MEDICARE SET-ASIDES: UNCERTAINTY AND CONFUSION

By Michael L. Weiner

Introduction

What defines a plaintiff's lawyer's worst nightmare come true? Is it when the lawyer knows they have a legal obligation to do something on behalf of a client involving money, perhaps even a lot of money, but they have virtually no guidance how to fulfill this obligation? Is it when they learn that the obligation is imposed by the federal government, but that the government will not (and cannot) advise them whether they are correctly fulfilling this obligation? While these worries are good candidates for a nightmare come true, the true scope of a nightmare that might come true comes fully into focus only when the lawyer learns the consequences of getting it wrong. Not only may the client suffer severe consequences (for which they will blame their lawyer), but the federal government may even have rights to recover monies back from both the attorney and the client (with the client even at risk of paying back double damages!) And what lies at the heart of this state of affairs? It is the Medicare Set Aside (MSA) required by the Medicare Secondary Payer Act (MSP). Congress imposed this obligation in 1980, but virtually no one knew about it until recently. Indeed, for many, this article will be the first they have even heard of it.

The obligations imposed by federal law upon everyone involved in a workers compensation or liability case . . . to protect the interests of Medicare for past, and even more importantly, future, medical expenses when resolving a workers' compensation or liability case date back to the enactment of the Medicare Secondary Payer provisions in 1980. The recent decision to begin enforcement has apparently been triggered by the government's concerns about the dire financial status of Medicare and its belief that it was not recovering anywhere near the amount it believed was due under this 1980 law.

Fortunately, not all is lost, for we plaintiffs' lawyers can find solace from a fundamental legal principle learned in our first year of law school, when none of us had a clue what the professor was talking about. This fundamental legal principle is commonly known as "the same boat" doctrine. For those that don't recall the doctrine, it is the great sense of relief we find when we realize we all are in the "same boat," utterly confused by an incredibly complicated subject. Hopefully, this article will shed some light on this important subject. However, the sheer complexity of almost every aspect of the Secondary Payer Act, ranging from who is covered, how to calculate these obligations, what to do with the Medicare Set Aside, coupled with the almost complete lack of federal guidance, make the MSP and MSA's the subject of a book, not an article, and even then, definitive answers remain elusive.

There is yet more "good news/bad news." The good news is that the vast majority of personal injury plaintiffs need not worry about MSA's because they are too young for Medicare or are not disabled under the Social Security standard. The bad news is that injured plaintiffs who are either currently enrolled in Medicare or have a "reasonable expectation" of Medicare enrollment are currently caught in a trap. There is little doubt among those who practice in this area that the federal government intends to begin enforcing MSP obligations in liability cases, just as it started to do in workers' compensation cases beginning in 2001. Yet, the government has not told us how to comply with these obligations. While this guidance is likely coming in the next year or two, everyone who must now comply with its obligations (everyone includes a "beneficiary, provider, supplier, physician, attorney, state agency, or private insurer") have nothing to work with except the government's policies in workers' compensation cases, which often have no applicability to liability cases.

Because of this present state of the law, this article (which is focused exclusively on MSP obligations in liability cases) is unfortunately more an analysis of the questions and confusion surrounding MSA's than a resource for answers. These answers are best sought from the growing number of law firms and businesses (locating them will be discussed below) that have entered the MSA market because of the increasing government enforcement of MSP obligations, but even these specialists are working with the same lack of guidance as the rest of us. In light of the many unanswered questions for liability cases, the best any plaintiff's lawyer can do at this point is attempt to fulfill these requirements in good faith. Hopefully, a good faith effort will be enough to avoid a nightmare ending for all.

Fundamental Principles Governing the Medicare Secondary Payer Act and Medicare Set-Asides.

