Total "Medicare" Compliance in a New Age
MSAs

By Jason D. Lazarus, J.D., LL.M., MSCC

In today's complicated regulatory landscape, a comprehensive plan for Medicare compliance has become vitally important to personal injury practices. Personal injury lawyers are personally exposed to damages and malpractice risks daily when they handle or resolve cases for Medicare beneficiaries. The list of things to be concerned about is growing daily. The list includes things such as:

1. Not knowing what medical information/ICD codes are being reported by defendant insurers complying with Mandatory Insurer Reporting laws (MIR).
2. Agreeing to onerous "Medicare Compliance" language that may be inapplicable or inaccurate which binds the personal injury victim.
3. Failing to report and resolve conditional payment obligations leading to personal liability.
4. Not using processes to obtain money back from Medicare using the compromise and waiver process.
5. Failure to identify a lien, such as those asserted by Medicare Part C lien holders thereby exposing the personal injury lawyer and the firm to double damages.
6. Inadequate education of clients about Medicare compliance when it comes to 'futures' and the risks of denial of future injury related care.

So what do you do? The answer is to develop a process to identify those who are Medicare beneficiaries in your practice and make sure that a process is put into place to deal with the myriad of issues that can arise. The first step is education about these various issues to trial lawyers and their staff so problems can be identified before they become a malpractice issue or worse yet, a personal liability for the plaintiff attorney. This article focuses on the educational component and suggestions for protecting your clients as well as your practice when it comes to dealing with clients who are Medicare beneficiaries.

The Basics

The Medicare program is made up of different parts. Part A and Part B are thought of as 'traditional Medicare' which includes hospital insurance and medical insurance. Part A is the hospital insurance which covers inpatient are in hospitals and skilled nursing facilities (it does not cover custodial or long term care – only Medicaid does). Part B benefits cover physician visits, durable medical equipment and hospital outpatient care. It also covers some of the services Part A doesn't cover such as physical and occupational therapies as well as some home health care. Part D is prescription drug coverage that is provided by private insurers approved by and funded by Medicare. Part C – Medicare 'Advantage Plans' or MAOs, offers all of the

coverages through Parts A, B and D but through a private insurer approved by Medicare. It is an alternative to the fee for service Part A and B coverages which can be elected and purchased by a Medicare beneficiary.

There is a connection between Medicare eligibility and Social Security Disability Income (hereinafter SSDI). SSDI is the only way to get Medicare coverage prior to retirement age. This is pertinent as many injury victims become Medicare eligible by virtue of disability. Medicare and Social Security Disability Income benefits are an entitlement and are not income or asset sensitive like Medicaid/SSI. Clients who meet Social Security's definition of disability and have paid in enough quarters into the system can receive disability benefits without regard to their financial situation. The SSDI benefit program is funded by the workforce's contribution into FICA (social security) or self-employment taxes. Workers earn credits based on their work history and a worker must have enough credits to get SSDI benefits should they become disabled. Medicare is our federal health insurance program and as discussed above, is broken up into multiple parts. Medicare entitlement commences at age sixty-five or two years after becoming disabled under Social Security's definition of disability.

Medicare Secondary Payer Act & Mandatory Insurer Reporting

Representing someone who is Medicare eligible automatically triggers concerns over the implications of compliance with the Medicare Secondary Payer Act (hereinafter MSP). A client who is a current Medicare beneficiary or reasonably expected to become one within 30 months has to be educated about the MSP and protected from the ramifications of non-compliance. The MSP is a series of statutory provisions enacted in 1980 as part of the Omnibus Reconciliation Act with the goal of reducing federal health care costs. The MSP provides that if a primary payer exists, Medicare only pays for medical treatment relating to an injury to the extent that the primary payer does not pay. The regulations that implement the MSP provide "[s]ection 1862(b)(2)(A)(ii) of the 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.

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). According to CMS, both are obligations in terms of compliance with the MSP which extends to both prior to settlement and into the future. The passage of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) has triggered heightened concerns of all parties to a settlement involving a Medicare beneficiary. Part of this Act, Section 111, extends the government's ability to enforce the Medicare Secondary Payer Act. 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. This is the so-called Mandatory Insurer Requirement, MIR for short.

