

MEDICARE REPORTING, RESOLVING CONDITIONAL PAYMENTS AND TAKING MEDICARE'S INTEREST INTO ACCOUNT FOR FUTURE PAYMENTS

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The Florida Defense Lawyers Association (FDLA) is pleased to present this White Paper Series on "Medicare Reporting, Resolving Contingent Payments and Taking Medicare's Interest into Account for Future Payments." We believe this paper may serve as a guide to businesses and their insurers that regularly process claims and settlements involving Medicare beneficiaries.

This series includes the history of the Medicare Secondary Payer (MMSP) Act and how to address Medicare in liability settlements. It provides a defense perspective on Section 111 Reporting as well as providing practice tips for attorneys and responsible reporting entities. A second series is planned in conjunction with the Florida Justice Association, with the intent to provide both a plaintiff perspective and a joint perspective on these critical issues. This White Paper was first distributed at the 15th annual Florida Liability Claims Conference in Orlando, Florida, on June 2, 2011. We welcome your questions and comments.

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INTRODUCTION

To enter into a liability settlement nowadays, one almost has to be an expert in the Medicare Secondary Payer Act. There are a myriad of nuances in the Medicare laws which need to be addressed in all liability settlements. Protecting Medicare's interest, conditional payments, and future medicals need to be considered in all settlements. However, there is limited guidance currently being provided by Medicare regarding liability settlements and there are serious penalties and fines for not properly protecting its interests. There is a lot of good and bad information circulating on how Medicare's demands should be addressed in liability settlements. Most attorneys, primary payers and injured parties are often left scratching their heads wondering how to ensure that they are protecting Medicare's interests.

This White Paper will present risk analyses and early identification strategies that will help primary payers decide how to proceed and how to limit potential exposure and guide the reader on how to address Medicare in settlements.

First things first: why are we concerned with Medicare in general liability settlements? In 1980, Medicare became a secondary payer in general liability cases as a result of the Omnibus Budget Reconciliation Act. The Medicare Secondary Payer (MSP) Program was part of this act. The MSP Program made Medicare the secondary payer to group health plans, liability, and no-fault insurance. The purpose of the MSP Program is to shift costs from the Medicare program to private sources of payment.¹ While Medicare has not issued any statements as to how it will enforce the Medicare Secondary Payer Act when it comes to liability settlements, as it has in Workers' Compensation settlements, addressing future Medicare covered medical needs in general liability settlements is highly recommended.

In order to better understand the reason why Medicare is trying to get involved in settlements, a brief overview of Medicare and its history and financial stability are needed.

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MEDICARE OVERVIEW

Medicare is part of Social Security. The responsibility for overseeing Medicare belongs to the Centers for Medicare and Medicaid Services (CMS). CMS is the federal agency responsible for administering the Medicare program. Medicare is a complicated federal program that is basically divided into four groups: Part A—Hospitals, Part B—Medical Doctors, Part C—Private Health Plans, and the most recent addition, Part D—Prescription Medications.² Medicare does not pay for all medical services. Medicare covers certain medical services and supplies in hospitals, doctors' offices, and other health care settings.

Medicare Part D was added to help beneficiaries pay for prescription medications. Due to the soaring costs of prescription medications, Part D has caused certain Workers' Compensation settlements to double, triple or more since the introduction of Part D. There have been numerous occasions where Workers' Compensation cases could not settle given the astronomical cost of the prescription medication.

HISTORY

Medicare was enacted in 1965.³ Since its enactment, Medicare has been a secondary payer to Workers' Compensation. Originally, Medicare only covered individuals 65 years of age and older.⁴

In 1972, Medicare was expanded to include individuals who were under the age of 65 that were receiving Social Security disability insurance payments. Medicare also expanded its coverage to include individuals with end-stage renal disease.⁵

In 1980, the Omnibus Budget Reconciliation Act was enacted. The Medicare Secondary Payer (MSP)

Program was part of this act. The MSP Program made Medicare the secondary payer to group health plans, liability, and no-fault insurance. The purpose of the MSP Program was to shift costs from the Medicare program to private sources of payment. From 1965 to 1980, Medicare was the primary payer of medical services except those covered by a Workers' Compensation program. It was not until the introduction of the Medicare Secondary Payer Program in 1980 that Medicare became the secondary payer to group health plans, liability, and no-fault insurance in addition to Workers' Compensation.⁶

In 2001, Medicare released the first of several Policy Memorandums dealing with how Medicare was going to handle the various nuances of Workers' Compensation settlements and future Medicare covered medical treatment. These Memorandums gave birth to Medicare Set-Asides.

In 2003, the Medicare Modernization Act (MMA) was enacted. This Act added Part D to Medicare. The intent of the MMA legislation was to help Medicare beneficiaries pay for prescription drug medications.⁷ Since the MMA added pre-

scription medications to the services that Medicare provided, prescription medications related to the injured party's injuries now had to be included in the Set-Aside. Hence, the cost of funding of the Set-Aside became more expensive.

In 2007 Section 111 of the Medicare, Medicaid and SCHIP Extension Act (Section III) was enacted. After several delays, mandatory reporting is scheduled to take effect on January 1, 2012, retroactive to October 1, 2011.⁸ Section 111 requires that 100% of all claims in Workers' Compensation, liability, Group Health Plans and no-fault insurance be checked to determine

the Medicare eligibility of the injured party. In cases where an injured party is discovered to be a Medicare beneficiary, certain data must be collected and reported to Medicare on a quarterly basis. In addition to quarterly reporting, all settlements with a Medicare beneficiary will need to be reported to Medicare.⁹

A SYSTEM IN FINANCIAL TROUBLE

Medicare is funded by our tax dollars. According to a 2010 *Time Magazine* article, entitlement programs such as Medicare will face a 45.8 trillion dollar deficit within the next 75 years.¹⁰ Fraud costs the Medicare program millions of dollars every year. Due to a lack of close scrutiny, Medicare overpays millions of dollars a year. Medicare is a system on the brink of financial disaster.

With the exception of Workers' Compensation, the MSP statute has not really been enforced. However, with the enactment of Section 111, it appears that Medicare is gearing up to start enforcing the MSP in general liability, group health plans, and no fault insurance.

According to the Kaiser Family foundation, as of 2008, 45 million people relied on Medicare for their health insurance coverage; 38 million people age 65 and over and 7 million people under the age of 65 are receiving social security disability benefits.¹¹ The Kaiser Family Foundation is predicting that the amount of people on Medicare is expected to grow. Beginning in 2011, the oldest baby boomers will be eligible for Medicare benefits. Additionally, people are living longer. Many baby boomers are expected to live well into their nineties. Between 2008 and 2030, the number of people receiving Medicare benefits is projected to rise from 45 million to 78 million.¹² According to a June 23, 2009 press release, the U.S. Census Bureau indicated that the world's 65-and-older population is projected to triple by midcentury, from 516 million in 2009 to 1.53 billion in 2050. As of 2009, less than 8 percent of the world's population

was 65 and older. By 2030, the world's population 65 and older is expected to reach 12 percent, and by 2050, that share is expected to grow to 16 percent.¹³ Additionally, the Congressional Budget Office is estimating that the share of the population that is working in paid employment is expected to fall from 60 percent to 55 percent.¹⁴ In a nutshell, there will be more people on Medicare and fewer people working to pay for Medicare, a truly unsustainable position.

Kaiser has indicated that In 2010, Medicare spending was approximately \$509 billion, accounting for 15 percent of the federal budget, and 3.6 percent of the gross domestic product.¹⁵ Medicare's budget is funded mainly by payroll taxes and premiums. However, 43% of Medicare's budget is financed from general revenues. Because of rising health care costs, general revenues will have to account for 62% of Medicare funding by 2030.¹⁶

With the aging population and expected increases in overall health care costs, Medicare spending is projected to grow at a faster rate than the overall economy. Part A—Hospital spending is expected to exceed income in 2010. Hospital reserves are projected to be exhausted in 2017.¹⁷

It is clear that Medicare is looking for ways to preserve its reserves. Medicare believes that one major way to conserve its resources is to closely scrutinize Workers' Compensation, group health plans, general liability, and no-fault insurance matters. Until Medicare issues instructive policy Memorandums on how to handle Medicare in liability settlements, general liability attorneys will have to turn to Workers' Compensation settlements for guidance in addressing Medicare. Parties in Workers' Compensation matters have had to deal with Medi-

care when settling cases for the past 10 years. In 2001, Medicare turned the Workers' Compensation world upside down when it started scrutinizing Workers' Compensation settlements. Now that Medicare has had a taste of settlement money from Workers' Compensation settlements, it is looking to get a bigger piece of the pie from group health plan, liability and no-fault insurance cases.

