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# The ElderLaw Report

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In This Issue

**Indiana Elder Law Attorneys Decry Excessive DRA Transfer Rules . . . . . 3**

**California Implements DRA, But Regs Must Be Written . . . . . . . . . . 4**

**Rhode Island's Medicaid Proposal Could Set Dangerous Precedent for Other States . . . . . . . . . . . 5**

**Keeping Current . . 6**
- ***Maryland Department of Health and Mental***
- ***Hygiene v. Centers for Medicare and Medicaid Services***
- ***Amos v. Amos***
- ***In Matter of Ruben N. v. Elizabeth T.***

**Practice Tips . . . . . 8**

## An Examination of the Medicare Secondary Payer Act and Set Aside Obligations

By Jason D. Lazarus

Many injury victims are Medicare beneficiaries, which implicates the Medicare Secondary Payer Act (MSP). The 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 provisions of the MSP can be found at Section 1862(b) of the Social Security Act. 42 USC § 1395y(b)(6) (2007).) The MSP provides that if a primary payer exists, Medicare only pays for medical treatment relating to an injury to the extent that the primary payer does not pay. 42 CFR § 411.20(2) Part 411, Subpart B, (2007). There are two issues that the MSP deals with: (1) Medicare payments made prior to the date of settlement, and (2) future Medicare payments for covered services. This article will focus on the latter issue as it relates to personal injury cases.

### *Historical Background*

Under the original Medicare law enacted in 1965, Medicare was the primary payer of medical services except those covered by a workers' compensation program. In an effort to shift costs back to other primary plans and save the Medicare program, Congress enacted a series of laws starting in 1980 referred to as the MSP. The MSP prohibits Medicare from making payments if payment has been made or is reasonably expected to be made by a workers' compensation plan, liability insurance, no fault insurance or a group health plan. However, Medicare may make a "conditional payment" if one of the aforementioned primary plans does not pay or can't be expected to be paid promptly. 42 USC § 1395y (2007). These "conditional payments" are made subject to being repaid when the primary payer pays. The conditional payment becomes a lien against settlement proceeds subject to subrogation by Medicare in the personal injury context.

Congress has given the Centers for Medicare and Medicaid Services (CMS) both subrogation rights and the right to bring an independent cause of action to recover its conditional payment from "any or all entities that are or were required or responsible . . . to make payment with respect to the same item or service (or any portion thereof) under a primary plan." 42 USC § 1395y (2007). Furthermore, CMS is authorized under federal law to bring actions against "any other entity that has received payment from a primary plan." Most ominously, the government may seek to recover double damages if it brings an independent cause of action. Given all of the foregoing, Medicare subrogation law is a problematic area for personal injury practitioners and a detailed examination of the subject is beyond the scope of this article. (For a good discussion of the issues relating to conditional payments, *see* Jonathan Allan Klein & Annmarie M. Liermann, *Medicare Lien Interests in Liability Settlements—Easy Solutions to Help Resolve Medicare Reimbursement Issues for Beneficiaries and Insurers*, Medicare Secondary Payer Act Reform Task Force (2007).) However, suffice it to say that it presents liability concerns for personal injury practitioners given the complexity of the MSP and difficulty in dealing with Medicare's subrogation bureaucracy.

While conditional payments are a complex area of the law in terms of the MSP and important to personal injury

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practitioners as the Act relates to the injury victim, the most important aspect of the MSP is how CMS has enforced its right as a secondary payer for future payments after a physical injury recovery. What I am referring to is the requirement to create a Medicare Set Aside (MSA or WCMSA). MSAs materialized in 2001 when CMS circulated a memo to all its regional offices announcing that compliance with the MSP required claimants to set aside a portion of their settlement for future Medicare-covered expenses on workers' compensation cases where the settlement closed out future medical expenses. The set aside requirement was designed to prevent attempts "to shift liability for the cost of a work-related injury or illness to Medicare." (Parashar B. Patel, *Medicare Secondary Payer Statute: Medicare Set-Aside Arrangements*, Centers for Medicare and Medicaid Services Memorandum, July 23, 2001.) A whole new settlement industry with a large professional association—the National Alliance of Medicare Set-Aside Professionals, Inc. (NAMSAP)—was spawned by what has come to be known as the Patel memorandum. Since 2001 there have been seven memos from CMS clarifying the requirements for workers' compensation MSAs.

