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Pennsylvania Court Addresses Subrogation in Context of Medicare Set-Asides

On April 5, 2019, the Commonwealth Court of Pennsylvania affirmed a Workers' Compensation Judge's ("WCJ") determination that the funds designated in a third-party settlement agreement to create a Medicare Set-Aside Arrangement ("MSA") for Jerome Marshall ("Claimant") were subject to subrogation under Section 319 of the Workers' Compensation Act, 77 P.S. § 671 ("Section 319"). While this is an unpublished opinion and contains further consideration of the change in Pennsylvania Workers' Compensation subrogation law that was established in *Whitmoyer v. Workers' Compensation Appeal Board (Mountain Country Meats)*, 186 A.3d 947, 949 (Pa. 2018), the case demonstrates the importance of understanding both the factors of timing and context of the Medicare issues that may arise within workers' compensation settlements.

Background

In 2005, Claimant sustained injuries in a motor vehicle accident while driving a bus for Easton Coach Company ("the Employer"). Claimant filed a third-party action against the driver of the vehicle that struck the bus, which resulted in a settlement of $35,000. Additionally, Claimant settled an uninsured motorist claim ("UIM") for $1.3 million in July 2015 with the Employer's UIM carrier. In the UIM settlement agreement, $413,333.33 was paid to Claimant's wife for loss of consortium with the remaining $886,666.67 payable to Claimant and subject to subrogation under Section 319. In addition, Claimant also received $153,982 from the UIM carrier to fund a proposed MSA in anticipation of settlement of all claims, including the workers' compensation claim.

Prior to the settlement, the Center for Medicare and Medicaid Services ("CMS") reviewed an MSA submitted by the parties and issued a letter in June 2013 indicating that an MSA should be funded in the amount of $335,874. The letter clearly stated that the approval of the MSA amount was not effective at that time and the MSA would not be finalized until a copy of the final executed workers' compensation settlement agreement was received by CMS. Ultimately, the workers' compensation case did not settle, and in 2015 Claimant engaged a Medicare Set-Aside vendor to reassess the MSA issues of the case. The vendor did conclude that an MSA was required to protect Medicare's interest and recommended the third party settlement should fund 55% of the proposed MSA amount with the workers' compensation carrier funding the remaining 45%. It was further recommended that the proposed annuity pricing recommended by CMS in their July 2013 letter be modified in consideration of passage of time. Their analysis indicated that it was based on the assumption that the parties will have resolved both the workers' compensation claim and the third party claims and were expected to pay for medical care from the date of settlement.

Following the settlement of the UIM claim, the Employer filed a Modification Petition asserting the parties were unable to agree on the Employers' subrogation interest. The Employer asserted that the $153,982 paid to fund a proposed MSA was subject to subrogation under Section 319 of the Workers' Compensation Act. Claimant argued that the $153,982 that had been set aside exclusively to fund an MSA should be excluded. The WCJ found that because settlement of the workers' compensation claim had not occurred, no such final agreement was sent to

CMS, which was noted in the July 2013 letter as a requirement to final approval of the MSA. As such, the WCJ held that the proposed MSA was not finalized and the Employer remained liable to pay for the medical treatment of Claimant's work injuries until the claim reached final settlement. The WCJ found the $153,982 was therefore subject to subrogation. Claimant appealed this decision to the Workers' Compensation Appeal Board ("Board"), which held that the WCJ was correct to allow inclusion of the MSA funds in the Employer's Modification Petition.

The Commonwealth Decision

In their opinion, the Court was quick to address the Supreme Court decision in *Whitmoyer*. In *Whitmoyer*, the Supreme Court determined that when an employer recovers from a third party settlement it can only take a credit against future disability benefits, but not future medical benefits. As the WCJ and Board decisions were issued prior to *Whitmoyer*, the Court remanded the case to determine if it was improperly allowing the Employer to take a credit against Claimant's ongoing medical benefits.

However, the Court also determined there was no error in the WCJ's conclusion that a valid MSA had not been created. Citing the fact that an employer is not released from paying future medical benefits until there is a final settlement, the Court correctly noted that the employer continues to be primarily liable for the medical treatment related to Claimant's work injury, and Medicare's interests are protected until settlement occurs. As the facts clearly demonstrated that Claimant's workers' compensation claim never settled, the Employer never paid the amount anticipated to be its contribution to the MSA under the MSA vendor analysis. The Court held that the fact that the UIM settlement agreement designated specific funds to be paid by the Employer as contribution for an MSA did not exclude those funds from being available for the Employer's subrogation claim. The Court noted that those specific funds would remain eligible for subrogation in the absence of a valid MSA and workers' compensation settlement agreement.

Analysis

The *Whitmoyer* decision will continue to be determinative for most Section 319 issues that arise as a result of the parties determining that an MSA is appropriate in the settlement of their case. However, this decision highlights some of the complexity and nuance of the timing issues that need to be understood by the parties to have effective and final resolution of their claims and to properly consider Medicare's interests. Most notably is the often overlooked CMS requirement that an MSA amount is only *conditionally* approved by CMS and not finalized until the parties provide a copy of the executed settlement agreement to CMS. Although the MSA amount was approved by CMS in this case, the approval letter provided by CMS clearly articulated that the MSA was not effective until a copy of the settlement agreement was submitted to CMS. While this may appear to be little more than administrative fine print, the reasoning is rooted in the core concept that Medicare will remain a secondary payer to any known primary payer. Until settlement of the workers' compensation claim has occurred, Medicare's interests are protected and the need for an MSA has not yet materialized.

It also should be noted that CMS approval of an MSA amount does not always immediately follow CMS review of an MSA, nor does it initiate a deadline to fund or settle an applicable claim within a certain period of time. There are valid reasons for which a claim may remain open following a conditional approval of an MSA by CMS, including the possibility that the CMS approved MSA amount is subject to change based on a variety of factors, such as clear errors made by CMS in their analysis of the MSA, the availability of records that should have been considered by CMS in their analysis of the MSA, and certain changes in care that have occurred since the initial conditional approval.

However, a delayed settlement, whether by choice or by circumstance, can create a new set of problems as well and the parties may not have a full complement of options available to them when the claim finally ripens for

settlement. For instance, in this matter, the CMS conditional approval letter was issued on July 24, 2013, and the workers' compensation claim remains unresolved. Absent a mathematical error or if there was documentation missing from the initial MSA submission, the current version of the WCMSA Reference Guide only permits a more substantive review of a new MSA for a period of up to four years following a conditional approval. As this period for review has elapsed in the instant case, the parties may be left with some questions and hard choices when final settlement is eventually reached, as the now nearly six year old conditional MSA is likely no longer representative of the beneficiary's care needs. Should the parties fund the MSA as instructed in the conditional approval letter even though this is likely more care than the beneficiary will now require? Should they reduce the MSA independently or based on the opinion of a vendor? What would occur if the workers' compensation carrier informed CMS that they were only funding an MSA consistent with their pro-rata share as determined by the MSA vendor? Has the UIM carrier satisfied their obligations to protect Medicare's interest now that the court has determined that a valid MSA has not been established?

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