ADDRESSING MEDICARE IN LIABILITY SETTLEMENTS—SECTION 111

Section 111 Reporting, Conditional Payments, and Medicare Set-Asides are different but intertwined pieces of the Medicare puzzle that need to be addressed before settlement of a case. First of all, Section 111 is simply a reporting tool that Medicare has established to assist in the identification of cases that involve Medicare beneficiaries and the associated injuries. Significantly, Section 111 Reporting does not change the way Medicare enforces

Medicare-covered benefits. However, failure to use this simple reporting tool as mandated may result in hefty penalties of \$1,000 per day per claim.¹⁸

A Responsible Reporting

Entity (RRE) is the ultimate payer of a claim; thus, the RRE is the entity that is required to report the existence of a claim by a Medicare beneficiary to Medicare. The general rule is that the RRE is the entity that funds the settlement, judgment, award or other money to a Medicare beneficiary or Medicare eligible claimant, which in the defense world is the insurance company or self-insured. As of January 1, 2011, you should be reporting existing claims with beneficiaries on a quarterly basis on Medicare's Coordination

of Benefits Secured Website. As of January 1, 2012, you should be reporting any TPOC (settlements, judgments or awards) retroactive to October 1, 2011.¹⁹

Section 111 Reporting is only required where the claimant is a current Medicare beneficiary, hence Responsible Reporting Entities (RREs) will only have to report claims where the injured party is receiving Medicare benefits. Thus, Section 111 Reporting will only impact a small percentage of an insurance company's open cases.

Insurance companies or self-insureds are not going to know which of their open claims involve Medicare beneficiaries since it is possible that an injured party can be a Medicare beneficiary for reasons not concerning the accident or injury. For example, a 24 year old person who slips and falls in a grocery store and injures his left wrist would not appear to be a Medicare beneficiary based on the injured party's age and accident description. However, that injured party may be on Medicare for unrelated issues and this case would be required to be reported to Medicare under the current Section 111 Reporting guidelines.

On March 1, 2011, Medicare added a Beneficiary Lookup Query Service to its website to assist RREs in determining whether a claimant is a Medicare beneficiary, thus triggering the RRE's reporting requirements. In order to query Medicare, the RRE must have the claimant's first name, last name, date of birth, gender and Medicare Health Insurance Claim Number (HICN) or Social Security Number (SSN). To ensure that RREs are not thwarted from complying with Section 111 Reporting requirements due to the claimant's refusal to provide the information necessary to query Medicare, Medicare provided model language²⁰ to assist in collecting this information.

Where an RRE utilizes this model language and a claimant refuses to provide the necessary information to query Medicare, the claimant must acknowledge refusal

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to provide the information requested and that such refusal may be violating obligations as a Medicare beneficiary to assist Medicare in coordinating benefits. In such cases, the RRE will be deemed to have complied with its next Section 111 file submission. To assist their clients in fulfilling their reporting obligations, practitioners should provide this model language request to claimant's attorneys from the outset of a claim or litigation. Importantly, practitioners should be aware that use of the model language will not provide a "safe harbor" to any RRE that uses it in an attempt to avoid reporting data about an individual known to the RRE to be a Medicare beneficiary.

It may also be helpful to direct difficult plaintiff's attorneys to case law²¹ holding that plaintiffs must provide their SSN and responses to interrogatories regarding the existence of Medicare liens in order to assist the RRE in complying with Section 111 Reporting requirements.

Additionally, just because an injured party is not on Medicare at the time of the original query does not mean that they will not become a Medicare beneficiary at a later date. In order to avoid penalties, it is highly recommended that the Medicare status of the injured party is checked regularly. Obviously, the severe penalty of \$1,000 per day per unreported claim has the potential to add up quickly. For example, failure to report 10 cases for two days equates to a fine of approximately \$20,000.

By this time, Primary Payers should have a reporting game plan in place. The reporting game plan should be re-examined and tweaked to ensure that by January 2012 they are collecting and correctly submitting the settlements, Judgments and Orders Medicare is requiring.

Section 111 reporting took effect in January 2011. Since that time, Primary Payers, through their Responsible Reporting Entity (RRE), have had to report to Medicare specific information on their active cases that involve Medicare beneficiaries. Insurance companies

have to report information such as description of the accident, CPT codes, ICD-9 codes, social security numbers, attorney's name, ongoing Responsibility for Medicals, and so on that Medicare will use to more quickly identify conditional payments and to determine what future treatment is related to the accident. At settlement, a separate report will need to be electronically submitted to Medicare outlining the settlement amount. There is a lot of information that Medicare is requesting through Section 111 reporting; most of it, if not all, will be information that is already being collected.²²

When Section 111 takes effect next January, Medicare will know, for the first time in its history, the type of accident, the ICD 9 codes and more detailed information on every single open liability claim that involves a Medicare beneficiary. Even more important, it will have information about every settled claim and the settlement amount. According to the CMS manual, the date of the settlement is the date the settlement is signed. If approval from a court is needed, then the settlement date is the date the court approves the settlement.²³ For years Medicare has depended on attorneys contacting it and advising it of a settlement or near settlement. The mandatory reporting coupled with the extensive information Medicare is collecting will make it much easier for Medicare to identify and collect on conditional payments and future Medicare covered medical needs of the injured parties. The introduction of this data gathering reporting tool is the main reason that Medicare will now have the ability to start enforcing the Medicare Secondary Payer Act in liability settlements.

PRACTICE POINTERS—SECTION 111 REPORTING

The way a case is approached

changes when conditional payments or future Medicare needs are a possibility. One of the easiest ways to limit Medicare's involvement is through early identification. As a result, utilizing Section 111 to determine the Medicare status of the injured party allows the insurance company and defense counsel to properly prepare a defense plan and take Medicare into consideration at the onset of the claim instead of addressing Medicare for the first time at settlement. It will also allow

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a dialogue to start with the plaintiff's attorney so that Medicare can be addressed as the case progresses. Early case preparation will need to include Medicare compliance strategies to ensure a smooth settlement.

ADDRESSING MEDICARE'S CONDITIONAL PAYMENTS

A conditional payment is defined in 42 CFR 411.21 as a Medicare payment for services for which another payer is responsible.²⁴ As stated, Medicare makes payments only for individuals who are on Medicare, either by age or disability. For example, a case involving a 64-year-old or younger individual who is not on Social Security Disability will not involve a Medicare beneficiary. As a result, conditional payments will not be an issue for settlement purposes. The overall majority of settlements will not have to be concerned with conditional payments.

However, if an individual is a Medicare beneficiary, either by age or disability, then Medicare is entitled to be reimbursed for any conditional payments it makes. Medicare is granted the authority to get reimbursed for conditional payments by 42 U.S.C. section 1395y(b), which reads in part that Medicare "may make payment under this subchapter with respect

to an item or service if a primary plan described in subparagraph (A) (ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly....” That section goes on to read that the payments made by Medicare “shall be conditioned on reimbursement....”

In the easiest terms, any medical payments made by Medicare that should have been made by a primary payer are conditional payments. Medicare, using the full force of 42 U.S.C. § 1395y(b)(2), expects to be paid back. A conditional payment is made so that the provider gets paid and continues to provide medical services.

Promptly addressing conditional payments is recommended. 42 U.S.C. § 1395y(b)(2) allows Medicare to charge interest if the conditional payments are not paid back within 60 days of notice. Medicare can also bring suit

for double damages of Medicare’s claim against the liability insurance carrier, a self-insured defendant or employer, or any entity which receives proceeds from the settlement, including the plaintiff and his or her attorney.²⁵ For example, in 2009 the United

States District Court for the Northern District of West Virginia, in *United States of America v. Paul Harris*,²⁶ held that the plaintiff’s attorney was “...individually liable for reimbursing Medicare in this case because the government can recover ‘from any entity that has received payment from a primary plan,’ including an attorney.” In that case, the plaintiff attorney did not respond to the 60 day notice letter, the settlement funds were disbursed and neither the plaintiff’s attorney nor his client filed an appeal disagreeing with the amount of conditional payments.

Another example of Medicare’s

‘no holds barred’ desire to recover conditional payments is exemplified in the case of *United States v Stricker*.²⁷

This case was a class action suit that settled for \$3,000,000 in 2003. The settlement did not take conditional payments into consideration. Medicare filed suit against everyone—

attorneys, insurance companies, plaintiffs and business entities. For unknown reasons, Medicare did not file suit until 2009, more than six years post settlement. The court held that the statute of limitations had expired and granted the defense’s motion to dismiss. The court held that the statute of limitations for

The statute of limitations for a primary plan is three years, and the statute of limitations for other entities, including the Medicare beneficiaries and their attorneys, is six years.

a primary plan is three years. A primary plan is defined in the MSP as a group health plan, a Workers’ Compensation law or plan, an automobile or liability insurance policy or plan or no-fault insurance. The statute of limitations for other

entities, including the Medicare beneficiaries and their attorneys, is six years. Even though Medicare was not able to recover in this case, the decision shows Medicare’s relentless desire to get to every conditional payment dollar possible.

However, in a more recent opinion, *Haro v. Sebelius*,²⁸ the plaintiffs sought to represent a class of Medicare beneficiaries challenging Medicare’s handling of the MSP program. More specifically, the Class challenged the collection practices used to recover Medicare conditional payments. *Haro* involved a automobile accident and liability settlement. Medicare demanded

reimbursement within 60 days under the threat of interest, double damages and referral to the Treasury for debt collection. Plaintiff *Haro* was disputing whether the lien for surgery was related to the accident. The court found that Medicare’s application of the 60-day requirement to collect reimbursement

claims from beneficiaries and their attorneys, when it is pursuing a waiver or appeal, is not authorized by the MSP. Also noteworthy was the court’s comment that plaintiff attorneys could not be forced to hold back disbursement of settlement proceeds and, in dicta, that “there is no statutory authority to support a direct action against attorneys, except to the extent they are end-point recipients of settlement proceeds.”²⁹ “The Court has found no case which has considered the propriety of direct recovery actions against attorneys, pursuant to 42 U.S.C. Sec. 1395y(b)(2)(B)(ii) and 42 C.F.R. Sec. 411.24(g), but generally courts and litigants have presumed the correctness of the premise.”³⁰

Of further note was a comment that “Congress expressly allocated the burden [of reimbursement to CMS] to the third party liability payer that makes its payment to a party other than Medicare when it is, or should be, aware that Medicare has made a conditional payment.”³¹ The court further commented, “Importantly, the regulation expressly provides the appropriate course of action for the Secretary: if the beneficiary or other party receives a third party payment and does not reimburse Medicare, the third party payer must reimburse Medicare even though it has already reimbursed the beneficiary.”³² The implication is that Medicare may have an easier path suing defendants and their insurers than beneficiaries and their attorneys. These comments should not be overlooked.

