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GARRETSON
RESOLUTION GROUP

Medicare Set Aside Analysis Under the Medicare Secondary Payer Act

March 21, 2012

Executive Summary: To assist settling parties to determine whether a Medicare Set-Aside ("MSA") is appropriate when resolving a workers' compensation or liability claim, the Garretson Resolution Group submits the following White Paper for review and consideration. After addressing these issues in thousands of settlements nationwide, we propose a four step formalized approach to addressing any MSA issue: 1) Screening to determine if the claimant is an MSA candidate; 2) Assessing whether the gross award contains any allocation for future medical expenses; 3) Valuing the claimant's actual future cost of care needs; and 4) Educating the claimant and parties about MSA obligations going forward. By screening, assessing, valuing and educating, that is the way to SAVE the Medicare Trust Funds (relative to future medicals).

By screening every case and having a formalized approach to verifying, resolving and satisfying potential MSA obligations, and documenting the file to demonstrate the steps the parties took, settling parties will ensure the following: 1) Medicare's future interest has been considered and protected appropriately; 2) the settling parties are fully compliant with the Medicare Secondary Payer Act (statute and regulations); and 3) the claimant's Medicare benefits are protected going forward.

To allow parties to apply this SAVE methodology in a practical manner for all types of claims, GRG developed the MSA Decision Engine. Based on the currently enacted statutory, regulatory and administrative guidance provided by CMS as well as relevant case law, we offer the MSA Decision Engine as a tool parties may utilize to demonstrate a reasonable good faith effort is made to comply with the Medicare Secondary Payer Act on the issue of future medical expenses. Based on our MSA methodology built on a decade plus experience in specifically addressing such issues, the MSA Decision Engine allows parties to address MSA issues in an affirmative manner and comply more substantially with the MSP Act.

This White Paper analyzes the propriety of using a Medicare Set-aside Arrangement ("MSA") in settlements pursuant to the Medicare Secondary Payer ("MSP") Act.[1] The primary issue addressed in this White Paper is determining when funding an MSA is the appropriate means of compliance in addressing the issue of future medical expenses under the MSP Act. This White Paper contains the academic and legal underpinnings behind the current MSA debate as well as practical guidance/tips for dealing with situations where a settling party (perhaps misinformed about the related requirements [or lack thereof]) is demanding an MSA be funded without the proper screening as to the appropriateness of an MSA based on the case specific facts.

[1] 42 U.S.C. §1395y(b)(2).

In all settlements[2], compliance with MSP rules and regulations can involve two broad reimbursement/resolution obligations: i) the verification and resolution of Medicare's reimbursement claim for injury-related care from the date of injury through the date of settlement; and ii) the evaluation of obligations associated with future costs of care that may be provided to the claimant from the date of settlement onward. In our experience, after assisting on thousands of cases for this specific purpose, the most logical way to assure that these obligations have been satisfied is to review the relevant statutes and regulations as well as any guidance from the Centers for Medicare & Medicaid Services ("CMS")[3] interpreting those statutes/regulations and apply this information to the facts of each case. Accordingly, this White Paper is based on the currently available guidance concerning satisfaction of Medicare's future interest under the MSP Act. This White Paper addresses:

MSA Overview

The purpose of an MSA, in both the liability and the workers' compensation ("WC") context, is to pay for future injury-related care which would otherwise be covered by Medicare. An analogy would be an insurance deductible which must be spent down and exhausted prior to an insurance

[2] Throughout this White Paper, when the term "settlement" is used, it encompasses settlements, judgments, awards and other payments where CMS's right of recovery ripens under the Medicare Secondary Payer ("MSP") Act.

[3] CMS is the federal agency charged by the U.S. Department of Health and Human Services with the administration of Medicare programs, including Medicare Secondary Payer.

carrier making payment on a claim. Here, CMS acts as the insurance carrier and the MSA is the deductible amount.

However, the MSA obligation in a liability settlement is less definable when compared to the traditional application in a WC settlement. A WC settlement, following no fault standards, contains only three "buckets" of damages: (1) indemnity/wage loss; (2) past medicals; and (3) future medicals. As such, if the parties know the indemnity component and have calculated the past medicals component, the balance can be said to be allocated to future medicals.[4] The same is not the case in a liability settlement, as issues of comparative fault, statutory caps and policy limit awards confound parties desiring a balanced, compliant approach to the MSA issue when resolving a liability case. The fact that liability settlements lack uniform damage allocations, perhaps, explains the minimal MSA guidance (to date) from CMS specific to the liability context.[5] This White Paper, therefore, synthesizes all currently available information (statutes, regulations, case law, relevant portions of CMS's WCMSA Policy Memoranda, CMS's LMSA Policy Memorandum, etc.) to provide respective counsel (both plaintiff and defense) with a roadmap for making a reasonable good faith effort at compliance[6] with the MSP Act.

Consider: if settlement involves a claimant who is enrolled or soon to be enrolled in the Medicare program, a WC settlement (which closes future medicals) has a definitive shift of the obligation to pay for future health care expenses from the WC carrier to Medicare. This shift-of-burden carries a clear obligation to protect Medicare's interest, at least when following the Memoranda issued by CMS, including the Workers' Compensation (Patel) Memo of July 23, 2001.[7] In WC settlements involving Medicare beneficiaries, federal regulations provide that the liability for medical expenses incurred due to work-related injuries should not be shifted to Medicare from the responsible

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[4] 42 C.F.R. §411.47(a).

[5] However, see *Hinsinger v. Showboat Atlantic City*, 2011 N.J. Super. LEXIS 96 (January 21, 2011) (determining that the same regulations and directives that apply to set asides created in workers' compensation cases apply to set asides created in liability cases).

[6] Reasonable good faith effort at compliance is the appropriate standard to be met when addressing MSA issues in all liability settlements. Discussed in depth later in the memo, this standard was most recently substantiated in a handout dated May 25, 2011, from Sally Stalcup, MSP Regional Coordinator, CMS, Region VI. "We are still asked for written confirmation that a Medicare set-aside is, or is not, required. As we have already covered the 'set-aside' aspect of that request we only need to state that IF there was/is funding for otherwise covered and reimbursable future medical services related to what was claimed/released, the Medicare Trust Fund must be protected. If there was/is no such funding, there is no expectation of 3rd party funds with which to protect the Trust Funds. **Each attorney is going to have to decide, based on the specific facts of each of their cases, whether or not there is funding for future medicals and if so, a need to protect the Trust Funds** (emphasis added)**.** They must decide whether or not there is funding for future medicals. If the answer for plaintiff's counsel is yes, they should (to) see to it that those funds are used to pay for otherwise Medicare covered services related to what is claimed/released in the settlement judgment award. **If the answer for defense counsel or the insurer, is yes they should make sure their records contain documentation of their notification to plaintiff's counsel and the Medicare beneficiary that the settlement does fund future medicals which obligates them (Medicare beneficiary and plaintiff's counsel) to protect the Medicare Trust Funds** (emphasis added)."

[7] Memorandum from Parashar B. Patel, Deputy Director, CMS Purchasing Policy Group, Center for Medicare Management, to All Associate Regional Administrators, "Workers' Compensation: Commutation of Future Benefits" (July 23, 2001), *available at* http://www.cms.hhs.gov/WorkersCompAgencyServices/ (last visited March 20, 2012).

party.[8] However, CMS's recommended means to protect Medicare's future interest involve defining that portion of a Medicare beneficiary's WC settlement which relates to future costs of care. According to CMS's WCMSA Policy Memoranda, these monies should be set aside to pay for the beneficiary's future work-related injury and/or illness.[9] Federal regulations provide that Medicare will not pay for any medical expenses for the work-related injury or illness until the amount allocated to future medical expenses is exhausted.[10]

Since liability cases often involve a mix of inter-related damages (beyond the statutorily defined silos of indemnity and medicals in the WC context), the application of WC-oriented MSA principles (and associated guidance from CMS) appears far from clear cut in the liability context. As such, WC-oriented MSA principles cannot merely be grafted onto a liability case due to the inherent differences between them. Instead, an independent review of damages, including an analysis intended to determine the existence of future costs of care, and the presence (or lack thereof) of a burden shift over to Medicare to pay for such care is proper to determine the propriety of an MSA in a liability case. Absent such threshold analysis up front, settling parties may be creating obligations which don't currently exist under the MSP program as currently constructed.

Medicare's Recovery Rights (the law)

Medicare's rights of recovery under the MSP Act extend both to the past and the future.[11] This is the case for both liability and WC cases. As such, when we talk about MSP compliance from the reimbursement/resolution perspective, we are really talking about two separate and distinct moving parts. On the one hand, Medicare may have past payments to be reimbursed (arising from date of injury through date of settlement). These are known as "conditional payments"[12], and the MSP Act provides that Medicare is to be reimbursed for any conditional payments it makes on

[8] 42 C.F.R. §411.46.

[9] CMS has issued sixteen (16) policy memoranda, from July 21, 2001 through May 11, 2011, discussing the use of MSAs in workers' compensation settlements. While these policy memoranda do not purport to discuss the use of MSAs in liability settlements, CMS issued the first policy memorandum about the use of MSAs in liability settlements on September 30, 2011. Here, CMS advises that if the settling parties have a certification letter from the beneficiary's treating physician indicating that treatment for the alleged injury related to the liability insurance settlement has been completed as of the date of settlement, and future injury-related care will not be needed, the parties may rely on that certification letter as the reason why an MSA was not warranted for that particular settlement. However, see *Hinsinger* at 4 - 5 ("Having concluded that the same regulations and directives that apply to set asides created in workers' compensation cases apply to set asides created in liability cases, …").

[10] 42 C.F.R. §411.46(d). "(1) *Basic rule*. Except as specified in paragraph (d)(2) of this section, if a lump-sum compromise settlement forecloses the possibility of future payment of workers' compensation benefits, medical expenses incurred after the date of the settlement are payable under Medicare. (2) *Exception*. If the settlement agreement allocates certain amounts for specific future medical services, Medicare does not pay for those services until medical expenses related to the injury or disease equal the amount of the lump-sum settlement allocated to future medical expenses."

[11] Memorandum from Thomas L. Grissom, Director, CMS Center for Medicare Management, to All Regional Administrators, "Medicare Secondary Payer-Workers Compensation (WC) Frequently Asked Questions", question & answer No. 13 (April 22, 2003), *available at* www.cms.hhs.gov/WorkersCompAgencyServices/ (last visited March 20, 2012).

[12] 42 C.F.R. §411.21.

behalf of a Medicare beneficiary for injury-related care.[13] On the other hand, Medicare also has an incentive to not pay for future medical expenses where funds were allocated to pay for such future expenses (arising from date of settlement onward).[14] Both past and future medical payments made or to be made by Medicare become a factor in settling cases to ensure MSP compliance in the reimbursement sense.[15]

In the case of past payments (date of injury to date of settlement), the MSP Act provides that *payment may not be made under Medicare for covered items or services to the extent that "payment has been made, or can reasonably be expected to be made, under a workmen's compensation law or plan of the United States or a State or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no-fault insurance."*[16] Thus, all past Medicare payments are conditioned on reimbursement to the Medicare program to the extent that payment with respect to the same items or services has been made, or could be made, **under a workers' compensation policy or plan, an automobile or liability insurance policy** or plan (including a self-insured plan) or no-fault insurance.

In the case of future payments (date of settlement onward) where a lump sum compensation award stipulates that the amount paid is intended to compensate the individual for all future medical expenses required because of the work-related injury or disease, federal WC regulations provide a mechanism whereby Medicare does not pay for such expenses until the amount of the future medical expenses equals that part of the lump sum payment.[17] Where a compromise settlement allocates a portion for future medical expenses and reasonably recognizes the income replacement element (indemnity portion), CMS can accept such apportionment as a basis for determining Medicare's future payments.[18]

How to SAVE the Medicare Trust Funds: Formalized Approach Yields Compliant Results.

