

# **White Paper**

## *Debunking the MSA Mystery: Clues to Solving Medicare Secondary Payer Compliance in Liability Settlements*

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## INTRODUCTION

In 2010, I published an article entitled “Medicare Myths: What Every Trial Lawyer Should Know about the MSP & Liability Medicare Set Asides”<sup>1</sup>. Since that time there have been many new clues provided by CMS and legal decisions providing guidance regarding what to do when settling a case with a Medicare beneficiary to address protecting Medicare’s “future interests”. This article seeks to clarify the current Medicare Secondary Payer (“MSP”) landscape as it relates to Medicare futures by analyzing the clues and suggesting some ways to make sure a liability settlement is MSP compliant. Despite all of the developments since 2010, there are still no statutes, regulations or cases which require a Medicare Set Aside (“MSA”) in liability settlements. Nevertheless, based upon the information available today it may be prudent to consider engaging in a “set aside analysis” if a settlement involves a current Medicare beneficiary or someone with a “reasonable expectation” of Medicare entitlement within 30 months. This does not necessarily mean setting aside anything, but what it does involve is a thorough analysis of the Medicare Secondary Payer related issues. If something is set aside, it also may include creating a legal justification for why a limited amount is being set aside if a full recovery wasn’t possible due to certain issues present in the case.

Confusion surrounding the need for an MSA in liability settlements began with the passage of Section 111 of the Medicare, Medicaid & SCHIP Extension Act in 2007 (“MMSEA”)<sup>2</sup> and its original reporting deadline of 7/1/09. This provision caused a tremendous amount of misunderstanding among insurance professionals, lawyers and settlement planners alike. Many people were led to believe that the “new law” required MSAs. Even today, there are still some that say this but it just isn’t the case. Simply put, the MMSEA imposes a mandatory insurer reporting requirement upon responsible reporting entities (“RREs”). As of the writing of this article, the MMSEA requires the reporting of every settlement of \$5,000 or greater if it involves the injury of a current Medicare beneficiary.<sup>3</sup> The threshold for reporting settlements will drop to \$2,000 as of 10/1/13 and then \$300.00 as of 10/1/14.<sup>4</sup> The reporting requirements involve reporting a substantial amount of information to Medicare, so much so that there is an almost 300 page manual for insurers to review to comply with the reporting.

## **MANDATORY INSURER REPORTING OVERVIEW**

President Bush signed the MMSEA into law on December 29<sup>th</sup> 2007.<sup>5</sup> Part of this Act, Section 111, extends the government's ability to enforce the Medicare Secondary Payer Act.<sup>6</sup> As of April 1, 2011, an RRE, (liability insurer, self insurer, no-fault insurer and workers' compensation carriers) must determine whether a claimant is a Medicare beneficiary ("entitled") and if so provide certain information to the Secretary of Health and Human (hereinafter "Secretary") Services when the claim is resolved.<sup>7</sup>

Under MMSEA, the RREs/insurers (hereinafter RRE) , must report the identity of the Medicare beneficiary to the Secretary and such other information as the Secretary deems appropriate to make a determination concerning coordination of benefits, including any applicable recovery of claim.<sup>8</sup> Failure of an applicable plan to comply with the reporting requirements shall incur a civil money penalty of \$1000 for each day of noncompliance with respect to each claim.<sup>9</sup> A single claimant can have more than one claim but the penalty is per claim. These reporting requirements make it very easy for CMS to review settlements to determine whether Medicare's interests were adequately addressed by the settling parties and potentially deny future Medicare covered services related to the injuries suffered.

The biggest problem with the reporting requirement is the required disclosure of ICD-9 medical diagnosis codes which identify the medical conditions that are injury related. These ICD-9 codes can form the basis for the care potentially rejected by Medicare in the future. If the plaintiff and plaintiff counsel are unaware of the conditions disclosed by the defendant/insurer through the reporting process, there could be some serious problems when the plaintiff seeks medical care from Medicare in the future. For example, a plaintiff sustained back and neck injuries which were claimed as a part of their lawsuit. The plaintiff had pre-existing neck problems. The case is ultimately settled with the defendant paying nothing for the neck injury because they determined that the neck injury was primarily due to a pre-existing condition. Now the defendant/insurer reports the settlement and lists the ICD-9 codes related to the neck injury even though they paid no settlement dollars towards that injury and rejected that part of the claim. The neck care could be rejected by Medicare in the future leaving the client with no set aside funds to pay for that care and no Medicare coverage either.

Every time I give a presentation to other lawyers about this particular issue, I suggest that the parties should be collaborating on this aspect of the Medicare settlement process. If the plaintiff does not know what is being reported then the scenario I just outlined could occur. The practical problem is that defense counsel typically is unaware of what is being reported and the ICD-9 codes aren't included in the release. Accordingly, there are no guarantees that even if the parties discuss this aspect of the reporting conundrum that the right codes will be reported. However, it still bears emphasis and discussion. Without focusing on this issue as part of the settlement process, a plaintiff and plaintiff lawyer may find there are serious repercussions that result.

## **OVERVIEW OF SET ASIDES**

Moving away from the mandatory insurer reporting to get at the heart of the MSA mystery requires an examination of the “law” of set asides. The rationale for creating an MSA is compliance with the MSP. The MSP is a series of statutory provisions<sup>10</sup> enacted in 1980 as part of the Omnibus Reconciliation Act<sup>11</sup> 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.<sup>12</sup> The regulations that implement the MSP provide “[s]ection 1862(b)(2)(A)(ii) of the Act precludes Medicare payments 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.<sup>13</sup>

There are two issues that arise when dealing with the application of the MSP: (1) Medicare payments made prior to the date of settlement (conditional payments) and (2) future Medicare payments for covered services (Medicare set asides). Since Medicare isn't supposed to pay for future medical expenses covered by a liability or Workers’ Compensation settlement, judgment or award, CMS recommends that injury victims set aside a sufficient amount to cover future medical expenses that are Medicare covered.<sup>14</sup> CMS’s “recommended” way to protect future Medicare benefit eligibility is establishment of an MSA to pay for injury related care until exhaustion.<sup>15</sup>

An MSA is a portion of settlement proceeds set aside, called an “allocation,” to pay for future Medicare-covered services that must be exhausted prior to Medicare paying for any future care related to the injury. The amount of the set aside is determined on a case-by-case basis and is submitted to CMS for approval if it is a Workers’ Compensation case and fits within the review thresholds established by CMS. CMS’s review and approval process is voluntary. There are no formal guidelines for submission of liability settlements and the CMS Regional Offices determine whether or not to review liability submissions. CMS explains on its Web site that the purpose of a Medicare set aside is to “pay for all services related to the claimant’s work-related injury or disease, therefore, Medicare will not make any payments (as a primary, secondary or tertiary payer) for any services related to the work-related injury or disease until nothing remains in the WCMSA.” According to CMS the set aside is meant to pay for *all* work-injury-related medical expenses, not just portions of those future medical expenses.

## **HOW DID SET ASIDES COME ABOUT?**

For many years, personal injury cases have been resolved without consideration of Medicare’s secondary payer status even though since 1980 all forms of liability insurance have been primary to Medicare. At settlement, by judgment or through an award, an injury victim would receive damages for future medical that were Medicare covered. However, none of those settlement dollars would be used to pay for future Medicare covered health needs. Instead, the burden would be shifted from the primary payer (liability insurer or Workers’ Compensation carrier) to Medicare. Injury victims would routinely provide their Medicare card to providers for injury related care.

