

The New Frontier of Liability Medicare Set Asides: What Should be Done when Settling a Liability Claim with a Medicare Beneficiary?

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Introduction

Since the Medicare, Medicaid and SCHIP Extension Act (“MMSEA”) was signed into law by President Bush at the end of 2007, significant confusion has existed regarding Medicare set asides in liability settlements. The MMSEA has nothing to do with liability Medicare set asides (“LMSA”). Instead, it creates a mandatory insurer reporting requirement for settlements with Medicare beneficiaries with stiff penalties for non-compliance. The passage of the MMSEA led to heightened scrutiny by insurers regarding their compliance with the Medicare Secondary Payer Act (“MSP”) which in turn led to questions regarding the applicability of Medicare set asides to liability settlements. Accordingly, since passage of the MMSEA case law has begun to develop and CMS has made two important pronouncements regarding Medicare set asides in liability settlements. I have outlined all of the important cases and CMS memos below in an attempt to bring some clarity to the current state of affairs.

The Medicare Secondary Payor Act (“MSP”) is a series of statutory provisions enacted in 1980 as part of the Omnibus Reconciliation Act with the goal of reducing federal health care costs.

The MSP provides that if a primary payer exists, Medicare only pays for medical treatment relating to an injury to the extent that the primary payer does not pay. The regulations that implement the MSP provide “[s]ection 1862(b)(2)(A)(ii) of the [a]ct precludes Medicare payment for services to the extent that payment has been made or can reasonably be expected to be made promptly under any of the following: i) workers’ compensation, ii) liability insurance, iii) no-fault insurance.”

According to CMS, the MSP requires not only satisfaction of conditional payments (payments made by Medicare prior to settlement) but also setting aside a portion of a settlement to cover future Medicare covered services related to the personal physical injury suffered. CMS’s position is based on its interpretation of 42 U.S.C §1395 y(b)(2) which is a provision in the federal law that the agency is charged with interpreting. In a recent memo issued by Sally Stalcup, a CMS Regional Director, she gave a succinct statement of CMS’s position as to what is required when it comes to Medicare futures. She stated that “[a]ny time a settlement, judgment or award provides funds for future medical services, it can reasonably be expected that those monies are available to pay for 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 and reimbursable by Medicare.”

The cases outlined below have discussed this interpretation and have simply assumed it has the force of law. While CMS is charged with interpreting the MSP there are no statutes or regulations it can cite to when it comes to a “set aside”. CMS’s recent memos state the agency’s interpretation of the law it is charged with interpreting. Generally agencies are afforded deference in terms of its interpretation of its own regulations under *Chevron, U.S.A, Inc. v. Natural Resources Defense Council, Inc.* The problem with Medicare set asides in liability settlements is that there are no regulations that exist outside of 42 C.F.R. §411.46 and 42 C.F.R. §411.47 which do not directly address “set asides” and are strictly limited to workers’ compensation matters. Nevertheless, case law has begun to develop and CMS is issuing memos as if set asides are “required” in liability settlements. Lawyers handling cases on behalf of Medicare beneficiaries and defense counsel representing insurers will have to interpret the case law and memos to make a decision as to the best course of action for their respective clients.

LMSA Case Law: Finke v. Hunter’s View, LTD. (August 2009)

In *Finke v. Hunter’s View, Ltd.* a Minnesota Federal District court held no liability Medicare set aside was necessary given the facts of the case. The plaintiff, Finke, was paralyzed from the chest down after a thirty foot fall from a tree while using a hunting deer tree stand manufactured by Hunter’s View. The plaintiff brought an action alleging the deer stand was defective in design and unreasonably dangerous to the user of the stand. Wal-Mart was also sued since it sold the stand. Mr. Finke received both Medicaid and Medicare benefits following his injury. Medicare has approximately \$18,000.00 in conditional payments. Mr. Finke also had private group healthcare coverage. The parties negotiated a settlement of \$1,500,000.

Approval of the settlement was sought from the United States District Court in Minnesota. The case is important for findings contained in the order approving the settlement. Specifically, the court made the following finding of fact “Medicare does not currently have a policy or procedure in effect for reviewing or providing an opinion regarding the adequacy of the future medical aspect of a liability settlement or recovery of future medical expenses incurred in liability cases.” The court pointed out that Mr. Finke was not currently receiving Medicare benefits, even though he was eligible, because he was covered by a private group health plan. The court stated “[t]he parties have considered the fact that it is not reasonably likely that Medicare will make any additional payments for future medical expenses in the reasonably

foreseeable future. The parties have also considered the fact that Plaintiff Darus Finke is currently subject to coverage under his wife, Shea Finke's, policy, and benefits available through that policy are more than adequate to cover all reasonably anticipated medical expenses for the reasonably anticipated future. In view of these facts there has been no allocation in the settlement for future medical expenses.”

The court went on to make some interesting conclusions of law. First, “[t]he parties shall, and have, reasonably considered and protected Medicare's interest in this matter. Second, “Darus Finke's reasonably anticipated future medical care expenses will be reimbursed by and governed by the Grand Itasca policy which will continue to be primary over Medicare.” Third and most importantly, “[t]o the extent that the parties are obligated to reasonably consider the interest of Medicare in reaching the settlement, the Court concludes the Parties have reasonably considered the interests of Medicare. The Findings of Fact support the Conclusion that it is not reasonably likely that Plaintiff Darus Finke will require Medicare benefits in the reasonably foreseeable future. The court concludes therefore that there is no reason for the parties to set aside any certain amount for future Medicare claims.” In the order, it stated “[t]he parties have reasonably and adequately considered the interest of Medicare in this settlement, and Plaintiffs Darus Finke and Shea Finke and Defendants Wal-Mart and Hunter's View will

not be subject to any claim, demand or penalty from Medicare, Medicaid, or any other party, as a result of its settlement payments in this matter.”

LMSA Case Law: Big R. Towing, Inc. v. Benoit et al. (January 2011)

In Big R. Towing, Inc. v. Benoit, the United States District Court for the Western District of Louisiana recognized an obligation to set aside funds for future Medicare covered services and allocated said funds in a non-Workers' Compensation case. David Benoit was employed by Big R Towing as a captain aboard a tugboat. At the time he was injured in December of 2009, he was working in that capacity and was covered as a seaman under the Jones Act. Benoit suffered a back and hip injury while performing deck work on the tow. He had a preexisting spinal condition which restricted him from performing the task he was injured while completing. His treating physicians recommended surgery for his back and hip.