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. Failure of an applicable plan to comply with the reporting requirements potentially exposes them to a civil money penalty for each day of noncompliance with respect to each 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 advent of MIR causes some very real and difficult problems for personal injury lawyers. For example, 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. Worse yet, your ability to negotiate a conditional payment made by Medicare may be complicated by including care that is unrelated. This issue is further exacerbated by the reporting data being submitted by outside reporting agents who are only provided initial case information without involvement of plaintiff counsel.

Another example arises when the date of accident that is reported doesn't match up with what the plaintiff reports. The MIR requirements don't relieve the personal injury lawyer's obligation to report through the BCRC and resolve the conditional payment. If the defendant insurer reports a date of accident that doesn't match with what was reported by plaintiff counsel, it could trigger a second and new conditional payment demand from Medicare. This often leads to frustration and complication in resolving the conditional payment obligation.

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

scenarios 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 unintended repercussions that result.

MMSEA/MIR Release Language

In this new age of hyper-vigilance surrounding Medicare Compliance as a result of MIR, release language about protecting Medicare can be longer than the release itself. This language is frequently inaccurate or wholly inapplicable. In practice, I have seen language that mandates that the personal injury victim will not apply for Medicare or even Social Security Disability benefits. Equally as bad, language is frequently included that place a burden on the plaintiff to comply with requirements that aren't mandated by any law. Most of the language improperly cites statutes or regulations that don't say anything relevant to the issues at hand.

Therefore, great care needs to be taken by the personal injury practitioner in terms of what is agreed upon and included in the release. Technically, there is nothing required by any law that needs to be addressed in the release as it relates to the MSP. Practically speaking though, language has to be there to placate the other side's misinformation about their own liability regarding many of the MSP related issues. It is simple to address these issues concisely and in a way that doesn't place any onerous obligations upon the plaintiff. Every case is different and the facts dictate the use of different language each time but there is a core set of provisions that can be done in one simple paragraph to deal with the Medicare related issues at hand.

MMSEA/MIR and Conditional Payments

The stated intent of the new reporting requirements was to identify situations where Medicare should not be the primary payer and ultimately allow recovery of conditional payments. The Medicare Secondary Payer Act (MSP) prohibits Medicare from making payments if payment has been made or is reasonably expected to be made by a workers' compensation plan, liability insurance, no fault insurance or a group health plan. However, Medicare may make a "conditional payment" if one of the aforementioned primary plans does not pay or can't be expected to be paid promptly. These "conditional payments" are made subject to being repaid when the primary payer pays. When conditional payments are made by Medicare, the government has a right of recovery against the settlement proceeds.

Congress has given the Centers for Medicare and Medicaid Services (CMS) both subrogation rights and the right to bring an independent cause of action to recover a conditional payment from "any or all entities that are or were required or responsible . . . to make payment with respect to the same item or service (or any

portion thereof) under a primary plan." Furthermore, CMS is authorized under federal law to bring actions against "any other entity that has received payment from a primary plan." Most ominously, the government may seek to recover double damages via an independent statutory cause of action.

Resolution of Conditional Payments – Failure to Pay Equals Personal Liability

The government takes its reimbursement rights seriously and is willing to pursue trial lawyers who ignore Medicare's interest. In U.S. v. Harris, a November 2008 opinion, a personal injury plaintiff lawyer lost his motion to dismiss against the U.S. Government in a suit involving the failure to satisfy a Medicare subrogation claim. The plaintiff, the United States of America, filed for declaratory judgment and money damages against the personal injury attorney owed to the Centers for Medicare and Medicaid Services by virtue of 3rd party payments made to a Medicare beneficiary. The personal injury attorney had settled a claim for a Medicare beneficiary (James Ritchea) for $25,000. Medicare had made conditional payments in the amount of $22,549.67. After settlement, plaintiff counsel sent Medicare the details of the settlement and Medicare calculated they were owed approximately $10,253.59 out of the $25,000. Plaintiff counsel failed to pay this amount and the Government filed suit.

