A Proposed Reduction Methodology for Liability Medicare Set Asides

By Jason D. Lazarus, J.D., LL.M., MSCC

The Medicare Secondary Payer Act (MSP) is a series of statutory provisions enacted in 1980 as part of the Omnibus Reconciliation Act with the goal of reducing federal health care costs. The MSP provides that if a primary payer exists, Medicare pays for medical treatment relating to an injury only to the extent that the primary payer does not pay. The regulations that implement the MSP provide "[s]ection 1862(b)(2)(A)(ii) of the [a]ct precludes Medicare payment for services to the extent that payment has been made or can reasonably be expected to be made promptly under any of the following: i) workers' compensation, ii) liability insurance, iii) no-fault insurance." 42 CFR § 411.20(2) Part 411, Subpart B, (2007).

According to the Centers for Medicare and Medicaid Services (CMS), the MSP requires not only satisfaction of conditional payments (payments made by Medicare prior to settlement) but also setting aside a portion of a settlement to cover future Medicare-covered services related to the personal physical injury suffered. (See Lazarus, J. "An Examination of the Medicare Secondary Payer Act and Set Aside Obligations," *The ElderLaw Report*, Nov. 2008, p. 1.) CMS's position is based on its interpretation of 42 U.S.C §1395 y(b)(2), which is a provision in the federal law that the agency is charged with interpreting. In a May 2011 memo, Sally Stalcup, MSP Regional Coordinator, CMS Dallas Region, succinctly stated CMS's position on what is required when it comes to Medicare futures. Stalcup wrote that "[a]ny time a settlement, judgment or award provides funds for future medical services, it can reasonably be expected that those monies are available to pay for future services related to what was claimed and/or released in the settlement, judgment, or award. Thus, Medicare should not be billed for future services until those funds are exhausted by payments to providers for services that would otherwise be covered and reimbursable by Medicare."

While I applaud Stalcup's efforts to clarify things with respect to liability Medicare Set Asides, application of what she suggests is a little more difficult in the real world with certain types of settlements. How do you deal with a case of $25,000 policy limits settlement where future Medicare-covered services are $200,000? What about a settlement where the recovery is $1 million but the MSA allocation is $2 million and damages exceed $40 million? I believe there are ways to deal with these situations using a reasonable reduction formula, discussed more fully below.

Limited recoveries happen every day in liability settlements. There are a myriad of factors that lead to a compromise settlement and in turn limit the recovery for future medical care. These factors include policy limits, caps on damages, comparative fault issues, and liability issues that impact the value of a

case. In addition, liability settlements are not allocated as they typically are in workers' compensation cases. A settlement will typically be for all the various components of the claim, which can include non-economic damages, economic damages and medical. If a case is settled for pennies on the dollar and the medical recovery is significantly reduced due to factors present in the case, the question becomes how to account for those issues when a settlement is achieved for a Medicare beneficiary and a set aside is contemplated. Why should Medicare's "future interest" apply beyond the medical portion of the recovery or possibly exceed the net proceeds to the client?

***Ahlborn* Suggests a Framework**

Obliviously, it does not work to have 100 percent of a settlement consumed by a Medicare set aside that the client can't touch except to pay for future Medicare-covered services. I would argue that this gets to the very root of the issue dealt with in the U.S. Supreme Court decision in *Arkansas Department of Health and Human Services v. Ahlborn*, 547 U.S. 268 (2006); see *The ElderLaw Report*, June 2006, p. 6. The *Ahlborn* decision forbids lien recovery by Medicaid state agencies against the non-medical portion of the settlement or judgment. While admittedly that decision dealt with Medicaid lien issues and the Medicaid anti-lien statute, the arguments by analogy can be applied in the Medicare set aside context. The *Ahlborn* holding gets at the fundamental issue of whether a lien can be asserted against the non-medical portion of a personal injury recovery. Justice Stevens, in stating the majority opinion, said "a rule of absolute priority might preclude settlement in a large number of cases, and be unfair to the recipient in others." Isn't this so in the Medicare set aside context (which is really a future lien)? How do you settle a case for an injury victim when all of the proceeds would have to go into a set aside? Wouldn't that force cases to trial where damages could be allocated to different aspects of the claim and a larger recovery might be possible?