Below is a detailed analysis and explanation of the framework for MSAs as laid out in the CMS memoranda since 2001. Also discussed is the potential future impact of MSAs for injury victims who settle their liability claims.

### *Medicare Set Asides*

According to CMS, all parties to a workers' compensation settlement "have significant responsibilities under the Medicare Secondary Payer (MSP) laws to protect Medicare's interests when resolving WC cases that include future medical expenses." *See* CMS Web site at *http://www.cms.hhs.gov/WorkersCompAgencyServices/08_setasiderelatedtopics.asp* CMS goes on to say that "[t]he recommended method to protect Medicare's interests is a Workers' Compensation Medicare Set-aside Arrangement (WCMSA). . .". As a starting point for discussions pertaining to MSAs it is helpful to understand what exactly an MSA is. It is a portion of settlement proceeds set aside, called an "allocation," to pay for future Medicare-covered services that must be exhausted prior to Medicare paying for any future care related to the work injury. The amount of the set aside is determined on a case-by-case basis and is submitted to CMS for approval if the case fits within the review thresholds established by CMS and discussed below.

CMS explains on its Web site that the purpose of a workers' compensation MSA is to "pay for all services related to the claimant's work-related injury or disease, therefore, Medicare will not make any payments (as a primary, secondary or tertiary payer) for any services related to the work-related injury or disease until nothing remains in the WCMSA." According to CMS the set aside is meant to pay for *all* work-injury-related medical expenses, not just portions of those future medical expenses.

There are two different ways to fund an MSA: with a single lump payment at the time of settlement, or annually by a structured settlement annuity. When an MSA is funded with a single lump-sum payment, the funds, including any earned interest, must be completely exhausted before Medicare will pay any future work-injury-related medical expenses. However, when an MSA is funded annually with a structured settlement annuity Medicare will make payments once the funds have been exhausted for that period plus any carryover from previous periods. See *http://www.cms.hhs.gov/WorkersCompAgencyServices/Downloads/structuredwcmsas.pdf* There is a requirement to provide "seed" money when an MSA will be funded by a structured settlement annuity. The seed money must

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be equal to the amount of money to pay for the first surgery, if applicable, and two years of the calculated annual payments to fund the WCMSA.

While Medicare's interests must always be considered when a workers' compensation case involving future medicals is settled, there are certain settlements that must be reviewed and approved by CMS before establishing an MSA. CMS can approve or disapprove an MSA arrangement. (Interestingly, there is no appeal process if a proposed set aside is not approved. The parties may submit more information to the regional office reviewing the set aside, but if the regional office rejects the additional information and the parties proceed to settlement anyway, then Medicare will not recognize the settlement.) CMS must review and approve a set aside if the workers' compensation claimant is a Medicare beneficiary and the total settlement amount is greater than $25,000. According to CMS this is a workload review threshold and not a "substantive dollar or 'safe harbor' threshold."

In addition, if the "claimant has a "reasonable expectation" of Medicare enrollment within 30 months of the settlement date and the anticipated total settlement amount for future medical expenses and disability/lost wages over the life or duration of the settlement agreement is expected to be greater than $250,000, then the set aside arrangement must be reviewed and approved. It is important to note that the review thresholds are fluid and subject to change by CMS. CMS says that a WCMSA is not necessary only if (1) the settlement is only for past medical expenses; "(2) there is no evidence that the individual is attempting to maximize the other aspects of the settlement . . . to Medicare's detriment"; and (3) the treating physician determines within a reasonable degree of medical certainty the individual will not need future Medicare covered services related to the WC injury.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 created Medicare Part D coverage for prescription drugs. As a consequence, all MSAs created as of January 1, 2006, must include prescription drugs in the calculation of the set aside amount. Post-January 1, 2006, when a set aside is submitted for approval it must delineate between the amount allocated for future Medicare-covered medical expenses and future Medicare-covered prescription drug expenses, with an explanation of how the costs for the prescription drugs were arrived at.