A motion to dismiss filed by plaintiff counsel was denied by the United States District Court for the Northern District of West Virginia despite plaintiff counsel's arguments that he had no personal liability. Plaintiff counsel argued that he could not be held liable individually under 42 U.S.C. 1395y(b)(2) because he forwarded the details of the settlement to the government and thus the settlement funds were distributed to his clients with the government's knowledge and consent. The court disagreed. The court pointed out that the government may under 42 U.S.C. 1395y(b)(2)(B)(iii) "recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity." Further, the court pointed to the federal regulations implementing the MSPS which state that CMS has a right of action to recover its payments from any entity including an attorney. Subsequently, the U.S. Government filed a motion for summary judgment against plaintiff counsel. The United States District Court, in March of 2009, granted the motion for summary judgment against plaintiff counsel and held the Government was entitled to a judgment in the amount of $11,367.78 plus interest.

Resolution of the government's interests concerning conditional payment obligations is simple in application but time consuming. The process of reporting the settlement starts with contacting the BCRC (Benefits Coordination Recovery Contractor). This starts prior to settlement so that you can obtain and review a conditional payment letter (CPL). These letters are preliminary and can't be relied upon to pay Medicare from. However, they are necessary to review and audit for removal of unrelated care. Once settlement is achieved, Medicare must be given the details regarding settlement so that they issue a final demand. Once the final

demand is issued, Medicare must be paid its final demand amount regardless of whether an appeal, compromise or waiver is sought. Paying the final demand amount within sixty days of issuance is required or interest begins to accrue at over ten percent and ultimately it is referred to the U.S. Treasury for an enforcement action to recover the unpaid amount if not addressed.

Resolution of Conditional Payments – Appeal, Compromise or Waiver

The repayment formula for Medicare is set by the Code of Federal Regulations. 411.37(c) & (d) prescribe a reduction for procurement costs and that is it. The formula doesn't take into account liability related issues in the case, caps on damages or policy limits. The end result can be that the entire settlement must be used to reimburse Medicare. The only alternatives are to appeal which requires you to go through four levels of internal Medicare appeals before you ever get to step foot before a federal judge or compromise/waiver. There is plenty of case law requiring exhaustion of the internal Medicare appeals processes which means that Medicare appeals are lengthy as well as an unattractive resolution method. What makes them even more unattractive is the fact that interest continues to accrue during the appeal so long as the final demand amount remains unpaid.

An alternative resolution method is requesting a compromise or waiver post payment of the final demand. By paying Medicare their final demand and requesting compromise/waiver, the interest meter stops running. If Medicare grants a compromise or waiver, they actually issue a refund back to the Medicare beneficiary. There are three viable ways to request a compromise/waiver. The first is via Section 1870(c) of the Social Security Act which is the financial hardship waiver and is evaluated by the BCRC. The second is via section 1862(b) of the Social Security Act which is the "best interest of the program" waiver and is evaluated by CMS itself. The final is under the Federal Claims Collection Act and the compromise request is evaluated by CMS. If any of these are successfully granted, Medicare will refund the amount that was paid via the final demand or a portion thereof depending on whether it is a full waiver or just a compromise.

Part C Plans – The "Hidden" Lien

Now that you have gone through the resolution process for your client and gotten the conditional payment related issues dealt with you might think you are finished, but alas, you are not. Or you might not be. What lurks out there is that a Part C Advantage Plan (hereinafter MAO) may have paid for some or all of your client's care. You may ask how that is possible when you were told that the client was a Medicare beneficiary and Part A/B was paid back for conditional payments. The reason is that MAOs aren't Medicare and injury victim clients can elect to enroll in an MAO during relevant enrollment periods. Therefore, an MAO may have made payments after election of which you are completely unaware. Neither Medicare, BCRC nor CMS will alert you to this fact nor do they have any information as it relates to MAOs. Therefore, personal injury attorneys must be vigilant and do their

own due diligence to track down possible MAO liens or face the possibility of having to personally pay the lien times two. Although shocking, it is an area of the law that is rapidly developing in favor of MAO plans.

MAO plans use the Medicare Secondary Payer statute as the basis for their claims to reimbursement. Accordingly, their repayment formulas are the same as Medicare under 411.37 (c) and (d) which only requires a procurement cost reduction. That being said, these plans are typically willing to negotiate and arguably must provide a mechanism for a compromise or waiver if they avail themselves of the MSP in terms of their recovery rights. All of that is well and good but what happens when you don't know that an MAO has a lien? The answer is fairly ominous for all the parties to a personal injury settlement. A private cause of action can be brought as an enforcement action for double the amount of the lien. This right is provided for in the Medicare Secondary Payer Act itself. While parties have long been afraid of the government using this provision, it is on behalf of the MAOs that these actions are now being brought effectively to enforce their reimbursement rights times two.

