When to Use a Liability Medicare Set-aside Arrangement

The Centers for Medicare & Medicaid Services (CMS) has put the insurance industry on high alert. Threat of penalties for failure to report liability claims involving a Medicare beneficiary has raised concerns over properly meeting obligations owed Medicare. One particular responsibility is a subject of great controversy – Does a settlement, judgment, award or other payment to a Medicare beneficiary need to protect Medicare's interest in the liability case? The answer follows.

Most experts opine "it depends," which regrettably is an unworkable solution for bringing closure to a liability case. The best approach is to examine each case step by step.

Step One: Is the plaintiff a Medicare beneficiary?

If yes, proceed to the next step. If not, stop, as there is no statutory requirement to protect Medicare's interest. A potential Medicare beneficiary is a red herring in this analysis. The CMS Workers' Compensation Medicare Set-aside Arrangement (WCMSA) workload review thresholds have caused this confusion but have no bearing on the liability claim. Unless CMS issues policy as it had in the past with workers' compensation claims, the Medicare Secondary Payer Statute (MSP)[1] can be reasonably interpreted to apply only when a Medicare beneficiary is involved.

A signature piece of MSP legislation and regulation is claim notification to Medicare. This exists for two purposes: 1) Coordination of Benefits; and 2) Recovery of conditional payments.[2]

Under the MSP reporting any settlement, judgment, award or other payment for a non-Medicare beneficiary case is not required. The Medicare & Medicaid SCHIP Extension Act of 2007, responsible for Section 111, only applies to Medicare beneficiaries.[3] Further, regulation[4] requiring reporting by insurance companies (primary plan as defined by MSP) only occurs if CMS has made a Medicare primary payment. CMS cannot make primary payments on behalf of a potential Medicare beneficiary. Thus, there is no legal requirement to notify Medicare of claim resolution with a non-Medicare beneficiary. Indeed, there is no mechanism by which to notify Medicare of a loss involving a non-Medicare beneficiary. Such a mandate applies only to workers' compensation cases because CMS has issued policy requesting information on non-Medicare beneficiary claim resolutions and only in limited situations.[5]

Essentially, the insurance industry complies with these recommended review thresholds for the workers' compensation claims because, by regulation, non-compliance will result in the settlement not being recognized.[6] No similar provision exists that would invalidate the liability settlement.

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[1] 42 U.S.C. §1395y et. seq.
[2] MMSEA Section 111 Medicare Secondary Payer Mandatory Reporting User Guide, ver. 3.1, p.11.
[3] 42 U.S.C. §1395y(b)(8)(A).
[4] 42 C.F.R. §411.25(a).
[5] Total settlement value must be $250,000 and plaintiff within 30 months of becoming a Medicare beneficiary. *See https://146.123.140.205/WorkersCompAgencyServices/04_wcsetaside.asp.*
[6] 42 C.F.R. §411.46(b)(2).

CMS cannot defend their ultimate interpretation of a statute or regulation when there is an absence of a policy statement that is clearly defined. A regulated party must be on notice of the intended consequences for non-compliance. No regulation exists that will invalidate a liability settlement, nor are there are any policy statements to deal with situations involving the non-Medicare beneficiary. In those situations a regulated party may not be punished.[7] Therefore, unless CMS issues proper policy (which it can only do if it has supporting a supporting regulation), the present statutory framework can be reasonably interpreted to not include a non-Medicare beneficiary.

Step Two: Does the liability case arise from a related workers' compensation illness or injury?

If not, proceed to step three. In all other cases, a WCMSA is required. Only one MSA can arise from an event to form the basis of the claim. Although a single claim may implicate different lines of business, it does not change the need for a single Set-Aside Arrangement. In order to resolve the liability case without compromising the underlying workers' compensation claim, there can be no shift to the Medicare Trust Fund. The workers' compensation plan would remain primary and presumably continue to report its Ongoing Responsibility for Medical (ORM).