These practices began to change in 2001 when set asides were officially recognized by CMS as a MSP compliance tool for Workers’ Compensation cases. Interestingly, around that same time the General Accounting Office was studying the Medicare system and pointed out that Medicare was losing money by paying for care that was covered under the Workers’ Compensation system.<sup>16</sup> Accordingly, CMS circulated a memo in 2001 to all its regional offices announcing that compliance with the secondary payer act required claimants to set aside a portion of their settlement for future Medicare covered expenses where the settlement closed out future medical expenses.<sup>17</sup> The new “set aside” requirement was designed to prevent attempts

“to shift liability for the cost of a work-related injury or illness to Medicare.”<sup>18</sup> Set asides ensure that Medicare does not pay for future medical care that is being compensated by a primary payer by way of a settlement or an award. The procedures and policy for set asides have been developed through subsequent CMS memoranda known as Frequently Asked Questions as discussed more fully below.

## **WHAT IS THE “LAW” AS IT RELATES TO SET ASIDES?**

A formal “Medicare Set Aside” is not required by a federal statute even in Workers’ Compensation cases where they have been commonplace since 2001. Instead, CMS has intricate “guidelines” and “FAQs” on their website for nearly every aspect of set asides from when to do one, to submission to administration for Workers’ Compensation settlements. There are only limited guidelines for liability settlements involving Medicare beneficiaries. Without codification of set asides, there are no clear cut appellate procedures from arbitrary CMS decisions and no definitive rules one can count on as it relates to Medicare set asides. While there is no legal requirement that an MSA be created, the failure to do so may result in Medicare refusing to pay for future medical expenses related to the injury until the entire settlement is exhausted. There has been a slow progression towards a CMS policy of creating set asides in liability settlements over the last seven years as a result of the MMSEA’s passage.

In 2011, CMS issued the first two written pronouncements related to liability Medicare set asides. The first was issued by a Regional Director at CMS in Dallas in May of 2011. The second was a memo issued by CMS headquarters in Baltimore in September of 2011. The May of 2011 Sally Stalcup handout 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 document is simply one CMS Regional Coordinator’s viewpoint and does not reflect the opinion of CMS headquarters. Nevertheless, it does provide a good road map of how to analyze these issue when a settlement involves a Medicare beneficiary or someone with a reasonable expectation of becoming one within 30 months. The September 2011 memo from CMS “HQ” requires a set aside in liability cases, arguably, by creating the negative (setting forth when a set aside does not have to be created). Below I will summarize both memorandums.

### *The May 2011 “Stalcup Handout”*

The May 2011 Stalcup handout 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 handout to the states covered by the Region 6 office, which are Oklahoma, Texas, New Mexico, Louisiana and Arkansas.

The central premise of the handout 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* handout 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 handout 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 11<sup>th</sup> 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 handout 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 handout 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 handout 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 handout 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.”

### *The September 2011 CMS HQ 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 certain conditions (outlined below) were met. 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.”

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.

### ***The ANPRM***

In an apparent attempt to create regulations governing liability set asides, on May 3 of 2012, the Office of Management and Budget received advanced notice of proposed rulemaking (ANPRM) entitled “Medicare Secondary Payer and ‘Future Medicals’ (CMS-6047-ANPRM)” from CMS. On June 14<sup>th</sup>, 2012 the contents of the proposal were released by CMS. A sixty day comment period began on 6/14/12 which expired on 8/14/12. The Medicare Secondary Payer Act provides that “[n]o rule, requirement or other statement of policy that establishes a substantive legal standard . . . shall take effect unless it is promulgated by the secretary by regulation . . .” Therefore, in order to establish a legal standard when it comes to Medicare set asides, the Agency (CMS), must promulgate regulations. The submission by CMS to the Office of Management and Budget of proposed rulemaking is the beginning of that process. The proposed rulemaking contains seven different options for dealing with future medicals for Medicare beneficiaries and the Agency solicited comments from all interested parties to create a standardized practice. To date, there are no proposed regulations.

### ***According to the notice:***

“This advance notice of proposed rulemaking solicits comment on standardized options that we are considering making available to beneficiaries and their representatives to clarify how they can meet their obligations to protect Medicare's interest with respect to Medicare Secondary Payer (MSP) claims involving automobile and liability insurance (including self-insurance), no-fault insurance, and workers' compensation when future medical care is claimed or the settlement, judgment, award, or other payment releases (or has the effect of releasing) claims for future medical care.”

...

“The primary purpose of this ANPRM is to respond to affected parties' requests for guidance on ‘future medicals’ MSP obligations, specifically, how individuals/beneficiaries can satisfy those obligations effectively and efficiently.”

### **CMS Proposed General Rule**

“If an individual or Medicare beneficiary obtains a ‘settlement’ and has received, reasonably anticipates receiving, or should have reasonably anticipated receiving Medicare covered and otherwise reimbursable items and services after the date of ‘settlement,’ he or she is required to satisfy Medicare's interest with respect to ‘future medicals’ related to his or her ‘settlement’ using any one of the following options outlined later in this ANPRM.”

The notice outlined seven options to comply with the general rule. As of the writing of this article, no further action has occurred with respect to the proposal for proposed rulemaking. Nevertheless, the fact that CMS has created a proposal to make proposed rules/regulations for Medicare future medicals indicates they are serious about addressing this issue. It also indicates potential enforcement of the MSP as it relates to future medicals in liability settlements. However, it is worth bearing in mind that these were proposals and the process may result in no regulations at all.

The problem is that ANPRM doesn't address some fundamental problems with liability settlements. As such, legal practitioners, Medicare beneficiary-injury victims and insurers are left guessing as to exactly what to do when a liability settlement is achieved. Many questions exist as to the proper course of action when a settlement involving a Medicare beneficiary is achieved. For example, consider the following questions. Is a formal liability set aside necessary? If so, how do parties determine if they are necessary? What rules apply if you do create a set aside? Do we look to the extensive CMS memoranda from Workers' Compensation? What about the differences between Workers' Compensation cases and liability cases? Will CMS take into account policy limits in a liability case in determining the sufficiency of an allocation? What happens if policy limits are \$50,000 and the future Medicare covered services are \$150,000? Will CMS take into account comparative fault/contributory negligence issues that

may reduce recovery? What about statutory or constitutional caps on damages? Can CMS fail to pay for Medicare covered services post liability settlement for the Medicare beneficiary-injury victim if there is no set aside created?

Many of these questions simply don't have answers at this point. I reviewed many of the comments filed with CMS regarding the ANPRM and these issues were raised by interested parties and industry participants alike with the hope that someone at CMS will consider these issues before regulations are created. I don't hold out much hope that any forthcoming regulations will take into account all of the troubling issues related to set asides in liability settlements. That being said, I do hope that some of the core differences between workers' compensation cases and liability settlements are taken into account before fashioning a set aside system that is similar to what exists today in workers' compensation settlements given the inherent differences between the two systems.

In addition to the memorandums and the ANRPM, some MSA case law has developed beginning in 2009 which is summarized below. Unfortunately, the case law does not address any of these fundamental questions either in any meaningful way. However, inspection of the cases out there is imperative to understanding the current landscape and obligations related to the MSP.