According to the MSP, a private cause of action exists when a primary plan fails to reimburse a secondary plan for conditional payments it has made. "There is established a private cause of action for damages (which shall be in an amount double the amount otherwise provided) in the case of a primary plan which fails to provide for primary payment (or appropriate reimbursement) in accordance with paragraphs (1) and (2)(A)." - 42 U.S.C. § 1395y(b)(3)(A)." 42 C.F.R. §422.108(f) extends the private cause of action to Medicare Advantage Plans. "MAOs will exercise the same rights to recover from a primary plan, entity, or individual that the Secretary exercises under the MSP regulations in subparts B through D of part 411 of this chapter." According to 42 C.F.R. §411.24(g), "CMS has a right of action to recover its payments from any entity, including a beneficiary, provider, supplier, physician, attorney, State agency or private insurer that has received a primary payment." In that regard, a plaintiff personal injury law firm was sued last year by Humana for a $191,000 lien that wasn't repaid because the firm was unaware of the lien. The damages claimed were $382,000 which is precisely double the lien that wasn't paid. That case was resolved confidentially out of court.

The seminal case on this issue is, for now, Humana v. Western Heritage Ins. Co., No. 15-11436 (11th Cir. Aug. 8, 2016) from late last year. This was a slip and fall case wherein just before settlement the existence of a Humana Medicare Advantage plan was discovered. Western Heritage, the defendant insurer, initially put Humana on the settlement check but a state court judge ordered it removed. The plaintiff failed to repay Humana, so Humana initiated litigation directly against the defendant insurer. Western Heritage placed the amount of Humana's demand in trust during the litigation and disclosed the existence and location to Humana. The 11th Circuit Court of Appeals granted Humana's Motion for Summary Judgment and held that Humana's right to reimbursement for the conditional payments it made on behalf of the plan beneficiary under a Medicare Advantage Plan was enforceable. Western Heritage had an obligation to independently reimburse Humana. When they failed to

do so, the Court ruled that as a matter of law, Humana was entitled to maintain a private cause of action for double damages pursuant to 42 U.S.C. § 1395y(b)(3)(A) and was therefore entitled to $38,310.82 in damages. The Eleventh Circuit said that placing the $19,155.41 in trust was not the same as paying the MAO and that the damages "SHALL" be double.

In summary, when it comes to MAO liens there is a good chance you may be unaware that a lien exists without your own research. A good practice is to obtain copies of all government assistance program cards and any health insurance cards to see just what the injury victim is receiving in terms of benefits/insurance coverage. Make sure a thorough investigation is done if the client is a Medicare beneficiary for the existence of Part
C/MAO liens. The investigation and inquiry should start upon intake and continue throughout representation with the final check occurring before disbursement of settlement proceeds. Failing to do so may expose you and your firm to personal liability for double damages to a Part C Plan or Medicare itself. Once a Part C/MAO lien is identified, you must aggressively pursue reduction methods either using traditional lien reduction arguments if the MAO doesn't insist upon adherence to the MSP or using the MSP's compromise or waiver process.

Medicare Futures – The Unregulated New Frontier

The first part of this article focused primarily on the issues with MIR and conditional payments/liens. While those issues are very important, a larger issue looms regarding payments made by Medicare after settlement. Today, there is a very real threat of Medicare denying future injury related care after the personal injury case is resolved. This can be very easily triggered by the MIR and reporting of injury related ICD codes that happens automatically now with any settlement of one thousand dollars or greater. Once a denial of care is triggered, a Medicare beneficiary has to go through the 4 levels of internal Medicare appeals plus a federal district court before ever getting the denial of care addressed by a federal appeals court. This is why it must be of primary concern for the personal injury practitioner to address these issues. Particularly so in catastrophic injury cases where denial of care could be devastating to the injury victim's medical quality of life.