Utilizing a formalized approach to addressing all MSP (reimbursement/resolution as well as reporting) is the best way to ensure MSP compliant results are rendered. In the future medicals

[13] 42 U.S.C. §1395y(b)(2)(B)(ii). "A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary … with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service."

[14] Technically, as opposed to a right of reimbursement for future injury-related medicals, the MSP Act endows CMS with the implicit right to NOT make payments for a claimant's future injury-related care when another primary plan or payer has already accepted responsibility for such payments and has made payment to a claimant of such funds allocated to the claimant's future cost of care needs. It is this right NOT to make a future payment which distinguishes this right from rights to reimbursement for any conditional payments made. *See also* 42 C.F.R. §411.46(d).

[15] While later discussion in this White Paper will include the Medicare, Medicaid and SCHIP Extension Act of 2007 ("MMSEA"), found at 42 U.S.C. §1395y(b)(8), that statute imposes a reporting obligation on certain entities and in no way alters or changes any pre-existing reimbursement obligations which are the topic of this White Paper.

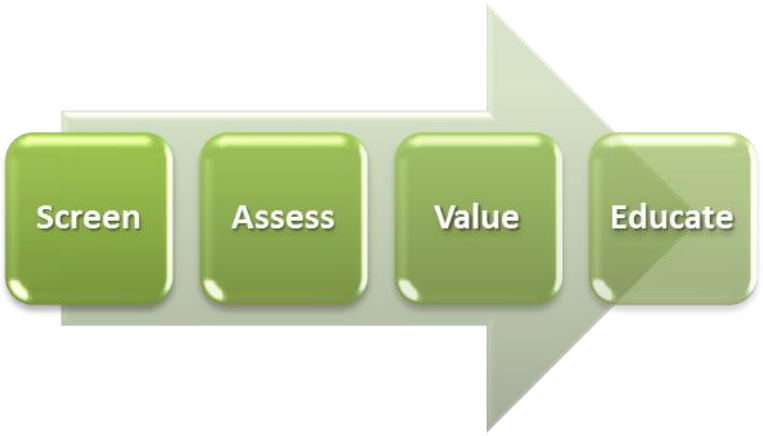
[16] 42 U.S.C. §1395y(b)(2)(A)(ii), *amended by* Pub. L. No. 109-171, 120 Stat. 4 (2006).

[17] 42 C.F.R. §411.46(d).

[18] 42 C.F.R. §§411.46(a), (b) and 411.47(a).

context, settling parties should apply the following four step approach when addressing the MSA issue in order to "SAVE" a Medicare beneficiary's Medicare card and the Medicare program itself (relative to future medicals):

1) **Screen** to validate a claimant's candidacy for an MSA;
2) **Assess** damages to determine whether an allocation for future medicals exists within the gross award or potential gross award;
3) **Value** future medicals for the claimant's case; and
4) **Educate** and administer the MSA results properly.



Screen - Every case should be screened when making this determination to validate a claimant's candidacy for funding an MSA as the appropriate means to protect his/her Medicare card. MSAs **are not** appropriate in every single case. Only after finding a claimant to be a candidate for use of an MSA (based on case-specific facts such as claimant's Medicare enrollment status, determining if claims resolution results in future medicals being closed such that Medicare becomes the primary payer of future injury-related medicals going forward, as well as other relevant factors) can it be said that an MSA may be appropriate. Any MSA allocation created without first determining a claimant's candidacy for an MSA based on case-specific facts has missed a critical threshold issue, and may be creating an obligation which would not otherwise exist for the settling parties. If a claimant is not deemed to be a candidate for an MSA, then the settling parties are compliant with the MSP Act by simply documenting their respective files as to the reason why an MSA was not appropriate based on the case-specific facts. If the claimant is determined to be an MSA candidate, then the parties should proceed to step two, the Assessment phase of the analysis.

Assess - Upon finding an injured person to be an MSA candidate, the parties must next determine if the (potential) gross settlement proceeds contain sufficient dollars to fund any MSA obligation through an allocation to future medicals. To do this, parties should assess the damages sustained, compare those to the gross award and conclude whether: i) the gross award actually contains dollars for future medicals; or ii) whether, due to the case-specific facts, the injured person is not being compensated for future medicals, despite the fact that future medicals are a damage component being pled and released and/or a life care plan may be in existence, evidencing the claimant's need for certain future injury-related care.[19]

[19] *See Zinman v. Shalala*, 67 F.3d 841, 846 (9th Cir. 1995), where the Court foresaw this inherent problem in liability settlements under the MSP Act.

Parties should rely on standardized damage allocation methodology in making this determination, ensuring a consistent application of these principles if challenged by CMS at a later date.[20] Such a standardized methodology should be based on all guidance in existence at the time of settlement (including statutory, regulatory and administrative guidance from CMS as well as relevant case law). Absent such a thorough methodology being applied, the parties could be led off the path one way (funding an MSA when not appropriate) or another (failing to fund an MSA when funding is appropriate).

In applying standardized damage allocation methodology (containing all relevant guidance) to every claim, settling parties and their counsel can identify, with reasonable certainty, whether an allocation exists for future medicals within a (potential) gross award. If a future medical allocation does not exist, then the settling parties are compliant with the MSP Act by simply documenting their respective files appropriately as to why an MSA is not appropriate (no allocation for future medicals present). However, if the settling parties determine that an allocation exists for future medicals, then an MSA is appropriate. The amount of the future medical allocation figure represents 100% value for all future medicals funded within the gross award and the maximum possible MSA figure. It **does not**, however, represent the final MSA amount. To determine that figure, the parties should proceed to Valuing the future medical damages component (step three).

Value - After assessing the damages in step two, if a reasonable person would determine that an actual allocation for future injury-related medical expenses exists in the award (based on standardized damage allocation methodology), the task becomes identifying the appropriate MSA amount to ensure compliance (and protect the claimant's Medicare card). To identify the appropriate MSA allocation, a future cost of care ("FCC") analysis should be conducted. This FCC analysis would identify all future injury-related care services/expenses expected to be incurred by the claimant, and then divide those services/expenses between Medicare-covered services/expenses and non-Medicare covered services/expenses. The resulting FCC figure would then be compared to the future medical allocation identified previously (in step 2 (Assess)). Based on this comparison, the MSA would be fully funded (and the MSA obligation fully addressed) for the lesser of the future medical allocation and the FCC analysis. Once the MSA allocation amount is finalized[21] (which can only occur once the settlement details are finalized), the parties should determine how the MSA results will be memorialized and implemented. To make this determination, the parties should move forward to the Education phase of the analysis (step four).

Educate – At this point, the claimant faces certain questions relative to funding and administering the MSA as well as whether seeking CMS review and approval is an appropriate action step. MSAs may be funded either with a full lump sum dollar amount up front or with an initial lump sum, combined with the purchase of an annuity or other structured settlement vehicle. MSAs may either be self-administered or administered by a professional custodian. CMS has no express preference on funding and administrative decisions, so long as the MSA proceeds are spent down and exhausted appropriately (on future injury-related care otherwise covered by Medicare).

[20] *Guidry, et al. v. Chevron USA, Inc.*, Civ. No. 6:10-cv-00868, 2011 U.S. Dist. LEXIS 148942 (W.D. La. December 28, 2011).

[21] *Hinsinger v. Showboat Atlantic City*, 18 A.3d 229 (N.J. Super. Ct. Law Div. 2011).

On the topic of submitting MSA proposals to CMS for review and approval, this is also a decision which should be left to the claimant. Since it is his/her Medicare benefits at stake if the MSA issue is not handled appropriately, they should have the final say as to whether this voluntary step should be taken. Submitting an MSA proposal, no matter what kind of MSA proposal, to CMS for review and approval is voluntary, not mandatory.[22] The only time such submission and getting CMS to review and approve the MSA proposal becomes mandatory is when the settling parties themselves choose to make such action a condition of settlement.[23] Absent such a condition of settlement, it becomes a voluntary means of MSP compliance, understanding that CMS employs certain workload review thresholds based on gross settlement amount to manage its caselaw. Later in this White Paper, we will discuss the particular nuances of submitting a workers' compensation MSA proposal versus a liability MSA proposal to CMS for review and approval.

Workers' Compensation Settlements (and MSAs)

As described above, parties resolving WC claims should address two MSP reimbursement obligations when the claimant is a current Medicare beneficiary: 1) verify and resolve any conditional payments made by Medicare from date of injury to date of settlement; and 2) determine **IF** an MSA is appropriate under the case-specific facts. While conditional payment reimbursement is a critical (and often overlooked) MSP obligation in WC matters, it is not the subject of this White Paper.

Per CMS Memoranda, Medicare's future interest should be considered in WC settlements in order to comply with the MSP.[24] In this regard, if a WC claimant will have future medical expenses as a result of his/her injury, the wise practitioner advises the claimant of the need to analyze and calculate the appropriate MSA allocation figure within the gross award (when appropriate) to pay for Medicare-covered expenses as the compliant means of protecting the claimant's Medicare

[22] Memorandum from Charlotte Benson, Acting Director, Financial Services Group, Office of Financial Management, "Medicare Secondary Payer – Workers' Compensation – INFORMATION (May 11, 2011), *available at* http://www.cms.hhs.gov/WorkersCompAgencyServices/ (last visited March 20, 2012). "There is no statutory or regulatory provisions requiring that a WCMSA proposal be submitted to CMS for review."

[23] *See Smith v. Marine Terminals of Arkansas*, 2011 U.S. Dist. LEXIS 90428 (August 9, 2011) (defendant engaged an MSA vendor to create a WCMSA, resulting in an MSA Allocation totaling $313,095.54. Mr. Smith engaged GRG to review the matter. The GRG WCMSA Allocation totaled $14,647. As a condition of settlement, the GRG WCMSA Allocation was submitted to CMS for review and approval. Even though the matter met CMS's published workload review thresholds, CMS decided not to review the WCMSA Allocation. The parties motioned the Court to approve the settlement agreement absent CMS approval of the GRG WCMSA. The Court, after viewing the evidence in front of it, approved the settlement, including the GRG WCMSA totaling $14,647.) *See also Schexnayder v. Scottsdale Insurance Company*, Civ. No. 6:09-cv-1390, 2011 U.S. Dist. LEXIS 83687, 2011 WL 3273547 (W.D. La. July 29, 2011) (finding that Schexnayder was obligated to reimburse Medicare for all conditional payments made prior to the time of settlement, and for all medical expenses submitted to Medicare prior to the date of the order, even if such conditional payments are asserted by Medicare subsequent to the effective date of the order, but also concluding that Schexnayder should set aside funds to pay for future medical expenses arising from the injuries alleged in the lawsuit).

[24] Memorandum from Parashar B. Patel, Deputy Director, Purchasing Policy Group, Center for Medicare Management, to All Associate Regional Administrators, "Workers' Compensation: Commutation of Future Benefits," (July 23, 2001), *available at* http://www.cms.hhs.gov/WorkersCompAgencyServices/ (last visited March 20, 2012).

card.[25] According to CMS, this is its preferred vehicle for considering and protecting its future interest in WC settlements. Applying the four-step SAVE methodology described above, we will walk you through the manner in which to analyze the MSA issue in WC cases.

Screen: Is the Claimant an MSA Candidate?

Based on currently enacted law and guidance provided by CMS, the following three criteria must be met in order to recognize a claimant as a candidate for needing an MSA to comply on the issue of future medicals in a WC case: 1) the claimant must be either currently enrolled in Medicare or possesses a "reasonable expectation" of Medicare enrollment within thirty (30) months of settlement[26]; 2) the WC settlement closes future medical expenses, effectively shifting the burden of future injury-related care from the WC carrier to Medicare going forward[27]; and 3) the claimant, in fact, requires future injury-related care that would otherwise be covered by Medicare. If, when a WC matter is resolved, it meets these three criteria, then the claimant is an MSA candidate and an MSA may be appropriate.