The obligations imposed by federal law upon everyone involved in a workers compensation or liability case (including, as noted above the "beneficiary, provider, supplier, physician, attorney, state agency, or private insurer," see Centers for Medicare and Medicaid Services (CMS) 11/22/03 memorandum and 42 CFR 411.26) to protect the interests of Medicare for past, and even more importantly, future, medical expenses when resolving a workers' compensation or liability case date back to the enactment of the Medicare Secondary Payer provisions in 1980. The recent decision to begin enforcement has apparently been triggered by the government's concerns about the dire financial status of Medicare and its belief that it was not recovering anywhere

near the amount it believed was due under this 1980 law.

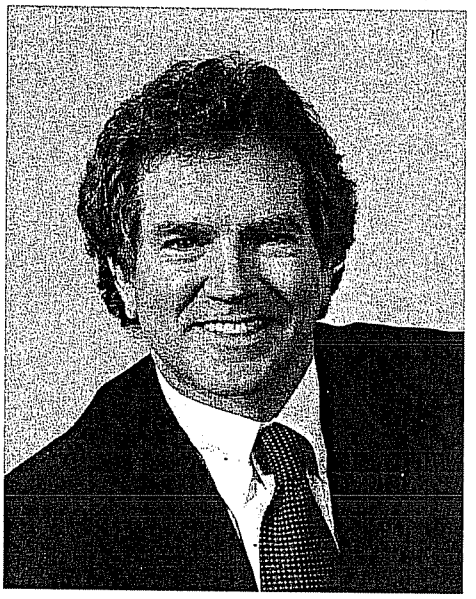
The basic premise of the MSP is that because Medicare[1] pays covered persons' medical bills with tax dollars, it is in the public's interest that employers and tortfeasors, who by definition are responsible for the harm that necessitated the medical bills, reimburse Medicare for these work- related or tort generated costs. Most plaintiff's lawyers are familiar with subrogation claims asserted by Medicare for past medical bills, and have experience in negotiating and paying these subrogation claims. The issue becomes particularly complex regarding future medical benefits for a person already on Medicare, or who has a "reasonable expectation" of Medicare coverage within 30 months of settlement of their claim. The MSP requires these future costs to also be paid out of the settlement or recovery, with the money to be held by the person until payment of these future medical expenses in a "Medicare Set-Aside Trust." While the principle that an employer or tortfeasor should pay these expenses may seem fair in the government's eyes, the devil is, as they say, in the details of how the government would enforce this obligation. The issues of who is required to establish such a trust, how much money should fund it, and what to then do with it, have been addressed by the federal government in workers' compensation cases, but not in liability cases. Hence, the tremendous uncertainty surrounding this subject in liability cases[2].

In order to understand the statutory basis of MSA's and why they have now become an issue of major concern, a bit of history is in order. MSA's are a product of Congress' 1980 legislation, The Omnibus Reconciliation Act of 1980. 42 U.S.C. Section 1395y comprises the Medicare Secondary Payer Statute. The essence of the law is that Medicare is to be protected as a "secondary payer" for medical treatment relating to an injury when a primary payer exists. Because federal law takes precedence over state laws and private contracts, Medicare will always claim to be the secondary payer, regardless of state law or plan provisions to the contrary, and even where the workers' compensation insurer or liability insurer denies liability. Under regulations enacted pursuant to this Statute, 42 C.F.R. Section 411.20 (2):

> Section 1862(b)(2)(A)(ii) of this 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 [3]
> (ii) Liability insurance
> (iii) No-fault insurance

The federal agency responsible for administering Medicare and Medicaid (as well as a host of other federal programs) is the "Centers for Medicare and Medicaid Services" (CMS) within the Department of Health and Human Services.

While the Medicare Secondary Payer (MSP) Statute was originally passed in 1980, actual enforcement by federal authorities did not materialize until 2001. On July 23, 2001, a CMS memorandum (often referred to as the "Patel Memorandum", named after its author) was circulated by CMS to the insurance industry. It announced that compliance with the MSP was required on workers' compensation cases where the settlements closed out future medical expenses. At that time, there was no mention about enforcement against liability and no-fault cases. The Patel memorandum is significant not only because of its substance, but because it was the beginning of CMS enforcing MSP obligations by way of "Policy Memorandums" or "Frequently Asked Questions" instead of formal agency rule making. Thus instead of turning to the Code of Federal Regulations for guidance, the practitioner must turn to the internet and read these memoranda. The listing and link to these documents is provided here[4]. Whether these memoranda have the same force of law as formally issued regulations is yet another unanswered question, and may well be a subject of future litigation[5].