In addition, the 11th Circuit *Bradley* decision addressed the issue of Medicare's lien rights in the context of Florida's wrongful death statute. *Bradley et al v. Sebelius* (11th Cir., No. 09-13765, Sept. 29, 2010). In *Bradley*, CMS took the position that only an allocation on the merits of a case would be recognized in terms of reducing a Medicare conditional payment obligation. The 11th Circuit approved a probate court's equitable distribution findings to reduce the Medicare conditional payment obligation. In so doing, the court found that it would be improper to require a trial on the merits of a case to determine an allocation for purposes of Medicare conditional payment resolution. The *Bradley* court focused on the strong public policy favoring "expeditious resolution of lawsuits through settlement." According to the court, Medicare's position would have a "chilling effect on settlement." This is so because Medicare's position compels plaintiffs to force their tort claims to trial, burdening the court system. The same argument could be made in the Medicare set aside context for liability settlements that are significantly compromised.

Why would an injury victim settle his case if it will all go into a set aside?

There is some basis in CMS's own regulations for a reduction. In 42 C.F.R. 411.47 there is a computation example for workers' compensation settlement where there is no allocation in a compromise situation. It is as follows:

As the result of a work injury, an individual suffered loss of income and incurred medical expenses for which the total workers' compensation payment would have been $24,000 if the case had not been compromised. The medical expenses amounted to $18,000. The workers' compensation carrier made a settlement with the beneficiary under which it paid $8,000 in total. A separate award was made for legal fees. Since the workers' compensation compromise settlement was for one-third of the amount which would have been payable under workers' compensation had the case not been compromised ($8,000/$24,000=1⁄3), the workers' compensation compromise settlement is considered to have paid for one-third of the total medical expenses (1⁄3×$18,000=$6,000).

Admittedly, this particular regulation deals with conditional payments and has been flatly rejected by CMS in terms of its use in the context of reducing workers' compensation Medicare set aside arrangements. Nevertheless, this type of analysis makes considerable sense in the context of liability Medicare set asides. Considering CMS has not given any guidance in the liability Medicare set aside area, how can CMS argue it is improper to employ such methods?

So how would a calculation be made to determine the amount of reduction of the set aside? One could take the approach found in 42 C.F.R. 411.47 or an *Ahlborn* approach. The *Ahlborn* approach would necessitate an estimate of the total value of the claim, which would then be compared to the actual recovery. From there you would determine the percentage of recovery that the settlement represented when compared to the total value of all damages. That type of analysis might look like the following:

$4,000,000 = Total Case Value

$1,000,000 = Settlement

$400,000 = Fees (40 percent fee)

$600,000 = Net

$200,000 = Set Aside

$30,000 = Reduced Set Aside (Client recovered 15 percent of total damages)

I want to make it very clear that there are no guarantees that CMS would ever approve of either method to reduce a liability Medicare set aside. However, submission to CMS of a liability set aside (and for that matter workers' compensation as well) is voluntary. Accordingly, if one of these methods was utilized

and the case was not submitted to CMS for review and approval, I believe CMS would be hard pressed to argue that it was an inappropriate course of action. Given the fact that CMS has ignored questions about how to deal with these issues for liability Medicare set asides and failed to provide any meaningful guidance whatsoever in this area, I believe one could make an estoppel type of argument if CMS ever claimed it was improper.

Conclusion

For liability Medicare set asides to work there has to be some methodology to deal with the realities of liability settlements. Liability cases are settled every day for significantly compromised amounts due to various issues in the case. There has to be a way to address these issues when calculating what amount of money should be set aside. Since CMS has chosen to remain silent regarding this issue, I would argue that any reasonable method employed to address the reduction is appropriate.

Jason D. Lazarus, J.D., LL.M., MSCC, is the founder of and managing partner of Special Needs Law Firm, in Orlando, Florida, providing legal services related to public benefit preservation, Medicare set asides, lien resolution and qualified settlement funds.