PRACTICE POINTERS—REDUCING OR ELIMINATING CONDITIONAL PAYMENT EXPOSURE

Even though Medicare will look under every rock to recover conditional payments, it will not be able to collect dollar for dollar. Conditional payments can be reduced and completely eliminated if it can be shown that the injured party's injury or condition is not related to the lawsuit, or that some or all of the conditional payments are not related to the plaintiff's condition. Conditional payments can be further reduced or eliminated if Medicare agrees to a compromise or reduces the conditional payments for hardship or procurement charges. However, cautious counsel will advise that Medicare is expecting to be reimbursed for conditional payments it makes.

The first approach to eliminating or reducing conditional payments is to show that the injured party's condition is not the responsibility of the primary payer or that some or all of the alleged conditional payments are not related to the plaintiff's injuries. This is accomplished either through a thorough review of the medical records or through legal argument. Documentation establishing that the conditional payments are not related should be sent to Medicare. Upon receipt, Medicare will review the argument and review the settlement. If Medicare agrees that some or all of the conditional payments are not related, then it will adjust the conditional payment demand.

Pursuant to C.F.R. §411.37, Medicare will reduce its recovery to take account of the cost of procuring judgment or settlement. For example, if a case settles for \$75,000 and Medicare had made conditional payments of \$40,000, Medicare would get \$26,800 (the \$40,000 in conditional payments less procurement cost, assuming a 33% contingency fee arrangement), the claimant would get \$23,450, and the plaintiff's attorney would get \$24,750. If Medicare payments equal or exceed the judgment or

settlement amount, the recovery amount is the total judgment or settlement payment minus the total procurement costs.

Another way to reduce or eliminate conditional payments is through 42 C.F.R. § 411.28 which reads that Medicare "may waive recovery, in whole or in part, if the probability of recovery, or the amount involved, does not warrant pursuit of the claim."³³ This type of pre-settlement compromise should be submitted to Medicare after agreement between all parties and their counsel. Medicare generally takes between 90-120 days to respond to the offer. These pre-settlement offers are most commonly accepted by Medicare where a defendant tenders policy limits and the Medicare lien is equal to or greater than the policy limits. Medicare may accept the offer in order to give the plaintiff incentive to settle so it can make any recovery.

The only other way to reduce the conditional payment amount is to file a 'hardship' claim with Medicare. The hardship claim details the financial difficulties that the injured party is facing as a result of his condition. This is a totally subjective determination on the part of Medicare.

THE PROCESS OF ADDRESSING THE MEDICARE CONDITIONAL PAYMENT

Medicare "begins identifying claims for recovery when it receives notice of a pending no-fault, liability, or WC matter."³⁴ Once Medicare is made aware of the injuries, Medicare will issue a *Rights and Responsibility (RAR)* letter advising claimant of the process. Thereafter, if requested, Medicare will issue a *Conditional Payment Letter (CPL)*. If there is any direct challenge to the entire claim, it should be made now. Medicare will not issue the *Conditional Payment Notice (CPN)* until there is *notice of settlement, judgment or award (NOS)*. At times, Medicare may issue an "*interim conditional payment letter*" listing conditional payments it has located up to that point. This interim letter

is not a final conditional payment amount; Medicare might make additional conditional payments while the beneficiary's claim is pending.

Then Medicare will issue a Conditional Payment Notice (CPN) to which the claimant has 30 days to dispute unrelated charges and reduce the lien by procurement costs and attorney's fees. To receive information from Medicare attorneys will need to file a "*Proof of Representation*" (POR) letter with Medicare, and a defendant wanting direct access to this information will need to have plaintiff execute a "*Consent to Release*" (COR) form.³⁵

Once there is a settlement, Medicare will issue a formal *recovery demand letter*. This letter is the formal notice that starts the 60-day clock. As indicated above, 42 U.S.C. § 1395y(b)(2) allows Medicare to charge interest if the conditional payments are not paid back within 60 days of notice. If the conditional payments are not received by Medicare after 120 days, they will issue an "*Intent to Refer*" letter and refer the matter to the Department of the Treasury. Medicare will not refer to the Department of the Treasury until at least 240 days from the date of the demand letter. If the conditional payments are still in dispute when the *Recovery Demand Letter* is received, it is highly recommended that prompt payment be made to Medicare as to avoid any interest charges or unnecessary litigation with Medicare. The conditional payment negotiations will continue until there is a determination. If Medicare determines that some or all of the conditional payments were inaccurate, it will reimburse the difference.³⁶

The process for combating conditional payments begins with the notification that the injured party is a Medicare beneficiary, not when the case is settled or worse, after the case is settled. With Section 111, the injured party's Medicare status will be known early on in the process. This gives everyone a head start on scrutinizing medical bills. They should be closely scrutinized to ensure accuracy and

necessity. Any and all duplications, errors or obvious over billing should be documented. If the beneficiary believes that any claims should be removed from Medicare's conditional payment amount, they must send documentation showing that the claims are not related.

Even though a 42 C.F.R. § 411.28 compromise may seldom be accepted by Medicare, an attempt should be made, especially on small conditional payment amounts. Emphasis should be the amount involved and that it does not warrant pursuit of the claim. A letter with the amount being offered to be repaid with supporting documentation should be sent to Medicare. Up to now, Medicare has not considered reducing past liens because of comparative or *Fabre* fault apportionment. It is believed this attitude derives from Workers' Compensation laws that essentially pay 100% of medicals for compensable injuries regardless of comparative negligence, pre-existing injury, statutory caps, immunity or *Fabre* fault. However, the recent decision in *Bradley v. Sebelius*³⁷ may change this philosophy at some point in the future. In *Bradley*, CMS refused to "equitably" reduce a conditional payment lien; the Eleventh Circuit reviewed the decision de novo to determine whether that refusal was "arbitrary, capricious, an abuse of discretion, unsupported by law or substantial evidence." The case involved a Florida Wrongful Death Action with survivors. Although the Florida Probate Court equitably reduced the lien to take into consideration the survivors' individual claims, CMS refused to honor the equitable reduction. The court found that the Secretary's position was error and unsupported by the statutory language of the MSP. The court further found that the Secretary's field manual (which did not allow such a reduction) was not controlling, nor law, and that the refusal to equitably resolve the lien would have a chilling effect on settlements. This case may make CMS more receptive to equitable distribution analysis on past conditional payment liens.

Otherwise, your only remaining option for a reduction is hardship. If a hardship waiver is going to be sought, then a SSA-632 request for waiver form needs to be filled out and submitted to Medicare.³⁸ This is an eight-page social security form that goes into great detail about the injured party's financial situation. Again, this and all other conditional payment reduction options, with the exception of the procurement costs, are subjective in nature.

ADDRESSING FUTURE MEDICAL TREATMENT (MEDICARE SET-ASIDES)

As indicated above, Section 111 and Conditional payments pertain only to current Medicare beneficiaries. If the injured party is not a Medicare Beneficiary at the time of the settlement, Section 111 and conditional payments are not a concern. However, accounting for future Medicare covered medical needs in a liability settlement includes Medicare and non-Medicare beneficiaries. Future medical treatment is the only scenario in which Medicare is going to reach out and affect cases which involve non-Medicare beneficiaries. Needless to say, this is where things get complicated.

Is an MSA required? Arguments against...

First things first, there is **absolutely no requirement** that a Medicare Set-Aside (MSA) be created. The term derives from the memoranda. Thus, there is no requirement that a Medicare Set-Aside be sent to Medicare for its review. It is as simple as that. Nowhere in the United States Code or Code of Federal Regulations will you find any such requirement. In fact, even if CMS started to enforce this position, to do so without formally promulgating regulations authorizing it to do so would arguably be unenforceable for several reasons. First, no regulations require MSAs in liability settlements. "*No 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...." 42 U.S.C. Sec. 1395hh(a)(2). So arguably "interpretations such as those in opinion letters, policy statements, agency manuals and enforcement guidelines, all of which lack the force of law — do not warrant *Chevron*-style deference."³⁹ The bottom line is that any attempt by CMS to penalize for failure to do a liability MSA could be met with staunch opposition.

Is an MSA ever recommended? Arguments for...

