CONSIDERING MEDICARE'S INTERESTS: WHY MEDICARE SET ASIDES MUST BE CODIFIED

BY JASON D. LAZARUS, ESQ.

For many years personal injury cases have been resolved without consideration of Medicare's secondary payer status even though since 1980 all forms of liability insurance have been primary to Medicare. At settlement, by judgment or through an award, an injury victim would receive damages for future medical that were Medicare covered. However, none of those settlement dollars would be used to pay for future Medicare covered health needs. Instead, the burden would be shifted from the primary payer (liability insurer or Workers' Compensation carrier) to Medicare. Injury victims would routinely provide their Medicare card to providers for injury related care.

These practices began to change in 2001 when Medicare Set Asides (hereinafter "MSA") were officially recognized by CMS for Workers' Compensation cases. Interestingly, around that same time the General Accounting Office was studying the Medicare system and pointed out that Medicare was losing money by paying for care that was covered under the Workers' Compensation system.[1] Accordingly, CMS circulated a memo in 2001 to all its regional offices announcing that compliance with the secondary payer act required claimants to set aside a portion of their settlement for future Medicare covered expenses where the settlement closed out future medical expenses.[2] The new "set aside" requirement was designed to prevent attempts "to shift liability for the cost of a work-related injury or illness to Medicare."[3] Set asides ensure that Medicare does not pay for future medical care that is being compensated by a primary payer by way of a

settlement or an award. The procedures and policy for set asides have been developed through subsequent CMS memoranda known as Frequently Asked Questions.

CMS' rationale for creating an MSA is compliance with the Medicare Secondary Payer Act (hereinafter "MSP"). The MSP is a series of statutory provisions[4] enacted in 1980 as part of the Omnibus Reconciliation Act[5] with the goal of reducing federal health care costs. 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.[6] The regulations that implement the MSP provide "[s]ection 1862(b)(2)(A)(ii) of the Act precludes Medicare payments 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.[7]

There are two issues that arise when dealing with the application of the MSP: (1) Medicare payments made prior to the date of settlement (conditional payments) and (2) future Medicare payments for covered services (Medicare set asides). Since Medicare isn't supposed to pay for future medical expenses covered by a liability or Workers' Compensation settlement, judgment or award, CMS recommends that injury victims set aside a sufficient amount to cover future medical expenses that are Medicare covered. CMS' recommended way to protect future Medicare benefit eligibility is establishment of an MSA to pay for injury related care until exhaustion.

The problem is that MSAs are not required by a federal statute even in Workers' Compensation cases where they are commonplace. Instead, CMS has intricate "guidelines" and "FAQs" on their website for nearly every aspect of set asides from submission to administration. There are no such guidelines for liability settlements

involving Medicare beneficiaries. Without codification of set asides, there are no clear cut appellate procedures from arbitrary CMS decisions and no definitive rules one can count on as it relates to Medicare set asides. While there is no legal requirement that an MSA be created, the failure to do so may result in Medicare refusing to pay for future medical expenses related to the injury until the entire settlement is exhausted. This creates a difficult situation for Medicare beneficiary-injury victims and contingent liability for legal practitioners as well as other parties involved in litigation involving physical injuries to Medicare beneficiaries.

Additionally, problems exist and greater costs may be incurred in the settlement of Workers' Compensation cases due to the lack of uniformity as well as clarity regarding Medicare Set Asides.[8] The lack of uniformity and clarity comes from the fact that CMS regularly changes its procedures through publishing new memoranda in the form of FAQs which articulate policy. There have been 11 such memos since the original 2001 memo announcing set asides. Submission of a set aside to CMS for review is sometimes a long process which causes extra costs for parties to the litigation. For example, medical and indemnity benefits typically continue to be paid in a non-controverted claim while CMS reviews the proposed set aside. The amount of the set aside does not take into account that the settlement amount may be lower due to other factors in the settlement apart from medicals. Fees are incurred in preparation of an allocation and submittal to CMS. The costs in creating a set aside may ultimately lower what is available to the claimant to compensate for wage loss. Delays in settlement or the inability to settle cases due to the set aside issue is another significant problem that has a large impact on the tort system. The absence of any law or guidelines in the liability context is also a tremendous

problem. Since guidelines only exist in Workers Compensation cases, those guidelines are frequently applied to liability settlements. However, this creates many problems as Workers' Compensation cases and liability cases are two very different animals.[9] Thus, codification is vitally important from a systemic and cost perspective for both comp and liability.