However, where a global settlement of both the liability and the workers' compensation claim occurs, then a WCMSA has to be documented. This is exactly the situation discussed by CMS Policy Memo:

> Third party liability insurance proceeds are also primary to Medicare. To the extent that a liability settlement is made that relieves a Workers' Compensation (WC) carrier from any future medical expenses, a CMS approved Workers' Compensation Medicare Set-aside Arrangement (WCMSA) is appropriate. The WCMSA would need sufficient funds to cover future medical expenses incurred once the total third party liability settlement is exhausted.[8]

The liability claim is partially exhausted in reimbursing the workers' compensation claim which will include as part of that reimbursement obligation the value of the WCMSA. The rate of reimbursement depends on consensus regarding the legal responsibility for the liability party; but, the WCMSA will always be for full value.[9] Medicare may compromise a liability claim, but because workers' compensation claims are mostly commutations, the WCMSA is not usually discounted.

Step Three: Is the liability case a commutation or compromise?

The word commutation first appears in the Patel Memo.[10] It is an attempt to distinguish it from a compromise in the workers' compensation context. Most workers' compensation settlements are commutations by definition because it really is meant as a replacement for the promised statutory workers' compensation benefits. Because most jurisdictions provide for lifetime medical benefits related to the injury or illness, any attempt to settle must be a commutation of that amount. Very few workers' compensation cases can therefore fall into the compromise category. On the other hand, the

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[7] *Gen. Elec. Co. v. U.S. Envtl Prot. Agency, 53 F.3e 1324, at 1333 – 1334 (D.C. Cir. 1995).*
[8] CMS Policy Memo, 4/21/2003, Q19.
[9] CMS Policy memo, 7/11/2005, Q11. *See also* 42 C.F.R. §411.47
[10] Parasher B. Patel, CMS Memorandum to All Regional Administrators, *Workers' Compensation Commutation of Future Benefits,* July 23, 2001.

liability claim is a mirror image, and very few situations involve a commutation of future medical benefits. Compromise occurs for most liability settlements.

Nonetheless, there are liability claim resolutions that involve considerable provision for future medical care. For these cases, there can be no reasonable dispute as to liability. The issue is one of damages only. This case would involve compelling medical testimony and include life care plans usually for a catastrophically injured plaintiff. If the liability claim involves damages only, proceed to step six. Otherwise, continue on.

Step Four: Is the plaintiff released from future medical treatment?

If yes, then no LSMA is required. Otherwise proceed to step five.

There is no cost shifting to the Medicare Trust Fund if the plaintiff has recovered from their injuries. [11] The best evidence to support this position would be a letter from the treating physician. If that is the state of the evidence, then there is no need for a LMSA. However, the file should be properly documented as such.

Step Five: Is the future medical treatment identified covered by Medicare?

Assuming that there is future treatment, determine whether the future treatment will be covered by Medicare. The LMSA purpose is to pay for treatment for which the Medicare Trust Fund would otherwise pay. If it can be demonstrated that the future treatment falls outside of Medicare coverage, then no LMSA is required. Otherwise, proceed to the next step.

Step Six: How to protect Medicare's interest?

The entire resolution amount is subject to recovery by Medicare. [12] It is irrelevant how the parties have structured the terms. Medicare will ignore a release document and seek recovery from the whole amount. How then can the parties know what must be secured for Medicare and what is otherwise available from the settlement, judgment or award? There are only two possible methods.

Allocation by Hearing on Merits

Damages in a liability claim can fall under different categories. Medicare will not distinguish between these damage types (such as pain and suffering, wage loss, property damage, medical, and so forth) unless they are allocated by court order on the merits. If done so, Medicare will limit its claim to the portion of the resolution amount identified as medical. It will not go beyond that designated amount.

Absent a court order, the only number for Medicare to consider is the settlement, award or judgment. What this means is that the Medicare beneficiary plaintiff cannot, with any confidence, use any portion the settlement amount for non-Medicare purposes.[13] If they do, Medicare will not recognize it. The

[11] CMS Policy Memo, 4/21/2001, Q20.
[12] Medicare Secondary Payer Manual, Chapter 7 §50.4.4
[13] The primary plan is exposed if the plaintiff does use the settlement, judgment or award in a manner for purposes other than Medicare. If Medicare makes conditional payments, it can seek reimbursement from the primary plan even if it has already paid the plaintiff in resolving the claim. *See 42 C.F.R. §411.24(i).*

allocation allows the Medicare beneficiary plaintiff to know what they can or cannot spend from the settlement amount.