There was conflicting medical testimony whether his need for surgery was related to his preexisting conditions or due to the accident. Big R filed suit for declaratory relief on the issue of whether benefits were due. Benoit filed a counterclaim seeking damages under the Jones Act and general maritime law. The case was settled at mediation for a lump sum of \$150,000. At the time of the settlement, Benoit was receiving Social Security disability benefits and part of the consideration for the settlement was

that Benoit would be responsible for protecting Medicare's interest under the Medicare Secondary Payer statute. Sound familiar?

An oral motion was made for the court to determine the future medical expenses in order for Benoit to set aside funding, taking Medicare's interest into account. The parties consented to allowing the United States District Court magistrate to rule on the issue of future medical expenses and a hearing was held with medical evidence presented as to future Medicare covered services. The court made the following important findings of fact:

"1. Medicare does not currently have a policy or procedure in effect for reviewing or providing an opinion regarding the adequacy of the future medical aspect of a liability settlement or recovery of future medical expenses incurred in liability cases."

"2. David Wayne Benoit's date of birth is August 2, 1952 and he will not obtain the age of 65 within 30 months of the date of settlement. However, he is currently receiving social security disability benefits."

"5. The parties have considered Benoit's projected future loss of earnings and projected future medical expenses. According to his health care providers, the future costs for low back surgery are \$32,000.00, inclusive of hospital and surgical fees, and the costs for a left hip

replacement are \$20,500.00. The figure will not materially change if Benoit opts not to have surgery on his hip, but instead goes through palliative treatment. The combination of these two figures, \$52,500.00, represents more than half of the net settlement proceeds and will be set aside by Benoit to fund these medical expenses."

After making the foregoing findings of fact, the court made the following noteworthy findings of law:

"1. The parties shall and have reasonably considered and protected Medicare's interests in the settlement of this matter."

"2. Medicare is a secondary payor under the Medicare secondary payor program, to the extent that there are Medicare covered expenses incurred by David Wayne Benoit, in the past or in the **future**, arising out of the accident and injuries alleged in this lawsuit." (emphasis added)

"4. The findings of fact support the conclusion that it is reasonably expected that David Wayne Benoit may become a Medicare beneficiary in the future. The sum of \$52,500.00 to be set aside by David Wayne Benoit out of the settlement proceeds for future medical expenses associated with lumbar surgery and left hip replacement or therapy

fairly **takes Medicare's interests into account** and David Wayne Benoit should set aside that amount to protect Medicare's interests as the **secondary payer for future medical expenses arising out of the injuries** alleged in this lawsuit.” (emphasis added)

Analysis of Benoit

While this case, like the Finke decision, is not an appellate decision and is limited to the facts presented to the court, it is still noteworthy. It was the first case I am aware of that actually recognizes an obligation to set aside monies for future Medicare services and allocates the funds in a non-Workers' Compensation matter. It is also very significant in terms of some subtle findings made by the court. The first such finding is the judicial determination of what the allocation is without a formal allocation being completed by a 3rd party company. The second noteworthy finding or lack of a finding is in regards to apportionment. There was no reduction of the set aside amount based upon the allocation encompassing more than half of the net proceeds. There was no Ahlborn type of apportionment so that the set aside only reached the medical portion of the recovery. Third, the court didn't add the allocation amount onto the settlement, it was deducted from the gross settlement amount. Lastly, Medicare is a secondary payer in liability cases in regards to **future** services.

One other important point from Benoit, is the apparent judicial notice of the procedures established by CMS in terms of Medicare Set Asides for workers' compensation settlements. The court, by reference to them in some of its findings, seems to approve their use in liability settlements. In my view this is troubling as the procedures do not take into account the unique differences between workers' compensation settlement and liability settlements. The fact that there was no consideration given to the fact that more than half of the client's net proceeds were being set aside even though the client was not recovering one hundred percent of future medical expenses. There was no analysis of what portion of the settlement was related to future medical. This is problematic and illustrates just one of the many problems in applying procedures meant for workers' compensation settlements to liability settlements in the MSA context.

LMSA Case Law: Hinsinger v. Showboat Atlantic City (May 2011)

Hinsinger v. Showboat Atlantic City is another illustration of the mess that has become the norm in the world of settlements involving Medicare beneficiaries. CMS has failed to offer any guidance on handling liability Medicare set asides. As a result, cases are now being litigated in state as well as federal court regarding specific issues related to liability set asides. In Hinsinger, the question that is addressed is whether a liability set aside is reduced for procurement costs. As a matter of practice,

procurement costs aren't deducted from WCMSAs. However, liability settlements and set asides are a different animal all together.

The facts of Hingsinger are quite interesting. The case was tried and the plaintiff prevailed in 2010. Prior to trial, in 2008, the plaintiff became eligible for SSDI benefits after being declared total disabled by the Social Security Administration. Since SSDI gives you early Medicare coverage (after 24 months), the plaintiff became Medicare eligible in late 2009. After trial, the parties settled the case for \$600,000. In an effort to comply with the requirements of the Medicare Secondary Payer Act (42 USC 1395y), plaintiff and defendant agreed to allocate \$180,600 to a Medicare Set Aside trust ("MSAT") to pay for Medicare covered future services related to the injury. This amount reflected the jury's award for projected future medical needs related to the injuries. As an aside, while a set aside is typically calculated by a third party vendor who creates an "allocation" that is done prior to a trial on the merits. Once a trial fixes the amount of dollars for future medical, that is the figure that CMS would be bound by in my opinion.

After agreeing to the set aside, plaintiff counsel sought permission from the court to withdraw a portion of his fees from the money allocated to the MSAT. In arriving at its decision whether this was appropriate or not, the court discussed Medicare set asides. The court seemed to take as a given that an injury victim must take

Medicare's future interests into account under the secondary payer act when settling/resolving an injury claim. While the court did note that there is no statutory or regulatory requirements mandating Medicare Set Asides, it did recognize that CMS recommends their use and it has become a "standard practice, particularly in workers' compensation cases, to create a set aside to protect the future interests of the injured individual and Medicare."