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The decision of CMS to aggressively enforce the Secondary Payer provisions in workers' compensation cases arose out of the government's conclusion that taxpayers were, in essence, paying for future medical bills that should have been covered by the

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workers' compensation insurers and settlements. For many years, workers' compensation insurers would settle (with the agreement of claimants and approved by workers' compensation judges) the "future medical" component of the injured worker's claim. The proceeds would go to the injured employee, but the employee would then immediately turn to Medicare to pay for the ongoing cost of injury-related care. A General Accounting Office report, Number 367 dated May 4, 2001, found that "between 1991 and 1998, workers received an average of about $43 billion each year in cash and medical benefits through the nation's workers' compensation programs to cover work-related injuries." The report indicated that the federal government was unintentionally subsidizing the workers' compensation insurance carriers throughout the United States on a dramatic scale. The July 23, 2001, Patel Memorandum was the beginning of CMS's actions to attempt to recover these funds.

While CMS offered a "safe harbor" to certain workers' compensation claimants who (by virtue of their Medicare eligibility and the amount of their settlements) were required to obtain CMS approval of their set-aside amounts, all others cannot obtain this safe harbor even if they want it. CMS's thresholds were originally set forth in its Patel Memorandum as claimants who had a "reasonable expectation" of Medicare enrollment in 30 months or less after the settlement **and** the total settlement value was greater than $250,000. As shown below, the threshold for persons already on Medicare is much lower. Originally there was no threshold, but it was later set at $10,000 and then raised to $25,000. CMS's April 22, 2003 Memorandum defines a "reasonable expectation" of Medicare enrollment as follows, and remarkably, even includes people already denied Medicare coverage by virtue of being denied Social Security disability benefits:

> Situations where an individual has a "reasonable expectation" of Medicai enrollment for any reason include bu are not limited to:
>
> a) The individual has applied for Social Security Disability Benefits;
>
> b) The individual has been denie 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 62 years and 6 months old (i.e., may be eligibl for Medicare based upon his/her age within 30 months); or
>
> e) The individual has an End Stage Renal Disease (ESRD) condition but does not yet qualify for Medicare based upon ESRD.

Workers' compensation claimants require to seek CMS review of their proposed MSA's actually benefited from the fact tha a CMS approval provided them with a "saf harbor." However, those not required to submit MSA's to CMS are not able to obtain this safe harbor even when they see it. In the workers' compensation realm, CMS will not review workers' compensation cases under its thresholds. Liability plaintiffs cannot seek it at all because CMS is not equipped or staffed tc review any proposed MSA. Nevertheless, as seen by CMS's memoranda of July 11, 2005 and April 25, 2006, where CMS provided its revised thresholds for those already enrolled in Medicare, CMS takes the position that workers' compensation claimants must protect Medicare's interests even though CMS cannot tell

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them if they have properly calculated their MSA.

CMS's July 11, 2005 Memorandum states:

> A2. Effective with the issuance of this memorandum, CMS will no longer review new WCMSA proposals for Medicare beneficiaries where the total settlement amount is less than $10,000. In order to increase efficiencies in our process, and based on available statistics, CMS is instituting this workload review threshold. However, CMS wishes to stress that this is a CMS workload review threshold and not a substantive dollar or "safe harbor" threshold. Medicare beneficiaries must still consider Medicare's interests in all WC cases and ensure that Medicare is secondary to WC in such cases. * * *
>
> Also note that both the beneficiary and non-beneficiary review thresholds are subject to adjustment. Claimants, employers, carriers, and their representatives should regularly monitor the CMS website at www.cms.hhs.gov/Medicare/cob/attorneys/att_wc.asp for changes to these thresholds and for other changes in policies and procedures.

