Medicare Set Asides in Liability Cases: What do we do now?

by Greg Maxwell, Esq. and Kent Hansen, Esq.

When the Centers for Medicare and Medicaid Services (CMS) submitted Notice of Proposed Rule Making (NPRM) to the Office of Management and Budget (OMB) in August 2013, it seemed clarity by way of rules governing Medicare Set Asides in third-party liability cases (LMSA) was on the immediate horizon. However, in October 2014, CMS quietly withdrew the NPRM because it failed to gain approval from the OMB. Now that no future rule is pending related to protecting Medicare's interests regarding future medical obligations in liability settlements, you may ask yourself, what do I do now when my client receives a judgment, settlement, or award? To help answer that question, let's take a minute to review how compliance with the Medicare Secondary Payer Act (MSP) got to this point, then discuss what you can do now to ensure your processes are compliant and your clients are covered.

History of Medicare Secondary Payer Act

In any case in which an individual who is eligible for Medicare settles a claim, the MSP applies. Currently, the MSP requires settlements to be reported and the Medicare program to be reimbursed for medical treatment for claimed injuries from the date of injury to the date of settlement, judgment, or award. The MSP also requires consideration of Medicare's interest for any future medical treatment for claimed injuries. These three requirements have developed over time. Until the 1980s, the Medicare program served as the primary source of healthcare funding for eligible beneficiaries, regardless of whether the beneficiary had private health insurance.[1] In 1980, in response to the cost of the Medicare program, Congress enacted several amendments to the Medicare statute. These amendments, collectively referred to as the Medicare Secondary Payer Act (*see generally* 42 U.S.C.S. § 1395y(b)), aimed to reduce Medicare payouts by making Medicare secondary to other sources, wherever possible.

While MSP provisions were enacted to shift the cost away from Medicare to "primary" providers of medical care, the initial effectiveness of the program was curtailed due to lack of enforcement. However, steps have been taken to increase enforcement of the MSP. Between 1982 and 1997, Congress narrowed Medicare's coverage responsibilities through a series of amendments under various Omnibus Budget Reconciliation Acts.[2] In the last decade, CMS broadened enforcement of the MSP through policy memos (in workers' compensation cases) and through changes to the statute, particularly through the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA)[3] and the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA).[4]

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Of particular importance to plaintiffs' attorneys, the MMA added enforcement provisions; including, that the United States may, if required to file suit, recover double damages from responsible entities.[5]

Also of importance, Section 111 of the MMSEA added reporting requirements that require providers of liability insurance (including self insurance), no fault insurance and workers' compensation insurance to determine the Medicare entitlement of plaintiffs and report certain information about those claims to the Secretary of Health and Human Services.

Most recently, CMS began the process to create official regulations regarding the allocation of future medical expenses. In June of 2012, CMS solicited public comment on how to implement a MSP process for liability settlements by releasing an Advanced Notice of Proposed Rulemaking (CMS-6047-ANPRM). In August of 2013, CMS took the next step by submitting NPRM to the OMB, however, as mentioned above, CMS withdrew the NPRM in October 2014.

Responsibilities in Settling Claims

Moving beyond the history of MSP, let's clarify the distinct obligations of the parties when resolving a lawsuit. First, in any case in which an individual who is eligible for Medicare (or will be within 30 months) settles a claim, the MSP requires the settlement to be reported. This reporting requirement belongs to primary payers, i.e., defendants and insurers. Second, the Medicare program must be reimbursed for medical treatment for claimed injuries from the date of injury to the date of the settlement, judgment, or award. This responsibility falls to the plaintiff and is commonly referred to as resolving Medicare's conditional lien. Third, consideration must be given to Medicare's interest regarding any future medical treatment for claimed injuries. This responsibility also falls to the plaintiff and is the reason for this discussion about MSAs.

Briefly, the Section 111 reporting requirement requires primary payers to report to CMS.[6] Failure to report a settlement could result in a "civil money penalty of $1,000 for each day of noncompliance with respect to each claimant."[7] Accordingly, defendants and insurers have the responsibility to inform plaintiffs about their obligations to Medicare and to report information about plaintiffs to CMS.