The court then launched into a discussion of the appropriateness of reducing the set aside by procurement costs. While plaintiff counsel argued that the guidelines created by CMS for workers' compensation cases didn't apply to liability settlements, the court disagreed. It stated it's rationale as follows:

"[T]his court finds no reason to apply a different standard to set asides created with money obtained from third-party liability claims than it applies to set asides created with money obtained from workers' compensation claims. The statutory and policy reasons for creating both of them are the same: to protect the government, and the Medicare system in particular, from paying medical bills for which the beneficiary has already received money from another source. In addition, the Center for Medicare and Medicaid Services has stated multiple times that the same statutes that necessitate or otherwise apply to Medicare set asides in workers' compensation cases apply to third-party liability situations. *Transcript of*

Center for Medicare and Medicaid Services Conference Call, 18 (October 29, 2008) (“I don't believe there is a General Counsel Memo that says that there are no liability set asides. We, in brief, we have a very informal, limited process for liability set asides. We don't have the same extensive ones we have for workers' comp. However, the underlying statutory obligation is the same.”); *Transcript of Center for Medicare and Medicaid Services Conference Call*, 61 (March 24, 2009) (the statutes that apply to workers' compensation situations also apply to liability situations).”

I find this to be a very important part of the holding as it seems to be indicating that the guidelines that CMS has issued for workers' compensation apply to liability settlements. The problem, as I have discussed in previous writings, is that the guidelines don't work in liability settlements.

After concluding that the same regulations and directives that apply to set asides created in workers' compensation cases apply to set asides in third party liability settlements, the court addressed whether those regulations allow for an attorney to recover fees for a judgment or settlement obtained on behalf of a client in a civil suit from the set aside itself. The court answered in the affirmative. The court's holding rested on its interpretation of 42 CFR 411.37 which provides a reduction formula Medicare uses when a primary payment is made as a result of a judgment or settlement. 411.37 provides

that Medicare reduces its recovery by the costs expended in procuring the judgment or settlement if “[p]rocurement costs are incurred because the claim is disputed” and “[t]hose costs are borne by the party against which CMS seeks to recover.” While the court acknowledged that is unclear whether 42 CFR 411.37 only applies to recovery of funds expended by Medicare in conditional payments or also to funds obtained through a settlement or judgment for future medical, it concluded it applied to funds recovered for future medical which are set aside. This conclusion, according to the court, was supported by the language of the regulation and the headings in 42 CFR Part 411. The court also reviewed the guidelines issued related to workers' compensation set asides which don't allow for the reduction for fees “associated with establishing the Medicare set-aside arrangement.” It stated that this directive applies only to attorney fees “specifically associated with establishing” an MSAT.

Applying the reduction for procurement costs to liability set asides was “in line with general principles of equity” according to the Hingsinger court. It stated, that “[w]here a plaintiff is, or will within a short time become, a Medicare recipient, the plaintiff's attorney also works on behalf of Medicare to secure funds to pay future medical expenses Medicare would otherwise pay.” Allowing Medicare to avoid paying its fair share of the procurement fees/costs would be unfair to injury victims. The court did identify a large problem associated with

Medicare set asides in liability settlements. It stated:

“In some situations, a plaintiff may end up getting nothing after creating the set aside and paying attorneys' fees or may even have to pay money out of pocket to his attorney after a lengthy trial. Such a result would not only be inequitable, it would deter persons on Medicare who are injured by the tortious acts of others from bringing claims.”

The court ultimately allowed the plaintiff attorney to take \$59,196.67 in fees from the set aside. This figure was based upon the ration of procurement costs to the total settlement which was 32.778%. Since plaintiff counsel was entitled to a total fee of 32.778% of the amount in the set aside, he was awarded \$59,196.67. No request for costs to be deducted from the set aside was made thus the court didn't reach that particular issue. Presumably the costs would be allowed based upon the same reduction formula as well under the court's rationale.

Analysis of Hinsinger

The concept of reduction of the set aside amount by the amount of legal fees incurred makes sense given the formula for reduction of conditional payments in the Code of Federal Regulations. See 42 CFR 411.37. 411.37 allows for a pro-rate reduction of conditional payment amounts by fees and costs. Why shouldn't a MSA be governed by the same type of reduction? A lawyer who provides services to a Medicare beneficiary that results in recovery

of future medical that Medicare ultimately does not have to incur should be subjected to a reduction for procurement costs in the same way it is applied to conditional payments.

May 2011 CMS Region 6 LMSA Memo

A memo was issued by Sally Stalcup, the MSP Regional Coordinator for CMS (Region 6 – Dallas RO) in May of 2011, which was the first detailed written pronouncement from CMS addressing Medicare set-asides in liability cases. While it is informative and gives a glimpse of the thoughts of some at CMS regarding liability Medicare set asides, it isn't law. The memo is simply one CMS Regional Coordinator's viewpoint. Until CMS issues formal guidance or there is law regarding Medicare set asides, we are left with nothing definitive to hang our hat on in terms of how to deal with Medicare's "future interest". Nevertheless, I will highlight the important portions of the memo below and try to add some clarity.

The memo starts out with an important statement. Ms. Stalcup indicates that the "information provided is only intended to be a general summary" but it isn't "intended to take the place of either the written law or regulations." While Ms. Stalcup encourages readers to review statutes, regulations and other materials issued by CMS on this subject, that is impossible as there is nothing that specifically addresses liability Medicare set asides. She limits the applicability of the memo to the states covered by the Region 6 office, which are

Oklahoma, Texas, New Mexico, Louisiana and Arkansas.

The central premise of the memo is laid out immediately that when settling a case involving a Medicare beneficiary, “Medicare's interests must be protected; however, CMS does not mandate a specific mechanism to protect those interests.” While she acknowledges that the law doesn’t require a “set-aside” in any particular situation, she indicates that the Medicare Trust Fund must be protected from payment for future services whether they arise from a Workers’ Compensation settlement or liability settlement because there is no distinction in the MSP. She goes on to say that a “Set-aside is our method of choice and the agency feels it provides the best protection for the program and the Medicare beneficiary.”