The law clearly requires the primary payer to protect Medicare's interests in a settlement. The Medicare Secondary Payer Act has been interpreted to include future medicals. Medicare's authority to demand that its interests be protected against future Medicare covered medical treatment stems from the general intent of the MSP statute and, more specifically, 42 U.S.C. §1395y(b)(2)(A). A settlement or a portion thereof is an extension of primary payer money given to the injured party. It is considered a payment that has been made by the primary payer for the injured party's future Medicare medical treatment. As indicated in 42 U.S.C. §1395y(b)(2)(A), once "payment has been made" then Medicare can not make payment. Monies received in a settlement are, in part, payment for future Medicare covered medical treatment. Although the process is voluntary, we believe that certain cases (brain damage, paraplegia, significant settlements) warrant the preparation and/or submission of an LMSA.

On May 6, 2011, one regional office (Western District of New York, http://www.nqbp.com/docs/uploads/wdny-msp_protocol.pdf) established a liability settlement threshold of \$350,000.⁴⁰ Other regional offices, including Atlanta (which oversees Florida) have reviewed and approved Liability MSA's on select cases (significant settlement and injuries). In Chapter 1, section 20 of its Medicare Secondary Payer

(MSP) Manual,⁴¹ CMS recently amended the definition of a “set-aside arrangement” as including a no fault liability Medicare set-aside arrangement (NFSA) or liability Medicare set-aside arrangement (LMSA).

Given the lack of direction by Medicare when it comes to protecting its interests in liability settlements, there are a few liberties (such as comparative fault reductions) that can be taken in liability settlements that cannot be taken in Workers’ Compensation settlements. Medicare has indicated that if it reviews an MSA and agrees with the allocation, it will agree that Medicare’s interest have been protected. That is the benefit of an approved MSA and the reason that it has been the accepted vehicle used to protect Medicare’s interest. If the injured party’s Medicare treatment ends up costing more than anticipated but Medicare had already approved an MSA, then Medicare will be responsible for any additional treatment above and beyond the amount of the Medicare-approved MSA.

The American Bar Association (ABA) recently passed a resolution at its mid-year meeting urging CMS and Congress to conclusively state that LMSAs are not required in liability cases.⁴² The argument is that there is no statutory basis for it under the MSPA.

REQUIRING A MEDICARE SET-ASIDE AS A CONDITION TO SETTLEMENT

That being said, given Medicare’s acceptance of the MSA format, the only “one hundred percent” way to eliminate your client from Medicare liability for future medical expenses is to use the current MSA format in liability settlements. It must be remembered that Section 111 and actual settlements are two different things completely. Section 111 is simply a reporting tool. We need

to turn our attention to the world of Workers’ Compensation settlement to try to determine how to address future Medicare covered medical treatment. Medicare has issued numerous policy Memoranda to help assist Workers’ Compensation attorneys, insurance companies,

Medicare has indicated that if it reviews an MSA and agrees with the allocation, it will agree that Medicare’s interest have been protected. That is the benefit of an approved MSA and the reason it has been the accepted vehicle used to protect Medicare’s interest.

employers and claimants maneuver through Medicare’s tangled web when it comes to settling Workers’ Compensation cases. The

obvious vehicle that the Workers’ Compensation world is using is the MSA. Again, there are no specific procedures on how to handle liability settlements when it comes to Medicare, all which is available is how Medicare wants Workers’ Compensation settlements to address Medicare. Some of the procedures in place may flow easily into liability settlements while some will not.

An MSA is a report that analyzes past medical records and determines what future Medicare covered medical care and treatment is needed. An MSA is usually prepared by an outside vendor (an allocation company) that has experience preparing Medicare Set-Asides. An allocation company will usually have medical professionals on staff with extensive experience in Medicare and Medicare Set-Asides that review the injured party’s medical records. Based on the allocator’s review of the medical records, he or she will prepare a report and a spreadsheet estimating the future Medicare covered medical needs of the injured party as it relates to their injuries. The MSA is supposed to protect Medicare’s interest by allocating a percentage of the settlement so that it covers the future Medicare covered medi-

cal needs of the injured party for the rest of his life. Despite Medicare’s belief, that does not mean that the injured party will need to get medical treatment for the rest of his life. An MSA is supposed to reasonably protect Medicare’s interest. A future Medicare allocation should cover treatment that would be reasonably expected as it relates to the injured party’s injuries. An injured party may need treatment for life or for a couple of months.

Medicare has indicated that in Workers’ Compensation it will review medical records and an MSA for settlements over \$25,000 if the injured party is a Medicare beneficiary. This classification of individuals has become known as *Class I claimants*.⁴³ Medicare will also review medical records and an MSA for any settlement over \$250,000 if the injured party has a reasonable expectation of becoming a Medicare beneficiary within 30 months. This classification of individuals has become known as *Class II claimants*.⁴⁴ Medicare has indicated that a reasonable expectation is (but is not limited to):

- a) The individual has applied for Social Security Disability Benefits;
- b) The individual has been denied Social Security Disability Benefits but anticipates appealing that decision;
- c) The individual is in the process of appealing and/or re-filing for Social Security Disability Benefits;
- d) The individual is 65 years (i.e., may be eligible for Medicare based upon his/her age within 30 months);
- e) The individual has an End Stage Renal Disease (ESRD) condition but does not yet qualify for Medicare based upon ESRD; or
- f) Other reasonable expectations.

The above list is very broad. For example, if an injured party is denied disability benefits, the party

has 65 days to appeal. However if the injured party is able to show good cause, the appeal period may be extended or the injured party can re-file right away. It is highly unlikely that an injured party is going to know the exact status of a disability application. It is recommended that a social security release be secured from the injured party to determine the status; however, even that status may be old by the time it is received. If an injured party has applied for social security or appealed in the recent past, it is best that the party be considered to be in the application process at the time of settlement if the party is not already a Medicare beneficiary. An affidavit from the injured party indicating that the party will not re-apply or appeal will more than likely not protect an insurance company or other primary payer. It must be remembered that the MSA is for future Medicare covered medical treatment.

Medicare has made it perfectly clear that the above settlement amounts are only review thresholds and that all settlements need to protect Medicare's interests. The July 11, 2005 Policy Memorandum reads "*The thresholds for review of a WCMSA (Workers' Compensation Medicare Set-Aside) proposal are only CMS workload review thresholds, not substantive dollar or "safe harbor" thresholds for complying with the Medicare Secondary Payer law.* However, the July 11, 2005 memorandum does offer a glimpse into Medicare's idea of future Medicare covered medical needs. The policy memorandum reads that "*under the Medicare Secondary Payer provisions, Medicare is always secondary to Workers' Compensation and other insurance such as no-fault and liability insurance. Accordingly, all beneficiaries and claimants must consider and protect Medicare's interest when settling any Workers' Compensation case; even if review thresholds are not met, Medicare's interest must always be considered.*" The take away for liability settlements is that Medicare is expecting that all settlements, regardless of Medicare

status and settlement amount, will need to protect Medicare's interest.

On occasion, Medicare will also review and approve a general liability MSA. However, as a general rule, at the present time (June 2011) Medicare's Atlanta regional office (handling Florida) has indicated it does not have the resources or staff to review general liability MSAs. Boston, New York, Philadelphia, Chicago and Dallas are also reviewing LMSAs on a case-by-case basis. For the most part, liability MSAs are being prepared to be attached to the settlement documents so that if Medicare questions the validity of the settlement, the MSA will be there to ensure that Medicare's interests were protected at the time of the settlement. It is also a good practice to allow an independent allocation company to do the MSA so that it does not appear that the future Medicare medical treatment number is slanted.

Liability settlements need to look at the Workers' Compensation guidelines for guidance. The question becomes should a MSA be prepared in liability settlements. That is a call that needs to be answered on a case by case basis. If the settlement falls within the review thresholds established by Medicare for Workers' Compensation matters, it is the opinion of the writer that an MSA be prepared and attached to the settlement documents. If the settlement falls outside of the review thresholds established by Medicare, then a risk analysis need to be done on how to proceed as Medicare has indicated that all settlements need to protect Medicare's interests regardless of Medicare status and settlement value.

Medicare requires a lot of information to be included on the MSAs it reviews. Medicare has published a sample MSA on its website. The following is just a sample of the information that Medicare wants included on the MSA.⁴⁵

- Claimant's Name
- Claimant's Date of Birth
- Claimant's Health Insurance Claim Number (HICN) or Social

Security Numbr

- Claimant's Address and Phone Number Claimant's Release
- Attorney Representing Claimant Employer's Information
- Insurer
- State of Venue
- Attorney Representing Employer or Insurer
- Injury/Disease Date
- Type of Injury/Disease and claim
- Proposed Medicare Set-aside Amount Life Expectancy
- Proposed Settlement Agreement
- Future Treatment
- Future Prescription Drug Information Total Settlement Amount
- Amount for Future Medical Treatment

When it comes to settlement of a case, it is recommended that the settlement have a line item outlining the amount of the settlement for future medical treatment. The future medical treatment allocation needs to be a number relative to the actual treatment that the injured is going to need. (This is what the MSA is for.) Medicare has indicated that it will not accept the terms of a settlement if the settlement does not adequately consider Medicare's interest. Pursuant to an April 22, 2003 Policy Memorandum from CMS, if Medicare's interests are not reasonably protected, they can refuse to pay for services related to the injury until "such expenses have exhausted the amount of the *entire* settlement." Again, it must be pointed out that these are the guidelines currently in effect for Workers' Compensation.