However, even assuming that hurdle has been overcome, an allocation by the court is not available for every liability claim as most claims are not litigated. It is also expensive, and the value of the claim must justify the cost to have a merits hearing. Thus, this solution has its disadvantages, but it is a process gaining recognition by the courts.[14] For those claims where this process is not feasible, consider the LMSA.

The Liability Medicare Set-aside Arrangement (LMSA)

First, let us dispel some of the common issues that serve as barriers to the use of the LMSA.

1) The American Association for Justice (AAJ) Position

On August 11, 2009, the AAJ communicated to its members that "Section 111 contains reporting requirements for responsible reporting entities (RREs) only. Section 111 does not impact or change the requirement for plaintiff attorneys." Absolutely true! The MMSEA reporting requirements do not alter, amend or otherwise change what is already required by the MSP. The reporting obligation is simply an addition to those responsibilities.

The AAJ message therefore begs the question as to what is presently required by the MSP. In answer, the message attempts to state definitively that the LMSA is not appropriate because CMS made such statements on MMSEA Town Hall Conference calls.[15] However, a close examination of MMSEA Town Hall transcripts states otherwise. [16] CMS asserts that the LMSA is indeed appropriate.

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[14] *Big R. Towing, Inc. v. David Wayne Benoit, et. al., 2011 U.S. Dist. LEXIS 1392.*

[15] See AAJ Message, dated August 11, 2009.

[16] (Bill Tominga): Hi. I'm with Global Aerospace in Short Hills, New Jersey. And we're curious about the applicability of Medicare set asides to liability claims?

Barbara Wright: If you've read transcripts from prior calls, that is not a Section 111 issue. And we are limiting these calls to Section 111 issues. There is not - the same formal process for liability set asides that there is for Worker's Compensation set asides. However the underlying statutory obligation is the same. For liability set asides if you - for Worker's Comp the process is technically not required to have a CMS blessed set aside.

For liability situations as I said, the underlying obligation is the same if you wish to pursue CMS approval of a liability set aside, your avenue approach is through the applicable regional office. Whether or not they agree to review, it does not provide - if they decline to review it, that doesn't provide any type of safe harbor. And the regions are making their determinations based on their workload. If their workload permits and they believe there are significant dollars at issue, regional offices are reviewing proposed set aside amounts but certainly not typically at the same small level that it's being reviewed through our Worker's Compensation review contractor or Worker's Comp set asides.

(Bill Tominga): Not sure, so is that a yes or a no? I'm not sure?

Barbara Wright: Well I don't know what you mean by yes or no. There is not the same formal process. You have the same legal obligations. This has nothing to do with Section 111. 111 did not change any pre-existing obligations. It added a separate reporting requirement.

2) *No Situation Exists Where CMS Requires LMSA.*

Verily there are no legal decisions which require the LMSA. However, CMS in March, 2009, amended its Medicare Secondary Manuals to add the definition for the LMSA.[17] Why was it necessary except to require its use? There is one pending district court case that could answer that question. [18] However, the court is reconsidering its ruling to dismiss the case based on the statute of limitations, potentially sidestepping the issue. Medicare is seeking recovery of conditional payments beyond the settlement date. If Medicare prevails, it could only do so if the court recognized that a payment after the settlement date relates back to the original settlement. Does the MSP law support this? Yes!

MSP law stipulates that the Secretary (Medicare) does not have to pay for any item or service for which the primary plan has or is expected to pay.[19] It follows then that if payment were made by the primary plan, the Secretary should not pay. However, the Secretary is authorized to pay in certain situations when the primary plan has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (defined as 180 days). [20] Thus, if a bill for an item or service is presented to Medicare that should have been covered for by the primary plan, then Medicare may pay for it, and this payment becomes a conditional payment.