She goes on to identify what she believes is the legal underpinnings of the need to address Medicare’s future interests. She states that “Section 1862(b)(2)(A)(ii) of the Social Security, Act [42 USC 1395 y(b)(2)], 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. This also governs Workers' Compensation. 42 CFR 411.50 defines the term "liability insurance". Any time a settlement, judgment or award provides funds for future medical services, it can reasonably be expected that those monies are available to pay for 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 and reimbursable by Medicare. If the settlement, judgment, award .y [sic] are not funded there is no reasonable expectation that third party funds are available to pay for those services.”

CMS does not have a formal process to review and approve Medicare set asides like they do in Workers’ Compensation cases according to Ms. Stalcup, which we already know. CMS review of proposed liability Medicare set asides is determined on a case-by-case basis by the appropriate regional office. For example, the Atlanta Regional office routinely refuses to review liability Medicare set asides we have submitted. Their typical response is that “[d]ue to resource constraints, CMS Is not providing a review of this proposed liability Medicare set aside arrangement.” The form letter goes on to say “this does not constitute a release or a safe harbor from **any** obligations under **any** Federal law, including the MSP statute.” (Emphasis added). In bold print the letter warns, “**All parties must ensure that Medicare is secondary to any other entity responsible for payment of medical items and services related to the liability settlement, judgment or award.**” Nevertheless, Ms. Stalcup states in *her* memo that “CMS does expect the funds to be exhausted on otherwise Medicare covered and otherwise reimbursable services related to what

was claimed and/or released before Medicare is ever billed” regardless of whether a set aside is reviewed/approved by CMS.

As is the case in Medicare conditional payments obligations, she emphasizes that allocations made in a settlement agreement to different categories of damages is ineffective in terms of getting around the obligation to set funds aside. The memo states that the “fact that a settlement/judgment/award does not specify payment for future medical services does not mean that they are not funded.” Further, the “fact that the agreement designates the entire amount for pain and suffering does not mean that future medicals are not funded.” While Medicare has been challenged and lost in the 11th Circuit on the issue of its failure to recognize allocations by a court order other than on the merits of the case (see *Bradley v. Sebelius*), Ms. Stalcup sticks to the CMS position on this issue and states that the “only situation in which Medicare recognizes allocations of liability payments to nonmedical losses is when payment is based on a court of competent jurisdiction's order after their review on the merits of the case.” “If the court of competent jurisdiction has reviewed the facts of the case and determined that there are no future medical services Medicare will accept the Court's designation.” The lesson from these statements is that CMS will not stand for attempts to shift damages to non-Medical categories and will not recognize allocations unless via a court order on the merits of the case.

While this may force issues of damages to be tried and clog the court system, CMS continues to take this ridiculous position.

To clarify what is considered future medical portions of a recovery and how to know whether a settlement includes them, the memo gives some examples. “Consider the following examples as a guide for determining whether or not settlement funds must be used to protect Medicare's interest on any Medicare covered otherwise reimbursable, case related, future medical services. Does the case involve a catastrophic injury or illness? Is there a Life Care Plan or similar document? Does the case involve any aspect of Workers' Compensation? This list is by no means all inclusive.” An important part of the memo addresses what is “case related” medical expenses. CMS’s view is that this includes “more than just services related to the actual injury/illness which is the basis of the case.” “Because the law 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, Medicare's right of recovery, and the prohibition from billing Medicare for future services, extends to all those services related to what was claimed and/or released in the settlement, judgment, or award. Medicare's payment for those same past services is recoverable and payment for those future services is precluded by Section 1862(b)(2)(A)(ii) of the Social Security Act.”

The memo does address CMS's view of plaintiff counsel's obligations in regard to future Medicare covered services incurred by the client. "We do however urge counsel to consider this issue when settling a case and recommend that their determination as to whether or not their case provided recovery funds for future medicals be documented in their records. Should they determine that future services are funded, those dollars must be used to pay for future otherwise Medicare covered case related services." CMS will not issue opinion letters or sign off on determinations of whether or not there is a recovery of future medical services triggering the need to protect the Medicare Trust Fund. The memo puts the determination of these issues in the lap of the attorney handling the claim. According to Ms. Stalcup, each "attorney is going to have to decide, based on the specific facts of each of their cases, whether or not there is funding for future medicals and if so, a need to protect the Trust Funds." "They must decide whether or not there is funding for future medicals. If the answer for plaintiffs counsel is yes, they should to [sic] see to it that those funds are used to pay for otherwise Medicare covered services related to what is claimed/released in the settlement judgment award."

LMSA Case Law: Schexnayder v. Scottsdale Insurance Company (July 2011)

In Schexnayder, the plaintiff was injured in an automobile accident while in the course and scope of his job. Mr. Schexnayder was struck

from behind by an 18-wheeler insured by National Casualty Company. As a result of the accident, the plaintiff underwent three surgical procedures related to his neck and back injuries. His past medical expenses exceeded \$377,000. The workers' compensation carrier that covered the employer Mr. Schexnayder worked for at the time of the accident paid a portion of the medical. The remainder of the medical expenses was paid for by private insurance and Medicare paid no portion of any of the medical bills.

The third party defendant admitted liability for the accident but defended disability, medical issues and economic losses. The case with the liability insurer was settled at mediation. Part of the agreed upon settlement was that the plaintiff would be solely responsible for protecting Medicare's interests under the MSP. The workers' compensation claim was also settled for waiver of a significant portion of its lien plus a partial reimbursement. An MSA was not done as part of the workers' compensation settlement because it was determined it wasn't necessary since Mr. Schexnayder was not a current Medicare beneficiary nor did he have a reasonable expectation of Medicare enrollment within 30 months of the settlement date.

The case came back before the court post settlement by consent of both of the parties. The court retained jurisdiction post order of dismissal if the settlement was not consummated. Because a CMS approved Liability Medicare Set Aside might not be

possible and or might not occur for quite some time, the settlement couldn't be finalized. In an effort to avoid rescinding the settlement completely, yet comply with the provisions of the MSP, the parties filed a joint motion for declaratory judgment seeking approval of the settlement and a declaration that the interests of Medicare were adequately protected by setting aside a sum of money for future medical expenses. The court held an evidentiary hearing on these issues ultimately leading to the order, which cited the Stalcup LMSA memo.