Unlike a liability settlement (discussed in detail below), a WC settlement often involves specific body parts for which the WC carrier has accepted responsibility. Remembering that CMS's rights of recovery ripen when a primary plan or payer has accepted responsibility for medicals, its rights of recovery, from a timing perspective may revert to when the WC initially pays medicals for a particular body part. Then, when the WC claim is resolved and futures medicals are closed, an MSA may be appropriate with regard to that body part in question.

MSAs are not needed in all WC settlements. If one of the criteria set forth above is not met, then an MSA is not necessary or appropriate for the settling parties to be MSP compliant on the future medical expense issue in the WC settlement. An MSA may not be necessary when: 1) the claimant lacks the requisite Medicare enrollment status (no current Medicare enrollment at settlement and/or no "reasonable expectation" of Medicare beneficiary status within thirty (30) months of settlement); 2) future medical coverage is not being settled (no burden shift exists or future medicals are left open); or 3) if the claimant's treating physician can support that no future injury-related care is necessary (no future costs of care in the first place).[28]

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[25] 42 C.F.R. §§411.46 and 411.47.

[26] Memorandum from Thomas L. Grissom, Director, Center for Medicare Management, to All Regional Administrators, "Medicare Secondary Payer – Workers' Compensation (WC) Frequently Asked Questions," question & answer No. 2 (April 22, 2003), *available at* http://www.cms.hhs.gov/WorkersCompAgencyServices/ (last visited March 20, 2012). "Situations where an individual has a "reasonable expectation" of Medicare enrollment for any reason include but are 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 62 years and 6 months old (i.e., may be eligible 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."

[27] When dealing with MSA issues, it is critical to note that in some jurisdictions, such as New York and Nevada, where the WC carrier has not permanently foreclosed the payment of future medicals (instead going on a "holiday" from those bills), there may be a burden shift temporarily. During that holiday period, an MSA may be appropriate until the WC carrier resumes primary responsibility to pay future medicals.

[28] Memorandum from Thomas L. Grissom, Director, Center for Medicare Management, to All Regional Administrators, "Medicare Secondary Payer – Workers' Compensation (WC) Frequently Asked Questions,"

To shed more light on the burden shift concept, let's assume the claimant sustains an on-the-job injury to his shoulder and back. The WC carrier has denied the claimant's WC claim for all treatment related to the shoulder and the back. The parties ultimately enter into an agreement to resolve the WC claims. However, the WC carrier never accepts responsibility for either the shoulder or the back. Under this scenario, an MSA would not be necessary since there is no burden shift. At no time did the WC carrier accept responsibility for the claimant's injuries. Even in settling the claims, the WC carrier is not accepting responsibility for medical expenses related to the shoulder or back. As such, no burden shift to Medicare exists, and funding an MSA would be an unnecessary and inappropriate means of compliance based on the case-specific facts.

When the claimant is not an MSA candidate based on the case-specific facts, the parties simply need to document their file to demonstrate compliance. However, assuming the claimant is identified as an MSA candidate, the parties should proceed to step two, the Assessment phase of the analysis.

Assess: What Portion of Gross Award is Allocated to Future Medicals?

Once it has been determined that the claimant is an MSA candidate, the next step is to determine whether the WC settlement contains an amount allocated to future medicals within the gross award. Unlike the liability context (explained in detail below), CMS has provided regulations and administrative guidance to follow when making this assessment. The default rule to keep in mind, provided by CMS at 42 C.F.R. §411.46(d), is that Medicare will pay for future medical expenses but for those occasions where the WC settlement contains an allocation for future medical expenses. If such an allocation exists, then the claimant should spend down and exhaust the amount of that allocation prior to having service providers submit bills/expenses to Medicare for payment.[29]

Next, the settlement community can look to the rule provided by CMS at 42 C.F.R. §411.47(a).[30] This rule allows parties to allocate damages into different buckets, indemnity/wage loss and medicals. If parties utilize this regulation, so long as they have reasonably assessed the indemnity/wage loss component to the WC gross award, they can rely on the fact that the balance would be allocated to medicals. Any WCMSA amount should then be capped by the total amount of that medical allocation.[31] If the gross award also contains an amount for past medical expenses,

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question & answer No. 20 (April 22, 2003), *available at* http://www.cms.hhs.gov/WorkersCompAgencyServices/ (last visited March 20, 2012). "It is unnecessary for the individual to establish a set-aside arrangement for Medicare if all of the following are true: a) The facts of the case demonstrate that the injured individual is only being compensated for past medical expenses (i.e., for services furnished prior to the settlement); b) There is no evidence that the individual is attempting to maximize the other aspects of the settlement (e.g., the lost wages and disability portions of the settlement) to Medicare's detriment; and c) The individual's treating physicians conclude (in writing) that to a reasonable degree of medical certainty the individual will no longer require any Medicare-covered treatments related to the WC injury."

[29] See footnote #10.

[30] 42 C.F.R. §411.47(a)(1). "If a compromise settlement allocates a portion of the payment for medical expenses and also gives reasonable recognition to the income replacement element, that apportionment may be accepted as a basis for determining Medicare payments."

[31] *Benson v. Sebelius*, 2011 U.S. Dist. LEXIS 30438 (Decided March 24, 2011) ("…if a settlement covers both medical and nonmedical costs, CMS's reimbursement may be apportioned so as to reach only the portion of the settlement allocated to cover medical costs.")

that amount for future medical expenses could be further reduced (by subtracting past medicals within the award from total medicals within the award). In short, based on the rules provided by CMS, any WCMSA amount **must** be capped by the gross award, and **should** be capped further based on the identification of any allocation for indemnity/wage loss within the gross award. The amount of this future medical allocation figure represents 100% value for all future medicals funded within the gross award and the maximum possible MSA figure. It **does not**, however, represent the final MSA amount. To determine that figure, the parties should proceed to Valuing the future medical damages component in step three of the analysis.

Value: What is the Proper MSA Allocation Amount?

Keeping in mind that the purpose of the MSA is to avoid an improper burden shift over to Medicare with respect to future injury-related medical payments, a future cost of care ("FCC") analysis helps with that determination. This FCC analysis would identify all future injury-related care services/expenses expected to be incurred by the injured person, and then divide those services/expenses between Medicare-covered services/expenses and non-Medicare covered services/expenses.

In conducting this FCC analysis, nurse allocators should note that CMS officials have informally advised that it places the following order of priority of medical records: 1) records from the treating physician; 2) records provided from a physician agreed upon by the parties; and 3) records provided from an Independent Medical Examiner ("IME"). If parties have records from both a treating physician as well as an IME, CMS will grant the treating physician's report maximum deference. In theory, the treating physician is more familiar with the claimant's condition than would an IME. Thus, CMS would rely on the treating physician's guidance when determining what future medical services/expenses are expected to be incurred.

When conducting an FCC analysis, the nurse allocator should take into account the state of jurisdiction. If the state of jurisdiction where a WC fee schedule exists, the nurse allocator should utilize that WC fee schedule when pricing future medical services/expenses. Should the state of jurisdiction not utilize a WC fee schedule, then the FCC analysis should be priced based on usual, customary and reasonable rates.[32]

Contrary to popular belief, MSAs are not priced at Medicare reimbursement rates. The reasoning for this is because the obligation to pay is one held by the primary plan/payer, Medicare would not be involved. If not involved, then care is not being rendered at a Medicare reimbursement rate. The same holds true for future medicals. The MSA should be priced either using the WC fee schedule for that particular state, or using usual, customary and reasonable rates. Then, once the MSA is spent down and exhausted, bills may be submitted to Medicare and would then be paid at the Medicare reimbursement rate.

[32] Memorandum from Gerald Walters, Director, Financial Services Group of Financial Management, to All Regional Administrators, "Medicare Secondary Payer (MSP) – Workers' Compensation (WC) Additional Frequently Asked Questions," question & answer No. 1 (October 15, 2004), *available at* http://www.cms.hhs.gov/WorkersCompAgencyServices/ (last visited March 20, 2012). "... CMS will use either the WC fee schedule (for states that have such schedules) of full actual charges for its review of a proposed WC Medicare Set-aside Arrangement based upon whichever methodology was used by the individual/entity submitting the proposal."

In recent years, the topic of prescription medications and how those interplay with MSAs has been a topic of discussion. Previously, nurse allocators could choose a reasonable pricing method to account for prescription medications within the MSA, and that would pass muster with CMS. However, CMS has advised that prescription medications should be priced in only one manner; usual, customary and reasonable.[33] This announcement is solely responsible for the increased costs of funding MSAs of late. Based on our experience, we have witnessed an increase in excess of 20% of MSAs where prescription medications are included.

Taken the above in account, once the resulting FCC figure is calculated, it would then be compared to the future medical allocation identified previously (in step 2 (Assess)). Based on this comparison, the MSA would be fully funded (and the MSA obligation fully addressed) for the lesser of the future medical allocation and the FCC analysis. Once the MSA allocation amount is finalized[34] (which occurs only once the settlement details are finalized), the parties should determine how the MSA results will be memorialized and implemented. To make this determination, the parties move forward to the Education phase of the analysis (step four).

Educate: Funding, Administration and CMS Submission.

After determining the appropriate amount with which to fund the MSA, questions relating to the manner of funding and the administration of the MSA need to be answered. Each question has two potential answers. Each question should be decided by the Medicare beneficiary after being fully informed. One final question to be answered relates to whether the MSA proposal itself should be submitted to CMS for review and approval.

An MSA can be funded one of two ways. First, the MSA may be funded using a lump sum amount of settlement proceeds up front. Once funded, those proceeds must be spent only on future injury-related care that would otherwise be covered by Medicare. Once those proceeds have been exhausted properly and the MSA has been spent down to zero, then the claimant may begin to bill Medicare again for injury-related medical care. The second option is to fund the MSA using an annuity or other structured settlement vehicle. Here, the MSA is funded with 'seed money' consisting of the first two years of medical expenses which would otherwise be Medicare covered plus the cost of the first contemplated surgery or procedure.[35] Then, the annuity would pay a sum

[33] Memorandum from Gerald Walters, Director, Financial Services Group, Office of Financial Management, to Consortium Administrator for Financial Management and Fee-for-Service Operations, "Medicare Secondary Payer (MSP) – Workers' Compensation - INFORMATION," (April 3, 2009), *available at* http://www.cms.hhs.gov/WorkersCompAgencyServices/ (last visited March 20, 2012). "The CMS will begin independently pricing future prescription drug treatment costs/expenses in WCMSA proposals beginning June 1, 2009 … CMS' independent pricing of the prescription drug amount will be calculated and priced using average wholesale price (AWP). The CMS will not use or recognize any other pricing, discounting, or calculation methods when determining the adequacy of the prescription drug amounts in WCMSA proposals."

[34] *Hinsinger v. Showboat Atlantic City*, 18 A.3d 229 (N.J. Super. Ct. Law Div. 2011).

[35] Memorandum from Gerald Walters, Director, Financial Services Group of Financial Management, to All Regional Administrators, "Medicare Secondary Payer (MSP) – Workers' Compensation (WC) Additional Frequently Asked Questions," question & answer No. 5 (October 15, 2004), *available at* http://www.cms.hhs.gov/WorkersCompAgencyServices/ (last visited March 20, 2012).

certain annually into the MSA for the remainder of the claimant's life expectancy to cover future injury-related care otherwise covered by Medicare. Medicare expresses no preference to one funding method or the other.

There are advantages and disadvantages to each method, with a claimant making an informed decision based on the facts and circumstances of his/her case. Typically, smaller MSA accounts (*e.g.,* less than $10,000) are funded as lump sums; whereas larger MSA accounts, which carry with them more significant future medical expenses, benefit from being able to become exhausted following complete disbursement of the seed money, and the first year's annual payment into the MSA. At that point, with proper documentation, Medicare reclaims its position as primary payer for non-injury and injury-related medical bills until the next annual installment payment is made into the MSA.[36] MSAs funded via annuity also have the benefit of being able to be funded at a lower net cost to the claimant. For example, if the MSA obligation totals $75,000, the claimant may be able to purchase an annuity which would cost $55,000 up front, but would pay $75,000 over time. Under this example, the claimant would fully fund the MSA obligation, but would have the benefit of putting $20,000 in his/her pocket, thus maximizing recovery. The claimant should be fully advised of both options before an MSA is funded.