The remainder of this article will explore the guidelines that do exist regarding compliance with the Medicare Secondary Payer Act for future medical services and the associated problems; past and current proposed legislation to codify Workers' Compensation Medicare set asides; and finally procedural due process and public policy reasons for codification of set asides.

The Current State of Affairs - MSP & Medicare set asides

Workers Compensation

The most important and confused aspect of the MSP today is how CMS has enforced its right as a secondary payer for future payments after a physical injury recovery. The only guidance on that subject comes from the Workers' Compensation system and the numerous CMS memoranda on the subject. 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."[10] CMS goes on to say that "[t]he recommended method to protect Medicare's interests is a Workers' Compensation Medicare Set-aside Arrangement (WCMSA) . . .". An MSA is a portion of settlement proceeds set aside, called an "allocation", to pay for future Medicare covered services which must be exhausted prior to Medicare paying for any future care related to the work

injury.[11] The amount of the set aside is determined on a case by case basis and may be submitted to CMS for approval if the case fits within the review thresholds established by CMS.[12]

CMS explains on their website that the purpose of a workers' compensation Medicare set aside 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."[13] 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.[14] CMS' legal justification for this position is 42 C.F.R. Section 411.46 which says Medicare payments may not be made for "work related injury or disease" until medical expenses related to the injury equal the amount of the future medical portion of the settlement. The same regulation provides that if a "settlement appears to represent an attempt to shift to Medicare the responsibility for payment of medical expenses for the treatment of a work-related condition, the settlement will not be recognized."[15] Further, it goes on to given the following example "if the parties to a settlement attempt to maximize the amount of disability benefits paid under workers' compensation by releasing the workers' compensation carrier from liability for medical expenses for a particular condition, even though the facts show that the condition is work-related, Medicare will not pay for treatment of that condition."[16] It is also important to note that CMS may determine its own "reasonable" allocation when it comes to future medical if the settlement fails to do so.[17] There are no such regulations aimed at non-work related injuries.

While Medicare's interests, according to CMS, must always be considered when a workers' compensation case involving future medicals is settled, there are certain settlements that fall within the review and approval guidelines issued by CMS. CMS can approve or disapprove a MSA allocation.[18] CMS, according to its memoranda, must review and approve a set aside if the workers' compensation claimant is a Medicare beneficiary and the total settlement amount is greater than twenty-five thousand dollars.[19] CMS says this is a workload review threshold and not a "substantive dollar" or "safe harbor" threshold."[20] In addition, if the "claimant has a "reasonable expectation"[21] 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 has to be reviewed and approved.[22] CMS says that a WCMSA is not necessary 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.[23]

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."[24] 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."[25]

Despite all of the foregoing, CMS has admitted in litigation over the agency's Workers' Compensation Medicare Set Aside practices that there is "no legal requirement that the WCMSA [Workers' Compensation Medicare Set Aside] process be utilized by a claimant."[26] At the same time CMS says that failure to consider Medicare's interests may result in the refusal to pay for future medical expenses related to a workers' compensation injury until the entire settlement is exhausted. An examination of the secondary payer statute and regulations reveals the complete absence of the terms "consider Medicare's interests" even though CMS uses this in its justification for set asides. Similarly, there is no punishment for failing to get CMS pre-approval of a set aside. However, if one submits a set aside to CMS for pre-approval there is no meaningful appeal process from the agency's decisions regarding set asides. While CMS, in Protocols, LLC v. Leavitt[27], asserts there is a Medicare administrative review and appeal process it is only applicable once Medicare services are denied.[28] There are no known reported cases of CMS decisions being reviewed through the legal system for Medicare Set Asides. Furthermore, the administrative review process puts the injury victim into an untenable position of having to wait until they are denied medical services by Medicare to appeal agency actions related to set asides. This is so because review of a set aside allocation is most likely not an official action of a government agency.[29]