At times there may be a party that will try not to involve Medicare in a settlement. Medicare addressed this issue in its April 22, 2003 Policy Memorandum and indicated that "the "cooperative" settling party should notify CMS, and Medicare will send the "uncooperative" party a letter (via certified mail) conveying

that Medicare's interests must be considered. Again, this is a Policy Memorandum that was written for Workers' Compensation settlements; it is only being discussed herein as a guide.

RULES AND PROCEDURES FOR WORKERS' COMPENSATION MEDICARE SET-ASIDES THAT CAN BE USED IN LIABILITY SET-ASIDES

Workers' Compensation settlements have come a long way since July 23, 2001. Insurance companies are spending much more to settle claims. Due to CMS backlogs, settlements are taking longer. Claimants are ill prepared to handle the responsibilities of annual reporting. The ever-changing Policy Memorandums are hard to follow, since changes to Policy Memorandums are not widely publicized. Without up-to-date Medicare information, attorneys, insurance companies and injured parties are not fully prepared to settle cases. As Medicare rolls out changes, the cost of a settlement increases. However, after ten years of Set-Asides, there are several things those Workers' Compensation attorneys have learned that may assist primary payers and attorneys as set-asides enter the world of liability settlements.

Litigation is adversarial by nature. However, in order to limit Medicare exposure, bring closure to cases and to maximize a plaintiff's settlement, Medicare compliance needs to be approached as a team. The following are just a few examples of how to limit Set-Aside exposure. The discussion in this section concerns only Medicare Beneficiaries with settlements of \$25,000 or more and those claimants who have a reasonable expectation of Medicare enrollment within 30 months and whose settlement is \$250,000 or more. We will follow this discussion with a detailed review of how Workers' Compensation has handled settlements with injured parties that do not fall into CMS' review thresholds.

A small percentage of cases will fall into those categories

First off, since CMS has not yet established review thresholds for the other primary payers, the current Workers' Compensation review thresholds can be used as a point of reference. On May 6, 2011, the Assistant U.S. Attorney for the Western District of New York issued a Medicare Secondary Payer Protocol that established a liability MSA threshold of \$350,000 for Medicare beneficiaries.⁴⁶ This is the only threshold we are aware of nationally as of June 1, 2011.

As discussed before, there are two review Workers' Compensation thresholds currently being utilized by CMS: Settlements with Medicare beneficiary over \$25,000 (Class I claimants). The second review threshold is a settlement with a claimant who has a "reasonable expectation" of Medicare enrollment within the next 30 months whose settlement is \$250,000 or more (Class II).⁴⁷ It is recommended that a Set-Aside be prepared for any settlement with a Class I or Class II plaintiff. All other settlements fall into Class III plaintiffs.⁴⁸ A risk analysis needs to be done with the plaintiffs who do not fall into Class I or Class II.

Early Identification

One of the easiest ways to limit the cost of a Set-Aside is through early identification. Identifying the cases that fall into these two categories early on is imperative as cases can be evaluated accurately and the case can be handled with Medicare in mind. This will allow a dialogue to start with the plaintiff's attorney so that Medicare can be addressed as the case progresses, not after a settlement amount has been reached. Early identification will allow primary payers to prepare accordingly. The way a case is approached changes when the need for a Medicare Set-Aside is possible; plaintiff deposition questioning strategy changes; physician deposition questioning strategies change; IME strategies change; settlement timing strategies change. Basically, case prepara-

tion will need to include Medicare compliance strategies.⁴⁹

Rated Age

A rated age is an excellent tool that can be used to reduce the cost of a Set-Aside. A rated age is an upward adjustment to an individual's actual age based on the physical condition and diseases that an individual suffers from. These physical conditions and diseases can be related to the injury, but they do not have to be; simple everyday conditions, such as smoking or obesity, can adversely affect an individual's life expectancy and lead to an increased rated age. Pursuant to the August 25, 2008 Memorandum, a Set-Aside is supposed to be estimated based on an individual's life expectancy. The only life expectancy estimate that CMS will accept is from the most current Center for Disease Control's Life Tables. However, the Memorandum goes on to state that a rated age can be utilized. Obtaining a rated age leads to a more cost effective Set-Aside because a rated age raises an individual's age, hence lowering his life expectancy. By reducing the life expectancy of an individual, a Set-Aside automatically gets reduced by the same number of years

Identifying a case with Set-Aside implications early on allows time for the gathering of information. Rated age strategies may include obtaining records from local hospitals and local pharmacies to ascertain the individual's prior medical history. Depending on the information garnered, additional records may need to be obtained. This information will also assist during the deposition of the injured party. Deposition questioning strategies will need to be tweaked to get more detailed information of the individual's medical past. The sooner that this information is gathered, the easier it will be to get a rated age when needed. A rated age has a shelf life of one year. As a result, the timing of obtaining a rated age has to be strategically done.⁵⁰

Deposition strategies

Another way to potentially reduce the amount of a Set-Aside is by including Medicare Set-Aside questioning strategies into depositions. As discussed above, rated age information needs to be gathered at the injured party's deposition. Additional information also needs to be gathered at the injured party's deposition.⁵¹

As we have discussed before, prescription medications that are being prescribed as a result of the injured party's accident need to be included in the Set-Aside. This could be the single most cost prohibitive item

on the Set-Aside. As you may recall, prescription medications must be priced out at the average wholesale price. As a result, it is important to get prescription medication information at the injured party's deposition.

Medicare Set-Aside questioning strategies need to be centered around:

- The brand name of any medications the individual is taking;
- Whether they have taken the generic equivalent of the above medications;
- The dosage of the above medications;
- Who prescribed the above medications;
- Why they are taking the above medications;
- How long they have taken the above medications;
- Are they taking the above medications as prescribed;
- How long do they need to take the above medications; and
- Where is the individual getting their prescriptions filled

The idea behind this strategy is to limit the future prescription medication cost on the Set-Aside. In Workers' Compensation settlements, medications will need to be priced out at the average wholesale price over the life expectancy of the individual. However, if the individual was taking that medication prior to the accident, there is a good chance that the medication will not need to be included in the Set-Aside.

Additionally, the future prescription medication cost on the Set-Aside can be reduced by substituting brand name medications with generics. If it is determined at the deposition or via medical bill reviews that the injured party is not taking the

medication as prescribed, the treating physician may alter or eliminate that prescription. The idea is to find ways to reduce the cost of the Set-Aside by maximizing any and all potential reductions. Since liability settlements are not being reviewed by Medicare, prescription medications can be priced at a lower, more reasonable price than the average wholesale price that needs to be used in Workers' Compensation settlements. The average wholesale price is the "sticker price" of the drug and, as when purchasing a vehicle, the sticker price is never paid. All that needs to be shown is that the pricing scheme was reasonable and that Medicare's interests were protected.

The deposition strategies for taking a physician's deposition should also be tweaked to include Medicare-pertinent questions. The deposition questioning strategy should include a line of questions centered on the need for the individual's future medical treatment, including prescriptions, as it relates to the subject accident or injury they sustained.

- How many visits will the individual need on an annual basis;
- Will the individual require less office visits as the years progress;
- How many years does the physician anticipate that the claimant will need office visits;
- Will the individual need any surgeries/removals/revisions in the future, and why;
- What diagnostic testing will the individual need over the years, the frequency of same, and why;
- What prescription medication will the individual need, and why;
- How long will they need the prescription medication, if for a long period, and why;
- Can they take the generic equivalent; if not, why not;
- When will the individual's dosage be lowered; if not, why not;
- Talk to the physician about the other medications the individual is taking to see if they conflict;
- Ask the physician whether the individual needs the prescription medication if based on review of the medical records, it shows that the individual is not buying the medication or is buying the medication at intervals that would indicate they are taking it less than prescribed or if the deposition transcript shows that the individual is not taking the medication as prescribed;
- Get the cost for office visits, surgical procedures, diagnostic testing, prescription medications;
- Find out if the prescription medication they are prescribing is being prescribed for any pre-existing condition;
- Find out how the individual's future medical treatment is related to the accident or injuries sustained in the subject case;
- Find out why the physician is recommending future medical treatment, i.e. is it medically

necessary, is it based on the individual's subjective complaints, is it based on sound medical decision making, would the recommendations stand up to peer scrutiny.

The idea behind the physician deposition questioning strategy is to specifically quantify future medical treatment. By reducing office visits, medications, diagnostic testing, or any other medical procedure, the Set-Aside is being reduced as well. Again, the idea is to find ways to reduce the cost of the Set-Aside by maximizing any and all potential reductions. A Set-Aside can be defended based on the responses to the above questions.⁵²

Structured Settlements

Another way to reduce the cost of funding a Set-Aside is through the use of a structured settlement. The use of a structured settlement can reduce the funding of an MSA by thousands of dollars. A structured settlement can be difficult at times; special language needs to be included in the settlement documents, the injured party has to agree with it, the laundry list of excuses go on and on. However, it is an easy way to reduce the cost of funding an MSA.

It is important to note that structured settlements cannot be used on every Set-Aside. The breakdown of the Set-Aside sometimes does not warrant the use of a structured settlement. A structured settlement is best utilized in a case with a large Set-Aside amount and a long life expectancy.