While Medicare may make payments for services or treatments that are legally the responsibility of another entity, it may later seek reimbursement if it is determined that the payments were actually the responsibility of another entity.[8] Once a settlement, award, or order approving settlement is entered, parties to the claim have 60 days to reimburse Medicare for conditional payments.[9] CMS' Benefits Contractor and Recovery Center (BCRC) outlines the process for resolving conditional liens. While this process has become more streamlined than it was in the past, it is often still frustrating and time consuming. It is wise to start the process long before you reach resolution of your case. Many firms prefer to outsource this task entirely.[10]

Since Medicare is prohibited by statute from paying for treatment that is the responsibility of another party, injured parties could potentially be left without future medical care if Medicare's future interest is not considered at the time of settlement. For better or worse, a rule from CMS would have provided some clarity in this regard. However, as no rule is currently forthcoming, what should you do now? In some circumstances a full MSA allocation may be warranted; in other circumstances, a letter to your client regarding their future medical care may be sufficient; and at times, an opinion from an outside firm may be best.

Liability Medicare Set-Asides

A Medicare Set-Aside (MSA) is a report suggesting a certain amount of money be set-aside after a settlement to satisfy the MSP requirements. The funds placed into an MSA would then be used to cover future medical expenses related to the injury for which Medicare would otherwise pay. An MSA can be analogized to a deductible that must be spent down before Medicare will pay for future injury-related medical care.

While currently there is no law requiring MSAs for any claim (even workers' compensation claims), CMS has issued guidelines for the use and approval of MSAs related to workers' compensation settlements through a series of policy memos. Interestingly, those guidelines do not extend to liability settlements and, at the time this article went to press, there is no requirement or process for submitting LMSAs for CMS approval. However, the lack of a law requiring an MSA does not change the fact that parties have a duty to consider Medicare's future interest at the time of settlement.

Therefore, as a general rule, if the injured-party is entitled to Medicare (or will be within 30 months), and will likely require future injury-related care that would be covered by Medicare, some measure should be taken to protect Medicare's future interest. As a practical matter, in every case you should analyze the responses to the following questions:

- Is the claimant currently on Medicare?
- Will the claimant become eligible for Medicare within the next 30 months?
- Will there be injury-related future care?
- Will Medicare be assuming the burden of that future injury-related care?
- Are specific future medical expenses allocated in settlement or judgment?
- Is the settlement large enough that a portion would be reasonably expected to cover future medicals?

In cases when you determine a set aside of settlement proceeds is necessary to protect Medicare's interest, there are further decisions to be made. For example, will the set aside be funded with a lump sum, or through an annuity? Likewise, will the claimant self-administer the MSA, or should a professional administrator be used?

Our advice on best practices: be proactive, educate the client, and document your file. Have a written policy on how your firm handles MSP compliance. Collect information about Medicare eligibility early in the case so it doesn't stall the settlement process. In your retainer agreement, disclose to your client that you will have to share certain personal information with the defendant for them to report the settlement. And of course, document your file to show your analysis regarding how you have considered Medicare's interest.

In summary, CMS will not be issuing a rule regarding the use of LMSAs (at least not in the immediate future, but stay tuned). However, there is still the requirement to ensure Medicare's future interest is considered. In each case, a formal process and analysis can show a good faith effort to comply with the MSP. Some cases will warrant an MSA, some will warrant an analysis from an outside firm, and some may only warrant a letter to your client—each case is unique. So until CMS issues a rule in this regard (and we believe it is a matter of when, not if), make sure your file shows your good faith effort to consider and protect Medicare's future interest in each settlement.

1. *Medicare Secondary Payer (MSP) Manual*, Ch. 1, Background and Overview § 10 (2005).
2. *See e.g.*, Pub. L. No. 97-248; Pub. L. No. 98-369; Pub. L. No. 98-272; Pub. L. No. 99-509; Pub. L. No. 100-203; Pub. L. No. 101-239; Pub. L. No.101-508; Pub. L. No. 103-66; and Pub. L. No. 105-33.
3. Pub. L. No. 108-173, § 103(b), 117 Stat. 2066, 2155–2158 (2003).
4. Pub. L. No. 110-173, 121 Stat. 2492 (2007).
5. *See* 42 C.F.R. §411.24(c)(1)–(2) and (m).
6. *See* 42 U.S.C. §1395y(b)(7), (8).
7. 42 U.S.C. §1395y(b)(8)(E)(i).
8. *See* 42 U.S.C. §1395y(b)(2)(B)(i).
9. *See* 42 U.S.C. §1395y(b)(2)(B)(ii).
10. Many plaintiffs' firms lack the time, expertise, or desire to navigate the Medicare lien resolution process. In January 2014, the Utah State Bar issued Ethics Advisory Opinion Number 14-01 that outlined the appropriateness of outsourcing Medicare and other lien resolution services to an outside firm that specializes in lien resolution.