## **MSA CASE LAW SURVEY**

The first case that I am aware of addressing MSAs came out in 2009. Since that time there have been a handful of opinions addressing a variety of issues. All of the decisions are trial court decisions with none of them making precedential rulings on what the MSP requires in terms of compliance relative to future medicals. Some decisions are focused on approval of a set aside the parties have agreed to while others have addressed narrow specific issues. Most of the cases fall into the category of a request for approval of an MSA where the parties agree on the necessity of an MSA but CMS refuses to review and approve the same. In these cases, the court is being asked to approve the set aside amount. A second category of cases are those where the parties agree to settle but can't agree on whether the settlement agreement includes creation of an MSA. The last category of cases deals with discrete issues surrounding MSAs. There is also

some important case law related to ripeness of claims under the MSP which are explored first. The case law summary below is broken down into these specific categories.

### ***Ripeness of MSP Claims***

There are many decisions that have addressed the ripeness of an MSP related claim to be heard by a federal district court. Since the MSP does have a five level appeals process before a case is heard in federal district court, MSP related issues would have to be dealt with first through that internal Medicare appeals process. That issue hasn't been litigated yet with respect to set asides since very few liability set asides are being reviewed at this point. As some point there will likely be an appeal stemming from the review and increase of a proposed liability set aside but we don't have any cases yet raising the issue. There are quite a few Medicare ripeness decisions out there as it relates to the conditional payment area of the law which most likely would be controlling. A perfect example of this is *Alcorn v. Pepples*<sup>19</sup> out of the Western District of Kentucky. In *Alcorn*, the court held that "Alcorn's claim with respect to the Secretary arises under the Medicare Act because it rests on the repayment obligations set forth under 42 U.S.C. § 1395y. She therefore must exhaust the administrative remedies established under the Medicare Act before this court may exercise subject matter jurisdiction over her claim."<sup>20</sup> The problem with this in the context of set asides is that the internal appeals process can take up to 420 days during which time in theory the injury victim could be without Medicare benefits.

### ***Category One – Judicial Approval of MSAs***

In 2009, *Finke v. Hunter's View, Ltd.*<sup>21</sup>, was decided by a Minnesota Federal District court which held that no liability Medicare set aside was necessary given the facts of the case. The plaintiff, Darus Finke, was paralyzed from the chest down after a 30 foot fall from a tree while using a hunting deer tree stand manufactured by Hunter's View. Mr. Finke received both Medicaid and Medicare benefits following his injury. Medicare had approximately \$18k in conditional payments. Mr. Finke also had private group health care 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.”<sup>22</sup>

In 2011, *Big R. Towing, Inc. v. Benoit*,<sup>23</sup> was decided by the United States District Court for the Western District of Louisiana which 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 and was injured in 2009 while covered as a seaman under the Jones Act. The case brought by Benoit 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.

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 is 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 3<sup>rd</sup> 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 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.

In *Schexnayder v. Scottsdale*,<sup>24</sup> a significant 2011 decision, the Stalcup handout was cited as a legal authority. In *Schexnayder*, the plaintiff was injured in an automobile accident while in the course and scope of his employment. 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 handout discussed earlier in the article.

In the order, Mr. Schexnayder was commanded to "promptly reimburse Medicare" for all 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.

In the 2011 *Smith v. Marine Terminals of Arkansas*<sup>25</sup> decision, 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 where CMS refused to review and approve a set aside allocation. 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 plaintiff's 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.

The decision is important from the stand point 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 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.

In an almost identical situation as *Smith*, a 2012 case in Louisiana called *Guidry v. Chevron*<sup>26</sup> was decided approving an MSA where CMS failed to review. *Guidry* involved a Longshore and Workers’ Compensation claim which was settled contingent upon CMS approval of an MSA. CMS failed to review and the *Guidry* court relying upon medical testimony determined that the proposed MSA sufficiently protected Medicare’s interests. The court did note that CMS has provided no mechanism or procedures to determine whether a liability MSA adequately protected Medicare’s future interests.

In the first MSA case of 2012 which is important for its discussion of the *Bradley v. Sebilius*<sup>27</sup> decision, *Frank v. Gateway Insurance*<sup>28</sup>, a United States District Court for the Western District of Louisiana had to consider a motion for “Determination of Need for, and Amount of Medicare Set Aside for the purpose of complying with the Medicare Secondary Payer Statute.” Mr. Frank was injured while working so this wasn’t a pure liability situation. There

was a workers' compensation component although that was not at issue in the case. Mr. Frank was unloading merchandise off of a trailer owned by the defendant in this matter who was insured by Gateway insurance. The trailer had a hole in it which Mr. Frank fell into and injured his back. Mr. Frank's employer was not involved in this litigation.

CMS was put on notice of the hearing regarding the necessity and amount of a potential set aside but refused to participate. The court addressed the *Bradley*<sup>29</sup> decision, which was an 11th Circuit decision that tackled the sanctity of a probate court's allocation of settlement proceeds in a wrongful death settlement involving Medicare conditional payments. Presumably, the discussion regarding Bradley was the Frank court's attempt to address the letter CMS had sent to the court through the US Attorney and any reliance upon the field manual to reject the court's Medicare Set Aside allocation. Implicit in the *Bradley* discussion is the court's belief that it could bind CMS by approving a liability Medicare Set Aside allocation. The portions of the *Bradley* opinion quoted by the *Frank* court seem to bolster this theory as it focused the attention on the fact that the field manual was not law and that CMS's failure to respect a court's allocation when the merits were not addressed encouraged litigation.

After discussing *Bradley* and its findings of fact, the court went on to determine as a matter of law that the sum of \$3,200 was reasonable and fair thus taking into account "Medicare's interests". According to the court, since CMS provides no procedure to determine the adequacy of protecting Medicare's interests for future medical in the case of a 3<sup>rd</sup> party settlement and there is a strong public policy favoring out of court settlements it was appropriate to find that Medicare's interests were adequately protected in this case. The order stated that Frank shall fund \$3,200 out of his settlement to fund future Medicare covered or reimbursable services related to what was claimed and released. The order also gave instructions for administration stating that the funds "shall" be deposited into an interest bearing account for the purpose of paying any injury related future Medicare covered services.

In a very similar case to *Frank*, *Bertrand v. Talen's Marine*<sup>30</sup>, a Western District of Louisiana federal court was asked to render a declaratory judgment finding that Medicare's interests were adequately considered by the amount being set aside for future medicals. The *Bertrand* court did approve the settlement. In its approval, it found the amount of \$64,866

“reasonably and fairly takes Medicare's interests into account in that the figures are based on reasonably foreseeable medical needs.” *Bessard v. Superior Energy Service*<sup>31</sup>s, another Western District of Louisiana federal court decision, involved identical issues as raised in *Bertrand*. The court’s findings of fact and conclusions of law are the same as in *Bertrand* with the court ultimately approving an MSA of \$6,100. *Cribb v. Sulzer Metco*<sup>32</sup>, a North Carolina federal district decision, also involved the approval of a proposed liability set aside where CMS refused to review and approve. The *Cribb* court approved a \$4,500 liability MSA. These cases demonstrate that when CMS will neither review nor approve of MSAs in the liability context, the parties can and will turn to the courts to perform that function.

In *Welch v. American Home Assurance*<sup>33</sup>, a Federal District Court was asked to determine the need for an MSA and the amount of the set aside. What is very interesting about the *Welch* decision is that the court does its own calculations for the amount to be set aside coming up with a figure higher than what was recommended to the court in testimony by a trained MSA allocator. The case is one which involves both a workers’ compensation claim and liability. However, future medicals were to be paid out of the liability settlement instead of the workers’ compensation settlement which is an unusual factual scenario.