Given the fact that an MSA must include all future Medicare-covered expenses, including prescription drugs, some lawyers have asked CMS whether the claimant can simply waive access to certain services and accordingly reduce the amount of the set aside. CMS answered in the negative and said that a workers' compensation claimant can't "promise not to bill Medicare for certain services in lieu of including those services in a Medicare set-aside arrangement." (Thomas Grissom,

## Indiana Elder Law Attorneys Decry Excessive DRA Transfer Rules

They are being called "the most punitive Medicaid rules in the country." Indiana elder law attorneys are asking the state's governor to order that proposed rules implementing the Deficit Reduction Act of 2005 be withdrawn and reworked to protect elderly and disabled Hoosiers.

"This just stretches the law beyond all credibility. Conceptually and legally, it makes no sense," Indianapolis elder law attorney Scott R. Severns told the *Indianapolis Star*.

The rules, proposed by Indiana Family and Social Services Administration (FSSA) and slated to take effect in December, include the following:

- The look-back period is five years for those who transferred assets on or after February 8, 2006. Indiana does not phase in the look-back period as many states have done and as the DRA seems to require;
- Even the smallest gift will be deemed to violate the transfer provision and cause at least one month of ineligibility;
- The state will total all transfers made in more than one month within the look-back period to determine the applicable cumulative penalty period;
- The rules prohibit credit for the partial return of transferred assets;
- Payments to family members for care of a relative are specifically targeted unless a written agreement is in place;
- The rules single out charitable gifts as disqualifying an individual from the undue hardship exemption;
- The hardship requirements "go out of their way to assure that hardship waivers will rarely be used in Indiana," according to the Indiana chapter of the National Acacemy of Elder Law Attorneys (NAELA);
- The provisions are retroactive to February 2006, although the state did not publish a draft until August 27, 2008.

"When we heard that FSSA was preparing the proposed rules, we asked to meet with them," said Indiana elder law attorney Wayne Walston. "We requested that new provisions apply only to future transfers. The agency ignored both requests."

To read Indiana's proposed rules, go to: *http://www.in.gov/legislative/iac/20080827-IR-405080325PRA.xml.pdf*

*Medicare Secondary Payer—Workers' Compensation (WC) Frequently Asked Questions*, Question 18, CMS Memorandum, April 22, 2003.) If Medicare's interests are not adequately considered by a Medicare beneficiary or someone with a reasonable expectation of becoming a Medicare beneficiary, "Medicare may refuse to pay for services related to the WC injury until such time as expenses for such services have exhausted the amount of the entire WC settlement." If a client ignores Medicare's interest in a WC case, CMS advises the attorney should "consult their national, state, and local bar associations for information regarding their ethical and legal obligations [and] . . . attorneys should review applicable statutes and regulations, including, but not limited to, 42 CF 411.24 (e) and 411.26."

If a claimant loses Medicare coverage after establishing an MSA, the funds can't be withdrawn and can only be used for Medicare-covered expenses until the set aside is exhausted or entitlement to Medicare is reestablished. Similarly, a Medicare beneficiary can't request termination of a set aside arrangement once established. However, in the past if the claimant could provide evidence to CMS that her treating physician had concluded that her condition had "substantially improved," she could have submitted a new WCMSA proposal covering the revised future medical expenses. There would have had to have been at least a 25 percent reduction in the outstanding WCMSA funds demonstrated by the new proposal and it could only be submitted after five years had elapsed since the original approval of the MSA arrangement. This is no longer the law. On August 25, 2008, CMS issued a new policy memorandum that rescinded this procedure to reduce the amount of the set aside so there is now no way to withdraw funds from an MSA or reduce an MSA prior to death.