In the order, Mr. Schexnayder is commanded to "promptly reimburse Medicare" for an conditional payments. He was also ordered to fund a \$239,253.84 Medicare set aside to pay for future medical items or services which would otherwise have been covered by Medicare related to the injuries he sustained in the accident. The order also specifically required the set aside funds to be put into an interest bearing account to be "self-administered" by Mr. Schexnayder's wife.

Analysis of Schexnayder

This case is another glaring example of the confusion over Medicare Set Asides and Medicare secondary payer compliance. I am perplexed by this order on many levels. First, the case does NOT involve a Medicare beneficiary. So this begs the question of why there was discussion and an order to reimburse Medicare for conditional payments. There were NONE. Further, why discuss Medicare set

asides when the case does not involve a Medicare beneficiary or someone with a reasonable expectation of being a Medicare beneficiary within 30 months? Second, even assuming this case was appropriate for an MSA why discuss the Stalcup memo since this settlement was a hybrid which did involve extinguishing a workers' compensation carrier's liability for future medical care. Accordingly, the CMS policy memos which govern workers' compensation Medicare set asides would be arguably applicable so a discussion of the Stalcup memo isn't necessary.

LMSA Case Law: Smith v. Marine Terminals (August 2011)

In Smith v. Marine Terminals of Arkansas, the United States District Court in the Eastern District of Arkansas was asked to determine a set aside amount in a Longshore/Jones Act case. Specifically, the plaintiff, Billy Smith, asked "the court to confirm and/or determine a reasonable allocation representing the future cost of medical treatment causally related to injury sustained in plaintiffs accident of April 14, 2006 that would also be covered by Medicare, commonly referred to as the 'Medicare Set Aside' ("MSA")." In so making this determination, the Smith court addressed what is necessary in its opinion under federal law when a case is settled on behalf of a Medicare beneficiary. The court stated that because "Billy Smith is a current recipient of Social Security Disability benefits, he is currently Medicare eligible and the parties must reasonably consider

and protect Medicare's interests consistent with the Medicare Secondary Payor Act, 42 U.S.C. § 1395y.”

Billy Smith filed a Longshore and Jones Act claim after being injured on a floating barge. Mr. Smith’s right hand was severely injured in April of 2006 while working on the floating barge. The Jones Act claims were dismissed on motion for Summary Judgment. Smith’s alternative claim under the Longshore and Harbor Workers’ Compensation Act survived summary judgment. The parties ultimately reached an agreement to settle the claim. As part of the settlement, the parties agreed to retain the services of a company to determine the Medicare set aside “allocation” amount and submit it to CMS for approval since it met the Workers’ Compensation Medicare Set Aside review thresholds.

A Medicare set aside allocation was created and submitted to CMS for review and approval. The set aside amount was determined to be \$14,647.00. After requests for more information made by CMS and discussions with CMS, the vendor who performed the MSA allocation was unable to get CMS to provide a response to the review. CMS’s failure to review the set aside was inexplicable given the settlement amount of \$1,000,000.00 and the \$25,000 review threshold for current Medicare beneficiaries. Given the fact that CMS failed to review and approve the MSA, the settlement was put into jeopardy because of the risk of non-review/approval of

the set aside amount. Accordingly, the parties requested the federal district court issue an order determining the set aside amount.

The court found that the MSA of \$14,647.00 was a “reasonable estimate and determination of the future expected medical treatment that Billy Smith will require resulting from his accident-related injuries that would otherwise be covered by Medicare.” Additionally, the court found there was no evidence that any of the parties were attempting to shift the responsibility for future medical expenses related to the injuries suffered to Medicare. The court then went on to make its conclusions of law. The Smith court concluded as a matter of law that the parties had “reasonably considered and protected Medicare’s interest” in the settlement. Further, the set aside amount of \$14,647.00 was deemed to have “fairly and reasonably” taken “Medicare’s interest into account”. Finally, the court ordered that the full amount of the set aside shall be placed in a separate bank account by Billy Smith for the “exclusive payment of future medical expenses incurred for treatment of injuries sustained in his accident of April 14, 2006 which would otherwise be paid or payable by Medicare.” Lastly and most importantly, the court ordered that the parties could rely upon the court’s acceptance of the MSA at the \$14,647 figure despite the lack of CMS approval.

Analysis of Smith

The decision is important from the standpoint of what can be done to achieve complete

compliance in a case where CMS refuses to review a set aside. Because CMS routinely refuses to review set asides in liability cases, the Smith decision provides a road map of how to get around the issue of a non-review. The parties can seek an order such as the one issued in the Smith case in similar circumstances. While CMS typically does not respect a decision which allocating settlement proceeds unless it is a decision on the merits of the case, it seems improbable that CMS could prevail with that type of argument when they fail to review a set aside allocation. If they are given the necessary information to review the set aside allocation, how can CMS then claim a federal court's decision allocating the funds is improper? It seems as though the parties in the Smith case did everything they possibly could do to comply with what they believed was necessary regarding the MSP and futures.

9/29/11 CMS LMSA Memo

On 9/29/11, CMS issued a memorandum indicating there is no need for a liability Medicare set aside and that its interests would be satisfied if the treating physician certifies in writing that treatment for the alleged injury related to the liability insurance has been completed as of the date of settlement.

Many have been asking for formal guidance regarding Medicare set asides in liability settlements. It seemed as though that was never going to happen. That came to an end in May of this year with the release of a memo from the

Region 6 CMS office regarding liability Medicare set asides. Up until last week there was nothing from the Baltimore headquarters for CMS. In the first memo coming from CMS HQ regarding Liability Medicare Set Asides, Charlotte Benson, Acting Director Financial Services Group for CMS, gives us an exception to the need to create a set aside in liability cases. According to the memo, a liability Medicare set aside isn't necessary when the Medicare beneficiary's treating physician certifies in writing that all of the care related to the claimed injury has been completed as of the date of the settlement.