The case involved a workplace injury to Welch’s left elbow. A workers’ compensation claim was filed against the employer. The employer denied compensability for the elbow injury based upon a physician’s note saying Mr. Welch had a pre-existing elbow injury. Welch prevailed in his workers’ compensation hearing and the employer/carrier began to pay benefits. Subsequently, Welch filed suit against the employer/carrier for alleged improprieties and bad faith in the denial of his claim. He claimed his elbow condition worsened as a result of the delay in treatment causing Complex Regional Pain Syndrome. The liability case settled after a settlement conference was held before the presiding federal district court judge. A condition of the settlement was that the federal district court “determine a Medicare Set Aside (MSA) such that the parties may comply with the provisions of the Medicare Secondary Payer Act, 22 U.S.C. §1395y(b)(2) and related federal regulations”. The defendant filed a motion requesting the federal district court to determine the necessity of an MSA and the amount of an MSA. The court held an evidentiary hearing and made certain findings of fact and conclusions of law.

During the hearing, a Medicare Set Aside expert testified that based upon the projected future medical estimated by the treating physician the future Medicare covered care amounted to \$174,762.85. However, the federal district court judge determined based upon his calculations that the actual amount should be \$278,019.08. In addition, the judge determined that Welch even though he was not a current Medicare beneficiary did have a reasonable expectation of becoming one within 30 months since he made application for Social Security Disability benefits. Given the foregoing facts, the *Welch* Court went on to its conclusions of law. The court decided that it did have jurisdiction over the matter since there was an actual controversy and the parties were seeking a declaration of rights and obligations to comply with the MSP for which there was no procedure in place by CMS. The court cited to other opinions such as *Frank v. Gateway* and *Schexnayder v. Scottsdale* discussed above for the proposition that other courts had decided the rights and obligations of settling parties under the MSP with respect to MSAs. The court went on to point out that since there is no procedure in place by CMS to determine how to adequately protect Medicare's future interests and there is a strong public policy interest in resolving cases through settlement, it is necessary to decide the necessity as well as amount of any set aside.

In its conclusions of law, the court finds that Welch is a "primary payer" by virtue of receiving payment from a primary plan and thus Medicare should not be billed for those items or services until the funds received from the primary plan for that purpose are exhausted. It concluded that the sum of \$278,019.08 adequately protected Medicare's future interests and in fact exceeded what Medicare would require. The court ordered that the sum of \$278,019.08 be placed in an interest bearing account to be self-administered as a Medicare Set Aside by Mr. Welch. The end result is rather strange because the court ultimately determines that the set aside amount should be more than what CMS would have accepted had it been submitted and reviewed under their own guidelines. This is noted by the court in footnote four of the opinion. The court stated that "[a]lthough \$174,762.85 may be accepted by CMS as an appropriate and sufficient MSA if submitted to CMS for approval, the Court is unwilling to use that amount in a Court-determined MSA." The question becomes shouldn't the court apply what CMS would have approved had it been reviewed? Herein lies the problem with a system that has no regulations or statutes that codify these guidelines.

In addition, it is interesting to note that the court is ordering a self-administered MSA. For most lay people, it is nearly impossible to figure out to properly administer an MSA. To properly administer, the injury victim must know what is Medicare covered, understand ICD codes and pay providers the proper amount. They have to document every penny that is spent. How many people can do that? If the MSA is annuity funded, which many are, then you have to determine when it is exhausted on a yearly basis and then have Medicare billed. Can anyone handle that? It seems to me that it invites misuse of the funds which runs counter to the whole premise of what the court is ordering in the first place which is compliance with the MSP. A professional administration<sup>34</sup> agreement would make much more sense despite the fact that Mr. Welch is competent. A full discussion of administration of set asides is beyond the scope of this article.

### ***Category Two – Need For an MSA***

*Bruton v. Carnival Corporation*<sup>35</sup> presented the issue of whether an MSA was required wherein the parties agreed at mediation to settle with a general release that included “Medicare provisions”. Bruton brought suit against Carnival for injuries allegedly suffered when she slipped and fell aboard one of Carnival’s cruise ships. The case was settled at mediation and the parties agreed to settle with a general release that included “Medicare provisions”. The release tendered to Bruton contained language requiring a professionally administered MSA. Bruton demanded removal of this language from the release. When Carnival refused, a “Motion to Compel Settlement Pursuant to Terms of Settlement Agreement” was filed in the United States District Court for the Southern District of Florida.

In the decision, the court found there was an enforceable agreement to settle. It held that the mediation agreement didn’t require the creation of a “Medicare set-aside trust account”. Specifically, the court found that the agreement made no mention of an MSA nor did Carnival claim that the parties had discussed that particular issue during the settlement negotiations. Since the release executed by the plaintiff did make Bruton responsible for satisfying any outstanding Medicare conditional payments, the release did address Carnival’s concerns about “Medicare’s interests and its own liability for Medicare liens.” Since Bruton complied with the

terms of the mediation agreement, the Court found that Carnival was in breach of the mediation agreement and ordered Carnival to tender the settlement check to Bruton.

In a case very similar to *Bruton* which was widely distributed across the country as standing for the proposition that an MSA wasn't necessary in a liability case, *Sipler v. Trans Am Trucking*<sup>36</sup> actually dealt with enforcement of a settlement due to a dispute over release language concerning the MSP. Sipler was injured when a bus he was riding was struck a truck owned by Trans Am Trucking. The case was set for trial but settled on the eve of trial. The agreement to settle was a payment of \$225,000 in exchange for a release from all claims arising out of the accident. There were no other terms discussed or agreed upon. Defense counsel drafted a release and the case was dismissed without prejudice but the court retained jurisdiction to enforce settlement.

Defense counsel sent a proposed release that contained a confidentiality clause and provisions relating to Mr. Sipler's health care liens and future care. Specifically, the plaintiff could not claim reimbursement from Medicare for injuries arising out of the accident; his private insurance could not pay for claims arising out of the accident because those injuries were preexisting and Medicare would not pay for any future treatment for injuries arising out of the accident. Plaintiff counsel refused to accept these provisions and defense counsel refused to consummate the settlement agreement without those provisions. A motion to enforce the settlement by plaintiff counsel ensued.

In bringing his motion to enforce settlement, plaintiff counsel argued that the parties didn't agree to confidentiality or any provisions relating to health care; federal law does not require the plaintiff to disqualify himself from Medicare benefits or establish a set aside and defendants had not authority to protect the rights of Medicare. Defendants argued that federal law requires personal injury settlements to protect the rights of Medicare with respect to both past and future medical expenses.

In its analysis of the issue, the court went through New Jersey law relating to enforcement of an agreement to settle. It also went through the basics of the Medicare Secondary Payer Act. The court then correctly goes on to point out that Medicare never paid

anything for Mr. Sipler's care and he had private health insurance which was primary. The court stated that "Mr. Sipler may not seek payments from Medicare for such expense to the extent they are provided for by his health insurance policy and/or the settlement." This is correct as the private health insurance coverage would be primary over Medicare.

The court, even though it didn't have to go any further, then addressed the question of whether the MSP requires language in the release specifying "(1) his obligation not to seek such payments from Medicare and (2) a particular portion of the settlement amount to be set aside for future medical expenses arising out of the accident." The defense cited the Sally Stalcup handout for the proposition that a set aside wasn't necessary. The court correctly points out that there is no federal law that requires set aside arrangements in personal injury settlements. The court in dicta does draw some distinction between workers' compensation settlements and third party liability settlements relating to the question of whether there is a need to set aside funds. In the end though the court states that the "parties in this case need not include language in the settlement documents noting Mr. Sipler's obligations to Medicare or fashion a Medicare set-aside for future medical expenses."

