS; the account cannot be used to pay the fees and costs used to establish the MSA.

CMS asserts that Medicare is still a secondary payer after the settlement of a personal injury claim. 42 U.S.C §1395y (b)(2)(A) (Payment under this subchapter may not be made...with respect to any item or service to the extent that...(ii) payment has been made or can reasonably be expected to be made promptly (as determined in accordance with regulations) under a workmen's compensation law or plan of the United States or a State or under an automobile or liability insurance policy or plan (including a self-insured plan) or under a no fault insurance plan.)

Medicare Set Asides in Personal Injury Cases

Section 1862(b)(2)(A)(ii) of the Social Security Act precludes Medicare payment for services to the extent that payment has been made or can reasonably be expected to be made promptly under liability insurance. Anytime a settlement, judgment or award provides funds for future medical services, it can reasonably be expected that those funds are available to pay for Medicare covered future services **related to what was claimed and/or released in the settlement, judgment, or award.** Thus, Medicare should not be billed for future services until those funds are exhausted by payments to providers for services that would otherwise be covered by Medicare. Sally Stalcup, Region 6, MSP (Medicare Secondary Payer) Regional Coordinator, UTSNT 2007 Conference, *Medicare Set-Asides*, February 2007. The Regional Coordinator also commented that "the fact that

a settlement/judgment/award does not specify payment for future medical services does not mean that they are not funded. The fact that the agreement designates the entire amount for pain and suffering does not mean that future medicals are not funded.” Sally Stalcup, Region 6, MSP Regional Coordinator, UTSNT 2007 Conference, Medicare Set-Asides, February 2007.

There is no statutory authority to determine what portion of the settlement represents payment for a future “item or service” absent an allocation in the settlement itself. Currently, CMS has no procedure to review Medicare set-asides in personal injury cases. Until CMS provides further guidance, parties must “reasonably consider Medicare’s interest in a personal injury settlement.

Expect any funds that are allocated for future medicals to be spent before any claims are submitted to Medicare for payment. The beneficiary will be asked on the initial enrollment questionnaire whether the beneficiary has received a personal injury settlement.

CMS has no current plans for a formal process for reviewing and approving Medicare set-asides. However, there is an obligation to inform CMS when future medicals were a consideration in reaching the judgment, award, or settlement as well as any instances where a settlement specifically covers medical expenses, including future medical expenses.

Example

An actual case example illustrates the procedure for creating a Medicare set-aside amount:

Client suffered a closed head injury that left him in a wheelchair. As result of a lawsuit, client received \$4,000,000 of which a portion is structured and another portion is used to fund a Supplemental Needs Trust. Client is eligible for Medicare coverage. A third-party analyst was hired and calculated a set-aside amount of \$175,000, representing injury related future medicals that Medicare would normally cover. The set-aside amount will be paid into a Medicare Set-Aside fund embedded within the special needs trust that will be and administered by the Trustee. The Trustee has authority to hire a third-party administrator to assist in the MSA management, including assistance with annual and final reports to CMS. The MSA set-aside was funded by seeding it with about \$50,000 and also purchasing a structured annuity costing approximately \$40,000 that will pay out over a fixed number of years.

New Reporting Requirements

Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (PL 110-173) amends the Medicare Secondary Payer (MSP) provisions of the Social Security Act (Section 1862(b) of the Social Security Act; 42 U.S.C. §1395y(b)) to provide for mandatory reporting for group health plan arrangements, liability insurance (including self-insurance), no-fault insurance, and workers' compensation. The provisions will be implemented on January 1, 2009.

Enforcement

To recover payments described in the MSP statute, the United States is authorized to bring an action “against any entity,” including a beneficiary, provider, supplier, physician, attorney, state agency or private insurer that has received any portion of a third party payment directly or indirectly if those third party funds—rather than Medicare—should have paid for the injury-related medical expenses. 42 U.S.C.