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MEMORANDUM TO ALL CLIENTS OF STEWART GREENBLATT MANNING & BAEZ

RE: INTERPLAY BETWEEN NEW YORK WORKERS' COMPENSATION LAW SECTION 32 WAIVER AGREEMENTS AND THE MEDICARE AS SECONDARY PAYER STATUTE 42 USC 1395(Y) ADDRESSING CLAIMANTS ATTORNEYS FEES

This memorandum will address an issue which continues to be raised before the New York State Workers' Compensation Board and specifically whether every Workers' Compensation Law Section 32 Waiver Agreement which includes payment for future medical expenses must take into consideration Medicare's interest pursuant to the Medicare as Secondary Payer (MSP) statute 42 USC 1395(Y), even where the claimant is not a current Medicare recipient or the Centers for Medicare & Medicaid Services (CMS) review threshold have not been met.

INTRODUCTION

In pertinent part, the MSP statute 42 USC 1395(Y)(b)(2) states "Payment under this subchapter may not be made, except as provided in subparagraph (B), with respect to any item or service to the extent that (i) payment has been made, or can reasonably be expected to be made, with respect to the item or service as required under paragraph

(1), or (ii) payment has been made or can reasonably be expected to be made under a workers' compensation law or plan".

The statute contains a penalty provision whereby an action may be brought against any entity responsible for payment, if said entity is found to have not protected Medicare's interests. Medicare can collect double damages against such entity. In addition, if Medicare's interests are not taken into account as part of the settlement, Medicare can refuse to pay for the future medical expenses up to the amount of any workers' compensation settlement (42 CFR 411.46).

Medicare has been secondary to Workers Compensation Plans since the inception of the Medicare program by virtue of Section 1862(b) of the Social Security Act which is codified at 42 USC Section 1395(Y) the MSP. Furthermore, regulations have been promulgated to effectuate the statute.

The MSP specifically provides that Medicare will pay medical benefits only when a "primary plan" does not provide for payment of medical bills. Pursuant to the MSP a primary plan means a group health plan or large group health plan, a Workers' Compensation Law or plan, an automobile or liability insurance policy or plan or no-fault insurance. There is no question that Workers' Compensation is considered a "primary plan" under the statute. Medicare payments may not be made if payment has been made or can reasonably be expected to be made promptly by a Workers' Compensation carrier or self-insured employer.

Recently, the Workers' Compensation Board has begun to reduce attorney's fees for any portion of the settlement that is related to medical treatment regardless of whether there is a Medicare Set-Aside (MSA) for future medical payments. The issue is whether the Workers' Compensation Board's position is consistent with the Federal Statute. We submit that in keeping with the plain language and intent of the statute, its amendments and various memoranda issued by CMS since its inception, the Workers' Compensation Board does have a mandate for requiring that Medicare's interest be considered in all settlement agreements which include payment for future medical benefits and for reducing attorney's fees for any portion of the settlement which represents medical either an MSA or an allocation.

BACKGROUND

The Medicare Secondary Payer (MSP) statute, 42 USC1395(Y), is a collection of statutes or provisions codified with the intention of reducing federal healthcare costs (US v. Baxter International, Inc., 345 F.3d 866, Cert. den. 124 S. Ct. 2907). In 1980 Medicare became a Secondary Payer as part of the Omnibus Reconciliation Act. The MSP Program was part of this act and its purpose was to shift costs from the Medicare Program to private sources of payment (Medicare Secondary Payer Manual (Rev. 65, Mar. 20 (2009)). In 2001, Medicare released the first of several policy memorandums dealing with how Medicare was going to handle the various nuances of Workers' Compensation settlements and future Medicare covered medical treatment. The goal was to increase enforcement of the statute. These memoranda gave rise to Medicare Set-Asides. What the legislation did not do was establish a requirement that a Medicare Set-Aside be created. Accordingly, there is no requirement that a Medicare Set-Asides be sent to CMS for its review. Even if CMS started to enforce this position, to do so without formally promulgating regulations authorizing it to do so would arguably be unenforceable. The reasoning is twofold. First, neither the statute nor the implementing regulations require MSAs to be submitted to CMS for approval. "No rule, requirement or other statement of policy that establishes a substantial legal standard…shall take effect unless promulgated by the secretary by regulation…" 42 USC 1395HH(a)(2).