One commentator raised a very interesting question regarding CMS approval of set asides and that is whether an approval would be binding on CMS at all.[30] His position is that a set aside approval is not a "formal action of the agency."[31] So would the

approval be a binding enforceable contract that could be enforced under a contract theory? How likely would it be to prevail in that kind of an action? Another question is whether a CMS decision regarding disapproval of an allocation or increase is within the authority given to CMS by law and would it be binding.[32] Since the entire review process is voluntary by CMS's own admission and there is no legal authority for agency action in regard to review, it doesn't seem likely that if challenged the decision could be binding. Furthermore, since it probably is not a final agency action no appeal would be possible. However, if CMS subsequently denied Medicare payments to the Medicare beneficiary that action would be subject to appeal and review.[33]

One author summarized the current situation by pointing out that "CMS does not have legal authority to mandate the use of set asides, their terms and conditions, or the right to pre-approve them."[34] Nevertheless, CMS's " 'stamp of approval' is the only way of being certain that Medicare will not assert a subsequent claim that it paid for care covered by workers' compensation."[35] This creates "an unacceptable risk" to the parties involved in any potential settlement.[36]

Liability Settlements

As uncertain and lacking in formal protections as is the Workers' Compensation system is regarding set asides, it pales in comparison to the current state of affairs in liability settlements. The only known formal mention of Medicare Set Asides in liability settlements comes in the form of an answer to a FAQ in an April 2003 CMS memo.[37] CMS stated:

> Third party liability insurance proceeds <u>are also</u> 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. The only exception to establishing a WCMSA would be if it can be documented that the claimant does not require any further WC claim related medical services. A WCMSA is also not recommended if the medical portion of the WC claim remains open, and WC continues to be responsible for related services once the liability settlement is exhausted.[38]

While the foregoing is not on point as it addresses the question of whether a set aside is necessary when a 3rd party settlement extinguishes a workers' compensation obligation, it is instructive in the sense that it states CMS's position that 3rd party proceeds are primary to Medicare always. However, a plain reading of the MSP can provide that type of information. There have been some recent statements by CMS officials regarding liability set asides during town hall conferences which gives insight into how CMS views liability set asides. These town hall conferences relate to the new Medicare mandatory insurer reporting requirements under the Medicare, Medicaid & SCHIP Extension Act of 2007 ("MMSEA") which requires insurers and self insureds to report settlements with Medicare beneficiaries to CMS.[39] Due to confusion about this law and misinformation that it somehow requires Medicare Set Asides in third party liability settlements; CMS has been forced to address liability Medicare Set Asides during these calls.

In one such call from 2008, Barbara Wright (Acting Director of the Medicare Debt Management division at CMS), said "I don't believe there is a General Counsel Memo that says there are no liability set asides."[40] She went on to say "we have a very informal, limited process for liability set asides. We don't have the same extensive ones we have for worker's comp." Finally, she reiterated an important admission that "CMS approval of a set aside amount is not required. It is a voluntary process." In a more

recent call from September of 2009, Barbara Wright again addressed the issue of liability set asides by stating "[t]here is not – the same formal process for liability set asides that there is for Workers' Compensation set asides. However, the underlying statutory obligation is the same."[41] In the most recent call in October of 2009, Barbara Wright again emphasized that the review process for liability settlements was voluntary and each CMS regional office makes its own decision whether to review or not.[42] When discussing whether a CMS regional office would review or not she indicated that if the regional office believes there are "significant dollars at issue", they may review a proposed set aside amount for liability.[43] However, she says that the "fact that they decline to review in a particular case does not create any type of safe harbor. So you're back to an obligation that has existed essentially since 1980."[44]

The most recent version of the Medicare Secondary Payer manual, revised on 3-20-09, was updated with references to set asides in the liability context. In Section 20, which contains definitions, set aside arrangement are defined as follows:

> An administrative mechanism used to allocate a portion of a settlement, judgment or award for future medical and/or future prescription drug expenses. A set aside arrangement may be in the form of a Workers' Compensation Medicare Set-Aside Arrangement (WCMSA), No-Fault Liability Medicare Set-Aside Arrangement (NFSA) or Liability Medicare Set-Aside Arrangement (LMSA).[45]

Clearly CMS has intentions to do something as it relates to liability settlements and set asides since this was included in the MSP manual. The question is what and how will guidelines be developed? Will it be similar to Workers' Compensation? How will the decidedly different issues involved in liability settlements be addressed?