Upon the death of the claimant, the MSA is terminated and all funds remaining in the set aside may be disbursed pursuant to state law or beneficiary designation. The set aside may not terminate immediately because often providers lag in their billing so the set aside must retain funds to pay for any outstanding bills submitted after death.

### *MSAs and SNTs*

A problematic area is the intersection of MSAs and special needs trusts. Some injury victims are dual eligible and an MSA gets no special treatment in terms of the resource test for Medicaid eligibility. According to CMS, "WCMSA funds should be evaluated to determine if they meet the legal definition of a resource for Supplemental Security Income (SSI) and, therefore, Medicaid purposes, i.e., 'cash or other assets that an individual owns and could convert to cash to be used for his or her support and maintenance.'" (Gerald Walters, *Medicare Secondary Payer (MSP)—Workers' Compensation (WC) Additional Frequently Asked Questions*, Question 13, CMS Memorandum, July 11, 2005.) Funds set aside for an MSA are held in an interest-bearing account and could be deemed an available resource for purposes of Medicaid. A potential solution, as recognized by CMS, is to have the funds for the MSA held by the trustee of a special needs trust and segregated to be used only for Medicare-covered expenses.

### *The Future of Medicare Set Asides*

You may be asking yourself "what relevance does this have to an injury victim who is not a workers' compensation claimant?" The answer is that the while CMS has never issued guidelines for set asides in liability cases, most believe they will in the near future and the MSP clearly mandates consideration of Medicare's interest when settling a personal injury case, since a primary payer exists. Because many injury victims are Medicare-eligible by virtue of their disabling injury, it is best to have a firm grasp of MSAs and a general understanding of how they operate. Several commentators have opined it is just a matter of time before CMS issues policy and guidelines for establishment of MSAs in liability settlements. (*See* John J. Campbell, *Update on Medicare's Position Regarding Future Medical Expenses in Third Party Liability Settlements*, The Medicare Set Aside Bulletin (February 21, 2005). *See also* Patty Meifert and Robert Lewis, *Considering Medicare's Interests in Liability Cases: Will the Real Expert Please Stand Up*, NAMSAP News (April 2005); Matthew L. Garretson, *Making Sense of Medicare Set Asides*, Trial (May 2006).) A possible indication of the future can be

## California Implements DRA, But Regs Must Be Written

California Governor Arnold Schwarzenegger has signed SB 483, implementing the Deficit Reduction Act of 2005. The legislation's provisions will apply prospectively only and commence only after regulations are adopted and filed with the California Secretary of State. The state's home equity limitation will be $750,000.

Hayward, California, elder law attorney Gene Osofsky notes that the statute was adopted as non-emergency legislation, which he believes means that the statute itself will not be effective until January 1, 2009. "However," Osofsky says, "in view of the fact that regulations will be necessary before it is fully implemented, advocates expect that full implementation will not be for some time after the effective date of the statute itself, and likely well into calendar year 2009."

To read SB 483, go to: *http://www.canhr.org/medcal/PDFs/sb_483_bill_20080826_enrolled.pdf*

found in one sentence in a 2003 CMS memorandum regarding WCMSAs. CMS said in response to a question about cases where there is a third-party liability claim and a workers' compensation claim that "[t]hird party liability insurance proceeds are also primary to Medicare." (Grissom memorandum referenced above) The following sentence of the memorandum says that an MSA is required if the third-party liability proceeds relieve a workers' compensation carrier of future liability. However, the statement that third-party liability insurance proceeds are primary is still a very important indication of the mindset at CMS.