In *Early v. Carnival Corporation*<sup>37</sup>, a Florida Federal District Court was asked to determine whether a Medicare Set Aside was required. Early filed suit against Carnival after allegedly being injured while a passenger on one of Carnival's cruise ships. The case was set for mediation and settled subject to two conditions. The conditions were that the court retained jurisdiction to enforce the terms of the settlement and to determine the issue of a possible Medicare set aside, if any. Post mediation, Early filed a Motion for Determination of Whether Medicare Set Aside is required. In the motion, the terms of the mediation agreement were outlined which included that the "parties disagree on whether a Medicare Set Aside ("MSA") is required in their settlement agreement, but agree to submit the issue for the court to decide." In Early's petition, it was argued an MSA was not required.

In the decision, the court examined the Medicare Secondary Payer Act and recognized that one method to comply with the MSP is to create a set aside arrangement. The Court cited articles authored by David J. Berg and myself<sup>38</sup> to support that idea. The court did recognize that the question of "[w]hether the MSP applies to every tort settlement, thus likely requiring an

MSA, is a question that confounds practitioners and litigants.” The court went on to address what constitutes a settlement under Florida law. Then the court turned to its analysis of the legal principles as applied to this case.

The issue to be addressed was stated succinctly as the “parties cannot agree on a settlement term and are requesting the Court to fill in that term for them or offer an opinion on the MSP’s legal requirements for guidance.” In reviewing other decisions regarding set asides, the court found they fell into two scenarios. The first category was cases where the parties have a settlement agreement and agree on the necessity of a set aside but can’t obtain approval by CMS of the MSA arrangement. There are several cases where courts have “approved” a set aside when CMS was unwilling to review and approve one for the parties. The second category was cases where the parties have a settlement agreement but disagree as to whether the settlement agreement’s terms included the creation of an MSA. In the instant case, the court found that it didn’t fit into either category and the parties were essentially asking for an advisory opinion or insert a term of settlement. The court held that the parties request had to fail because the Court can’t create terms for the parties’ private settlement agreement or render advisory opinions. Ultimately, the Court found that there was in fact no settlement at all! By virtue of the parties submission of this critical term of the purported settlement to the court was evidence that there was no meeting of the minds or settlement. It is an unfortunate result as I am quite sure the parties really wanted to settle the matter. It shows the inherent risks of submitting these issues to the court for a decision.

### ***Category Three – Discrete Issues***

#### ***Is an MSA a Marital Asset?***

*In re Marriage of Christopher Washkowiak*<sup>39</sup> involved an Illinois appellate court having to consider whether an MSA was a marital asset subject to division in dissolution of marriage. Christopher Washkowiak was injured on the job in 2008. In December of 2010, an arbitrator for the Illinois Workers’ Compensation Commission approved Washkowiak’s workers’ compensation settlement. The settlement was for \$365,000 plus a \$70,000 Workers’ Compensation Medicare set aside (WCMSA). In August of 2010, prior to the settlement being

approved, a family law court issued an order dissolving Mr. Washkowiak's marriage and awarding (per Mr. and Mrs. Washkowiak's divorce settlement agreement) 17.5% of his net settlement proceeds to his former spouse. This amounted to \$12,250 of the funds set aside in the WCMSA. A dispute arose as to whether Mrs. Washkowiak was entitled to that portion of the MSA. Mr. Washkowiak argued that the MSA was not part of his net settlement proceeds. Mrs. Washkowiak argued she was entitled to 17.5% of the MSA since the funds didn't fall under the excluded category of "attorneys' fees and usual and customary litigation fees and expenses" as provided in the judgment of dissolution. The trial court agreed with Mrs. Washkowiak and Mr. Washkowiak appealed.

The appellate court analyzed the situation based upon the definition of net settlement proceeds as the dissolution decree defined that term. The decree provided that " 'net proceeds' include reimbursement for medical payments actually paid by" Washkowiak. The court then stated that unless there was something that removed the MSA funds from the definition of "net proceeds", then the MSA funds would fall within the definition of "net proceeds". The opinion proceeded to go through an explanation about the underpinnings of Medicare set aside from a CMS regulatory standpoint. The court concludes that the money placed in the WCMSA were for the "sole purpose of paying . . . [Washkowiak]'s medical bills" and thus "the settlement is reimbursing him for his future medical costs." Therefore, according to the court, the money in the "MSA fall[s] squarely under the definition of 'net proceeds' contained in the dissolution agreement."

According to the opinion, there was no evidence presented by Mr. Washkowiak that the funds in the MSA were not "net proceeds" and without question the money was his. Therefore, since the dissolution decree defined "net proceeds" to include payments for future medical costs, the funds held in the MSA were "net proceeds". Accordingly, the trial court correctly determined that Mrs. Washkowiak was entitled to 17.5% of the entire settlement including the MSA. Mr. Washkowiak unsuccessfully argued that the MSA funds could only be used to pay for future medical costs related to his injuries. The opinion points out that Mr. Washkowiak could provide 17.5% of the "net settlement" proceeds from the non-MSA funds he received and still leave the \$70,000 in the MSA. The court found the result would not be inequitable because Mr.

Washkowiak could fully fund the \$70,000 MSA from the 82.5% of the settlement proceeds he had left over after paying Mrs. Washkowiak.

### **Procurement Cost Reduction of an MSA**

The facts of *Hinsinger v. Showboat Atlantic City*<sup>40</sup>, 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 totally 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. 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 according to its own field manual, 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. 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 conditional payment is made prior to settlement or judgment. Section 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 the conditional payment context, it concluded it applied to funds recovered for future medical which are set aside.

Applying the reduction for procurement costs to liability set asides was "in line with general principles of equity" according to the *Hinsinger* 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. "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's statement addresses a fundamental problem in liability settlements involving Medicare beneficiaries who are faced with setting aside funds for future medical when there is a limited recovery.

### **Unfunded Future Medicals**

In *Sterrett v. Klebart*<sup>41</sup>, a Connecticut court was asked to decide whether Medicare's interests were reasonably considered pursuant to the Medicare Secondary Payer Act. In *Sterrett*, the plaintiff brought suit against the homeowner of a home he visited as an invitee and subsequently fell down a set of stairs rendering him a paraplegic. The negligence claim was

based on the lack of a handrail on the staircase. The defendant raised contributory negligence claims asserting specifically that the plaintiff was under the influence of alcohol to a degree that made it impossible to walk down the stairs. The parties settled the case at mediation for \$550,000. Of the \$550,000 settlement, \$183,333 was allocated to resolve Ms. Sterrett's loss of consortium claim.

The Connecticut court agreed with the parties and found that future medicals were not funded. Specifically, the court stated that "the settlement payment to Sterrett does not address any future medical expenses that may be covered by Medicare and the facts of this case mandate the conclusion that the defendants and their carriers lack liability with regard to any such expenses." The court found that the settlement represented a "substantial compromise" considering the potential verdict range. The settlement was a compromise due to the nature of the injuries and defenses according to the court. Further, the court understood that even though Sterrett would incur medical bills payable by Medicare, the settlement didn't compensate for such future medical benefits. Instead, the limited settlement funds it found were payable for the plaintiff's non-economic damages with a small portion to be used for non-Medicare covered economic damages. For those reasons, the court held that no set aside was required and found that the parties had reasonably considered the interests of Medicare in the settlement of the case.