Given all of the foregoing, legal practitioners, Medicare beneficiary-injury victims and insurers are left guessing as to what to do when a liability settlement is

achieved. Is a set aside necessary? If so, how do parties determine if they are necessary? Is it only "significant dollars" cases? What rules apply if you do create a set aside? Do we look to the 12 CMS memoranda? What about the differences between Workers' Compensation cases and liability cases? Will CMS take into account policy limits in a liability case in determining the sufficiency of an allocation? What happens if policy limits are $50,000 and the future Medicare covered services are $150,000? Will CMS take into account comparative fault/contributory negligence issues that may reduce recovery? What about statutory or constitutional caps on damages? Can CMS fail to pay for Medicare covered services post liability settlement for the Medicare beneficiary-injury victim if there is no set aside created?

It should be painfully obvious from the foregoing discussion that codification of set asides is imperative. Given the possible loss of Medicare benefits, as threatened by CMS, a Medicare beneficiary has significant risks when it comes to Medicare Set Asides with little or no corresponding legal remedies. Significant delays persist in the Workers' Compensation MSA process which in some instances leads to settlements falling apart.[46] In addition, liability cases brought on behalf of Medicare beneficiaries may decrease due to the possibility of having to put all of the net proceeds into an MSA. As Rick Swedloff put it in his 2008 law review article, it creates a classic situation of "can't settle, can't sue".[47] In the context of conditional payments, he said that the "MSP discourages Medicare beneficiaries and their contingency fee attorneys from bringing suit in simple tort disputes."[48] That statement is all the more profound today in the face of the increasing complexities of conditional payments and the confusion over Medicare Set Aside issues.

Codification Attempts for MSAs and Pending Legislation

In late 2004, the Tort Trial and Insurance Practice Section ("TIPS") of the American Bar Association ("ABA") approved a recommendation to the association urging Congress to codify set asides in Workers' Compensation cases.[49] The TIPS committee noted there was a "unique level of accord" amongst the "Plaintiff's bar, the Defense bar, the insurance industry and workers' compensation agencies and adjudicators" regarding the need for codification of set asides.[50] The stated rationale was the need to "return some level of certainty, predictability and efficiency to this Medicare set aside process so as to integrate it into the State, Federal and Territorial Workers' Compensation systems which have been premised on the need for certitude, predictability, and efficiency."[51]

The TIPS report to the ABA pointed out that under 42 CFR 411.26 attorneys have potential exposure under the MSP "including professional liability exposure for failure to abide by its terms and or adequately advise clients" regarding set asides.[52] It recognized that Medicare beneficiaries who fail to obtain CMS approval of an MSA may "(1) receive a notice terminating future Medicare coverage, (2) be required to prove to CMS that they have spent the equivalent of 100% of the entire settlement solely for medical expenses before receiving Medicare reimbursements, and/or (3) lose Social Security disability benefits on a dollar for dollar basis until the MSP claim, including interest, has been satisfied."[53] Lastly, the TIPS committee highlighted the private cause of action that exists under 42 U.S.C. §1395y (b)(3)(A) "for double damages for failure to provide primary payment or appropriate reimbursement."[54] A possible result, as recognized by TIPS, is an insurance company being "forced to pay CMS 200% of the amount CMS

determines should have been set aside in the settlement for future Medicare eligible expenses required to treat the occupational injury."[55]

On February 14, 2005 the ABA House of Delegates adopted a resolution urging Congress to enact legislation relating to Medicare Set Asides.[56] The resolution highlighted the need for a low dollar threshold below which an MSA would automatically be unnecessary in light of the expense compared to the amount at stake.[57] It urged Congress to clarify the process for approving set asides; set a deadline for approval after which it is automatically approved if there is no CMS response and create an appeal procedure if parties dispute a CMS decision.[58] Additionally, it recommended the use of Workers' Compensation fee schedule to compute set aside allocations; create a "Safe Harbor" that Medicare's interests are protected if the set aside is at least a set percentage of the total claim cost or total medical benefits and allow the costs of obtaining CMS approval and cost of administration to be funded out of the set aside allocation.[59] Interestingly, it offered up the idea to allow the parties to elect to turn the allocated funds over to CMS releasing all parties from any liability under the MSP.[60] In an effort to streamline the process, it suggested creating standard forms for CMS submission to expedite approval process.[61] Finally, it recommended including only medical expenses which are compensable under both applicable state, federal or territorial Workers' Compensation Act and Medicare in the computation of the set aside amount.[62]