The memo says:

“Where the beneficiary's treating physician certifies in writing that treatment for the alleged injury related to the liability insurance (including self-insurance) “settlement” has been completed as of the date of the “settlement”, and that future medical items and/or services for that injury will not be required, Medicare considers its interest, with respect to future medicals for that particular “settlement”, satisfied. If the beneficiary receives additional “settlements” related to the underlying injury or illness, he/she must obtain a separate physician certification for those additional “settlements.”

When the treating physician makes such a certification, there is no need for the beneficiary to submit the certification or a proposed LMSA amount for review. CMS will not provide the settling parties with confirmation that

Medicare's interest with respect to future medicals for that "settlement" has been satisfied. Instead, the beneficiary and/or their representative are encouraged to maintain the physician's certification."

Analysis of 9/29/11 CMS LMSA Memo

The memo is very important for a number of reasons. First, it is the first official memorandum from the CMS central office in Baltimore to substantively address liability Medicare set asides. Second, it provides a mechanism, if the case facts fit the criteria, to avoid the necessity of creating a liability Medicare set aside. It is a limited exception as the treating doctor must attest in writing that all of the treatment for the released injuries was completed at the time of settlement. Third, it avoids the need to request CMS review of a proposed "zero" liability Medicare set aside and the parties just need to retain a copy of the doctor's letter/certification. Fourth, and most importantly, it reinforces the negative in that if you don't fall within this exception then a liability Medicare set aside should be considered.

Despite the foregoing, every lawyer (plaintiff or defense) should read the Sally Stalcup memo regarding liability Medicare set aside arrangements. The memo was issued back in May of this year by the Dallas Region 6 CMS office. The memo, to summarize, indicates that "Medicare's interests must be protected; however, CMS does not mandate a specific

mechanism to protect those interests."

Furthermore, the law "does not require a 'set-aside' in any situation." Nevertheless, the law does require "**that the Medicare Trust Funds be protected from payment for future services whether it is a Workers' Compensation or liability case.**"

From CMS's perspective, a set aside is their "method of choice and the agency feels it provides the best protection for the program and the Medicare beneficiary."

If an injury victim is a Medicare beneficiary or has a reasonable expectation within 30 months of becoming a Medicare beneficiary, a set aside should be considered. If however a treating physician certifies that all treatment for the released injuries is complete as of the date of settlement, then no set aside is necessary.

Navigating the MSP related issues at settlement can be difficult as well as confusing. From the lawyer's perspective, the most important thing is to make sure the injury victim client completely understands the potential impact of settling the case has upon future Medicare coverage of injury related care.

What Does This All Mean & What Do You Do?

In light of the case law I have outlined and the two memos issued by CMS regarding liability Medicare set asides, the tough question for all parties is what to do when a settlement is reached on behalf of a Medicare beneficiary or someone with the "reasonable expectation"

within 30 months. First and foremost, the parties must realize what is at stake. Failure to establish and fund a set aside may jeopardize future eligibility for Medicare covered injury related care for the injury victim. With mandatory insurer reporting beginning with settlements occurring as of 10/1/2011, Medicare will be on notice of all settlements with Medicare beneficiaries and the ICD9 codes for the injury related care. This will enable Medicare to flag injury victim's Medicare numbers to prevent payment for injury related care when the involved ICD9 (soon to be ICD10) codes are submitted for payment. Accordingly, the injury victim takes a large risk if the case is settled without a set aside as Medicare coverage which could greatly exceed the set aside amount would be lost.

There are no penalties or damages provisions related to failure to establish a set aside that I can find in the MSP. Some have pointed to provisions that provide a mechanism for recovery of conditional payments and double damage provisions relating to the same as evidence of liability for damages if a set aside isn't established. However, there is not a single case I am aware of where the government has pursued damages related to set asides by extending the application of those provisions beyond conditional payments. The lawyers who are involved in a settlement do have personal liability when it comes to conditional payments. See U.S. v. Harris. However, there isn't any legal basis for similar liability when it comes to

Medicare futures. That being said, if an injury victim settles their case without a set aside and isn't informed about the option to create one or the risk of failing to create one, a legal malpractice claim against the attorney handling the case on their behalf might result.

For insurers, the focus should be on making sure they report under the MMSEA when they settle with Medicare beneficiaries and mandating the satisfaction of Medicare conditional payments. If conditional payments are not satisfied, the insurer can be held responsible for the repayment of the conditional payment even if they paid the injury victim already and they are exposed potentially to double damages. It is important to note that there is no case I am aware of where the government has sought double damages related to failure to repay conditional payments. Even in the landmark recovery action brought by the government in US v. Stricker seeking in excess of three hundred million in non-reimbursed conditional payments, the government didn't seek double damages. When it comes to Medicare futures and set asides, there simply aren't any penalties or damages which could be asserted since there is no statutory or regulatory basis for such.

In the May of 2011 CMS memo, Sally Stalcup outlined the responsibilities of the parties under the MSP when it comes to Medicare futures. According to Ms. Stalcup, each "attorney is going to have to decide, based on the specific facts of each of their cases, whether or not there

is funding for future medicals and if so, a need to protect the Trust Funds.” “They must decide whether or not there is funding for future medicals. If the answer for plaintiff’s counsel is yes, they should to [sic] see to it that those funds are used to pay for otherwise Medicare covered services related to what is claimed/released in the settlement judgment award.” “If the answer for defense counsel or the insurer, is yes the should make sure their records contain documentation of their notification to plaintiff’s counsel and the Medicare beneficiary that the settlement does fund future medicals which obligates them to protect the Medicare Trust Funds.” “It will also be part of their [sic] report to Medicare in compliance with Section 111, Mandatory Insurer Reporting requirements.” There is no mention of penalties, fines or damages.

The question for attorneys representing a Medicare beneficiary is what do I do to comply with what CMS expects? The answer is, in my opinion; educate the client on the risks of failing to set aside the money for future Medicare covered services. Given the fact that Mandatory insurer reporting of settlements with Medicare beneficiaries will allow Medicare to know every facet of a settlement and will give Medicare the ability to flag a Medicare beneficiary’s number then refuse to pay for Medicare covered services related to the injury, a Medicare eligible injury victim must understand that this risk is present when they settle their case. A plaintiff attorney’s closing statement should be amended

to address this issue, he or she should consider using a waiver if the client refuses to do the set aside and should develop a comprehensive letter to address these issues with a client when a settlement is reached.