This case is a perfect example of the problems associated with Medicare set asides in liability settlements with no method for apportionment. Without a formula to reduce a set aside where damages are great but the recovery is limited, this kind of result can occur. If however a formula similar to equitable distribution was used in this case, it might yield a result such as follows:

<b>Reasonable value of claim:</b>	<b>\$2,000,000</b>
<b>Actual settlement:</b>	<b>\$550,000</b>
<b>Fees &amp; Costs:</b>	<b>\$255,000</b>
<b>Liens:</b>	<b>\$14,448</b>
<b>Consortium Claim:</b>	<b>\$183,333</b>

<b>Net to Client:</b>	<b>\$97,219</b>
<b>Set Aside:</b>	<b>\$100,000</b>
<b>Reduced Set Aside (4.86%):</b>	<b>\$4,860</b>

This presumes a set aside amount of \$100,000 and a formula that yields 4.86% as the reduction. So since the client is only recovering 4.86% of his total damages, the \$100,000 set aside is reduced to \$4,860. Instead of nothing being set aside, a minimal amount is set aside and there is a justifiable basis for the amount being set aside.

Unfortunately, CMS has refused to address this problem in the context of liability settlements. The reality of liability cases is that many times there is a limited recovery in relation to the significant damages suffered. It is impossible to have a set aside in a case such as *Sterrett* where there is a limited recovery and insufficient funds to pay for future medicals. If Sterett were forced to set aside monies it likely would eat into his economic damages that aren't for future medical, such as lost wages, or for non-economic damages. The non-economic damages are arguably substantial in a case where a client is rendered a paraplegic. Furthermore, here the injury victim's wife had a recognized consortium claim which served to greatly reduce the recovery to the injury victim. The end result is that the court reached an outcome similar to what I have suggested but without engaging in the right analysis. Until CMS addresses this issue, parties are left to figure out how to deal with this particular situation.

### **Reduction of Liability MSA due to Liability Issues**

In *Benoit v. Neustrom*<sup>42</sup>, the United States District Court for the Western District of Louisiana rendered an unprecedented decision. In a case where a limited recovery was achieved due to complicated liability issues with the case, the Court reduced a liability Medicare Set Aside allocation by applying a reduction methodology. This case validates the argument I have made since the passage of the MMSEA brought liability Medicare Set Asides to the forefront. Because of the fundamental differences between the Workers' Compensation system and the liability system, you can't have MSAs in general liability settlements without apportionment. The court in *Benoit* agreed with me.

Benoit filed suit against the Sheriff of Lafayette Parish (Neustrom) and the Warden of the Lafayette Parish Correction center alleging injuries suffered while incarcerated. The plaintiff alleged he was allowed to remain in his jail cell without pre-medical evaluation when he was clearly suffering from the effects of alcohol detoxification. Benoit was found unresponsive in his cell and was transported to the hospital where he was diagnosed with a hypoxic brain injury secondary to a seizure, followed by cardiac arrest, secondary to alcohol withdrawal and hypoxic encephalopathy. The resulting injuries included an anoxic brain injury with bladder incontinence, anosmia, short term memory deficit, tremors and behavioral issues. After inpatient care in a nursing home, Mr. Benoit was released to the care of his wife. Mr. Benoit had his care paid for partially by Medicare and Medicaid.

In October of 2012, the case was settled conditioned upon a full release by Mr. Benoit and his assumption of sole responsibility for “protecting and satisfying the interests of Medicare and Medicaid.” To that end, a Medicare Set Aside allocation was prepared by an MSA vendor. The MSA cost projections gave a range of future Medicare covered injury related care of \$277,758 to \$333,267. The gross settlement amount was \$100,000.00. Medicaid agreed to waive its lien. Medicare asserted a reimbursement right for its conditional payments of \$2,777.88. After payment of fees, costs and the Medicare conditional payment, Mr. Benoit was left with net proceeds of \$55,707.98. Mr. Benoit filed a motion for Declaratory Judgment confirming the terms of the settlement agreement, calculating the future potential medical expenses for treatment of his injuries in compliance with the Medicare Secondary Payor Act and representing to the court that the settlement amount was insufficient to provide a set aside totaling 100% of the MSA.

The matter was set for hearing and Medicare was put on notice of the hearing. Medicare responded with a written letter asserting its demand for repayment of the conditional payment in the amount of \$2,777.88 but didn't address the set aside. The Medicaid lien was waived prior to the hearing with conditions for creation of a Special Needs Trust to preserve Medicaid eligibility. At the hearing, the sum of \$2,777.88 was established without objection as the amount to be reimbursed to Medicare for the conditional payments made by Medicare. This left the only issue for the court to address was the question of the future Medicare covered services for Mr. Benoit and the “extent to which the Medicare set-aside trust can or should be reduced to account for the

financial hardship to the beneficiary, Michael Benoit.” During the hearing, the MSA allocation was submitted into evidence with a cost considerably larger than the net settlement figure. A Social Security financial statement was also offered into evidence to demonstrate the financial hardship of Mr. Benoit. Mrs. Benoit testified about Mr. Benoit’s extensive needs for things the MSA would not pay for and the limited income they received from Social Security. The defendants provided testimony regarding the liability issues with the case which could have resulted in summary judgment had the case not settled.

Having heard testimony, the court rendered its opinion in April of 2013. The court began its discussion with a citation and quotation of Sally Stalcup’s Region VI handout regarding set asides. The quoted language addresses the idea of an allocation of the damages. CMS’s official position is that the only allocation they will respect is when it is by a court after their review on the merits of the case. The court pointed out that CMS took that same position in the *Bradley v. Sebelius* case regarding conditional payments and lost. Language from the *Bradley* decision was cited which stated that Medicare’s field manual was not entitled to administrative law based deference (under *Chevron*) and that the requirement of a decision on the merits of a case before respecting an allocation frustrated the long standing public interest in the resolution of lawsuits through settlement. After discussing those points, the court went on to make its findings of fact and conclusions of law.

The first significant finding of fact was that Benoit’s claims were highly contested on liability and damages with a very real possibility of summary judgment being granted or an adverse liability verdict. The second significant finding was that given the significant past and future losses suffered by Mr. Benoit offset by the difficult liability issues in the case, the settlement of \$100,000 was a reasonable compromise to avoid the uncertainty and expense of a trial. The fourth significant finding was that the estimate of future medical costs in the MSA allocation was both reasonable and reliable. The bombshell finding was that the net settlement was 18.2% of the mid-point range of the MSA projection and using that percentage as applied to the net settlement, the sum to be set aside was \$10,138 and not \$305,512. The court found that \$10,138 adequately protected Medicare’s interests.

In its conclusions of law, the court first found it had jurisdiction to decide the motion because there was “an actual controversy and the parties seek a declaration as to their rights and obligations in order to comply with the MSP and its attendant regulations in the context of a third party settlement for which there is no procedure in place by CMS.” The court then found that the sum of \$10,138 “reasonably and fairly takes Medicare’s interests into account.” Lastly, the court found that since CMS provides no procedure to determine the adequacy of protecting Medicare’s interests for future medical needs in third party claims and since there is a strong public policy interest in resolving lawsuits through settlement, Medicare’s interests were “adequately protected in this settlement within the meaning of the MSP.” The court ordered that the MSA be funded out of the settlement proceeds and be deposited into an interest bearing account to be self-administered by Mr. Benoit’s wife.