On May 4th 2006, Rep. Clay Shaw, a republican House member from Florida, introduced HR 5309, a bill entitled "Medicare Secondary Payer and Workers' Compensation Settlement Agreements Act of 2006."[63] The Congressional Research

Services summarized the act as follows "Medicare Secondary Payer and Workers' Compensation Settlement Agreements Act of 2006 – Amends title XVIII (Medicare) of the Social Security Act to: (1) create an exception to Medicare secondary Payer requirements for certain workers' compensation settlement agreements; and (2) provide for the satisfaction of such requirements through use of qualified Medicare set-asides under workers' compensation settlement agreements."[64] On May 15, 2006 the bill was referred to the Committee on Ways and Means and Committee on Energy and Commerce. HR 5309 included many of the provisions urged by the ABA in its February 14, 2005 resolution. The bill was both praised and vilified by insurance companies and legal practitioners.[65] The bill never became law.[66]

On May 21, 2009, a revised but similar bill to the 2006 bill was reintroduced by Democrat House member John Tanner as HR 2641 entitled "Medicare Secondary Payer and Workers' Compensation Settlement Agreements Act of 2009."[67] Upon introduction it was referred to the Committee on Ways and Means and the Committee on Energy and Commerce where it presently sits.[68] Some commentators believe the legislation solves many of the problems in the MSA process for Workers' Compensation cases. For example, Douglas Holmes, president of UWC-Strategic Services on Unemployment and Workers' Compensation and coordinator of the Coalition for Medicare Secondary Payer reform said the "Medicare Secondary Payer and Workers' Compensation Settlement Act of 2009 will provide clear and consistent standards for CMS administrative process."[69] He pointed out that "CMS takes too long to review proposed set-asides, fails to provide consistent standards for determining amounts to be set aside, and provides no avenue to appeal CMS determinations."[70] Ed Romano, President of Workers Injury Law and

Advocacy Group, a collection of attorneys that represents injured workers said that this "bill is about process improvement and fair treatment of all parties."[71] Further, he said that in "case after case, we hear of delays in approval, uncertainty of the amount to be reimbursed by injured workers, and changes in amounts to be set aside after settlements have already been approved." While I will not address the merits of the legislation, it is important to examine the highlights of it in terms of what it would do to resolve the issues currently facing Workers' Compensation MSAs.

HR 2641 would establish a "Safe Harbor" for settlements $25,000 or below. These settlements would be by operation of law exempt from the Secondary Payer provisions relating to set asides. Also included would be settlements where the claimant is unlikely to become Medicare eligible within 30 months. Where a "compromise settlement" was reached and the claim was denied in whole, there would be no need for a set aside. A "compromise settlement" is defined as a settlement where the workers' compensation claim is denied or contested, in whole or in part and the settlement does not provide full compensation of benefits. Where a claim was denied in part, the set aside amount could be reduced by a percentage in direct proportion to the full value of the claim. In this scenario, the percentage reduction for the set aside would be equal to the percentage of benefits denied as compared to full value. This provision deals with the problem of settlements where injuries are disputed and the injured worker gets half or less of the full value of the claim. Under the current system, an MSA must be funded for the value of all future medical even though the settlement is well below full value.

The bill also requires the allocation be based on the claimant's state workers' compensation fee schedule. A very important aspect of the legislation is that the parties

could deduct from the set aside the costs and expenses incurred in establishing, administering and securing approval of the MSA. The MSA would be reduced by a proportional share of costs and expenses such as attorney's fees, third-party vendor costs and any set aside administrator fees incurred by the parties. MSAs submitted to CMS for approval are automatically approved, under the new legislation, unless disapproved no later than 60 days after receipt of the submission. It also sets up an appeal process for adverse decisions. Review includes reconsideration by the Secretary of Health and Human services; a hearing before an administrative judge and a judicial review of the Secretary's final determination.