A structured settlement consists of two parts, upfront seed money and an annuity. The rules for structured settlements can be found in the October 15, 2004 Policy Memorandum. In order for CMS to approve a structured settlement, there needs to be a lump sum payment (seed money) in an amount equal to the first surgical procedure and/or replacement and two years of annual payments. The remaining money is annuitized into annual payments over the claimant's life

expectancy. It bears repeating, a structured settlement can reduce the cost of funding an MSA by thousands of dollars. A good rule of thumb on whether a structured settlement should be used is to look at the first surgical procedures and/or replacements; if they make up the bulk of the Set-Aside amount then a structured settlement may not be beneficial since the bulk of the MSA will be given to the injured party in a lump sum payment (seed money).

The structured settlement also offers additional benefits if it is reviewed and approved by CMS. Every year, the injured party gets an annuity payment. If the injured party uses all of his annuity money within the year and he can show that it was used for Medicare covered medical needs as it relates to his injuries, then Medicare will pay for his Medicare covered medical needs for the rest of the year. If the injured party does not use the entire annuity payment in a given year, it gets rolled over to the next year and gets added to the new annuity payment.

However, if the injured party uses the annuity funds for a purpose other than his Medicare covered medical needs as it relates to his injuries, then Medicare can deny any additional treatment for the remainder of that year. The good thing is that if the claimant uses his annuity funds for a purpose other than Medicare-covered medical needs as it relates to his injuries, he is only penalized for that one year. Once the injured party gets the next annuity payment he can use it to get Medicare-covered medical needs as it relates to his injuries.⁵³

CMS Submission

A Set-Aside that is not submitted to CMS can actually be priced out at a more realistic cost. As indicated earlier, as of June, 2011, Medicare is not consistently reviewing liability set-asides except in very large settlements or catastrophic injury cases. As a result, it may be in the primary payer's best interest to submit a Liability MSA to Medicare. Medicare will more than likely

not review the MSA because it is a liability settlement. It will be very difficult for Medicare to come back later on and say that the settlement did not protect Medicare's interests, especially, with an MSA allocation attached to the settlement and a letter from Medicare indicating that it would not review the submitted MSA because it was a liability settlement. If Medicare does review it, you will have an approved MSA that basically ensures that Medicare's interests are protected.⁵⁴

Settlement after MMI/Surgery

Another way to limit the cost of a Set-Aside is to settle the case after the claimant reaches Maximum Medical Improvement or after the injured party undergoes any needed surgeries. The future Medicare-covered medical treatment is estimated through a review of the injured party's medical records; if the individual is undergoing active medical treatment, the Set-Aside will have to reflect the active medical treatment. If the medical care has plateaued and the injured party is being seen on a palliative nature, the Set-Aside will reflect the lessened medical treatment. It costs less to fund an MSA for an individual who is being seen on a palliative nature.⁵⁵

Pre-Existing Conditions

As discussed earlier, it is imperative that an injured party's prior medical history be investigated in detail during discovery. The repetitive theme is to find ways to reduce the cost of the Set-Aside by maximizing any and all potential reductions. If the injured party had previously injured the body parts that were injured in the subject injury, then it will cost much less to bring the injured party back to baseline.⁵⁶

Subsequent Accident

The same is true for subsequent injuries: if the individual gets into a subsequent injury, then the primary payer's responsibility is limited as well, hence reducing the cost of funding an MSA or eliminating it entirely.⁵⁷

Legal Reasons that Primary Payer is Not Liable for Medical Care

The easiest way to reduce the cost of funding an MSA is to not be liable to pay for the injured party's medical care. Fraud, if applicable, needs to be looked at closely, the injured party's pre-existing conditions need to be looked at closely, and any portion of any applicable statute that removes or limits the primary payer's responsibility need to be completely investigated.

Another important item to discover is how many quarters or credits an individual has worked. Under normal circumstances an individual has to work 40 quarters in order to be eligible for social security benefits and Medicare.⁵⁸

Protection from the Actions of the Injured Party

One of the most important things to take from this paper is that the attorney on both sides and the primary payer are going to need protection from the actions of the injured party. It is highly recommended that the settlement release or a stipulation that is executed by the injured party clearly and unequivocally lists the responsibilities of the injured party on how the allocation of medical funds is to be used.

ADDRESSING MEDICARE IN LIABILITY SETTLEMENTS—CLASS III INDIVIDUALS

With a Class I or Class II individual, the best and safest option for a primary payer is to prepare an MSA proposal and attach it to the settlement documents. However, as we have discussed throughout this paper, all settlements must protect Medicare's interests. So what is a Class III individual? An injured party that falls in neither category, such as a 17-year-old paraplegic or brain damaged person.

With Class III individuals, CMS submissions are not an option as CMS will not review them. The only assistance CMS has given us is the cryptic message "*Medicare's interest must always be considered.*" As

a result, every settlement in some fashion or another needs to protect Medicare's interests. The recommendation of the authors is that, the closer a Class III individual gets to becoming a Class I or Class II individual, the greater the need for a formal Set-Aside.

Basically, a risk analysis needs to be done. At least one decision has considered whether it was even necessary, *Finke v. Hunter's View, Ltd.*⁵⁹ In *Finke*, a U.S. District Court in Minnesota reviewed a case where the plaintiff was paralyzed from the chest down after a fall from a deer stand manufactured by Hunter's View, Ltd. The plaintiff received Medicare and Medicaid benefits prior to becoming eligible for coverage under his wife's group health insurance coverage. The court held that "*it is not reasonably foreseeable that [the plaintiff] will receive Medicare benefits in the future,*" based on the existence and availability of his wife's group coverage; that the parties adequately took Medicare's interest into account by reimbursing Medicare for the total of its conditional payments as of the date of settlement; and that no MSA was required to cover his future medical expenses. This ruling is surprising given that the plaintiff is eligible for Medicare and the only thing preventing him from utilizing Medicare in the future is his wife's health care coverage. This holding fails to consider factors such as whether the wife will continue in her current employment, continue in her marriage to the plaintiff so as to allow him to share in her employment benefits, or continue to be able to afford carrying the group coverage for both herself and her husband. We believe the case should not be used as a guide.

BEST PRACTICES—TIPS FOR SATISFYING PAST CONDITIONAL PAYMENTS

- *Identify early if Medicare has a lien or Plaintiff is a beneficiary*

Don't wait until the mediation. Obtain this information early and ob-

tain an authorization (COR) signed by the plaintiff to communicate directly with Medicare about the lien. If it's pre-suit and a pro se plaintiff won't cooperate, one option is to consider Federal Rule of Civil Procedure 27 and Florida Rule of Civil Procedure 1.290, which allow pre-suit discovery in order to "prevent a failure or delay of justice." Pursuant to the Rules, a party may file a verified petition seeking an order authorizing the petitioner to depose an individual pre-suit. A potential defendant presented with a Medicare situation and a non-cooperative plaintiff in certain circumstances might consider filing a petition in Florida state or federal court seeking an order allowing it to take the plaintiff's deposition for the limited purposes of obtaining information necessary to comply with the requirements of Section 111 of the Medicare, Medicaid and SCHIP Extension Act. A defendant could argue the limited testimony is necessary to obtain the information required by the Act and would require little effort on behalf of the plaintiff. Further, a denial of the petition could result in harsh sanctions upon the defendant.

- *Obtain critical information needed to report the settlement*

Medicare requires specific information from the claimant, such as claimant's full name, Social Security, date of birth and Medicare Health Insurance Claim Number.

- *Pay the conditional payment directly to Medicare from the settlement proceeds*

Best practice would be to control the payment and hence, the resolution of the lien. In this situation, the defendant will hold the amount of the Medicare lien back from the settlement closing while the lien is negotiated and then issue the payment directly to Medicare once the Final Demand letter is received. Although this requires a bit more administration in the closing, it pretty much guarantees closure because if the plaintiff or his attorney fail to

satisfy the lien, the defendant and/or insurer is responsible to pay it within 60 days regardless of whether they already paid the plaintiff. You should insist on this method and you are more likely to get the plaintiff to agree to this method by jointly using a vendor experienced in negotiating Medicare liens.

A note of caution here in situations where policy limits are demanded and being tendered, and time is of the essence. An especially complicated situation arises when an insurer is presented with a time limit settlement demand. The insurer may be forced to evaluate the risks of non-compliance with Medicare and a potential bad faith claim. Depending on the time limit provided in the demand, the insurer probably won't have adequate time to comply with both the demand and Medicare. In these situations, the insurer should consider the potential exposure for non-compliance and the potential damages stemming from a bad faith claim.⁶⁰ If the insurer determines it must tender within the time limit to avoid a bad faith situation, it may consider enclosing the settlement draft in correspondence reminding the plaintiff and his/her attorney of their obligations pursuant the MSP and specifically citing relevant portions of the Act. Although this will not isolate the insurer from liability for non-compliance if the plaintiff and his/her attorney fail to comply with the Act, it will be some evidence of the insurer's attempts to comply. It may also be a more practical and limited exposure to the carrier than the alternative, a bad faith case and extra contractual damages.

- *Alternatively, require plaintiff's counsel in writing to not to disburse the entire lien until the Final Demand or CPN amount is paid*

This provides no guarantees, but from a practical standpoint it is probably how the majority of settlements currently occur. Although most settlement agreements add indemnity language to the settlement agree-

ment, indemnity from a plaintiff does NOT protect your client from having to pay the lien if it isn't satisfied. Although you can require plaintiff's counsel to agree not to disburse until the lien is paid, you cannot require counsel to indemnify and hold you harmless for the lien or future liens.⁶¹ In a recent informal advisory opinion, The Florida Bar indicated it is not ethical for a plaintiff's lawyer to personally agree to indemnify the defendant for a Medicare lien or future obligation, nor is it ethical for the defense attorney to request the plaintiff's counsel to do it.