CMS's April 25, 2006 Memorandum states:

> The purpose of this memorandum is to replace Q/A #2 of the July 11, 2005 Memorandum with regard to the Centers for Medicare & Medicare Services' (CMS') low dollar WCMSA threshold for Medicare beneficiaries. Effective with the issuance of this memorandum, CMS will only review new WCMSA proposals for Medicare beneficiaries where the total settlement amount is greater than $25,000.00. The CMS wishes to stress that this is a CMS **workload review** threshold and not a substantive dollar or "safe harbor" threshold. Medicare beneficiaries must still consider Medicare's interests in all WC cases and ensure that Medicare is secondary to WC in such cases.

CMS imposes harsh sanctions on workers' compensation claimants who do not obtain CMS approval of an MSA when required under CMS's thresholds, or who underfund the MSA. If Medicare pays medical bills it believes should have been properly paid by the claimant's MSA, it may, among other actions:

1. Deny the claimant future medical care.

2. Designate its own allocation (which may be the entire settlement amount) if an allocation is unreasonable or non-existent at the time of settlement. See 42 CFR 411.46(b)(2)(which permits the government to "not recognize" a settlement which "appears to represent an attempt to shift to Medicare the responsibility for payment of medical expenses for the treatment of a work-related condition")

3. Sue for repayment from everyone involved, including the claimant's attorneys, as stated by CMS in its memorandum of April 22, 2003, quoted below. Double damages may also be sought against the "primary payer" under the authority of 42 CFR 411.24(c)(2), and if the government is unable to recover against the "primary payer," against the "beneficiary." 42 CFR 411.24(l)(1),

> **From where can CMS recover funds if Medicare's interests are ignored in a WC case?**
>
> **Answer:** The CMS has a direct priority right of recovery against any entity, including a beneficiary, provider, supplier, physician, attorney, state agency, or private insurer that has received any portion of a third party payment

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directly or indirectly. The CMS also has a subrogation right with respect to any such third party payment. See, for example, 42 CFR 411.24(b), (e), and (g) and 42 CFR 411.26

CMS addresses, in its April 22, 2003 memorandum, the "ethical and legal obligations" of attorneys representing workers' compensation claimants when their clients want to "ignore Medicare's interests in a WC case," citing to the CFR section that gives CMS a claim against the attorneys.

> **Answer:** Attorneys should consult their national, state, and local bar association for information regarding their ethical and legal obligations. Additionally, attorneys should review applicable statutes and regulations, including, but not limited to, 42 CFR 411.24(e) and 411.26

How (and whether) CMS intends to apply its workers' compensation criteria to liability cases is completely unknown. The differences between the two systems of recovery for injuries, one linked to automatic compensation for on-the-job injuries and the other a fault-based system, are vast. In liability cases, limitations on recovery abound, including the following:

1. Seriously injured plaintiffs often recover far less then full compensation because of limited funds for recovery, due to: (a) the defendant's inadequate insurance coverage; or (b) statutory caps on the liability of governmental defendants.

2. A plaintiff's recovery may be reduced due to their own contributory fault, which in most jurisdictions reduces their recovery by their own percentage of fault.

3. Most important, the vast majority of liability cases are settled, and settlements always reflect a whole constellation of concerns that affect a plaintiff's likelihood of success at trial. These concerns, just to name few, include difficult liability cases where the plaintiff may recover nothing, plaintiffs with significant prior similar medical problems, anc plaintiffs with backgrounds that wil make them unsympathetic. When cases are settled, no apportionment usually made between the various types of compensable damages nor does the settlement reflect the reduction of damages due to these concerns.

Whether the amount of the MSA should b reduced for all of the limitations on liability recoveries discussed above is al obviously not covered by policy memoranda focused on workers' compensation cases. The U.S. Supreme Court addressed this question of limited funds for recovery in the context of Medicaid, in *Arkansas Department of Health and Human Services v. Ahlborn*, 126 S.Ct. 1752 (2006), ruling that Medicaid could not, as it sought, collect "first dollar" reimbursement out of a limited liability recovery, but only a pro-rata share. Whether CMS would apply thi principle to reduce the amount of money be put into a MSA in a liability case is unknown.