While this proposed legislation would bring welcome clarity to the Workers' Compensation MSA process, it is not a panacea and most importantly it does not address liability settlements. The framework created by this legislation could be the backbone of legislation relating to set asides in the liability context. However, it does not appear at this point that there is any push to codify set asides outside of Workers' Compensation cases. The biggest challenge for codification of set asides in liability settlements would be coming up with an appropriate "Safe Harbor" below which a set aside would be unnecessary and a system to deal with issues such as policy limits, comparative fault/contributory negligence as well as caps on damages in calculating the set aside amount.

Procedural Due Process: A Reason for Codification

While a constitutional discussion of procedural due process is beyond the scope of this paper, the lack thereof in the current MSA process is a significant justification for codification. As such, a brief discussion of the due process argument as it relates to set

asides is appropriate. In the Protocols case, the plaintiff asserted in their complaint that CMS's decisions regarding MSAs can't be directly appealed which therefore violates the Fifth Amendment right to due process.[72] Procedural due process safeguards apply to deprivation of interests under the Fourteenth Amendment's protection of liberty and property.[73] If protected liberty or property interests are impacted by government action, some form of hearing would be required before final deprivation of the interest.[74] It has been clearly recognized that money constitutes a property interest.[75]

The Protocols case involved a claim of harm by an MSA allocation provider and there was discussion in their court filings about whether the loss of their potential fees was a property interest under the due process analysis. Clearly that is a non-issue when dealing with a Medicare beneficiary-injury victim's settlement dollars and a potential deprivation of their property interest therein. As Protocols pointed out in their Motion for Summary Judgment, in order to demonstrate a violation of procedural due process a Medicare beneficiary would need to prove that an adverse CMS MSA decision would "threaten a deprivation of a protected property interest and that CMS has denied adequate procedural protections."[76] Since money is a property interest under due process case law, the first prong would arguably be satisfied under the correct fact pattern.[77] The second prong is arguably an easy call as well since CMS admitted in the Protocols case that "[t]here are no appeal rights stemming from a CMS determination of the appropriate amount of a WCMSA."[78]

While there was significant discussion in the court filings of the Protocols case by both parties about the other appellate remedies available to Medicare beneficiary-injury victims, none of them appear "meaningful."[79] According to due process case law, as

cited by the plaintiff in Protocols, "'[t]he fundamental requirement of due process is the opportunity to be heard at a meaningful time and in a meaningful manner.' Time and again, the Supreme Court has made clear that 'some form of hearing is required before an individual is finally deprived of a property interest.'"[80] While CMS has a process for correcting "obvious mistakes and "errors"; a reconsideration process if new information or additional evidence is obtained and an appellate process for denial of a submitted claim based upon non-exhaustion of an MSA, that is insufficient in this author's opinion to satisfy due process. Those processes fail to address the deprivation of settlement dollars from an adverse CMS determination regarding the amount of an MSA which can cause a settlement to fall apart completely. In addition, the only real avenue of appeal is to wait for a denial, years in the future, of a specific benefit due to failure to exhaust the MSA. I agree with the plaintiff in Protocols that "CMS's promise of a hearing at some point in the distant future is hardly due process offered at a 'meaningful time'". [81]

The lack of a right to timely appeal under the current MSA process is an important reason for codification. Without an appeal right, parties have absolutely no recourse against arbitrary decisions by CMS relating to the amount of a set aside. This leads to avoidance of the review system and/or delay and frustration of the settlement process. This is so because when CMS comes back with a number that is higher than the submitted MSA allocation, the parties frequently re-evaluate whether to settle the case at all. This sort of outcome frustrates the efficient operation of the tort system and prevents any recovery by CMS.

Public Policy: Reasons for Codification

While there are compelling legal reasons to codify set asides, there are strong public policy reasons for codification of set asides. Codification in the liability context could help offset the difficult financial straights of the Medicare Part A trust fund. In addition, from a public policy standpoint we don't want Medicare to pay for care that an injury victim received compensation for from a liability insurer or Workers' Compensation carrier through a settlement or award. This type of double dipping or cost shifting from a primary payer to Medicare is exactly what the MSP was designed to avoid.