Similarly, an MSA may be administered one of two ways. First, the MSA may be self-administered by the claimant. In this scenario, the claimant controls when MSA proceeds are used to pay for future injury-related care which would otherwise be covered by Medicare as opposed to when other funds should be used to pay for such expenses. In the alternative, an MSA can also be administered by a professional third party custodian/trustee. In this scenario, a custodian/trustee serves as the fiduciary of the account, determining the propriety and extent to which MSA funds are applied to pay for future injury-related care. Medical providers bill the custodian/trustee, and the custodian/trustee sorts through the bills, debiting the MSA account as appropriate.

As with funding options, both administrative methods have advantages and disadvantages. Self-administered MSAs are more simple and cost effective. However, since the goal is to preserve the claimant's Medicare card as well as protect Medicare's interest, it is imperative that the claimant has a full understanding of how the MSA proceeds should be spent and what expenses are Medicare-covered versus those that are not. Absent this understanding, a claimant runs the risk of spending the MSA proceeds inappropriately, and this jeopardizes his/her Medicare card. When such careful steps have been taken to this point, it seems redundant to advise you that the claimant needs to be fully advised of their responsibility to spend the MSA proceeds properly, but too often is the case where a claimant is given a check for the MSA amount without properly guidance. Professionally administered MSAs can be a more compliant solution with the right custodian/trustee, as the determination regarding when MSA funds are to be spent is left to a professional fiduciary experienced in such matters. Asking a fiduciary to assist greatly maximizes the chance MSA proceeds are spent in a compliant fashion, as well as eliminates the concern of the

[36] Memorandum from Thomas L. Grissom, Director, Center for Medicare Management, to All Regional Administrators, "Medicare Secondary Payer – Workers' Compensation (WC) Frequently Asked Questions," question & answer No. 10 (April 22, 2003), *available at* http://www.cms.hhs.gov/WorkersCompAgencyServices/ (last visited March 20, 2012). *See also* Memorandum from Gerald Walters, Director, Financial Services Group of Financial Management, to All Regional Administrators, "Medicare Secondary Payer (MSP) – Workers' Compensation (WC) Additional Frequently Asked Questions," question & answer No. 5 (October 15, 2004), *available at* http://www.cms.hhs.gov/WorkersCompAgencyServices/ (last visited March 20, 2012).

claimant needing to figure out which medical expenses are typically covered by Medicare versus those not typically covered by Medicare. However, professionally administered MSAs may be costly and complex. Again, the claimant should be fully advised of both options prior to being asked to make an informed decision.

Finally, the parties should determine whether they wish to submit the MSA to CMS for review and approval. This is an often misunderstood concept on two levels in our experience. First, submitting a WCMSA to CMS for review and approval is **voluntary not mandatory**, no matter what the gross settlement amount totals. While CMS has provided a series of guidelines to help the parties properly address the MSA issue in all WC settlements, CMS only will "review and approve" WC settlements (and associated MSA calculations) that meet certain workload review thresholds.[37] CMS established the following workload review thresholds to help manage the number of WCMSA proposals submitted for review and approval: 1) for a claimant who is a current Medicare beneficiary, the gross settlement amount must exceed $25,000; and 2) for a claimant who is not yet Medicare enrolled but possesses a "reasonable expectation" of Medicare status within thirty (30) months of settlement, the gross settlement amount must exceed $250,000.[38]

The second often misunderstood concept here is that these thresholds are **workload review thresholds, not safe harbor amounts**. Therefore, if the WC settlement involves a current Medicare beneficiary and the gross settlement is $20,000, it does not mean that an MSA is not proper to establish. Likewise, if the WC settlement involves an individual who is not yet entitled to Medicare but does possess a "reasonable expectation" of Medicare entitlement within thirty (30) months of settlement, the fact that the gross settlement is only $200,000 does not mean that an MSA is not appropriate. It merely means that if that MSA proposal was submitted to CMS for review and approval, CMS would not review it.[39] MSAs are appropriate whenever they are appropriate, no matter what the final gross settlement amount totals.

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[37] Social Security Act §1862, *as amended*, 42 U.S.C. §§ 1395y(b)(2), 1395y(b)(5)(d), 1395y(b)(6), *amended by* Pub. L. No. 109-171, 120 Stat. 4 (2006); *see also* Memorandum from Gerald Walters, Director, CMS Financial Services Group, Office of Financial Management, to All Regional Administrators, "Medicare Secondary Payer (MSP) – Workers' Compensation (WC), Additional Frequently Asked Questions", question & answer No. 2 (July 11, 2005), *available at* http://www.cms.hhs.gov/WorkersCompAgencyServices/ (last visited March 20, 2012); *amended by* Memorandum from Gerald Walters, Director, Financial Services Group, Office of Financial Management, to All Regional Administrators, "Workers' Compensation Medicare Set-Aside Arrangements (WCMSAs) and Revision of the Low Dollar Threshold for Medicare Beneficiaries" (April 25, 2006), *available at* http://www.cms.hhs.gov/WorkersCompAgencyServices/ (last visited March 20, 2012); *see also* Memorandum from Charlotte Benson, Acting Director, Financial Services Group, Office of Financial Management, to Consortium Administrator for Financial Management and Fee-for-Service Operations, "Medicare Secondary Payer—Workers' Compensation—INFORMATION" (May 11, 2011), *available at* http://www.cms.gov/WorkersCompAgencyServices/08_setasiderelatedtopics.asp#TopOfPage (last visited March 20, 2012).

[38] http://www.cms.gov/WorkersCompAgencyServices/04_wcsetaside.asp#TopOfPage (last visited March 20, 2012).

[39] At times, CMS may choose not to review a WCMSA proposal which meets its published workload review thresholds. *See Smith v. Marine Terminals of Arkansas*, 2011 U.S. Dist. LEXIS 90428 (August 9, 2011). Here, defendant engaged an MSA vendor to create a WCMSA, resulting in an MSA Allocation totaling $313,095.54. Mr. Smith engaged GRG to review the matter. The GRG WCMSA Allocation totaled $14,647. As a condition of settlement, the GRG WCMSA Allocation was submitted to CMS for review and approval. Even though the matter met CMS's published workload review thresholds, CMS decided not to review the WCMSA Allocation. The parties motioned the Court to approve the settlement agreement absent CMS approval of the GRG WCMSA. The Court, after viewing the evidence in front of it, approved the settlement, including the GRG WCMSA totaling $14,647.

Because of these workload review thresholds, it cannot be said that parties are required to submit MSA proposals to CMS for review and approval. CMS approval of the set-aside calculation is voluntary, not mandatory.[40] Though voluntary, CMS approval of the MSA proposal ensures that only a predefined portion of the settlement, rather than the entire settlement, must be spent before Medicare resumes payment of future injury-related medical expenses.[41] Nevertheless, CMS review and approval of the MSA proposal remains the one proven method to ensure Medicare will not challenge the set aside calculations later on. Therefore, as part of installing an MSP compliance program in your practice or company, seeking CMS review and approval whenever a WC case meets the workload review thresholds established at the time of your settlement may become the final step to ensure MSP compliance. Even if parties choose to submit the MSA proposal for review, they should take care to detail what steps are to be taken if CMS either declines to review the MSA proposal (thus prohibiting a possible settlement condition from being satisfied)[42] or if CMS reverts with a dollar figure higher/lower than that which was submitted.[43]

Taking the above mentioned guidance one step further, submitting a zero dollar WCMSA allocation to CMS for review and approval is also voluntary. CMS advises the settlement community that it lacks the time and resources to review all MSA proposals. Thus, the workload review thresholds are in place. However, if the attorney does not seek CMS approval, following client input, it is imperative to document the file and memorialize the comprehensive efforts that were undertaken to properly consider and protect Medicare's future interest, to use Medicare's vernacular. Ways to document the file may include obtaining letters from treating physicians supporting the analysis, MSA evaluations prepared by independent third parties and claimant education regarding the proper use and accounting of the MSA funds as well as proper release language and MSA Disclosure Forms executed by the claimant.

Why are Liability Settlements Treated Differently Than Workers' Compensation Settlements?

The fundamental statutory principle requiring settling parties to consider and protect Medicare's future interest in WC settlements already exists and appears to apply to liability settlements as well. The MSP provisions state Medicare is always secondary to WC and other insurance, including

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[40] Memorandum from Charlotte Benson, Acting Director, Financial Services Group, Office of Financial Management, to Consortium Administrator for Financial Management and Fee-for-Service Operations, "Medicare Secondary Payer – Workers' Compensation -- INFORMATION, (May 11, 2011), *available at* http://www.cms.hhs.gov/WorkersCompAgencyServices/ (last visited March 20, 2012). "There are no statutory or regulatory provisions requiring that a WCMSA proposal be submitted to CMS for review."

[41] If CMS approves the set-aside, you can be certain Medicare will resume primary coverage after the claimant demonstrates that the set-aside proceeds were properly depleted. While such certainty gives some peace of mind, obtaining it often comes at a price of additional time and money. Parties are forced to accept CMS'S methodologies for calculating the set-aside without any right of appeal, and the agency may take six months or longer to review and approve the calculations submitted.

[42] *Smith v. Marine Terminals of Arkansas*, 2011 U.S. Dist. LEXIS 90428 (August 9, 2011).

[43] *ArvinMeritor, Inc. v. Johnson*, 2011 Ala. Civ. App. LEXIS 59 (Released February 25, 2011).

no-fault, automobile and liability insurance.[44] Again, under the Social Security Act, payment *may not be made under Medicare for covered items or services to the extent that payment has been made, or can reasonably be expected to be made, under a* ***liability insurance policy or plan***.[45] Also, Medicare's authority to review liability settlements arises under the same statute as does its authority to review WC settlements.[46]

While the statutory principle to consider/protect Medicare's past and future interests in liability settlements is uncontroverted, the extent of the MSA obligation in a liability settlement remains unclear. Unlike the use of MSAs in WC settlements, which can be supported by specific regulations and multiple administrative announcements, the same cannot be said for using MSAs in liability settlements. When the various individual factors are viewed in their totality, one cannot conclude that the process for determining the extent of the MSA obligation in a liability settlement equals that of a WC settlement at this time.

The composition of a liability settlement is much more complex than a WC settlement. A WC settlement contains a finite number of potential recovery buckets: 1) indemnity; 2) past medical expenses; and 3) future medical expenses. On the other hand, a liability settlement contains many more potential recovery buckets when both economic damages (*i.e.*, past medical expenses, future medical expenses, loss of earning capacity, loss of household services, etc.) and non-economic damages (*i.e.*, pain & suffering, mental anguish, loss of independence, loss of society, etc.) are considered. Typically, these settlements also differ in the fact that settlement proceeds are often allocated specifically in a WC settlement while settlement proceeds are not often allocated specifically in a liability settlement.[47] The inherent difference between WC and liability settlements requires that we fully examine the MSA issue from the liability perspective to determine and verbalize the appropriate standard of compliance today in the issue of future medical expenses in liability settlements under the MSP Act.

Current Guidance (Statute, Regulations and Administrative).

The launching point for analyzing any MSA issue (or any MSP issue generally) is the MSP Act itself. As discussed previously, federal law provides that Medicare is intended to be the payer of second and last resort when a primary payer or plan has accepted responsibility (but not necessarily liability) for medical expenses and then provides compensation for those medical expenses. This is true for past medicals (date of injury to date of resolution) as well as future medicals (date of resolution going forward). However, the MSP Act lends no specific guidance as to how to properly consider/protect Medicare's future interest; just that Medicare is to remain the secondary payer under the circumstances set forth above. The term "Medicare Set-aside Arrangement" or "MSA" does not appear in the MSP Act. Simply put, the obligation regarding future medicals under the MSP Act is vague or ambiguous, at best.