A large problem with today’s MSP compliance hysteria is that defense attorneys and insurers are routinely including “kitchen sink” language in their releases to address Medicare. This language frequently shifts all of the responsibility of creating a Medicare set aside to the injury victim while identifying an arbitrary amount to be set aside. This practice is dangerous because those releases typically have the injury victim acknowledge a responsibility to set funds aside while picking an arbitrary, usually small, amount to be set aside. This is a bad practice and exposes the injury victim as well as plaintiff counsel since if CMS ever refused to pay for Medicare covered services related to the injury there would be no way to justify the amount of the set aside. A better practice is to actually do an MSA analysis, which may or may not include getting a formal MSA allocation done. There are certain instances where an MSA may be unnecessary based upon factors present in the case such as a private primary health insurance policy, Workers’ Compensation coverage for future medical or where there is no future Medicare covered expenses related to the injury. These should be identified and the release language specifically tailored to that exception but with an indication that Medicare’s future interests where

considered with nothing needing be set aside. If the case requires the full-blown MSA analysis, it should be done and the cost of doing so passed along as a client cost. Most MSA allocation reports cost between two thousand and three thousand dollars, which is a small price to pay for the proper analysis of the client's future Medicare covered services. The allocation gives all parties the proper amount to be set aside, arguably subject to a reduction formula.

LMSA Reduction Methodology

While I applaud Sally Stalcup's May 2011 efforts to clarify things with respect to liability Medicare set asides, application of what she suggests is a little more difficult in the real world with certain types of settlements. What happens with the \$25,000 policy limits settlement where future Medicare covered services are \$200,000? How do you deal with that situation? What about a settlement where the recovery is \$1,000,000 but the MSA allocation is \$2,000,000 and damages exceed \$40,000,000? There are ways in my opinion to deal with these situations using a reasonable reduction formula discussed more fully below.

Limited recoveries happen every day in liability settlements. There are a myriad of factors that lead to a compromise settlement and in turn limit the recovery for future medical care. For example, there are policy limits; caps on damages; comparative fault issues and liability issues which impact the value of a case. In addition, liability settlements are not allocated

like they are typically in workers' compensation cases. A settlement will typically be for all the various components of the claim which can include non-economic damages, economic damages and medical. If a case is settled for pennies on the dollar and the medical recovery is significantly reduced due to factors present in the case, the question becomes how to account for those issues when a settlement is achieved for a Medicare beneficiary and a set aside is contemplated. Why should Medicare's "future interest" apply beyond the medical portion of the recovery or possibly exceed the net proceeds to the client?

Obliviously, it does not work to have one hundred percent of a settlement consumed by a Medicare Set Aside that the client can't touch except to pay for future Medicare covered services. I would argue that this gets to the very root of the issue dealt with in the *Ahlborn* US Supreme Court decision. The *Ahlborn* decision forbids recovery by Medicaid state agencies against the non-medical portion of the settlement or judgment. While admittedly that decision dealt with Medicaid lien issues and the Medicaid anti-lien statute, the arguments by analogy can be applied in the Medicare set aside context. The *Ahlborn* holding gets at the fundamental issue of whether a lien can be asserted against the non-medical portion of a personal injury recovery. Justice Stevens, in stating the majority opinion, said "a rule of absolute priority might preclude settlement in a large number of cases, and be unfair to the

recipient in others.” Isn’t this so in the Medicare set aside context (which is really a future lien)? How do you settle a case for an injury victim when all of the proceeds would have to go into a set aside? Wouldn’t that force cases to trial where damages could be allocated to different aspects of the claim and a larger recovery might be possible?

In addition, the 11th Circuit *Bradley* decision addressed the issue of Medicare’s lien rights in the context of Florida’s wrongful death statute. In *Bradley*, CMS took the position that only an allocation on the merits of a case would be recognized in terms of reducing a Medicare conditional payment obligation. The 11th Circuit approved a probate court’s equitable distribution findings to reduce a Medicare conditional payment obligation. In so doing, the court found that it would be improper to require a trial on the merits of a case to determine an allocation for purposes of Medicare conditional payment resolution. The *Bradley* court focused on the strong public policy favoring “expeditious resolution of lawsuits through settlement.” According to the *Bradley* court, Medicare’s position would have a “chilling effect on settlement.” This is so because Medicare’s position compels plaintiffs to force their tort claims to trial, burdening the court system. The same argument could be made in the Medicare set aside context for liability settlements that are compromised significantly. Why would an injury victim settle his case if it will all go into a set aside?

There is some basis in CMS’s own regulations for a reduction. In 42 C.F.R. 411.47 there is a computation example for workers’ compensation settlement where there is no allocation in a compromise situation. It is as follows:

As the result of a work injury, an individual suffered loss of income and incurred medical expenses for which the total workers’ compensation payment would have been \$24,000 if the case had not been compromised. The medical expenses amounted to \$18,000. The workers’ compensation carrier made a settlement with the beneficiary under which it paid \$8,000 in total. A separate award was made for legal fees. Since the workers’ compensation compromise settlement was for one-third of the amount which would have been payable under workers’ compensation had the case not been compromised ($\$8,000/\$24,000=1/3$), the workers’ compensation compromise settlement is considered to have paid for one-third of the total medical expenses ($1/3 \times \$18,000 = \$6,000$).

Admittedly, this particular regulation deals with conditional payments and has been flatly rejected by CMS in terms of its use in the context of reducing workers’ compensation Medicare set aside arrangements. Nevertheless, this type of analysis makes a lot of sense in the context of liability Medicare set asides. Considering CMS has not given any guidance in the liability Medicare set aside area,

how can CMS argue it is improper to employ such methods?