For example, if a liability plaintiff with damages stipulated at $500,000 recovere only $50,000 because of policy limits, it unclear whether CMS would reduce the amount of the MSA. If the defendant had insurance coverage of one million dollars but the plaintiff settled for the same $50,000 because of liability or medical causation concerns, how CMS would treat their MSA obligation is also unknown.

In yet another adverse effect, plaintiffs obligated to pay future medical expenses out of a MSA will likely find that the actu costs of these future medical expenses ar increased exponentially. Medicare always pays a vastly reduced amount of the expenses billed by doctors and hospitals, but plaintiffs, obligated to pay the medical expenses themselves because of the MSP,

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will not share in the benefit of the cost reductions negotiated by Medicare with the providers whose services Medicare pays. Plaintiffs will have to pay the full amount because they cannot take the Medicare discount. For example, while a hospital may be required to accept $10,000 from Medicare as full payment of a $50,000 bill, the plaintiff would be required to calculate as their future obligation the full $50,000.

To make matters even more complicated, even plaintiffs who are unlikely to have future surgery or procedures that would require large set-asides may still face major MSP obligations because of the 2003 inclusion of a drug benefit to Medicare beneficiaries. The future drug costs over the plaintiff's lifetime that are due to the injury/illness/disease caused by the tortfeasor are required to be included in the MSA, and these costs can be immense, particularly given American's increased longevity.

At the same time, it must always be kept in mind that the only future expenses covered by the MSP (and thus included in a MSA) are those that would be recoverable from the tortfeasor. Medicare is a secondary payer only when the plaintiff has medical evidence that these particular future medical expenses are, to a reasonable degree of medical certainty, causally linked to the injury/illness/disease in question, and are more likely than not to be incurred.

Resources for Assistance

Fortunately, resources exist to help the practitioner with these complex issues. Unfortunately, because the focus to date has been on workers' compensation claims, these resources may not be able to provide any clear answers to many of these questions. Nevertheless, they can help the plaintiff's attorney make a good faith attempt to comply with these obligations.

The best place for the practitioner to start, besides wading through CMS's policy memoranda and website covering workers' compensation cases, http://www.cms.hhs.gov/, is the national organization recently formed to deal with these issues. This private organization, the National Alliance of Medicare Set-Aside Professionals (NAMSAP), can be contacted at http://www.namsap.org/, and its website provides valuable links to articles and other resources. In addition, another private organization, the Commission on Health Care Certification (CHCC) certifies attorneys and other professionals as knowledgeable on these issues, and lists them at: http://www.chcc1.com/2MSCC%20Listing%20Page.htm. To date, only a handful of Minnesota attorneys are so certified, and they can be found at this website.

For those that want to choose between the many national firms and businesses that can provide advice, a quick search on the internet will quickly reveal the scope of this issue, particularly regarding workers compensation cases. Numerous businesses and law firms have entered the market to advise, prepare and manage MSA's.

Finally, this subject is best left with two points, first that CMS is likely to address this issue in the not-too-distant future, if only because of the vast number of people involved in all aspects of liability cases currently left in limbo because of CMS's lack of guidance, and second, that things may get worse before they get better. Just a couple of months ago, on October 2, 2006, CMS consolidated all MSP recovery "functions and workloads" that had previously been the responsibility of some 46 "Fiscal Intermediaries" and "carriers" into a single "MSP Recovery Contractor." Whether that will help or hurt the process remains to be seen. Indeed, one commentator noted that the "consolidation of the MSP recovery functions may provide a glimmer of light at the end of a long dark tunnel but it is anticipated that the tunnel may get even darker in the months to come[6]."

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1. Medicare covers persons based on age or disability, as compared with Medicaid, which is based on lack of assets.