When it comes to set asides, there are a few key takeaways from this portion of the article. First, you only have to worry about this issue if you are dealing with someone that is a current Medicare beneficiary or arguably those with a reasonable expectation of becoming one within 30 months. The latter includes those who have applied for or begun receiving Social Security Disability benefits. At present, there is no regulation, statute or case law requiring a Medicare Set Aside to deal with futures. Instead, it has become analogous to the situation in resolving cases with those who are on Medicaid or SSI. In those cases, a client must be educated about the opportunity to set up a special needs trust to remain eligible for needs based benefits. Similarly, a Medicare beneficiary should be informed about the opportunity to set up a Medicare Set Aside to protect future Medicare eligibility for injury related

care. The good news for personal injury attorneys, is that a Medicare Set Aside allocation can be used in an offensive manner to set the floor for medical damages in a case.

All of that being said, you might be wondering why even consider doing a Medicare Set Aside when they aren't required by any law? The answer is that it is less important as to whether anything is actually set aside versus doing the legal analysis to determine why anything should be set aside. Said a different way, this is a plaintiff issue and not a defense issue. The only penalty for failing to address this is issue is the potential loss of future Medicare coverage for only injury related care. So you ultimately want to educate the client on the risks of failing to do a set aside analysis and then document your file about what was being done. The next question might be: What risk is there if there isn't any law requiring set asides? Again, the answer boils down to CMS's interpretation of the MSP. According to CMS, since Medicare isn't supposed to pay for future medical expenses covered by a liability or Workers' Compensation settlement, judgment or award, it recommends that injury victims set aside a sufficient amount of a personal injury settlement to cover future medical expenses that are Medicare covered. CMS's 'recommended' way to protect future Medicare benefit eligibility is establishment of an MSA to pay for injury related care until exhaustion.

Why & How Did CMS Come Up with MSAs?

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 developed 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. 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. 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." 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.

What is a Medicare Set Aside?

Before getting into an overview of the regulatory environment of MSAs, it is first important to explain what exactly a set aside is. 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 (most presently do not review). 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.

Regulatory 'Scheme' - What if Any 'Law' is there as it relates to Set Asides in Personal Injury Settlements?

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 as a result of the MMSEA's passage and the onset of MIR. This culminated with the presumed codification of formal regulations back in 2014. However, without explanation those regulations were withdrawn after having gone through significant vetting along with public commentary. The apparent reason was complaints from both sides about the regulations fairness and workability in practice.

In 2016, it became evident that CMS was not fazed by previous failed attempts at codification of rules for set asides in liability cases and determined to develop a process to avoid shifting of the burden to Medicare post resolution of a personal injury settlement. Last year, the Department of Health and Human Services issued its budget for 2017 which included a line item indicating CMS had requested legislative authority to pursue a new policy regarding the treatment of future medicals. In June of 2016, CMS issued an alert that they were considering expanding

their voluntary review process to liability cases. Late last year, CMS sought proposals for a new review contractor for set asides which included the anticipated review of 51,000 liability proposed set asides annually. Then in 2017, Medicare sent a memorandum to its contractors indicating that Medicare and its contractors will reject medical claims submitted post-resolution of a liability settlement on the basis that those claims "should be paid from a Liability Medicare Set Aside (LMSA)".

So while there is no regulation or statute requiring anything be done when it comes to set asides, sticking your head in the sand isn't the answer. It is obvious that Medicare interprets the MSP as preventing shifting the burden from a primary payer to Medicare post resolution of a personal injury settlement. The problem is: How do you do that in a liability settlement given the issues that cause those cases to frequently settle for less than full value? There is no good answer to that question. However, there are two cases in particular that have addressed a couple of very important issues in that regard. While they are only trial court orders, they are instructive in terms of how to deal with the issues.

Several Cases of Note

One of the big issues that can arise in trying to do a set aside is the question of funding of future medicals. Funding of future medicals is a prerequisite to any type of set aside analysis in the first place. The first question that always is asked is whether the client is a current Medicare beneficiary or has a reasonable expectation of becoming one within 30 days. If the answer is no, there is no need for a set aside analysis. Similarly, if future medicals aren't funded then there is no need to engage in a set aside analysis.

The issue of funding of future medicals was addressed by a Connecticut state court. In Sterrett v. Klebart (Conn. Super. Ct. Feb. 4, 2013), the court was asked to decide whether Medicare's interests were reasonably considered pursuant to the Medicare Secondary Payer Act. The Connecticut court found that future medicals were not funded in this case due to competing claims. 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.