So how would a calculation be made to determine the amount of reduction of the set aside? You could take the approach found in 42 C.F.R. 411.47 or an *Ahlborn* approach. The *Ahlborn* approach would necessitate an estimate of the total value of the claim which would then be compared to the actual recovery. From there, you would determine the percentage of recovery that the settlement represented when compared to the total value of all damages. That type of analysis might look like the following:

\$4,000,000 = Total Case Value

\$1,000,000 = Settlement

\$400,000 = Fees (40% fee)

\$600,000 = Net

\$200,000 = Set Aside

\$30,000 = Reduced Set Aside (Client recovered 15% of total damages)

I want to make it very clear that there are no guarantees that CMS would ever approve of either method to reduce a liability Medicare set aside. However, CMS submission of a liability set aside (and for that matter workers' compensation as well) is voluntary. Accordingly, if one of these methods was utilized and the case was not submitted to CMS for review and approval, I believe CMS would be hard pressed to argue that it was an inappropriate course of action. Given the fact

that CMS has ignored questions about how to deal with these issues for liability Medicare set asides and failed to provide any meaningful guidance whatsoever in this area, I believe one could make an estoppel type of argument if CMS ever claimed it was improper.

For liability Medicare set asides to work there has to be some methodology to deal with the realities of liability settlements. Liability cases are settled every day for significantly compromised amounts due to various issues in the case. There has to be a way to address these issues when calculating what amount of money should be set aside. Since CMS has chosen to remain silent regarding this issue, I would argue that any reasonable method employed to address the reduction is appropriate. Nevertheless, none of the foregoing is legal advice which can be relied upon and certainly no one can guarantee what CMS's response would be if they ever answered this question.

CMS Review & Approval

Before concluding, a quick word about CMS review and approval of liability Medicare set asides is in order. By CMS's own admission, review and approval of a set aside be it a Workers' Compensation settlement or liability settlement is a "voluntary" process. The decision to review a set aside allocation is left up to each CMS Regional Office. Sally Stalcup says in her May 2011 memo that "when the recovery is large enough, or other unusual facts exist within the case" her CMS Regional Office

“will review the settlement and help make a determination on the amount to be available for future services.” However, the Regional Office that reviews set asides in liability settlements for my home state of Florida is the Atlanta Regional Office. The Atlanta Regional office routinely refuses to review liability Medicare set asides we have submitted. Their typical response is that “[d]ue to resource constraints, CMS Is not providing a review of this proposed liability Medicare set aside arrangement.” The form letter goes on to say “this does not constitute a release or a safe harbor from any obligations under any Federal law, including the MSP statute.” In bold print the letter warns, “All parties must ensure that Medicare is secondary to any other entity responsible for payment of medical items and services related to the liability settlement, judgment or award.”

The upside of submitting a set aside for review and approval is that you potentially get a letter back approving what has been proposed to be set aside. In addition, if you get a letter such as the one issued by the Atlanta Regional Office stating they will not review the proposed set aside that is helpful as well to some extent. It could be argued that CMS’s refusal to review a proposed set aside gives the parties the ability to take the position that they did everything possible to attempt to comply with the MSP. However, in my opinion, the risks of submitting a set aside to CMS for review and approval outweigh the potential benefits. For example, if a set aside is submitted in a liability settlement it

could be reviewed and increased. If it is increased, there are no procedures to appeal that decision and the parties are left with the possibility that the settlement may no longer be feasible. CMS could also object to the use of any type of reduction formula. If CMS does not review the set aside and issues a letter such as the one typically issued by the Atlanta Regional office, what real value does that letter have to the parties?

Out of the ten CMS Regional Offices, only 6 will potentially review a liability set aside allocation amount. The offices that will review, limit how many they will review and typically are only larger settlements. The four that will not review set asides will typically issue the type of letter that the Atlanta Regional Office sends out which is of limited value. The parties to a liability settlement where a set aside allocation is being done should carefully consider whether it is worth the increased costs in submitting a set aside to CMS for review. The parties should also consider the issue of timing. In many Workers’ Compensation settlements the review of the set aside by CMS can take up to 12 months. A 12 month wait for review and approval of a set aside could cause significant delays for the complete resolution of a liability claim which may not be in either party’s best interest.

Conclusion

In an effort to clear up confusion, I want to emphasize that the first step in determining what

is necessary for Medicare secondary payer compliance is determining whether you are dealing with a Medicare beneficiary in the first place. If the answer is no, there isn't going to be a Medicare conditional payment issue or a Medicare set aside issue. However, if the client has a "reasonable expectation" of becoming a Medicare beneficiary within 30 months (having been awarded SSDI or by virtue of age), you will have a potential Medicare set aside issue that will need to be addressed. The reasonable expectation issue has nothing to do with conditional payments as Medicare only makes conditional payments for current Medicare beneficiaries only. If a case extinguishes a workers' compensation carrier's liability for future medical care for a Medicare beneficiary then the set aside is governed by the CMS policy memorandums issued for WCMSAs. There is extensive guidance for set asides in workers' compensation settlements. If there is no workers' compensation settlement and the case is a pure third party liability settlement then there are no formal guidelines that govern Liability Medicare set asides. That being said, all parties should now read the only official guidance issued by a CMS regional office on LMSAs which is the Stalcup memo from Region 6. The memo lays out as clearly as you are going to get at this point what CMS' policy is regarding LMSAs. In addition, the CMS HQ memo on LMSAs should be reviewed as well. All parties to a settlement involving a Medicare beneficiary have significant obligations under

the Medicare Secondary Payer Act. Attorneys should take the time to familiarize themselves with these obligations as it is critical in today's hyper sensitive Medicare settlement landscape. If a case does not involve a Medicare beneficiary or someone with the reasonable expectation of becoming a Medicare beneficiary within 30 months, then there isn't any need to report that settlement under the Mandatory insurer reporting; there isn't any need for language in the release regarding conditional payments and there isn't any need for a Medicare set aside. Insisting upon any of this when a case does not involve a Medicare beneficiary is foolish and causes unnecessary delays in resolving cases. Everyone should take a deep breath when it comes to Medicare compliance and be reasonable in terms of what is demanded at settlement. I am not saying that all parties shouldn't protect themselves when a case involves a Medicare beneficiary, but having a good understanding of the issues is the first step to handling these issues the right way.

As I have written before, we need definitive law, an appellate procedure and protections of all parties' rights in the MSP process. While change appears to be coming in the reform of the MSP in relation to Medicare conditional payments, that isn't the case for Medicare set asides. Hopefully at some point in the near future, someone will take up the matter with Congress so legislation can be introduced. Until then, we have to deal with this the best way we can. Being armed with accurate knowledge and

reviewing all of the cases and memos outlined above is essential to have a good handle on this complicated subject.