[44] 42 U.S.C. §§1302, 1395w-101 through 1395w-152, 1395hh (2000 & Supp. 2004); *see also* 42 C.F.R. §411.40.

[45] 42 U.S.C. §1395y(b)(2), *amended by* Pub. L. No. 109-171, 120 Stat. 4 (2006).

[46] Social Security Act §1862, *as amended,* 42 U.S.C. §§1395y(b)(2), 1395y(b)(5)(d), 1395y(b)(6), *amended by* Pub. L. No. 109-171, 120 Stat. 4 (2006).

[47] *See* 42 C.F.R. §§411.46 and 47.

Regulations enacted in support of the MSP Act (starting at 42 C.F.R. §411.20) also (currently) lend little guidance on the LMSA issue. In the workers' compensation context, existing regulations guide parties as to when Medicare will not pay for future medical expenses (found at 42 C.F.R. §411.46(d)(2)) and when an apportionment may be accepted as the basis for determining Medicare payments (found at 42 C.F.R. §411.47(a)(1)). These regulations represent official statutory interpretation by CMS, which were subject to fair notice and commentary pursuant to the Administrative Procedure Act.[48] However, no such regulations exist specific to future medical expenses in liability insurance matters.

Administrative guidance, in the form of policy memorandum, guidelines or other statements, from Medicare on the liability MSA issue is minimal so far. To date, CMS has issued sixteen (16) policy memos specific to the use of MSAs in workers' compensation matters, but only one (1) official policy memo about the use of MSAs in liability insurance matters.[49] In May 2011, a CMS official circulated a handout regarding the use of MSAs in liability insurance matters, but that handout did not purport to represent an official policy of CMS.[50]

In light of the lack of specific, official guidance on how to properly consider/protect Medicare's future interest in liability insurance matters[51] (absent those occasions where the claimant does not need any future injury-related care post-settlement), parties are beginning to look to the judiciary for guidance.[52] As a result of seeking guidance from the bench, current case law concludes that

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[48] 5 U.S.C. §706(2).

[49] Memorandum from Charlotte Benson, Acting Director, Financial Services Group, Office of Financial Management, to Consortium Administrator for Financial Management and Fee-for-Service Operations, "Medicare Secondary Payer – Liability Insurance (Including Self-Insurance) Settlements, Judgments, Awards, or Other Payments and Future Medicals -- INFORMATION, (September 29, 2011), *available at* http://www.cms.hhs.gov/WorkersCompAgencyServices/ (last visited March 20, 2012). Importantly, this CMS Policy Memo represents the first official CMS guidance on the use of liability MSAs and it was promulgated almost 31 years after the enactment of the MSP Act (December 5, 1980).

[50] In a May 25, 2011 handout, Sally Stalcup, MSP Regional Coordinator for CMS Region VI, states "…IF there was/is funding for otherwise covered and reimbursable future medical services related to what was claimed/released, the Medicare Trust Funds must be protected. If there was/is no such funding, there is no expectation of 3rd party funds with which to protect the Trust Funds. Each attorney is going to have to decide, based on the specific facts of each of their cases, whether or not there is funding for future medicals and if so, a need to protect the Trust Funds. They must decide whether or not there is funding for future medicals. If the answer for plaintiff's counsel is yes, they should (to) see to it that those funds are used to pay for otherwise Medicare covered services related to what is claimed/released in the settlement judgment award. If the answer for defense counsel or the insurer, is yes they should make sure their records contain documentation of their notification to plaintiff's counsel and the Medicare beneficiary that the settlement does fund future medicals which obligates them (Medicare beneficiary and plaintiff's counsel) to protect the Medicare Trust Funds"

[51] To date, the only official guidance from CMS regarding the use of MSAs in liability settlements comes in the form of a Policy Memorandum dated September 30, 2011. Here, CMS advises that if the settling parties have a certification letter from the beneficiary's treating physician indicating that treatment for the alleged injury related to the liability insurance settlement has been completed as of the date of settlement, and future injury-related care will not be needed, the parties may rely on that certification letter as the reason why an MSA was not warranted for that particular settlement.

[52] As evidenced in *Schexnayder v. Scottsdale Insurance Company*, Civ. No. 6:09-cv-1390, 2011 U.S. Dist. LEXIS 83687, 2011 WL 3273547 (W.D. La. July 29, 2011) (finding that Schexnayder was obligated to reimburse Medicare for all conditional payments made prior to the time of settlement, and for all medical expenses submitted to

MSAs are warranted in some liability insurance matters (such as Big R Towing[53] and Schexnayder[54]) but not in others (such as Finke[55]). However, this is not a viable solution going forward as reviewing such issues for all personal injury settlements would clog judicial dockets. Therefore, settling parties need a more efficient and practical solution to assess the case-specific facts of each liability settlement.[56]

Deference Owed to CMS on LMSA Issue

The MSP Act[57] is a source of angst, frustration and confusion nationwide. Specifically, the LMSA issue muddies what may have otherwise been a clear and unambiguous settlement agreement between plaintiff and defendant. While parties generally agree that the MSP Act is either vague or ambiguous on the subject of future medical expenses in liability settlements and agree that CMS has not yet promulgated regulations about future medical expenses in liability settlements (specifically contemplating LMSAs or otherwise), parties continue to disagree about how to address the LMSA issue when resolving a liability claim. Despite the fact that federal law provides that "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 …"[58], CMS officials state that its rights to not pay for future medical expenses in the liability context under certain circumstances emanates from the same physical sentence of the MSP Act as its rights in the workers' compensation context. But are those rights really the same?

Medicare prior to the date of the order, even if such conditional payments are asserted by Medicare subsequent to the effective date of the order, but also concluding that Schexnayder should set aside funds to pay for future medical expenses arising from the injuries alleged in the lawsuit).

[53] *Big R Towing v. Benoit*, Civ. Action No. 10-538, 2011 WL 43219 (W.D. La. Jan. 5, 2011) (finding that Benoit was obligated to reimburse Medicare for all conditional payments made prior to the time of settlement, and for all medical expenses submitted to Medicare prior to the date of the order, even if such conditional payments are asserted by Medicare subsequent to the effective date of the order, but also finding that Benoit should set aside funds to pay for future medical expenses arising from the injuries alleged in the lawsuit).

[54] See footnote #52.

[55] *Finke v. Hunter's View, Ltd. and Wal-Mart Stores, Incorporated*, Civ. No. 07-4267 (WRW/RLE), 2009 WL 6326944 (D. Minn. Aug. 25, 2009) (holding that Medicare's interests were properly considered and protected when Plaintiffs reimbursed Medicare for all conditional payments made from date of injury to date of order (identified therein to be $18,448.18) as well as any additional conditional payments made by Medicare subsequent to the date of the order for services provided prior to the date of the order, but concluding that there was no reason for the parties to set aside any certain amount for future Medicare claims).

[56] *Guidry, et al. v. Chevron USA, Inc.*, Civ. No. 6:10-cv-00868, 2011 U.S. Dist. LEXIS 148942 (W.D. La. December 28, 2011) (finding that parties, in hiring and relying upon an MSA vendor whose opinion was found by the Court to be reliable and ***based on sound methodology*** (emphasis added), adequately considered and protected Medicare's interests "since CMS provides no other procedure by which to determine the adequacy of protecting Medicare's interests for future medical needs and/or expenses in conjunction with the settlement of third-party claims, and since there is a strong public interest in resolving lawsuits through settlement." The Court also ordered that Guidry reimburse CMS for any conditional payments made by CMS prior to the date of the order.

[57] 42 U.S.C. §1395y(b)(2).

[58] 42 U.S.C. §1395hh(a)(2).

A relevant question to be asked and answered, at this point, is "How much deference does the settlement community owe CMS (based on current statutory, regulatory and administrative guidance issued by CMS along with relevant case law) on the LMSA issue?" As we previously detailed, CMS officials have stated that its rights to have its future interest "considered and protected" in liability settlements comes from the same physical sentence of the MSP Act as do its rights in workers' compensation settlements. The following section provides the reasoning behind why the appropriate standard settling parties need to meet in order to comply is "reasonable good faith effort at compliance" and so long as parties are meeting that standard and able to evidence those efforts, CMS cannot punish the parties for failure to fund an LMSA when resolving a liability claim.

In discussing the topic of deference, it's important to lay the following foundation: 1) CMS is a federal administrative agency, operating under the Department of Health and Human Services; 2) CMS has the ability to promulgate regulations providing its official statutory interpretations once regulated parties have notice of the proposed regulation and have had the ability to comment on the proposed regulation pursuant to the Administrative Procedure Act[59]; 3) CMS has not promulgated a regulation about future medical expenses in liability settlements under the MSP Act; and 4) CMS has not provided a proposed regulation about future medical expenses in liability settlements under the MSP Act where regulated parties have been afforded notice and the ability to comment on the proposed regulations.[60] With this understanding, we will next provide a detailed analysis of case law whose subject matter (admittedly) has nothing to do with MSAs or Medicare in any direct way, but are directly on point when discussing the amount of deference owed to a federal administrative agency's statutory interpretation when that agency has not yet promulgated regulations containing its statutory interpretation.

Chevron U.S.A. Inc. v. National Resources Defense Council, Inc.

Any discussion about deference owed to a federal administrative agency starts with the Chevron[61] test. Decided by the United States Supreme Court in 1984, Chevron provides a two-step test to apply when determining whether a federal agency's statutory interpretation is granted a broad amount of deference. Step one assesses whether Congress, in enacting legislation, has spoken unambiguously about an issue within the statute itself.[62] If Congress did not speak unambiguously, then step two asks whether the federal administrative agency's statutory interpretation enacted in a regulation is reasonable.[63]

Applying the current question to the Chevron test, it fails step one of Chevron since Congress did not speak unambiguously about the issue of future medical expenses in liability settlements within the MSP Act. Importantly, it also fails step two of Chevron, since CMS has not yet promulgated a regulation about future medical expenses in liability settlements. Therefore, at this point, it cannot be said that CMS is entitled to broad, sweeping deference on the issue of LMSAs based on Chevron.

[59] 5 U.S.C. §706(2).

[60] 5 U.S.C. §609.

[61] *Chevron U.S.A. Inc. v. National Resources Defense Council, Inc.*, 467 U.S. 837, 104 S. Ct. 2778, 81 L. Ed. 2d 694 (1984).

[62] *Id*. at 842 - 843.

[63] *Id*. at 844.

Skidmore v. Swift & Co.

Though not entitled to broad deference on the LMSA issue pursuant to Chevron, the question becomes "Is CMS owed some lesser amount of deference?" on the LMSA issue. A United States Supreme Court case entitled Skidmore v. Swift[64] sets out a lesser deferential standard owed to a federal administrative agency's statutory interpretation. Skidmore affords a federal administrative agency some deference towards its statutory interpretation when a regulation has not be promulgated, but the amount of deference owed "depend[s] upon the thoroughness evident in its [the agency's] consideration, the validity of its reasoning, its consistency with earlier and later pronouncements, and all those factors which give the power to persuade, if lacking power to control."[65] Later cases, such as Cathedral Candle[66] and Photocure ASA[67], have shed light on these Skidmore criteria. "While the Skidmore standard does not entail the same degree of deference to administrative decision-making as the Chevron standard, it nonetheless requires courts to give some deference to informal agency interpretations of ambiguous statutory dictates, with the degree of deference depending on the circumstances."[68] Is CMS's position on the LMSA issue entitled to Skidmore-style deference? Applying subsequently decided case law, we will next examine and answer that question.