This opinion is so important because it hits the nail on the head regarding an argument I have been making since the advent of liability MSAs. As the American Association for Justice pointed out in its commentary<sup>43</sup> to the ANPRM, a liability insurer is not legally obligated to provide medical care in the future whereas Workers’ Compensation carriers are obligated to pay for future medical as long as the injury related conditions persist. Furthermore, liability settlements are fundamentally different from Workers’ Compensation settlements in that liability cases are settled for a variety of reasons which do not necessarily include contemplation of future medical treatment. Even when future medical care is contemplated as part of a settlement, the amount can be very limited when compared to what the ultimate costs may end up being. So accordingly, if set asides are done in liability settlements without recognition of these differences and with no apportionment of damages, you can conceivably have a situation where a party is setting aside their entire net settlement even though it is made up of non-medical damages. In effect it can eliminate the recovery of the non-medical portion of the damages by requiring the Medicare beneficiary to set aside all of their net proceeds. There is nothing in the MSP regulations or statute that requires Medicare to seek one hundred percent reimbursement of future medicals when the injury victim recovers substantially less than his or her full measure of damages.

Prior to the *Benoit* opinion, I argued based upon the United States Supreme Court Decision in *Arkansas Department of Human Services v. Ahlborn*<sup>44</sup> that an MSA should be

reduced by using a formula similar to that decision because the situations were analogous. The argument goes something like as follows. 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. Similarly, a set aside shouldn't encompass non-medical portions of the recovery. 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. *Ahlborn* was recently affirmed by the US Supreme Court in *WOS v. EMA*. While admittedly both the *Ahlborn* and *WOS* decisions 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 the *Benoit* case, the plaintiff took the position he was only recovering 10% of his total damages. Therefore, based upon my *Ahlborn* analysis, the figures would look like:

<b>Total Case Value</b>	\$ 1,000,000.00
<b>Actual Settlement</b>	\$ 100,000.00
<b>Fees, Costs &amp; Liens</b>	\$ 44,293.00
<b>Net to Client</b>	\$ 55,707.00
<b>Set Aside Amount</b>	\$ 305,512.00
<b>Percentage of Recovery</b>	5.57%

<b>Reduced Set Aside Amount</b>	<b>\$ 17,019.16</b>
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The *Benoit* court was even more aggressive in its analysis. Instead of looking at a ratio of the total case value versus the net, it looked at the ratio of the MSA amount to the net. The analysis looks like:

<b>Actual Settlement</b>	\$ 100,000.00
<b>Fees, Costs &amp; Liens</b>	\$ 44,293.00
<b>Net to Client</b>	\$ 55,707.00
<b>Set Aside Amount</b>	\$ 305,512.00
<b>Net as a Percentage of MSA</b>	18.23%
<b>Reduced Set Aside Amount</b>	<b>\$ 10,157.60</b>

Both methodologies get to the correct end result in my opinion. While the *Benoit* case is incredibly important because it is the first recognition by a federal court of the fundamental problem involved with cases where there is a limited recovery but a large future Medicare component, it is only a United States District Court opinion. It is a trial court's order on a motion for declaratory judgment. Unless Medicare somehow intervenes and appeals, we will not see a Circuit Court of Appeals decision that would have precedential value. Despite the foregoing, the court's rationale supports applying a reduction methodology where before the *Benoit* opinion there was no direct authority for this. If Medicare ultimately creates regulations related to liability Medicare Set Asides, one can hope they will look very carefully at a workable solution to this type of situation. The *Benoit* decision provides one possible way to address the issue created by limited settlements with big future medicals.

## WHAT TO DO?

So what do trial lawyers do given all of the foregoing? In my opinion, you must put into place a method of screening your files to determine those that involve Medicare beneficiaries or those with a reasonable expectation of becoming a Medicare beneficiary within 30 months. Once you identify a client as falling in one of those two categories, you must determine if future medicals have been funded and advise the client regarding the legal implications of the MSP. The easiest way to remember the process once you have identified someone as a Medicare beneficiary or someone with the reasonable expectation is by the acronym “CAD”. The “C” stands for consult with competent experts who can help deal with these complicated issues. The “A” stands for advise the client about the MSP implications related to future medical. The “D” stands for document what you did in relation to the MSP. If the client decides that they don’t want an MSA or to set aside anything, a choice they can make, then document the education they received about the issue with them signing an acknowledgement. If they elect to do an MSA analysis, hire a company to do the analysis so that they can help you document your file properly to close it compliantly.

In addition, release language is critical when it comes to the question of documentation of considering Medicare’s future interests. Release language I have seen prepared by defendant/insurers is typically inappropriate or overbearing. Frequently the language cites regulations that are related to workers’ compensation settlements and typically will specifically identify a figure to be set aside. The latter can potentially cause a loss of itemized deductions for the client. Not only is release language an important consideration, so is the method of calculation of the set aside, potential reduction methodologies and funding alternatives (lump sum vs. annuity funding). These issues do impact how the release is crafted as well as considerations of whether to submit to CMS for review and approval. Submission of a liability set aside isn’t required and a settlement should never be made contingent upon CMS review and approval in my opinion. Some regional offices will not review a liability set aside while others will. Since review/approval is voluntary, I typically don’t recommend submission given the lack of appeal process should CMS come back with an unfavorable decision. Furthermore, making a settlement contingent upon CMS review/approval could create an impossible contingency if the

settlement is in a jurisdiction where the regional office will not review such as my home state of Florida.

## **CONCLUSION**

I believe the easiest way to think about MSAs in liability settlements is by analogy to special needs trusts. If a client is a Medicaid recipient, it would be malpractice not to educate them on the potential of establishing an SNT to keep them eligible for future Medicaid benefits. Failure to advise a client regarding establishing an SNT is clearly legal malpractice. That doesn't mean a client must set up an SNT; it just means they must be advised about the option to create the trust and the impact of foregoing it in terms of future Medicaid benefits. Similarly, Medicare beneficiaries must understand the risk of losing their Medicare coverage should they decide to set aside nothing from their personal injury settlement for future Medicare covered expenses related to the injury. So it is about educating the client to make sure they can make an informed decision relative to whether they desire to protect their future Medicare eligibility by setting aside funds to be used for future medical.

Beyond education of the client, the most critical issue becomes how to properly document your file about what was done and why. This part is where the experts come into play. For most practitioners, it is nearly impossible to know all of the nuances and issues that arise with a set aside. From the creation of the allocation to the release language and the funding/administration of a set aside, there are issues that can be daunting for even the most well informed personal injury practitioner. Without proper consultation and guidance, mistakes can lead to unhappy clients or worse yet a legal malpractice claim.

The lesson to take away from this article and the cases described herein, is not to wind up in federal court over these issues. Instead, deal with these issues pre-settlement strategically. If a client is a Medicare beneficiary, then make sure you know which ICD codes will be reported under the Mandatory Insurer Reporting law and evaluate with the client the possibility of a set aside. Discuss with competent experts the proper steps for MSP compliance. Potentially use the set aside as an element of damages to help improve settlement value. Properly word the release if a set aside is being used to make sure the client doesn't get saddled with inappropriate

language or lose itemized deductions. Appropriate planning will avoid this kind of outcome or unnecessary trips to federal court.

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<sup>1</sup> Jason D. Lazarus, Medicare Myths: *What Every Trial Lawyer Should Know About the MSP & Liability Medicare Set Asides*, FL BAR JOURNAL at 46 (November 2010).

<sup>2</sup> Codified at 42 U.S.C. § 1395y(b)(8)(C).

<sup>3</sup> CMS Alert, Office of Financial Management/Financial Services Group, *Mandatory Total Payment Obligation to the Claimant (TPOC) Dollar Thresholds for Certain Liability Insurance* (Including Self-Insurance), June 20, 2012.