Nonetheless, the statue, as consistently interpreted, clearly requires the primary payer to protect Medicare's interest in all settlements. The Medicare Secondary Payer Act has been interpreted to include future medical. Medicare's authority to demand that its interests be protected against future Medicare covered medical treatment stems from the general intent of the MSP statute and, more specifically, 42 USC 1395Y(b)(2)(a). A settlement or a portion thereof is an extension of primary Payer money given to the injured party. It is considered a payment that has been made by a primary Payer for the injured parties future Medicare medical treatment. As indicated in 42 USC 1395Y(b)(2)(a), once "payment has been made" then Medicare cannot make payment. Monies received in a settlement are, in part, payment for future Medicare covered medical treatment. Therefore, Medicare's interests, in accord with the foregoing, must always be considered. Failure to do so may result in the application of harsh penalties.

MEDICARE AND WCL SECTION 32 WAIVER AGREEMENTS

As we have indicated, there is no statutory requirement that a Medicare Set Aside be created or that it be forwarded to CMS for review. The fact is that Medicare's interests must be considered in all Workers' Compensation cases. The absence of a clear-cut regulation has created significant uncertainty about when an employer had to consider Medicare's interests or what consideration would be "adequate". Although CMS has implemented a review threshold setting forth when CMS approval would be recommended, arguably, since the review threshold is meant to be a voluntary guideline and not a mandate, reliance on the review threshold itself will not insure that Medicare's interest has been properly considered, however, it will provide deference to CMS.

Briefly, CMS has indicated that it will review medical records and an MSA for settlements over $25,000.00 if the injured party is a Medicare beneficiary. CMS will also review records and an MSA for any settlements over $250,000.00 AND if the injured party has a reasonable expectation of becoming a CMS beneficiary within 30 months. CMS has made it perfectly clear that the above guidelines are only review thresholds, that is, they will not review any MSA that does not fall within those parameters, and that all settlements do need to protect Medicare's interests nonetheless. CMS has issued the following clarification: "The threshold for review of WCMSA proposals are only CMS workload review thresholds, not substantive dollar or "safe harbor" thresholds for complying with the Medicare Secondary Payer law. Under the Medicare Secondary Payer Statute/Provisions 42 USC 1395Y, Medicare is always secondary to workers compensation and other insurance such a no fault and liability insurance."

Accordingly, all beneficiaries and claimants must consider and protect Medicare's interest when settling any workers' compensation claim, even if the review thresholds are not met. Given the volume of cases where future medical expenses are closed, CMS has indicated it is not in Medicare's best interests to review every Workers' Compensation settlement nationwide. Thus, the establishment of the review guidelines. Specifically, the CMS July 11, 2005 policy memoranda reads in part

"thresholds for review of a Workers' Compensation MSA proposal are only CMS work load review thresholds, not substantive dollar or 'safe harbor' thresholds for complying with Medicare Secondary Payer Act." The memorandum does, however, offer a glimpse into Medicare's idea of future Medicare covered medical needs. The policy memorandum further reads that "under the Medicare Secondary Payer provisions, Medicare is always secondary to Workers' Compensation and other insurance such as no fault and liability insurance. Accordingly, all beneficiaries and claimant's must consider and protect Medicare's interest when settling any Workers' Compensation case; even if review thresholds are not met, Medicare's interest must always be considered". The take away is that Medicare is expecting that all settlements, regardless of Medicare status and settlement amount will need to protect Medicare's interests.

The work load review threshold does not provide safe harbors. While CMS will review certain MSA proposals, it does not have the resources to review everything. Thus, it imposes a certain work load review threshold which helps its contractors to determine which cases to review and which not to review. If a case fails to meet the threshold, it does not mean that the parties can ignore the Medicare issue. Medicare specifically counsels otherwise: "These thresholds are created based on CMS work load, and are not intended to indicate that claimants may settle below the threshold with impunity. Claimants must still consider Medicare's interest in all Workers' Compensation cases and ensure that Medicare pays Secondary to Workers' Compensation in such cases". (CMS, WCMSA Reference Guide Section 8.1. Guidance can be found in the Workers' Compensation Medicare Set Aside Arrangement Reference Guide published July 10, 2010). Further, Section 3.0 entitled "What are Workers' Compensation Medicare Set Aside Arrangements" states "any claimant who receives a Workers' Compensation settlement, judgment or award that includes an amount for future medical expenses must take Medicare's interest with respect to future medicals into account". The WCMSA Reference Guide updated on March 19, 2018 states that in order to comply with 42 USC Section 1395Y(b)(2) and Section 1862(b)(2)(A)(ii) of the Social Security Act, Medicare may not pay for a beneficiary's medical expenses when payment "has been made or can reasonably be expected to be made under a Workers' Compensation plan, an automobile or liability insurance plan or a self-insured plan or no-fault insurance. Further insight is found in Section 4.2 which states that Medicare's interests are protected by submitting a WCMSA in a proposed amount for review but same is never required "but Workers' Compensation claimants must always protect Medicare's interests."