General Electric Company v. United States Environmental Protection Agency

First, we look to the General Electric Company v. United States Environmental Protection Agency[69] decision. Here, the Court stresses the importance of the public being entitled to receive fair notice of a federal administrative agency's statutory interpretation of the statute it administers and regulations it promulgates.[70] Without such fair notice, "*where the regulations and other policy statements are unclear, where the petitioner's interpretation is reasonable, and where the agency itself struggles to provide a definitive reading of the regulatory requirements, a regulated party is not 'on notice' of the agency's ultimate interpretation of the regulations, and may not be punished*" (Emphasis added).[71] General Electric stands for the proposition that until CMS provides regulated parties of its official statutory interpretation of the LMSA issue, so long as those regulated parties adopt a reasonable statutory interpretation of the LMSA issue, then CMS may not punish those parties if CMS disagrees with that statutory interpretation. But what constitutes 'fair notice?'

Christensen v. Harris County

[64] *Skidmore v. Swift & Co.*, 323 U.S. 134, 65 S. Ct. 161, 89 L. Ed. 124 (1944).

[65] *Id*. at 140.

[66] *Cathedral Candle Co. v. United States Intl. Trade Comm'n*, 400 F.3d 1352, 1365 (Fed. Cir. 2005).

[67] *Photocure ASA v. Dudas, et. al.*, 622 F. Supp. 2d 338, 350 (E.D. Va. 2009).

[68] *Cathedral Candle* at 1365.

[69] *General Electric Company v. United States Environmental Protection Agency*, 53 F.3d 1324, 311 U.S. App. D.C. 360 (D.C. Cir. 1995).

[70] *Id*. at 1328.

[71] *Id.*at 1333 – 1334.

A United States Supreme Court case entitled Christensen v. Harris County[72] lends more color to the issue of 'fair notice.' While the federal administrative agency's statutory interpretation, as promulgated in policy memos, handouts, statements on websites, etc., may be persuasive, Christensen holds that the agency's statutory interpretation is not accorded the same deference as a regulation interpreting an ambiguous statute.[73] "Interpretations such as those in opinions letters – like interpretations contained in policy statements, agency manuals and enforcement guidelines, all of which lack the force of law – do not warrant Chevron-style deference."[74] Further, the Court held found the agency's statutory interpretation unpersuasive when applying Skidmore criteria.[75] Coupling Christensen with General Electric, they collectively support the notion that reasonable good faith effort at compliance is the proper standard to adopt when considering the current language of the MSP Act in light of the fact that no regulations have yet been promulgated about future medical expenses in liability settlements under the MSP Act.

Cathedral Candle Co. v. United States Intl. Trade Comm'n.

Another case applying the Skidmore criteria recently is Cathedral Candle v. United States Intl. Trade Comm'n.[76] The Cathedral Candle Court concluded that, in applying Skidmore, the United States Supreme Court "intends for us to defer to an agency interpretation of the statute it administers if the agency has conducted a careful analysis of the statutory issue, if the agency's position has been consistent and reflects agency-wide policy, and if the agency's position constitutes a reasonable conclusion as to the proper construction of the statute…"[77]

The Court ultimately defers to the agency's statutory interpretation in Cathedral Candle for the following reasons. First, "the [agency's] interpretation … represents an agency-wide position; it is not an interpretation that was made at a low level within the agency and that does not necessarily represent the views of the agency as a whole."[78] Second, "the [agency's] interpretation was contemporaneous with the enactment of the [federal law] and has been adhered to consistently by the agency since that time. It is not a position formulated belatedly in response to litigation … nor is it inconsistent with positions … previously taken."[79] Third, "the [agency] has explained its reason for adopting the policy. Although … brief, it made clear the statutory basis for the [agency's] position."[80] Fourth, "the [agency's] position is consistent with the [agency's] position…"[81] Finally,

[72] *Christensen v. Harris County*, 529 U.S. 576, 587 (2000).

[73] *Id*. at 587 – 588.

[74] *Id*. at 587.

[75] *Id*.

[76] *Cathedral Candle Co. v. United States Intl. Trade Comm'n*, 400 F.3d 1352 (Fed. Cir. 2005).

[77] *Id*. at 1366.

[78] *Id*. at 1367.

[79] *Id*.

[80] *Id*.

[81] *Id*.

"the interpretation is the product of the [agency's] "specialized expertise" … and reflects a single uniform interpretation on the part of the agency."[82] The Court, based on Skidmore, deferred to the agency's statutory interpretation as it meets those criteria set forth in Skidmore. Cathedral Candle stands as an example of when an agency is entitled to Skidmore-style deference.

Photocure ASA v. Dudas

Next, we contrast Cathedral Candle with the Photocure ASA[83] case. Unlike Cathedral Candle, the federal administrative agency in Photocure ASA had not promulgated a regulation on point. The agency argued that Skidmore-style deference was warranted since: 1) it had consistently applied the same principles and had been careful in its analysis; 2) its statutory interpretation is a reasonable conclusion as to the proper construction of the statute at issue; and 3) it possessed a high level of expertise in the area at issue.[84] The Court disagreed. It found that, in the absence of a regulation enacted by the federal administrative agency interpreting the statute, the agency's statutory interpretation failed to achieve both Chevron and Skidmore deference.[85] Any level of deference earned by the agency based on its "expertise" was lost for not being "consistent" in its statutory construction and not being "careful" in its analysis.[86] Thus, regulated parties were not forced to abide by the federal administrative agency's statutory interpretation.

How Much Deference Does the Settlement Community Owe CMS on LMSA Issue?

With this foundation, we are prepared to address the question at hand. Looking at the LMSA issue through the prism presented above, the judiciary would not likely afford CMS a high amount of deference under Skidmore, if any, should the judiciary be given the opportunity to address the issue. First, CMS's position on its ability to recover future medicals in a liability settlement is inconsistent.[87] To meet Skidmore, all CMS guidance (including policy memos, manuals, statements on websites, etc.) would need to be consistent. Second, CMS's interpretation that it has a right to not pay for future medicals in liability settlements was not announced contemporaneous with the enactment of the MSP Act.[88] To meet Skidmore, CMS should have announced its interpretation during the Carter or Reagan administrations instead of four Presidents and thirty years later. Third, it cannot be said that CMS has provided a 'careful' analysis of the LMSA issue to date.[89] With

[82] *Id*.

[83] *Photocure ASA v. Dudas*, 622 F.Supp. 2d 338 (E.D. Va. 2009).

[84] *Id*. at 349 – 350.

[85] *Id*. at 348 – 350.

[86] *Id*. at 350.

[87] Although CMS officials have stated that its right to not pay for future medicals in the liability context come from the same physical sentence of the MSP Act as do its rights to not pay for future medicals in the workers' compensation context, see Medicare Secondary Payer Manual, Chapter 7, §50.5. "There should be no recovery of benefits paid for services rendered after the date of a liability insurance settlement."

[88] *Cathedral Candle*, 400 F.3d at 1367. With the issuance of its first LMSA Policy Memo in September 2011, more than 30 years have passed since the enactment of the MSP Act.

[89] *Photocure ASA v. Dudas, et. al.*, 622 F. Supp. 2d 338, 350 (E.D. Va. 2009) (holding that in the absence of a regulation enacted by a federal administrative agency interpreting a statute, the agency's statutory interpretation was not entitled to deference under *Skidmore*).

the only substantive guidance currently on point existing in the form of a one page policy memo (apart from statements made during teleconference calls not held to address the issue) which does not provide the statutory basis supporting its assertion, no Court would likely conclude that a 'careful' analysis has been conducted and provided to regulated parties. Finally, CMS has not provided regulated parties with 'fair notice' of its official statutory interpretation of the LMSA issue. Ultimately, CMS's interpretation of the MSP Act on the issue of future medicals in liability settlements is neither persuasive nor consistent, and would not likely be afforded Skidmore-deference by the judiciary, based on the current status of the MSP program.[90]

Keeping in mind the case law discussed above, "reasonable good faith effort at compliance" represents the proper standard to meet (the "Good Faith Standard"). So long as settling parties' statutory interpretation of the MSP Act with regard to future medical expenses in liability settlements is "reasonable" and they have documented their respective files to memorialize that "reasonable" statutory interpretation, CMS cannot punish the parties (according to General Electric). In order to meet this standard, parties should, when resolving liability claims, determine IF an LMSA is needed based on the case-specific facts and then document the file. Following this formalized process on every claim will ensure that CMS does not punish you going forward on the LMSA issue.

The LSMA issue is subject to much discussion and debate nationwide. Everyone (plaintiffs and defense as well as respective counsel and insurance carriers) seeks the proper level of compliance to ensure that CMS will not seek post-settlement reimbursement for future medicals when resolving a liability claim. The above discussion is intended to bring some facts and case law to that discussion, presenting why parties can comply quite easily with the appropriate standard today. Simply put, the MSP program, with regard to LMSAs, is not developed enough to allow CMS to punish anyone on the LMSA issue so long as your statutory interpretation on the LMSA issue is "reasonable" and you can evidence that reasonable interpretation to a CMS official if asked to do so. Consequently, until such time as CMS promulgates regulations specific to the topic of future medical expenses in liability insurance matters under the MSP Act, its statutory interpretation of its rights of recovery to future medical expenses under the MSP Act will not receive Chevron-style deference or Skidmore-style deference from the judiciary.[91] Settling parties should keep this in mind when resolving claims, not allowing this premature issue from derailing the parties' joint desire to resolve a claim compliantly.

Liability Settlements (and MSAs)

The obligation to fund an MSA in a liability settlement is only clear (on its face) in the specific case where a definitive allocation for future injury-related medical expenses exists for an injured Medicare beneficiary. For example, a liability MSA would be properly utilized in the case where a liability action proceeds to trial, results in a judgment in favor of a Medicare beneficiary, and the trier of fact determines that a specific portion of the judgment is to be applied to pay for future medical expenses. In that fact pattern, there would be an identifiable portion of the judgment against which to apply future medicals. Prior to concluding an MSA may be in the best interest of the Medicare beneficiary, the parties would also need to identify whether there also exists a burden shift to Medicare of the obligation to pay for that future injury-related care due to the lack of any

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[90] *Photocure ASA v. Kappos*, 603 F.3d 1372, 1376 (Fed. Cir. 2010).

[91] *Id*.

primary payer (other than Medicare) to make such payments. If both of these queries result in an affirmative determination, establishing an MSA and seeking CMS approval may be the best, but not only, way to ensure compliance.

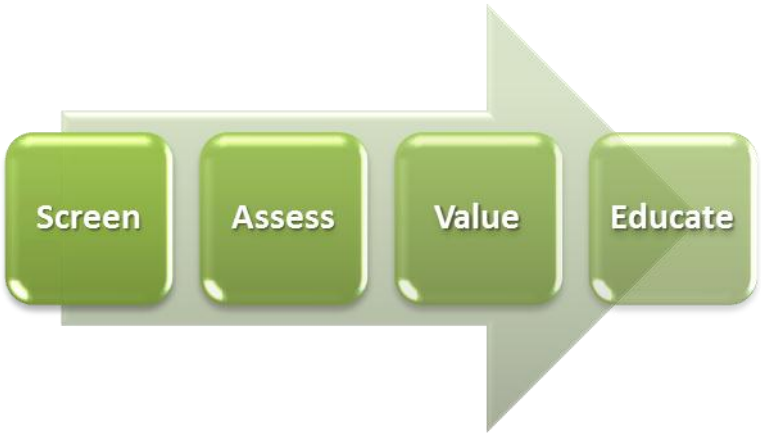
On the other hand, in the majority of settlements where the parties settle liability claims using a broad, general release of all claims and do not specify or otherwise allocate settlement proceeds to particular damages, whether due to policy limitations or other confounding factors to a claimant's full recovery of damages sustained, the procedures by which one can determine the propriety of an MSA becomes much less clear. When settling a liability case in which payment for future medical expenses is not specifically negotiated, if a general release is implemented that uses broad language (for example, referring to "all claims past and future"), a future medical expense component is not readily identifiable. The mere fact that a claimant has pled for future medical expenses as part of the claim or the insurance carrier is being released (under the terms of the settlement) from the obligation to pay for future medical expenses going forward does not necessarily mean the gross award contains proceeds for future medical expenses. Also, the mere presence of a life care plan does not mean that the gross award contains proceeds for future medical expenses. While a claim may contemplate future medical expenses, that in and of itself does not guarantee the gross award contains proceeds for future medical expenses, even if the release makes reference to "all claims past and future." In short, funding a settlement with the intent to cover future medical expenses may be vastly different than the reality of an allocation for future medical expenses actually existing within the gross award.