In a liability case, Medicare can reasonably expect the primary plan to pay for medical items and services related to the tort that is released. As most releases are both prospective and retrospective, the medical component has a past and future component to it. Therefore, Medicare would expect payment for items and services related to the tort that take place after the date a claim is resolved. Support for this can be found in Medicare's authority to seek reimbursement of conditional payments.[21] Medicare will better understand the situation where benefits are to be conditional once Section 111 is enforced for liability cases.

So long as the primary plan requires a general release, it is obligated to make certain that Medicare's interests are protected with regard to future medical awards.

3) Medicare Secondary Payer Manual – No Liability beyond the Settlement Date

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(Bill Tominga): Okay. Thank you.

MMSEA Town Hall Transcript, 9/30/2009, pages 25 – 26.

[17] Medicare Secondary Payer Manual, Chapter 1, §20

[18] *U.S. v. Stricker, CV 09-BE-2423-E, U.S. Dist. Court for Northern District of Alabama, Eastern Division.* Although preliminarily decided on other grounds, Medicare sought recovery of conditional payments both pre and post settlement against various defendants, including plaintiff attorneys and primary plans. The ultimate issue of whether Medicare was entitled to recover was never reached as the case turned on statute of limitations issues which are being presently under reconsideration.

[19] 42 U.S.C. §1395y(b)(2)(A).

[20] 42 U.S.C. §1395y(b)(2)(B).

[21] 42 U.S.C. §1395y(b)(2)(B)(ii). Primary plan shall reimburse Medicare with respect to an item or service if it is demonstrated that such primary plan *has or had a responsibility* to make payment.

Medicare states there *should* be no recovery of benefits paid for services rendered after the date of a liability insurance settlement.[22] If the parties complete their obligations owed Medicare properly, then there *should* be no reason for Medicare to pay after a settlement. However, what happens if the parties do not protect Medicare? The language does not expressly prohibit Medicare from paying given its authority under the MSP to pay for items and services even after a liability settlement in the event of delayed compliance by primary plan.

The Manual offers no safe harbor for parties from the MSP. It simply reinforces that Medicare *should* not have to pay after a liability settlement. It does not mean that it is prohibited from doing so if the parties have not carefully considered Medicare's interests.

LMSA in proper situation is appropriate vehicle to protect Medicare's Interests.

Now that we have dispelled some of the barriers for the use of the LMSA in a liability settlement, what is the best approach? The first inquiry is to understand the different motivations for each side.

1) Plaintiff

The key issue here is suspension of future Medicare benefits. Medicare is becoming aware of more liability claims each day.[23] It uses this information to coordinate future benefits. When Medicare is not properly informed of the claim settlement amount and allotment for future medical payments, then it will examine the entire settlement amount.[24]

One way to limit CMS consideration of the entire amount is to prepare the LMSA and to communicate that value to the CMS regional office. In June, 2009, CMS modified its database known as the Common Working File to accept information for the amount of the MSA.[25]

When benefits are suspended, the Medicare beneficiary as plaintiff can reinstate benefits, but only if they can show that the liability settlement was exhausted. Where the allocation or LMSA was not performed, the Medicare beneficiary has an enormous burden with regard to reinstating his or her Medicare benefits. More than likely, the Medicare beneficiary will react adversely to this situation and seek redress. This circumstance can and should be avoided by taking the necessary steps with Medicare to protect its interests.

2) Plaintiff Attorney

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[22] Medicare Secondary Payer Manual, Chapter 7, §50.5.

[23] The liability industry is contacting the Coordination of Benefits Contractor (COBC) before settlement, judgment, award or other payment to start the process to secure the Conditional Payment Letter. When this information is received, the COBC populates its database, the Common Working File, to assist in coordinating future benefits. The COBC's primary mission is to prevent Medicare from making payment that is the responsibility of another plan.

[24] Medicare Secondary Payer Manual, §50.5. "However, the entire amount of a settlement is subject to recovery, whether the liability payment is made at the time of settlement, or over a period of time agreed by parties in a structured settlement."