The guidelines and the memoranda set forth only those situations where settlements will be reviewed by CMS. These are recommendations only; the thresholds are not codified and it is simply a tool implemented by CMS to manage its workload. Conversely, the creation of a workload review threshold does not preclude an MSA/Allocation or a protective MSA in any case. Indeed, considering the intent of the statute, the clarifications issued by CMS and the penalty provisions set forth in the statute, it is prudent to establish an MSA/Allocation in every case to ensure that Medicare's interests are considered and protected.

As the Circuit Court for the US Court of Appeals stated in Matter of Caldera v. Insurance Company of the State of Pennsylvania, 716 F.3d 861, the Federal Implementing Regulation provides that "Medicare benefits are secondary to benefits payable by a primary payer even if state law or the primary Payer states that its benefits are secondary to Medicare benefits or otherwise attempts to limit payments to Medicare beneficiaries 42CFR Section 411.32(a)(1). Congress explicitly prohibited Workers' Compensation and other insurers from subordinating their payment obligations to those of Medicare. The plain language of the MSP illustrates its harmonious relationship with the state Workers' Compensation Law: A Workers' Compensation carrier "is primary" only if "payment has been made or can reasonably be expected to be made under Workers' Compensation Law or Plan. The Court in Caldera concluded that Congress intended the MSP to complement, not supplant, state Workers' Compensation rules. See: Blue Cross & Blue Shield of Texas v. Shalala, 995 F.2d 70, 73 (5th Cir. 1993).

ATTORNEYS' FEES

CMS has made it clear that attorneys' fees associated with establishing the MSA arrangement cannot be charged against the set-aside amount. Rather, the payment of these costs must come from some other payment and ensure that is completely separate from the MSA arrangement funds (5/7/04 Memorandum from the Director-Center for Medicare Management).

With regard to Section 32 Settlement Agreements, Workers' Compensation Law Section 24 provides that attorney's fees shall not be enforceable unless approved by the Board pursuant to 12 NYCRR 300.36(i). Accordingly, a Section 32 Agreement

"may provide for reasonable fees commensurate with the services rendered" made payable to the claimant's attorney or representative. The Board in Matter of Prestige Care, Case No. 0083 5838 (10/1/14), found that the standards set forth in 12 NYCRR 300.17 apply in determining the proper attorneys' fee with regard to a Workers' Compensation Law Section 32 Agreement. 12NYCRR 300.17 states; "In the representation of a claimant before the Board or a Workers Compensation Law Judge in any case (f) Whenever an award is made to a claimant who is represented by an attorney…and a fee is required, the board in such case shall approve a fee in the amount commensurate with the services rendered and having due regard for the financial status of the claimant…in no case shall the fee be based solely on the amount of the award". In Matter of Evergreen Commons, Case No. G021 2727 (5/5/14) the Board specifically held and referenced the CMS Memorandum dated May 7, 2004 as follows:

While Medicare recognizes that legal services may be needed to negotiate workers' compensation settlements containing Medicare Set-Aside provisions, the Center for Medicare & Medicaid Services (CMS) has made it clear that attorney's fees associated with establishing the Medicare Set-Aside arrangement cannot be charged against the Set-Aside amount. Rather, "the payment of these costs must come from some other payment source that is completely separate from Medicare set-aside arrangement funds" (May 7, 2004 Memorandum from: Director – Center for Medicare Management; available at www.cms.hhs.gov/WorkersCompAgencyServices).

CONCLUSION

Accordingly, based upon the above, it is clear that the MSP mandates that Medicare's interests must be taken into consideration in all settlement agreements which include payment for future medical benefits releasing the primary payer and for closing future medical benefits. Additionally, it is clear that attorney fees associated with negotiating a Section 32 Settlement Agreement inclusive of a Medicare Set-Aside or allocation cannot be deducted from the Medicare Set-Aside or allocation and must come from some other payment source that is completely separate from the Medicare Set-Aside or allocation.

Should there be any questions or should you require any additional clarification on these issues please contact our office accordingly.

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