To meet the Good Faith Standard, when a liability claim is resolved, whether through a jury verdict or a settlement agreement, if the injured person will incur future medical expenses as a result of the injuries pled in the case, settling parties should take steps to: 1) determine **whether** an MSA is appropriate under the case-specific facts; and then 2) **document the file** accordingly. By screening every case and having a formalized approach to verifying, resolving and satisfying potential MSA obligations, and documenting the file to demonstrate the steps the parties took, settling parties will ensure the following: 1) Medicare's future interest has been considered and protected appropriately; 2) the settling parties are fully compliant with the Medicare Secondary Payer Act (statute and regulations); and 3) the injured person's Medicare benefits are protected going forward. The following walks the reader through our formalized approach to addressing MSA issues in liability settlements.

Formalized Approach Yields Compliant Results.

Settling parties should apply the following four step approach when addressing the liability MSA issue in order to "SAVE" a Medicare beneficiary's Medicare card and the Medicare program itself (relative to future medicals):

1) **Screen** to validate an injured person's candidacy for an MSA;
2) **Assess** damages to determine whether an allocation for future medicals exists within the gross recovery or potential gross recovery;
3) **Value** future medicals for the injured person's case; and
4) **Educate** and administer the MSA results properly.



Screen - Every case should be screened when addressing the LMSA issue to validate an injured person's candidacy for funding an LMSA as the appropriate means to protect his/her Medicare card. LMSAs **are not** appropriate in every single case. Only after finding an injured person to be a candidate for use of an LMSA (based on case-specific facts such as claimant's Medicare enrollment status, determining if claims resolution results in future medicals being closed such that Medicare becomes the primary payer of future injury-related medicals going forward[92], as well as other relevant factors) can it be said that an LMSA may be warranted.[93] Any MSA allocation created without first determining an injured person's candidacy for an MSA based on case-specific facts **has missed a critical threshold issue**, and **may be creating an obligation which would not otherwise exist** for the settling parties.[94] If an injured person is not deemed to be a candidate for an MSA, then the settling parties are compliant with the MSP Act by simply documenting their respective files as to the reason why an MSA was not appropriate based on the case-specific facts. If the injured person is determined to be an MSA candidate, then the parties should proceed to step two, the Assessment phase of the analysis.

Assess - Upon finding an injured person to be an MSA candidate, the parties must next determine if the (potential) gross settlement proceeds contain sufficient dollars to fund any MSA obligation through an allocation to future medicals. To do this, parties should assess the damages sustained, compare those to the gross recovery and conclude whether: i) the gross recovery actually contains dollars for future medicals; or ii) whether due to the case-specific facts, the injured person is not being compensated for future medicals despite the fact that future medicals are a damage component being pled and released and/or a life care plan may be in existence, evidencing the injured person's need for certain future injury-related care.[95]

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[92] *Finke v. Hunter's View, Ltd. and Wal-Mart Stores, Incorporated*, Civ. No. 07-4267 (WRW/RLE), 2009 WL 6326944 (D. Minn. Aug. 25, 2009).

[93] *Big R Towing v. Benoit*, Civ. Action No. 10-538, 2011 WL 43219 (W.D. La. Jan. 5, 2011).

[94] In our experience, we have witnessed hundreds of MSA allocations created without addressing threshold issues such as Medicare enrollment. Such funding could be said to have led to millions of dollars being needlessly spent by the insurance industry as well as hundreds of MSAs funded when a more in-depth analysis may have been warranted and may have yielded a different conclusion.

[95] *See Zinman v. Shalala*, 67 F.3d 841, 846 (9th Cir. 1995) (where the Court foresaw this inherent problem in liability settlements under the MSP Act).

Parties should rely on standardized damage allocation methodology in making this determination, ensuring a consistent application of these principles if challenged by CMS at a later date.[96] Such a standardized methodology should be based on all guidance in existence at the time of settlement (including statutory, regulatory and administrative guidance from CMS as well as relevant case law). Absent such a thorough methodology being applied, the parties could be led off the path one way (funding an MSA when not warranted) or another (failing to fund an MSA when warranted).

In applying standardized damage allocation methodology (containing all relevant guidance) to every case, settling parties and their counsel can identify, with reasonable certainty, whether an allocation exists for future medicals within a (potential) gross award. If it does not, then the settling parties are compliant with the MSP Act by simply documenting their respective files appropriately (no allocation for future medicals present). However, if the settling parties determine that an allocation exists for future medicals, then an MSA is warranted. The amount of the future medical allocation figure represents 100% value for all future medicals funded within the gross award and the maximum possible MSA figure. It **does not**, however, represent the final MSA amount. To determine that figure, the parties should proceed to Valuing the future medical damages component; step three of the analysis.

Value - After assessing the damages in step two, if a reasonable person would determine that an actual allocation for future injury-related medical expenses exists in the settlement (based on standardized damage allocation methodology), the task becomes to identify the appropriate MSA amount to ensure compliance (and protect the injured person's Medicare card). To identify the appropriate MSA allocation, a future cost of care ("FCC") analysis should be conducted. This FCC analysis would identify all future injury-related care services/expenses expected to be incurred by the injured person, and then divide those services/expenses between Medicare-covered services/expenses and non-Medicare covered services/expenses. The resulting FCC figure would then be compared to the future medical allocation identified previously (in step 2 (Assess)). Based on this comparison, the MSA would be fully funded (and the MSA obligation fully addressed) for the lesser of the future medical allocation and the FCC analysis. Once the MSA allocation amount is finalized[97] (which occurs only once the settlement details are finalized), the parties should determine how the MSA results will be memorialized and implemented. To make this determination, the parties move forward to the Education phase of the analysis (step four).

Educate – At this point, the injured person faces the same funding and administrative decisions presented in the workers' compensation context. LMSAs may be funded either with a full lump sum dollar amount up front or with an initial lump sum, combined with the purchase of an annuity or other structured settlement vehicle. LMSAs may either be self-administered or administered by a professional custodian. What differs greatly from the workers' compensation context at this point is the ability to submit the MSA proposal to CMS for review and approval. While workers' compensation MSAs are submitted to a central CMS office and CMS has a formalized approach to the review of workers' compensation MSAs, LMSAs may be properly submitted only to the appropriate CMS regional office. The CMS regional offices may choose to review a LMSA based on

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[96] *Guidry, et al. v. Chevron USA, Inc.*, Civ. No. 6:10-cv-00868, 2011 U.S. Dist. LEXIS 148942 (W.D. La. December 28, 2011).

[97] *Hinsinger v. Showboat Atlantic City*, 18 A.3d 229 (N.J. Super. Ct. Law Div. 2011).

unpublished internal workload review thresholds, and those thresholds are subject to change without notice. Simply put, CMS does not have the same formal review process for LMSA proposals as it does for WCMSA proposals, and it may prove difficult to get CMS to review and approve a LMSA proposal. Therefore, if the settling parties are considered making CMS review and approval of a LMSA proposal a condition of settlement, they should take the extra step to ensure that the appropriate CMS regional office would be willing to review a LMSA proposal based on the case-specific fact pattern. As an added layer of protection, the parties should consider contingencies such as what would result if CMS declines the opportunity to review and approve the LMSA proposal. We have witnessed several settlements stall or disintegrate on this very issue alone.

As of the date of this White Paper, CMS does not encourage parties to submit a LMSA for review and approval. Nevertheless, even though CMS does not currently have the resources to review LMSAs (as a general rule), that does not mean that analysis and (perhaps) ultimately funding a LMSA is unnecessary in today's environment. CMS officials have stated that its right to NOT pay for future medical expenses in certain liability cases comes from the same statutory rights under 42 U.S.C. §1395y(b)(2) and its accompanying regulations as do its rights to <u>not</u> pay for future medical expenses in the workers' compensation arena.

<u>Who's Liable to CMS for What?</u>

Based on currently enacted law, the liability to Medicare with regards to satisfaction of its past and future payments differs. 42 C.F.R. §411.24 (Recovery of conditional payments) discusses liability for conditional payment reimbursement. 42 C.F.R. §411.24(e) sets forth that Medicare may assert a direct right of action against any entity that makes a primary payment.[98] 42 C.F.R. §411.24(g) allows Medicare to recover its conditional payment interest from any party receiving a primary payment.[99] When Medicare makes a conditional payment for injury-related care, Medicare may seek recovery from any entity that either makes or receives a primary payment. Though it has traditionally pursued claimants (and claimants' counsel in extreme circumstances)[100] to recoup that conditional payment interest, Medicare is also willing to pursue corporate defendants for conditional payments that were not made as part of a settlement program.[101] In short, Medicare

[98] 42 C.F.R. §411.24(e). "*Recovery from primary payers*. CMS has a direct right of action to recover from any primary payer."

[99] 42 C.F.R. §411.24(g). "*Recovery from parties that receive primary payments*. CMS has a right of action to recover its payments from any entity, including a beneficiary, provider, supplier, physician, attorney, State agency or private insurer that has received a primary payment."

[100] *U.S. v. Harris*, 2009 WL 891931 (N.D. W.Va.).

[101] *U.S. v. Stricker* (E.D. N.D. Ala. 2009) (No. CV-09-PT-2423-E). In *Stricker* (filed in December 2009, dismissed by the Eleventh Circuit court on September 30, 2010 due to statute of limitations application), the United States government filed a case in U.S. District Court to recover conditional payments and double damages plus interest under the Medicare Secondary Payer Act (42 U.S.C. §1395(b)(2)) from certain attorneys who represented individuals involved in a mass tort settlement program. Although the U.S. has brought previous actions against claimants and their attorneys to recover conditional payments, the *Stricker* case represents the most recent attempt by the government to seek recovery from insurance carriers after funds were received into and distributed from a settlement account. The Court held that a three year statute of limitations applied to the attorney defendants who did not secure a reimbursement for Medicare, and a six year statute applied to the corporate defendants, measured at the latest by the date payment was made into the settlement fund.

can recoup its conditional payment interest from any entity that makes or receives a primary payment.

That same liability paradigm does not exist when it comes to dealing with Medicare as a secondary payer for future medical expenses. Because the reimbursement obligation under the federal regulations contemplates conditional payments made, and Medicare does not make conditional payments post-settlement once it has been reimbursed and closed its file, the language set forth in 42 C.F.R. §411.24 does not apply. As such, Medicare looks to the claimant (and claimants' counsel) if/when it asserts a future subrogation interest in those situations where a claimant has failed to properly avoid a permanent burden shift over to Medicare at the time of settlement.[102] Further, the current version of the MSP Manual notes that Medicare will not recover for future interests (*i.e.*, future medical expenses) in a liability settlement.[103]

The MMSEA Statute Does Not Require MSAs

Despite considerable urban legend, the Medicare, Medicaid and SCHIP Extension Act of 2007 ("MMSEA")[104] does not contain any new guidance or requirements related to MSAs. The relatively new MMSEA statute has nothing to do with MSAs. The MMSEA statute requires defendants/insurers to **report** certain information regarding settlements with Medicare beneficiaries to the Secretary of Health and Human Services when appropriate.[105] In fact, the sole purpose of the MMSEA is to ensure that settling parties fully comply with the previously existing Medicare Secondary Payer requirements – that is, past Medicare payments must be verified and resolved in all liability, workers' compensation and no-fault settlements. In this regard, if plaintiff's counsel is already verifying and resolving Medicare's reimbursement claim in all settlements, as far as MMSEA is concerned, it is business as usual for plaintiff's counsel and his/her clients. This new law (to date) has nothing to do with identifying Medicare-covered future costs of care, which leads to MSA issues and analysis.