Forty seven million people have Medicare health insurance coverage.[82] Of those forty seven million, eight million are permanently disabled under the age of 65. Sixteen percent of the Medicare population is under the age of 65 and permanently disabled.[83] According to Kaiser Family Foundation studies, permanently disabled Medicare recipients tended to have lower incomes and tend to have relatively high rates of health problems.[84] A fairly significant share of the population (40%), are dual eligible for Medicare and Medicaid.[85]

Medicare makes up twelve percent of the federal budget and twenty percent of total national health expenditures.[86] Medicare spending is predicted to double from $528 billion in 2010 to $1,038 billion in 2020.[87] The Kaiser family foundation points to several factors that will present future fiscal challenges for Medicare including the skyrocketing medal costs, aging population, decline in the number of workers per Medicare beneficiary and increases in life expectancy.[88] "From 2010 to 2030, the number of people on Medicare is projected to rise from 46 million to 79 million, while

the ratio of workers per beneficiary expected to decline from 3.7 to 2.4."[89] By 2017 the part A Medicare trust fund is projected to be depleted.[90] Part A spending has exceeded income for the Medicare program since 2008.[91]

These statistics are staggering and sobering. Many aged and injured disabled Americans receive their healthcare thru Medicare. They depend on Medicare coverage for their future medical treatment. The Medicare Secondary Payer act was designed to avoid having Medicare pay when a primary exists and force the primary to take financial responsibility for a Medicare recipient's healthcare thereby protecting the Medicare trust fund. The MSP program, which includes MSAs and conditional payment recoveries, has been rapidly increasing since 2000. In 2000, the MSP saved Medicare $3.12 billion.[92] However, in 2006 that figure rose to $6.09 billion.[93] Thru the implementation of Workers' Compensation MSAs, CMS saved $180 million in 2005 and over $390 million in 2006.[94] According to CMS, it costs approximately $187.00 to review each MSA that is submitted.[95] Based upon that cost point, the government spent $2,957,779.00 on MSA review in 2005 and $2,640,440 in 2006. That represents an approximate cost of 1.7% as a percentage of recovery in 2005 and approximately .7% in 2006. One can quickly see how this math could result in substantial savings to the Medicare trust fund if all settlements involving Medicare beneficiaries required a set aside.

While at least one commentator believes codification of set asides in all cases might lead to a disincentive to settle, with proper legislative constraints that should not be the case.[96] If there was no change to current CMS MSA practice, there likely would be a disincentive to settle cases where all of the money might repay conditional payments and go into a set aside. For example, an injury victim might net nothing where you have a

$50k policy limits settlement stemming from an auto crash and future Medicare covered services are $150,000 and $25,000 in conditional payments. To deal with this type of a situation, future liability set aside legislation would need to address how to reduce the set aside allocation in proportion to what was recovered versus actual damages. An approach similar to the one espoused in Arkansas Department of Health and Human Services v. Ahlborn[97] would make a lot of sense in this type of scenario. This analysis would allow for a reduction of the set aside amount based upon the injury victim's failure to recover all of his future medical damages due to a compromise settlement. With this approach, the settlement would have to be allocated between types of damages and then a calculation would be done to determine what percentage of the future medical care needed was recovered and the set aside amount would be reduced by that percentage. This is similar to the way HR 2641, deals with the issue in the context of Workers' Compensation set asides.[98]

However, if done incorrectly, codifying set asides in all cases could lead to more cases being tried instead of settled. This is so because if the injury victim will net zero from a proposed compromise settlement due to conditional payments and a set aside, the likelihood would be that they would go to trial to try to obtain more money. Going to trial could increase expenses; cause a strain on the judicial system and increase the chances of Medicare as well as the injury victim recovering nothing. Accordingly, while I have advocated for codification of set asides, it must be a fair system to all parties taking into account the size of the recovery in relation to future medical expenses.

Conclusion

CMS has used the MSP as justification to encourage the use of Medicare Set Asides in Workers' Compensation and liability settlements despite the fact that there is no statute or regulation referencing MSAs. All Medicare beneficiary-injury victims have to rely upon for guidance in this area are published CMS internal memoranda and FAQs. This has led to substantial uncertainty; lack of due process for redress of CMS decisions; delays and the potential to discourage meritorious lawsuits.