The really problematic issue is how do you deal with cases where future medicals are funded but they were settled for pennies on the dollar? Can you apportion the settlement such that you create a reduction formula tied to a comparison of the full value of damages versus what was actually recovered? For example, if the totalvalue of the damages was $1M but only $100k was recovered due to policy limits, can you set aside only 10% instead of 100% of the value of future medical expenses that are Medicare covered related to the injuries suffered? This issue was addressed by a Federal District Court back in 2013. In Benoit v. Neustrom (W.D. La. 2013), 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.

The Benoit case was settled in October of 2012, 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 Payer 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. Having heard testimony, the court rendered its opinion in April of 2013. The court made its findings of fact and conclusions of law which were not worthy of mention aside from the bombshell finding 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 both sides have pointed out to CMS in vetting proposed regulations for liability set asides, 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.

The last case of note is the most dangerous since it is frequently misinterpreted. Many lawyers have said that the Aranki v. Burwell decision holds that MSAs are not required in liability settlements and that these issues need not be addressed at all. The former is accurate but the latter assertion could not be further from the truth. In Aranki, the parties sought to have a federal district court declare there was no obligation to set anything aside. The court said "[n]o federal law or CMS regulation requires the creation of a MSA in personal injury settlements to cover potential future medical expenses". The court did not determine that Medicare's future interest didn't need to be protected. The court actually echoed existing CMS memoranda in finding that an MSA is not required by any stature or regulation. Most importantly the court did not conclude that Medicare can't deny injury related care based upon what is reported to it by defendant insurers as part of MIR. The nuance of this case should be considered carefully, it certainly does not represent a 'get out of jail free card' in regards to these issues.

What do you do to be totally Medicare Compliant?

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. You must contact Medicare and report appropriately

the settlement to get a final demand. Then, you audit the final demand and avail yourself of the compromise/waiver process. You must also make sure you identify any potential Part C/MAO liens and resolve those as well.

If you have a Medicare beneficiary or one with a reasonable expectation of becoming one within 30 months as a client, you must determine if future medicals have been funded and if so advise the client regarding the legal implications of the MSP related to futures. 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/educate 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 and 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 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 (which is rarely a good idea). Submission of a liability set aside isn't required and a settlement should never be made contingent upon CMS review and approval. Some regional offices will not review a liability set aside whiles 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.

Conclusion

Start early and do not let the defendant-insurer control the Medicare compliance process. At the outset of your case you have to confirm disability eligibility with Social Security and get copies of all insurance as well as government assistance cards. Make sure you understand who is potentially Medicare eligible such as those who are on SSDI, those turning 65, someone with end stage renal disease (ESRD), Lou Gehrig's disease (ALS) or a child disabled before age 22 with a parent drawing Social Security benefits. Collaborate with the other side regarding what is being

reported under MIR. Be active in mandating the proper ICD codes to be included in the release.

Trial lawyers must be in the know when it comes to dealing with Medicare conditional payments as well as Part C/MAO liens. 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 these issues. 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 the Medicare Secondary Payer Act. From identifying liens, resolving conditional payments, deciding to set money aside, 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 a bad outcome or unnecessary trips to federal court.

About the Author:

Jason D. Lazarus, J.D., LL.M., CSSC, MSCC
Mr. Lazarus is the managing partner and founder of the Special Needs Law Firm; a Florida law firm that provides legal services related to public benefit preservation, liens and Medicare Secondary Payer compliance. He is also a founding Principal and Chief Executive Officer of Synergy Settlement Services. Synergy offers healthcare lien resolution, Medicare secondary payer compliance services, pooled trust services, settlement asset management services and structured settlements. Jason received his B.A. from the University of Central Florida and his J.D. with high honors from Florida State University. He received his LLM in Elder Law with Distinction from Stetson University College of Law. Mr. Lazarus is a Medicare Set Aside Consultant certified by the International Commission on Health Care

Certification. His written work has been cited, as authoritative on Medicare compliance, by the Supreme Court of Florida and the United States Southern District Court.

He can be reached at 877-977-3387 or via email at jason@jasondlazarus.com. His law firm website is www.specialneedsfirm.com and Synergy's website is www.synergysettlements.com

Ready to schedule a consultation?
The Synergy Settlements team will work diligently to ensure your case gets the attention it deserves. Contact one of our legal experts and get a professional review of your case today.