[25] NAMSAP's 2009 Conference featured Tom Bosserman, from the CMS Regional Office located in Northern California. During his presentation, Mr. Bosserman made mention of the addition of the MSA field to the Common Working File and the importance for that field to be properly documented. If not, the settlement amount would populate that field.

Not all Medicare beneficiary plaintiffs retain counsel. For those situations where the Medicare beneficiary is represented, the plaintiff attorney is also subject to MSP liability.[26] Under the Medicare Modernization Act of 2003, the plaintiff attorney is considered an entity that receives payment from a primary plan upon receipt of the settlement proceeds. If Medicare should make the decision to pay for medical items and services after the settlement date, the plaintiff attorney is exposed to a reimbursement claim. Where Medicare decides to suspend future Medicare benefits until a liability fund is exhausted, the plaintiff attorney is subject to a potential malpractice action if those interests were not adequately considered. Thus, from the plaintiff attorney's perspective there should be ample incentive to agree on this point.

3) Primary Plan (Defendant)

It is clear the primary plan cannot on its own decide to require a LMSA. It could, but it would be entirely responsible to pay and fund it over and above the settlement amount, which makes that an unlikely occurrence. Thus, to properly protect Medicare's interest, the primary plan must rely heavily on the cooperation of the Medicare beneficiary and, where such cooperation does not occur, do everything it can to properly place the Medicare beneficiary and his counsel on notice.

The primary plan is like an English police officer who has all of the responsibilities of enforcement without any firearm to enforce it. As the LMSA process is not well defined by CMS, it is left to the parties to determine when it is appropriate to do so. This may lead to difference of opinion, and the primary plan must be able to take steps to best protect itself. The response of the primary plan will be based on its tolerance for risk.

The incentive for the primary plan to secure cooperation is high. First, only the primary plan is exposed to double damages in a claim by the U.S. for recovery of conditional payments. Second, the primary plan is more likely to be subject to a debt collection action by the Department of Treasury. Third, it is the deep pocket. Hence, the primary plan should marshal considerable resources to seek cooperation, which can only start at the commencement of the liability claim, not on the date of settlement.

Steps to Complete the LMSA

The threshold question to be asked is whether the proposed settlement amount will support a LMSA. This answer is fairly easy to calculate. Take the settlement amount and deduct from it attorney fees, costs, liens and other damages that are subject to being liquidated, such as wage loss and property damage. If the amount is zero or less, no LMSA is required.[27]

Where the calculated amount is a number greater than zero, a LMSA should be put in place. However, for the liability case, consideration should be given to claim defenses in proportion to the LMSA of the damages, a certain departure from CMS's compromise position that CMS regarding WCMSA.[28]It is a position, however, that is valid and reasonable for the liability case. Is it in the best interests of Medicare where the chances of successful litigation are questionable? Unlike most workers'

[26] *U.S. v. Harris 2009 WL 89191 (N.D.W. Va.).* Held plaintiff attorney for Medicare beneficiary legally responsible for conditional payments owed Medicare as entity that received payment from primary plan. Responsibility is not discharged when settlement proceeds are distributed.
[27] CMS Policy Memo, 4/21/2003, Q20.
[28] CMSP Policy Memo, 7/11/2005, Q11.

compensation cases, the liability case does not continue to pay benefits to the Medicare beneficiary if there is no settlement. No benefits are paid, thus the burden to pay remains with Medicare. Furthermore, because liability is at issue, compromise makes sense where litigation is questionable. Such consideration is authorized by statute.[29]

The LMSA is a useful vehicle to bring finality to the liability claim. It is not required by law, but it is a reasonable approach that parties can adopt to protect themselves from MSP liability. It is cost effective, compared to a court allocation, as well as easily accessible.

The most common argument against use of the LMSA is that it increases the cost of the claim. It should not. Short of a trial on the merits, parties reach consensus on the settlement value. The LMSA does not add to that amount but comprises a portion of it. The figure represents damages for future medical cost related to the claim for which Medicare would otherwise pay. It simply protects this allotment for payment for medical items and services, thereby protecting the Medicare Trust Fund.

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[29] 31 U.S.C. §3711.