- *Negotiating the lien*

With respect to past conditional payments, Medicare will generally take into consideration procurement costs and hardships. However, as of now Medicare normally will not equitably reduce a lien to take into account comparative fault, pre-existing injury, statutory caps, immunity and *Fabre* defenses that reduce the settlement value from the 100% value. However, this doesn't mean that you shouldn't try. *Bradley v. Sebelius*, discussed above, is a good authority for the proposition that CMS should consider comparative and other equitable distribution principals to reduce past conditional payment liens. Additionally, Florida Standard Jury Instruction 6.2 requires a jury to attempt to determine what portion of the plaintiff's condition resulted from an aggravation and only award damages based upon the aggravation. So we recommend you gather information such as plaintiff's initial demand, affirmative defenses and interrogatories establishing comparative and *Fabre* fault, laws on statutory caps and other factors that demonstrate the settlement was less than the actual value. It is recommended that you use a vendor or law firm that has a designated individual familiar with this process.

BEST PRACTICES TIPS FOR PROTECTING AGAINST FUTURE MEDICAL COSTS

- *Identify early the future medical cost projections*

Don't wait. If a case involves a substantial injury with anticipated future medical expenses and loss of ability to earn in the future, you are probably going to seriously have to consider one of the following; a Liability Medicare Set-Aside, a Medical Cost Projection or a Self Administered Allocation of future medicals in the settlement agreement. Which vehicle you use is dependent upon many factors, such as the amount of your settlement, the extent of the injury and disability, the age of the plaintiff and most certainly the willingness of your opposing counsel to agree. Your leverage ends at settlement, so you should be negotiating these deal points early on and make them a condition to settlement.

- *Best Practices: Settlements of Beneficiaries (Class 1)*

Remember a Class 1 is an actual Medicare beneficiary, either because of age, SSDI or specified disease. The Workers' Compensation threshold to do an MSA is \$25,000. Medicare has not established a uniform policy or threshold for liability cases, yet. However, regional offices are reviewing select LMSAs and this year the Western District of New York established a \$350,000 threshold when Medicare doesn't respond to an MSA submission. Is a Set-Aside in general liability settlements required, **no**. Is it recommended, **yes in certain cases**. Medicare is treading in uncharted waters and they are taking us along for the ride. It all comes down to this: Medicare's interests always have to be protected. So even though Medicare will probably refrain from reviewing your MSA, you are likely to get a letter for your file demonstrating that they are not reviewing liability MSA's and this along with the document is more than enough to prove you took

Medicare's interests into consideration. Thus, the safest practice is to prepare and attempt to submit an LMSA on significant settlements and injuries. If you can't agree on submission, then do an LMSA or Medical Cost Projection, or at the very least, agree on an amount that is reasonably related to the evidence, and establish the amount in the settlement agreement that will be reserved and allocated for future medical costs.

- *Alternative Practices: Settlements of Beneficiaries (Class 1)*

It is still difficult to get plaintiff's counsel to agree to MSAs, even in 2011. But after a reimbursement suit or denial of benefits, we believe the plaintiff's bar will come around. It's really your choice. If your settlement exceeds \$25,000 but you are getting no cooperation from plaintiff and don't want to lose the settlement, then it may be better to settle the case using an alternative to an MSA, rather than trying it over this issue. Medicare has given us zero guidance on how to handle these situations. Without established thresholds or guidelines, we are left to guess, do nothing, follow the Workers' Compensation guidelines or come up with our own decisions on a case by case basis.

The choice is yours. If the settlement is important to your client, then ask counsel to agree to self-allocate in the settlement agreement the specific amount plaintiff will allocate for future medical expenses. Better yet, obtain a Medical Cost Projection that uses the usual and customary fee schedule. These projections may result in higher costs than the Workers' Comp or Medicare fee schedule, but the preparation fee is slightly cheaper than a full MSA. Use this projection as a benchmark to show you made a good faith effort to protect Medicare's interest and that the future medical number allocated in your settlement agreement wasn't just pulled out of "thin air." Attach the cost projection and incorporate it into the settlement agreement.

If all else fails (no MSA, no Cost Projection document), then at the very least, you should demand that the plaintiff allocate some portion of the total settlement for future medicals and state it in the settlement agreement. To do nothing is extremely risky for the plaintiff, as Medicare may just decide the entire settlement was for future medicals.

- *Settlements of Anticipated Beneficiaries (Class 2 and 3)*

A Class II beneficiary is recognized in the CMS Workers' Compensation scheme as a person that is reasonably expected to become a beneficiary. But what if your claimant is a 23-year-old paraplegic; or a 37-year-old victim of a closed head injury with a life care plan; or a 59-year-old with a broken hip; or somebody that has applied for but was denied SSDI? All these plaintiffs fall into Class III. Both classes are reasonably expected to become Medicare beneficiaries. Every settlement, whether it is Workers' Compensation or liability, should protect Medicare's interests regardless of the settlement amount or age of the injured party, especially if the plaintiff is releasing your client from future medical liability. Workers' Compensation guidelines establish a Class II beneficiary as a person 62.5 or older; or persons on SSDI for 24 months. \$250,000 is the current threshold and is the guideline many are using nationally. But it cannot be emphasized enough that each case must be considered on its own facts. For example, the 23-year-old paraplegic, not on Medicare or SSDI yet, still warrants consideration for an LMSA and CMS would probably review that LMSA if the settlement was significant. Failure to do something exposes you to future liability, in the authors' opinion. At the very least, allocate in the settlement agreement an amount that is reasonably related to the facts of the case that plaintiff will agree to use for future related Medicare medical costs.

- *Equitably Reducing the MSA, Cost Projection or Self Allocation*

Yes, any MSA, Future Medical Cost Projection or Self Allocation in your settlement agreement can probably be reduced by taking into account comparative fault, *Fabre* fault, statutory caps, immunity and other factors that resulted in a settlement less than the demand or 100% value of the case.⁶² Though Medicare doesn't ordinarily take these factors into account for past conditional payments, they are currently at a loss to challenge these reductions when applied to future medical costs; it is our understanding that they are currently not challenging these types of reductions when LMSAs are reviewed. So come prepared and be sure to gather information such as the plaintiff's initial demand (to compare to the actual settlement), affirmative defenses and interrogatories establishing comparative and *Fabre* fault, laws on statutory caps and other factors that demonstrate the settlement was less than the value if liability was 100%, and be sure to document everything. Use of an experienced vendor is recommended.

- *Release and Settlement Agreement Language*

The settlement agreement terms must be flexible as policy and procedure change. The following paragraphs are only suggestions and need to be modified depending on the circumstances of your case, your client's position and what you negotiate (e.g., who pays the past conditional payment lien, whether an LMSA is being prepared, what amount is being allocated for purposes of future medical):

As a condition of and to induce settlement, the Defendant(s) and its insurer(s) have requested and Plaintiff and their counsel have agreed to determine if the plaintiff is a Medicare beneficiary or is reasonably expected to become a Medicare beneficiary, and if so, to take all necessary steps to satisfy such liens, past and future. Plaintiff

agrees to the following:

- 1. Reporting:** Plaintiff represents they have reported the settlement to the Center for Medicare Services (CMS) to determine whether the Plaintiff is a Medicare beneficiary or Medicare eligible as defined by 42 U.S.C. Section 1395(y) and 42 C.F.R. Section 411.25 (hereinafter the Medicare Secondary Payer Statute). Plaintiff will notify defendants in writing if CMS has a lien, reporting or set aside requirement and provide the releasor's full address, Social Security Number, date of birth, gender and if available, their Medicare Health Insurance Claim Number (HICN). Provision of this information is a condition of settlement and spaces are provided at the end of the release for compliance.
- 2. Conditional Payment Liens:** Plaintiff further covenants and agrees that if CMS has made conditional payments and/or has a lien and/or is expected to make future payments prior to closing, Plaintiff agrees not to disburse the settlement funds until they have (i) reported the settlement to CMS; (ii) obtained a *conditional payment notice / recovery demand letter*; (iii) fully paid and satisfied the Medicare lien; (iv) and faxed or emailed proof of same.
- 3. Medicare Set Asides:** It is further expressly understood and agreed, to the extent applicable, Plaintiff agrees to set aside funds necessary to pay for any anticipated future medical and/or health care needs of Plaintiff, for any injury and/or condition that requires treatment that arises from the injuries related and/or caused by the accident in question. Plaintiff agrees to set aside \$_____ of the settlement for these purposes or, if an LMSA or Medical Cost Projection was done, the amount stated therein. Any

LMSA or Medical Cost Projection is hereby incorporated by reference into this agreement. Alternatively, if nothing has been set aside for future costs it is because Plaintiff has covenanted that they do not reasonably anticipate that they will require medical and/or health care treatment for the injuries and/or conditions related and/or arising from the accident in question and to the extent they do, they will use the net settlement proceeds for Medicare related costs as they are incurred.