Campbell, as well as Meifert and Lewis, have quoted CMS officials as reinforcing this attitude and giving a glimpse of what the future might hold. Campbell quoted CMS as saying that "CMS' position is that we expect any funds that are allocated for future medicals to be spent before any claims are submitted to Medicare for payment and the beneficiary will probably be asked about it on the initial enrollment questionnaire that is systems-generated, but, we are not asking that MSA's be established in these cases, nor are we reviewing/approving/denying them." In addition, according to Campbell, CMS said it has "no current plans for a formal process for reviewing and approving liability Medicare set-aside arrangements. However, even though no formal process exists, there is an obligation to inform CMS when future medicals were a consideration in reaching the liability settlement, judgment or award as well as any instances where a settlement, judgment or award specifically provides for medicals in general or future medicals." A reading of the Medicare Secondary Payer Act clearly supports the idea that the requirement of set asides is not limited to workers' compensation cases. The MSP makes it clear that Medicare is always the secondary payer to workers' compensation and liability insurance.

A recent law passed by Congress and a corresponding appropriation of money for enforcement of the MSP may play a role in the decision by the government of whether to issue guidelines and policies regarding MSAs for liability settlements. On December 29, 2007, President Bush signed into law the Medicare, Medicaid, and SCHIP Extension Act of 2007. The purpose of this legislation (specifically Section 111), as expressed by its sponsor, Sen. Charles Grassley (R—IA), is to *"[C]ontinue to improve accountability in the Medicare Program. There are situations when Medicare is not the primary payer for a beneficiary's health care, but it is currently difficult to identify these situations. This legislation will improve the Secretary's ability to identify beneficiaries for whom Medicare is the secondary payer by requiring group health plans and liability insurers to submit data to the Secretary."* Congressional Record, US Senate, December 18, 2007, S15835, paragraph 9.

Section 111 of the Act extends the government's ability to enforce the MSP. As of July 1, 2009, an applicable plan (liability insurer, self insurer, no-fault insurer and workers' compensation carriers) shall determine whether a claimant is a Medicare beneficiary and if so provide certain information to the Secretary of Health and Human Services when the claim is resolved. Under the new law, the insurers described above must report the identity of the Medicare beneficiary to the Secretary and such other information as the Secretary deems appropriate to make a determination concerning coordination of benefits, including any applicable recovery of claim. Failure of an applicable plan to comply with these new requirements will incur a civil money penalty of $1,000 for each day of noncompliance with respect to each claimant. These new reporting requirements will make it very easy for CMS to review settlements to determine whether Medicare's interests were adequately addressed by the settling parties.

The problem with the new act is that it raises quite a few questions. The first is what will need to be reported besides the identity of the Medicare beneficiary. The determination of what information will be required to be reported will eventually be cleared up once announced by the Secretary. In addition, there is no clarity concerning the manner, frequency or the form of the reporting requirements. Of more importance is the question of why does the government want this

## Rhode Island's Medicaid Proposal Could Set Dangerous Precedent for Other States

On August 8, Rhode Island Gov. Donald Carcieri (R) submitted a proposal to the Centers for Medicare and Medicaid Services (CMS) for permission to radically transform the state's Medicaid program.

Under Rhode Island's proposal, for five years the state would receive an annual federal block grant of a fixed amount and would limit its own Medicaid spending to a constant share of the state budget. In exchange, the state would gain the freedom to alter Medicaid eligibility and services as it sees fit and as budget requirements dictate.

Among other changes, Rhode Island wants to make nursing home care much harder to receive. Three categories of need for long-term services would be established, and only individuals who are at the highest level of need would be guaranteed any form of long-term care. The rest, including some eligible for nursing home care under the state's current program, could be put on a waiting list.