2. The intent of CMS to apply the MSP to liability cases was demonstrated by its position in *United States of America v. Baxter International*, 345 F. 3d 866 (11th Circuit 2003). This was a breast implant class action, and in 2001, the Office of General Counsel filed suit on behalf of Medicare asserting a right of recovery for the payments Medicare made to treat the breast implant victims. Medicare's claim was dismissed by the trial court, but the Eleventh Circuit reversed and remanded the case, concluding Medicare did indeed have a right of recovery.

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3. Besides the vast majority of workers' compensation cases brought under state law, federal law also provides workers' compensation benefits under the Federal Employees Compensation Act, the U.S. Longshoreman's and Harbor Workers' Compensation Act, and the Federal Coal Mine Health and Safety Act of 1969 as amended (the Federal Black Lung Program). The Jones Act, which covers seamen, and the Federal Employers Liability Act, which covers employees of interstate railroads, are not workers' compensation acts.

4. The link to these documents, which can all be downloaded in Adobe format, can be found on the CMS website at http://www.cms.hhs.gov/WorkersCompAgencyServices/. They can also be downloaded from the website of the National Alliance of Medicare Set-Aside Professionals (NAMSAP), at http://www.namsap.org/ and http://www.namsap.org/useful_links.html. These documents, issued from July 2001 to the present, are the following:

* July 23, 2001 letter, "Workers' Compensation: Commutation of Future Benefits."

* April 21, 2003 letter "Medicare Secondary Payer - Workers' Compensation (WC) Frequently Asked Questions." Medicare Secondary Payer Regional Office WC contacts are listed in an attachment to this letter. The WC contacts can provide a detailed list of documents necessary to complete a review of a settlement that includes a Medicare set-aside arrangement for future medical benefits.

* May 23, 2003 letter "Medicare Secondary Payer - Workers' Compensation (WC) Additional Frequently Asked Questions."

* On May 7, 2004, CMS issued a Memorandum discussing its new policy regarding the use of administrative fees in WC cases.

* On October 15, 2004, CMS issued a Memorandum discussing new and updated Workers' Compensation (WC) Frequently Asked Questions.

* On July 11, 2005, CMS issued a Memorandum discussing new and updated Workers' Compensation (WC) Frequently Asked Questions.

* On December 30, 2005, CMS issued a Memorandum discussing Part D and Workers' Compensation Medicare Set-aside Arrangements (WCMSAs) Questions and Answers.

* On April 25, 2006, CMS issued a Memorandum discussing the Workers' Compensation Medicare Set-Aside Arrangements (WCMSAs) and the revision of the low dollar threshold for Medicare beneficiaries

* On July 24, 2006, CMS issued a Memorandum discussing the Medicare Part D prescription drug program.

5. For example, CMS has no appeal process regarding its approval of MSA amounts in workers' compensation case: which raises serious due process issues. CMS's April 22, 2003 memorandum stat that the only time the employee can contest CMS's MSA determination is wh Medicare denies a particular bill on the basis that it should have been paid out of MSA.

If Medicare rejects a proposed Medicare set-aside arrangement, how can the parties to a WC settlement appeal this rejection?

Answer:
The CMS has no formal appeals process for rejection of a Medicare set-aside arrangement. However, whe CMS does not believe that a proposed set-aside adequately protects Medicare's interests, the parties may provide the RO [Regional Office] with additional information/documentation order to justify their proposal. If the additional information does not convince the RO to approve the set-aside arrangement, and the parties proceed to settle the case despite the RO's objections, then Medicare will no recognize the settlement. Medicare wil exclude its payments for the medical expenses related to the injury or illness until such time as WC settlement funds expended for services otherwise reimbursable by Medicare exhaust the entire settlement. At this point, when Medicare denies a particular beneficiary's claim, the beneficiary may appeal that particular claim denial through Medicare's regular administrative appeals process. Information on applicable appeal right is provided at the time of each claim denial.

6. The Medicare Conditional Payment Crisis: The Darkness Before the Dawn, Meifert and Lewis, Settlement News, June 2006. The article, like many others, is available on the NAMSAP website at http:/ www.namsap.org/articles.html.