- 4. Cooperation and Indemnity:** Plaintiff and their counsel agree to fully cooperate with the defendant and CMS at Plaintiff's own expense with respect to these provisions, including production of documents or information or preparation of a Medicare set aside. Plaintiff agrees to execute any authorizations required by defendant, its insurer or CMS for purposes of complying with these paragraphs. Plaintiff and their counsel understand that these conditions are a basis of the settlement and plaintiff's counsel agrees to the above terms. Plaintiff agrees to hold harmless and indemnify the defendant(s) and their insurers, including their own negligence, from and against any and all damages, including costs and attorney's fees, for plaintiff's failure to comply with the terms of this release.

There is no "canned" or "boiler plate" language to fit every settlement. The above language is one example. Your Medicare provisions, if applicable, should be tailored to the terms and conditions you negotiated and what you know at the time of settlement. For example, paragraph 2 would be stated differently if the defendant's insurer was withholding a portion of the settlement check to pay the lien directly. Paragraph 3 may be modified depending on whether you are preparing an

LMSA, simply agreeing to a self-administered allocation in the settlement agreement, or doing nothing based upon the representations and evidence that future related costs are not anticipated.

IN SUMMARY

Medicare is a system on the brink of financial failure. The MSP was enacted to ensure that Medicare funds are spent efficiently. Medicare can no longer afford to pay for services for which Medicare is not the primary payer. A primary payer is responsible for the Medicare-covered medical treatment of an injured individual as it pertains to the injuries he or she sustained. The question then becomes, does a primary payer's responsibility end when it enters into a settlement with the injured individual? The intent of the Medicare Secondary Payer Statute suggests that the responsibility of the primary payer does not end until the need for Medicare-covered medical treatment ends. As a result, every settlement should attempt to take future Medicare-covered medical treatment into consideration.

As we have discussed throughout this paper, the extent of the consideration depends on the individual circumstances of each case. Past conditional payments need to be identified early and resolved in every settlement. Claims with significant future medical needs or disability may warrant consideration of a formal Medicare Set-Aside prepared by an allocation company. In many cases, at a minimum, some attempt should be made to allocate a portion of the settlement for future "related" medical expenses if the settlement releases such liability. Using the risk analysis and the early identification strategies discussed herein will help primary payers decide how to proceed and how to limit potential exposure. The failure to consider Medicare's interests may result in significant exposure including: (i) double damages for the insurance carrier or self-insured; (ii) government action against the attorney(s)

or primary payer under right of recovery; (iii) claimant's loss of benefits under Medicare; (iv) a post settlement malpractice claim by the claimant. These risks affect *everybody*, so all parties should work together to resolve these issues at the time of settlement.

- 1 Medicare Secondary Payer (MSP) Manual (Rev. 65, Mar. 20, 2009), <http://www.cms.gov/manuals/downloads/msp105c01.pdf>.
- 2 Medicare Benefits, Medicare.gov, <http://www.medicare.gov/navigation/medicare-basics/medicare-benefits/medicare-benefits-overview.aspx>.
- 3 Marian E. Gornick et al., *Thirty Years of Medicare: Impact on the Covered Population*, Health Care Financing Rev. vol. 18, no. 2 (Winter 1996), available at <http://www.ssa.gov/history/pdf/ThirtyYearsPopulation.pdf>.
- 4 Kaiser Family Foundation, *Medicare At A Glance — Fact Sheet* (Sept. 2010), <http://www.kff.org/medicare/upload/1066-13.pdf>.
- 5 Kaiser Family Foundation, *Medicare: A Timeline of Key Developments*, <http://www.kff.org/medicare/medicaretimeline.cfm>.
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- 7 Toby S. Edelman, *Oversight and Enforcement of Medicare Part D Plan* (Kaiser Family Foundation, Sept. 2006), <http://www.kff.org/medicare/upload/7558.pdf>.
- 8 CMS, *Implementation of Medicare Secondary Payer Mandatory Reporting Provisions* (Nov. 12, 2010), <http://www.cms.gov/MandatoryInsRep/Downloads/NGHPICD9RRE.pdf>.
- 9 CMS, *Statutory Language for the Medicare Secondary Payer Mandatory Reporting Provisions in Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007* (June 11, 2008), <http://www.cms.gov/MandatoryInsRep/Downloads/StatutoryLanguage.pdf>.
- 10 Fareed Zakaria, *Fixing the Deficit: Our Biggest Test*, TIME.com, (Nov. 18, 2010), <http://www.time.com/time/magazine/article/0,9171,2032122,00.html>.
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- 12 Kaiser Family Foundation, *Medicare Now and in the Future* (Oct. 2, 2008), http://www.kff.org/medicare/h08_7821.cfm.
- 13 See http://www.census.gov/newsroom/releases/archives/international_population/cv09-97.html.
- 14 Statement of Douglas W. Elmendorf, Director, Congressional Budget Office, "The Long-Term Budget Outlook" (July 16, 2009), https://www.cbo.gov/ftpdocs/104xx/doc10455/Long-TermOutlook_Testimony.1.1.shtm.
- 15 *Kaiser Fast Facts Medicare Chartbook* § 8 (4th ed. 2010), <http://facts.kff.org/chart.aspx?cb=58>.
- 16 *US Federal Budget — How the FY 2012*

- Social Security Budget and Health Care Budget Affects the US Economy*, About.com, US Economy and Business - US Economic Indicators - US Economic News, <http://useconomy.about.com/od/fiscalpolicy/p/Mandatory.htm> (last visited May 28, 2011).
- 17 *2009 Annual Report of the Boards of Trustees of The Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* (May 12, 2009), <http://www.cms.gov/ReportsTrustFunds/downloads/tr2009.pdf>.
 - 18 *Statutory Language*, *supra* n. 9.
 - 19 CMS, *Medicare Secondary Payer Mandatory Reporting Provisions in Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007* (See 42 U.S.C. 1395y(b)(7)&(b)(8)), Office of Financial Management/Financial Services Group (Dec. 21, 2010), <http://www.cms.gov/MandatoryInsRep/Downloads/RevTimeline122110.pdf>.
 - 20 CMS, *MMSEA Section 111 Medicare Secondary Payer Mandatory Reporting GHP User Guide at 21* (Version 3.0, January 2010), <http://www.cms.gov/MandatoryInsRep/Downloads/N/GHPUserGuideV3.2.pdf>.
 - 21 See *Hackley v. Garofano*, 2010 WL 3025597 (Superior Court Conn. July 1, 2010); *Seger v. Tank Connection, LLC*, 2010 WL 1665253 (U.S. D. Neb. April 22, 2010).
 - 22 42 CFR Pt. 411, available at http://www.access.gpo.gov/nara/cfr/waisidx_02/42cfr411_02.html; see also CMS, *Mandatory Insurer Reporting Overview* (Aug. 1, 2009), <http://www.cms.gov/MandatoryInsRep/>.
 - 23 User Guide, *supra* n. 20, at 12.
 - 24 See *supra* n. 22.
 - 25 42 U.S.C. § 1395y ("Exclusions from Coverage and Medicare as Secondary Payer"), available http://www.law.cornell.edu/uscode/uscode42/usc_sec_42_00001395--y000-.html.
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 - 27 2010 WL 6599489 (N.D. Ala. 2010).
 - 28 2011 WL 2040219 (Slip Op. D. Ariz. 2011).
 - 29 *Id.* at *16.
 - 30 *Id.* at *14 (citing 42 CFR 411.24(i)(2)).
 - 31 *Id.*
 - 32 *Id.* (citing 42 C.F.R. Sec. 411.24(h) and (i)(1)).
 - 33 CMS, *Medicare Secondary Payer Recovery Claim Process Overview* (last modified Jan. 21, 2011), <https://www.cms.gov/MSPRecov-ClaimPro/>.
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 - 35 Forms, letters and model language are available at the Medicare Secondary Payer Recovery Contractor website, <http://www.msprc.info/>.
 - 36 *Id.*
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 - 45 CMS, *Sample Submission/Checklist for a Workers' Compensation Medicare Set-aside Arrangement Proposal* (last accessed May 27, 2011), <http://www.cms.gov/WorkersCompAgencyServices/Downloads/samplesubmission.pdf>.
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 - 48 Popolizio, *supra* n.43.
 - 49 Reinaldo Alvarez, *Medicare in General Liability Settlements* (July 2011), <http://www.ls-law.com/media/publications/11Q3LU.pdf>.
 - 50 *Id.*
 - 51 *Id.*
 - 52 *Id.*
 - 53 *Id.*
 - 54 *Id.*
 - 55 *Id.*
 - 56 *Id.*
 - 57 *Id.*
 - 58 *Id.*
 - 59 2009 WL 6326944 (D. Minn. Aug. 25, 2009).
 - 60 See, e.g., *Peraza v. Robles*, 983 So. 2d 1189 (Fla. 3d DCA 2008) (underscoring the importance of accepting a policy limits demand on its precise terms); *Tomlinson v. Landers*, 2009 WL 1117399 (M.D. Fla. 2009) (refusing to enforce a settlement in a tender case where the carrier put Medicare on the check, a term not negotiated or agreed to in the time limit demand).
 - 61 See *Florida Bar Staff Opinion 30310* (April 4, 2011) <http://www.settlementlawfirm.com/files/Florida%20Bar%20Staff%20Opinion.pdf>.
 - 62 See generally *Bradley v. Sebelius*, 621 F.3d 1330 (11th Cir. 2010).