In fact, CMS, in town hall teleconferences related to the MMSEA implementation, has informed the legal community that CMS'S routine recovery processes have not changed. Specific examples of these statements may be found in teleconference call transcripts dated March 24, 2009, October 22, 2009 and January 28, 2010.[106] Based on the CMS town hall teleconference transcripts, we see that

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[102] As evidence of this, we look to the CMS website at the following link: http://www.cms.hhs.gov/WorkersCompAgencyServices/02_workerscompensationoverview.asp#TopOfPage. Here, CMS advises as follows: "If Medicare's (future) interests are not considered, CMS has a priority right of recovery against any entity that received a portion of a third party payment either directly or indirectly. Medicare may also refuse to pay for medical expenses related to the WC injury until the entire settlement is exhausted." Though this relates to workers' compensation specifically, this is an indication that Medicare would look to those entities receiving a primary payment as opposed to those entities making/receiving a primary payment.

[103] Medicare Secondary Payer Manual, Chapter 7, §50.5. "There should be no recovery of benefits paid for services rendered after the date of a liability insurance settlement."

[104] 42 U.S.C. §1395y(b)(8).

[105] While not the subject of this White Paper, GRG regularly updates the dedicated MMSEA section of our website. See www.garretsongroup.com for further information regarding MMSEA and related practice tips.

[106] During the March 24, 2009 CMS town hall teleconference related to MMSEA Section 111 reporting implementation, CMS officials said, "…As we've said in more than one call, we don't anticipate changing our

the set-aside process (whether it is for WC or liability) is: 1) voluntary, not mandatory; and 2) the same as it has been in the past.

Perhaps more persuasive to this point is the Congressional Research Service ("CRS") analysis of the MMSEA statute.[107] This comprehensive analysis of the new legislation (and its intent) does not mention, at any point, the concept of Medicare Set Asides in liability cases. Certainly if such purpose (*i.e.*, requiring MSAs in liability settlements) were part of the Congressional intent of MMSEA, one would reasonably expect it would have been in the CRS analysis (after all it would be a rather notable revenue-generating component of such new law if it were a part of it).

Though off-topic from the stated intent, these same CMS town hall teleconferences have provided indicia from CMS officials as to the appropriate methods for considering and protecting its future interest. During the October 22, 2009 call, a call participant asked for the best way a party settling a liability case can ensure that Medicare's future interest was being reasonably considered and protected. Ms. Barbara Wright (Technical Advisor, Division of Medicare Debt Management) responded by saying that parties should be taking Medicare's future interests into account, whether by setting up an MSA or documenting what steps have been taken to consider and protect Medicare's future interest.[108] During the March 16, 2010 call, a call participant asked if MSAs were ever going to be something that enters the liability world. Ms. Wright responded that the obligation is the same, no matter whether the claim involves WC or liability, and that when future medicals are a consideration as part of a settlement, arrangements should be made to exhaust those future

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routine recovery processes…The fact that you are reporting to us doesn't change any other obligations or eliminate any other obligations." During the October 22, 2009 CMS town hall teleconference, CMS officials said, "We continue to get questions about Medicare Set-Asides and the Section 111 process…What we will reiterate again is that Section 111 is a new and additional requirement for MSP…It doesn't change any preexisting obligation…It has nothing to do with set-asides." During the January 28, 2010 CMS town hall teleconference, CMS officials said, "In terms of reporting requirements, again, with respect to recovery, various entities seem to be confusing the Section 111 process with the preexisting and ongoing recovery process for conditional payments once there's been a settlement, judgment, payment, award or other payment…we have a multistep process that establishes a potential recovery…to start collecting conditional payment information. This process is not the same as the Section 111 process and does not eliminate any Section 111 requirements."

[107] See http://opencrs.com/ (last visited March 20, 2012).

[108] During the October 22, 2009 teleconference call, the following exchange took place: (Call Participant): "I was wondering if you could advise me as to the best way a party settling a liability case especially a self insured like my company to ensure that Medicare's interests are being quote/unquote reasonably considered."; (Barbara Wright): "The idea of set asides is based on the fact that Medicare is prohibited from making payment where payment has already been made. So that if you have a settlement, judgment or other payment that takes into account in any way future medicals that settlement, judgment, award or other payment should be exhausted …before Medicare is billed for the associated services…if an entity has not been taking this into consideration and taking steps, whether it's to do a set aside or somehow else take care of it, it's something they now need to be documenting and taking care of…"; (Call Participant): "So should the regional office not have the resources to formally review a set aside or a claims settlement allocation that I would want to put together in one of my releases and I go out to an independent third party…they do an independent analysis, and either a zero dollar amount or some small portion of the total settlement award is dedicated as a set aside and plaintiff's counsel is agreeable to that. We attach that as an exhibit or an amendment to the assigned release upon settlement. In CMS'S eyes, is that going to be sufficient?"; (Barbara Wright): "We don't have any formal process…It does sound like one way to appropriately document what you've gone through and that you've made a reasonable consideration…You need to at least think about having a process in place where you're documenting why or why not there are future medicals and how you took care of that."

medicals prior to billing Medicare for related services.[109] These comments support our long-standing position that parties should be reviewing MSA issues as part of a liability settlement and then either establishing an MSA for an appropriate amount (if necessary) or documenting the file with the reasons why an MSA was not appropriate based on the case-specific facts in light of the currently enacted law and guidance provided by CMS. MSP compliance on the MSA issue cannot be achieved without at least documenting the reasons why an MSA was not appropriate under the case specific facts.

In sum, the obligation under the MSP statute is to ensure Medicare remains a secondary payer by considering and protecting Medicare's interests, not to set up MSAs in every single liability settlement. An MSA could be the appropriate way to consider and protect Medicare's future interest, but only after arriving at that conclusion based on an evaluation of the case specific facts in light of the current law and guidance. To that end, the appropriate standard to be applied to MSA analysis in liability settlements is "reasonable good faith effort at compliance", appreciating the fact that there is neither a statutory requirement nor guidance for the use of MSAs in liability settlements. While MSAs are not recommended in every liability settlement, it is recommended that the settling parties analyze the MSA issues in liability settlements, and then document their files accordingly. In most liability settlements, Medicare Secondary Payer compliance can be achieved short of establishing an MSA so long as those conclusions and reasoning supporting those conclusions have been documented in the file.

How to Memorialize Compliance (Documenting the File)

The above is intended to help an attorney or claims adjustor sift through the confusion surrounding MSAs and emerge with a better understanding of the appropriateness of MSAs when resolving a claim. However, no analysis would be complete without a discussion of what to do if the settling parties cannot agree on an appropriate MSP compliance standard for MSAs. In these situations, it becomes critical to break any settlement impasse by adopting a formalized MSP compliance process.

To that end, with the goal of ensuring efficient and practical compliance with the Good Faith Standard, GRG created a MSA decision-making tool called the "MSA Decision Engine". The MSA Decision Engine is a web-based product which attorney users can access anytime on a "self-serve" basis. The user is asked a series of questions to develop a claimant profile, a claim/injury profile, a healthcare profile and a litigation profile. Based on the information provided by the user, the MSA Decision Engine provides guidance as to whether an MSA is appropriate under the case-specific facts. The output may then be downloaded by the user in the form of a pdf document along with exhibits such as data input by user, sample release language to be used by the parties and an MSA Disclosure Form to be reviewed and executed by the claimant. This output can then be used to

[109] During the March 16, 2010 teleconference call, the following exchange took place: (Call Participant): "Do you have any thoughts or any expectation that doing Medicare set asides is ever going to be something that enters the world of the liability and casualty payers?"; (Barbara Wright): "It has already entered. As we've said on many calls, CMS has a formalized process to review proposals for workers' compensation Medicare set aside amounts. It does not have the same formalized process for liability Medicare set aside arrangements. The process for workers' compensation is voluntary…regardless of whether CMS has a formalized process…the statute has the same language in either situation. It's not parallel language. It's not similar language. It's literally the same physical sentence that we're not to make payment where payment has already been made. So where future medicals are a consideration in arriving at the settlement, et cetera, then appropriate arrangements should be made for appropriate exhaustion of the settlement before Medicare is billed for related services."

memorialize the fact that Medicare's future interest has been considered and protected. This represents the proper level of compliance in today's environment.

The MSA Decision Engine is based on all relevant statutory, regulatory and administrative guidance from CMS as well as relevant case law from across the country (discussed in detail above). This tool follows the same approach described above, and mirrors the process we utilize internally when reviewing a matter for MSA determination purposes. In introducing this tool to the settlement community, GRG hopes to ease MSA concerns in providing the "one source of the truth" when it comes to these issues.

Regardless of the efforts pursued to "consider and protect" Medicare's future interest, we recommend always disclosing to the injured claimant the analysis above to ensure he/she is fully informed about why an MSA is or is not being established. An example of such a disclosure statement is contained in the booklet entitled "Medicare, Medicaid & Private Health Insurance Plans: Important Information about Healthcare Liens in Personal Injury Settlements" which can be accessed at http://www.garretsonfirm.com/garretson/resources/?pageID=49.

Final Thoughts – MSAs as Part of the Medicare Compliance Puzzle

While the above is intended to help an attorney and/or claims adjustor identify the situations when MSAs may need to be part of the discussion in settling claims, MSAs are but one part of the overall Medicare Secondary Payer compliance puzzle. Earlier in this White Paper, we discussed Medicare's reimbursement rights as consisting of past interests (date of injury to date of settlement) and future interests (date of settlement going forward). Therefore, determining if an MSA is needed really only solves one half of the Medicare Secondary Payer compliance puzzle. MSA analysis should be the final step in the settling parties' Medicare Secondary Payer compliance initiatives. A properly compliant settlement should accomplish three goals: 1) set forth the formalized approach to affirmatively verify and resolve any conditional payments made by Medicare from date of injury to date of settlement; 2) identify the appropriate data points which may need to be reported to Medicare to satisfy any reporting obligations under the MMSEA[110] statute; and 3) appropriately "consider and protect" Medicare's future interest by determining if an MSA is needed and if so, the appropriate amount with which to fund the MSA.[111]

Conclusion

The use of MSAs is a topic of nationwide debate. The lack of any statutory requirement in the liability context complicates the debate. While the legal community can follow guidance about how to use MSAs in WC settlements, no similar guidance exists about how to use MSAs in liability settlements. As a result, any entity professing that MSAs are now routinely required in all liability settlements absent: 1) a true good faith analysis, such as that discussed above; 2) specific regulatory guidance promulgated by CMS after fair notice has been provided to regulated parties and regulated parties have had an opportunity to comment; and/or 3) a bill passed by Congress and signed into law regarding the use of MSAs in liability settlements may, in fact, be improperly

[110] 42 U.S.C. §1395y(b)(8). Though reporting for MMSEA Section 111 purposes is outside the scope of this White Paper, please see www.garretsongroup.com/mmsea for detailed practice tips, alerts and articles on our dedicated MMSEA Compliance webpage.

[111] *See Wright v. Liberty Medical Supply*, 2011 U.S. Dist. LEXIS 81621 (July 25, 2011).

promoting a cost recovery mechanism that has no legal foundation, thus needlessly costing the insurance industry millions of dollars annually.

This White Paper is based on our company's many years of experience with Medicare Secondary Payer compliance issues. While our analysis is subject to interpretation, having specifically addressed this issue in both single event and mass tort settlement programs with CMS, we submit that until actual statutory guidance or any type of CMS guidance is provided, the question whether an MSA is required in liability settlements will be extremely fact-intensive.

We submit this White Paper to assist settling parties to better understand the use of MSAs. At the same time, hopefully, we have provided some practical guidance/tips for dealing with situations where the settling parties are confused about their Medicare Secondary Payer compliance obligations, especially with respect to the related requirements (or lack thereof) concerning MSAs.

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