If the proposal is approved, warns the Center on Budget and Policy Priorities, it could "set a national precedent" that would affect low-income people in other states, including the elderly and disabled, who rely on Medicaid to obtain needed health care.

data and what will it do with it? The most important question for trial lawyers is whether this will affect how liability settlements are negotiated and whether it signals the consideration of a specific enforcement policy for set asides in liability settlements. Through the collection of this data, government officials will now have the information at their fingertips to examine liability settlements to see if the burden is being shifted to Medicare when a secondary payer exists. If that is the intent—collection of information to review settlements where Medicare's interests are not adequately considered—the government could use that information to decide to pursue aggressive enforcement of the set aside requirement outside of workers' compensation settlements. Creating a reporting obligation, providing for stiff fines and appropriating money for the purpose of enforcing the new Act seems to signal the government's seriousness regarding this issue. For the time being, there are no answers to these questions and only time will tell.

If the government does decide to formally require set asides in liability settlements and promulgate guidelines, the issue of extending set asides to liability cases is fraught with problems. At least one commentator has recognized the difficulty in applying the concept of set asides outside of workers' compensation cases because liability cases are settled differently from the no-fault workers' compensation system. (Matthew L. Garretson, *Making Sense of Medicare Set Asides*, Trial (May 2006).) Liability settlements can be reduced by the victim's own negligence. In addition, liability settlements can be capped by the amount of available insurance or tort reform damage caps. Many liability settlements also do not differentiate between the damages the settlement compromises, unlike workers' compensation, where settlements typically allocate how much money is for indemnity benefits versus future medical expenses. Given these realities, many liability settlements are not full compensation for injuries and it is difficult to apportion an exact dollar figure to future medical expenses. CMS's current methodology and requirements are based on the premise of a settlement for the full value of the future medical expenses for the work-related injury and a bright line allocation of the settlement proceeds between indemnity versus future medical expenses. In this author's opinion, there would need to be new policies and guidance issued for liability settlements if CMS decides to issue guidelines for liability set asides and pursues aggressive enforcement.

### *Conclusion*

The issue of what to do when settling a liability case involving a Medicare beneficiary in light of all the foregoing is difficult at best. Meifert and Lewis have suggested that a trial lawyer should address Medicare's interests in liability settlements if the client is a Medicare beneficiary or if there is a "reasonable expectation" of Medicare enrollment within 30 months of the settlement date and the anticipated total settlement amount for future medical expenses and disability/lost wages over the life or duration of the settlement agreement is expected to be greater than $250,000. Given the current state of affairs, prudence may dictate at the very least to obtain an MSA allocation for settlements involving a Medicare beneficiary or if there is a reasonable expectation of Medicare eligibility. If one were to be more cautious, there are two suggested courses of action to address Medicare's interests in any settlement. The first is to obtain an estimate of future medical expenses; clearly identify settlement funds allocated for future medical expenses; put the plaintiff on notice that these funds should only be used for Medicare-related expenses; and draft settlement documents in such a way as to indicate Medicare's interests have been addressed. The second is to obtain a traditional MSA allocation and submit the set aside for approval to CMS even though current CMS policy does not guarantee it will even be reviewed.

Given the ramifications of loss of Medicare benefits and potential liability a lawyer faces for failure to comply with the MSP, it is extremely important to understand the issues and thoroughly explain these matters to the injury victim who may need Medicare coverage in the future. While there are no definitive answers on the liability side for MSAs, it is appropriate and prudent for every lawyer to examine this area of the law.

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## KEEPING CURRENT

# US Court Rejects Maryland Ban On Preeligibility Deductions

*Maryland Department of Health and Mental Hygiene v. Centers for Medicare and Medicaid Services* (4th Cir., No. 07-1512, Sept. 25, 2008). A federal appeals court upholds CMS's rejection of a Maryland State Plan Amendment that would have prohibited Medicaid beneficiaries living in long-term care facilities from using their income to pay for the medical expenses they incurred before they became eligible for Medicaid.

In 2003, Maryland elder law attorney Ron M. Landsman informed the Centers for Medicare and Medicaid Services (CMS) that Maryland was not allowing Medicaid recipients to deduct from their patient pay amount the cost of medical expenses they