<sup>4</sup> *Id.*

<sup>5</sup> Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110-173). This Act was passed by the House on December 19, 2007, and by a voice vote in the Senate on December 18, 2007.

<sup>6</sup> Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110-173).

<sup>7</sup> *Id.*

<sup>8</sup> *Id.*

<sup>9</sup> *Id.*

<sup>10</sup> The provisions of the MSP can be found at Section 1862(b) of the Social Security Act. 42 U.S.C. § 1395y(b)(6) (2007).

<sup>11</sup> Omnibus Reconciliation Act of 1980, Pub. L. No. 96-499 (Dec. 5, 1980).

<sup>12</sup> 42 CFR § 411.20(2) Part 411, Subpart B, (2007).

<sup>13</sup> *Id.*

<sup>14</sup> Sally Stalcup, MSP Regional Coordinator (May 2011 Handout). *See also*, Charlotte Benson, *Medicare Secondary Payer – Liability Insurance (Including Self-Insurance) Settlements, Judgments, Awards, or Other Payments and Future Medicals – INFORMATION*, Centers for Medicare and Medicaid Services Memorandum, September 29, 2011.

<sup>15</sup> *Id.*

<sup>16</sup> Edward M. Welch, *Medicare and Worker's Compensation After the 2003 Amendments*, WORKERS' COMPENSATION POLICY REVIEW, at 5 (March/April 2003).

<sup>17</sup> Parashar B. Patel, *Medicare Secondary Payer Statute: Medicare Set-Aside Arrangements*, Centers for Medicare and Medicaid Services Memorandum, July 23, 2001.

<sup>18</sup> *Id.*

<sup>19</sup> *Alcorn v. Pepples*, 2011 U.S. Dist. LEXIS 19627 (W.D. Ky. Feb. 25, 2011).

<sup>20</sup> *Id.* *See also* *Hicks v. Chamberlain*, 2010 U.S. Dist. LEXIS 112969 (E.D. Ky. Oct. 21, 2010) (holding that “[w]hether the Secretary will seek reimbursement, and if so, how much, can only be reviewed by a federal court after Medicare’s administrative procedure has been exhausted”); *Black v. Doe*, 2011 U.S. Dist. LEXIS 46935 (E.D. Ky. May 2, 2011); *Walters v. Leavitt*, 376 F.Supp.2d 746, 755-56 (E.D. Mich. 2005) (deciding it did not have jurisdiction because plaintiffs had not exhausted their remedies under § 405(g) where “Plaintiffs [were] seeking a determination of the amount of reimbursement that Defendant will seek under its subrogation rights created by the Medicare Act’s MSP provisions”); *Truett v. Bowman*, 288 F.Supp.2d 909 (W.D. Tenn. 2003) (limiting defendants to the administrative procedure codified in § 405 though defendants sought advance knowledge of what Medicare might do in the future, and determining that defendants had not established that the Secretary had issued a final decision)

<sup>21</sup> *Finke v. Hunter's View, Ltd.*, 2009 U.S. Dist. LEXIS 126830 (D. Minn. Aug. 25, 2009).

<sup>22</sup> This is the first and only decision I have come across on such an issue. It is interesting for several reasons. First, CMS has taken the position in the context of Workers’ Compensation Medicare Set Asides that the existence of private health insurance does not avoid the need to establish a set aside. The *Finke* case rules the opposite way on that issue. The following is CMS’s position from their website: Group Health Plan (GHP) Insurance, Managed Care Plan, and Veterans' Administration (VA) Coverage (Ref: 7/11/05 Memo Q8): “In a WC settlement, a WCMSA is recommended where the claimant is covered under a GHP or a managed care plan or has coverage through the VA. A WCMSA is still appropriate because such other health insurance or health service could in the future be canceled or reduced, or the injured individual may elect not to take advantage of such services. It is important to remember

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that workers' compensation is always primary to Medicare and many other types of health insurance coverage for expenses related to the WC claim or settlement.”

<sup>23</sup> *Big R Towing, Inc. v. Benoit*, 2011 U.S. Dist. LEXIS 1392 (W.D. La. Jan. 5, 2011).

<sup>24</sup> *Schexnayder v. Scottsdale Ins. Co.*, 2011 U.S. Dist. LEXIS 83687 (W.D. La. July 28, 2011).

<sup>25</sup> *Smith v. Marine Terminals of Ark.*, 2011 U.S. Dist. LEXIS 90428 (E.D. Ark. Aug. 9, 2011).

<sup>26</sup> *Guidry v. Chevron USA, Inc.*, 2011 U.S. Dist. LEXIS 148942 (W.D. La. Dec. 28, 2011).

<sup>27</sup> *Bradley v. Sebelius*, 621 F.3d 1330 (11th Cir. Fla. 2010).

<sup>28</sup> *Frank v. Gateway Ins. Co.*, 2012 U.S. Dist. LEXIS 33581 (W.D. La. Mar. 13, 2012).

<sup>29</sup> *Id.*

<sup>30</sup> *Bertrand v. Talen's Marine & Fuel LLC*, 2012 U.S. Dist. LEXIS 78053 (W.D. La. June 4, 2012).

<sup>31</sup> *Bessard v. Superior Energy Servs. LLC*, 2012 U.S. Dist. LEXIS 124690 (W.D. La. Aug. 30, 2012).

<sup>32</sup> *Cribb v. Sulzer Metco (US) Inc.*, 2012 U.S. Dist. LEXIS 134900 (E.D.N.C. Sept. 5, 2012).

<sup>33</sup> *Welch v. Am. Home Assur. Co.*, 2013 U.S. Dist. LEXIS 25948 (S.D. Miss. Feb. 26, 2013).

<sup>34</sup> An MSA may either be “self-administered” or “professionally administered”. 10.1.6 Section 30 – WCMSA Administration Agreement, CMS Workers’ Compensation Medicare Set Aside Arrangement (WCMSA) Reference Guide (March 29, 2013).

<sup>35</sup> *Bruton v. Carnival Corp.*, 2012 U.S. Dist. LEXIS 64416 (S.D. Fla. 2012).

<sup>36</sup> *Sipler v. Trans Am Trucking, Inc.*, 881 F. Supp. 2d 635 (D.N.J. 2012).

<sup>37</sup> *Early v. Carnival Corp.*, 2013 U.S. Dist. LEXIS 16711 (S.D. Fla. Feb. 7, 2013).

<sup>38</sup> Jason D. Lazarus, Medicare Myths: *What Every Trial Lawyer Should Know About the MSP & Liability Medicare Set Asides*, FL BAR JOURNAL at 46 (November 2010).

<sup>39</sup> *In re Marriage of Washkowiak*, 966 N.E.2d 1060 (Ill. App. Ct. 3d Dist. 2012).

<sup>40</sup> *Hinsinger v. Showboat Atlantic City*, 420 N.J. Super. 15 (Law Div. 2011).

<sup>41</sup> *Sterrett v. Klebart*, 2013 Conn. Super. LEXIS 245 (Conn. Super. Ct. Feb. 4, 2013).

<sup>42</sup> *Benoit v. Neustrom*, 2013 U.S. Dist. LEXIS 55971 (W.D. La. 2013).

<sup>43</sup> Letter to Suzanne Kalwa, Centers for Medicare and Medicaid Services, Re: Advanced Notice of Proposed Rulemaking on Medicare Secondary Payer and Future Medicals (Docket No. CMS-6047-ANPRM), Sarah Rooney American Association for Justice (Aug. 14, 2012).

<sup>44</sup> *Ark. Dep’t of Human Servs. Ahlborn*, 547 U.S. 268 (2006).