I believe the ABA put it best that "[b]ecause CMS has been unable to fix the problems, legislation is needed to provide for certainty, predictability, and efficiency to this set-aside process which was mandated by Medicare without statute or regulation referencing MSP set-asides or providing for a CMS settlement review process." As the ABA pointed out, legislation regarding Medicare Set Asides needs to establish straightforward criteria for when an MSA should be reviewed; create clear cut rules for establishing an MSA and provide certainty along with reducing delays now disrupting the tort system across the country. I would add that there needs to be an appeal process in place to allow Medicare beneficiary-injury victims to appeal arbitrary decisions in the MSA process. Finally, any legislation needs to address liability settlements and MSAs not just Workers' Compensation settlements.

From a public policy standpoint, as a society, we don't want injury victims to double dip by settling their case and then turning to Medicare for health care coverage when part of their recovery was for future medical. Protecting the Medicare trust fund so it is viable into the future requires we insist that primary payers take financial

responsibility and not shift the burden to Medicare. This is what the MSP was meant to do and that objective can be accomplished if legislation is properly crafted.

The Medicare Set Aside process is based on policy memorandum as opposed to federally enacted law. Given what is at stake for Medicare beneficiary-injury victims and other parties, codification is essential to properly protect their rights and provide legitimacy to the system. In the end, codification should mean more certainty for the parties and more money recovered for Medicare.

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[1] Edward M. Welch, *Medicare and Worker's Compensation After the 2003 Amendments*, WORKERS' COMPENSATION POLICY REVIEW, at 5 (March/April 2003).
[2] Parashar B. Patel, *Medicare Secondary Payer Statute: Medicare Set-Aside Arrangements*, Centers for Medicare and Medicaid Services Memorandum, July 23, 2001.
[3] *Id.*
[4] The provisions of the MSP can be found at Section 1862(b) of the Social Security Act. 42 U.S.C. § 1395y(b)(6) (2007).
[5] Omnibus Reconciliation Act of 1980, Pub. L. No. 96-499 (Dec. 5, 1980).
[6] 42 CFR § 411.20(2) Part 411, Subpart B, (2007).
[7] *Id.*
[8] Eric J. Oxfeld, *Congress Must Reform Medicare Set Asides*, FLA. UNDERWRITER, May 2006, at S-9.
[9] Zinman v. Shalala, 67 F.3d 841, 846 (9th Cir. 1995). The Zinman court recognized how different Workers' Compensation settlements are from liability. The court pointed out that "[a]pportionment in workers' compensation settlements therefore involves a relatively simple comparison of the total settlement to the measure of damages allowed for individual components of the settlement, pursuant to a prescribed formula. Tort cases, in contrast, involve noneconomic damages not available in workers' compensation cases, and a victim's damages are not determined by an established formula. Apportionment of Medicare's recovery in tort cases would either require a factfinding process to determine actual damages or would place Medicare at the mercy of a victim's or personal injury attorney's estimate of damages."
[10] *See* CMS website at http://www.cms.hhs.gov/WorkersCompAgencyServices/08_setasiderelatedtopics.asp
[11] *See* Parashar B. Patel, *Medicare Secondary Payer Statute: Medicare Set-Aside Arrangements*, Centers for Medicare and Medicaid Services Memorandum, July 23, 2001. *See also* CMS website at http://www.cms.hhs.gov/WorkersCompAgencyServices/08_setasiderelatedtopics.asp
[12] *Id.*
[13] *See* CMS website at http://www.cms.hhs.gov/WorkersCompAgencyServices/08_setasiderelatedtopics.asp. *See also* Parashar B. Patel, *Medicare Secondary Payer Statute: Medicare Set-Aside Arrangements*, Centers for Medicare and Medicaid Services Memorandum, July 23, 2001.
[14] *Id.*
[15] 42 CFR § 411.46(b)(2)
[16] *Id.*
[17] 42 CFR § 411.47
[18] Interestingly, there is no appeal process if a proposed set aside is not approved. Thomas Grissom, *Medicare Secondary Payer – Workers' Compensation (WC) Frequently Asked Questions*, Question 14, Centers for Medicare and Medicaid Services Memorandum, April 22, 2003. 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.

Id. If this occurs, the entire settlement would have to be exhausted before Medicare would make any payments for work injury related medical services. *Id.*

[19] Gerald Walters, *Workers' Compensation Medicare Set-Aside Arrangements (WCMSAs) and Revision of the Low Dollar Threshold for Medicare Beneficiaries*, Centers for Medicare and Medicaid Services Memorandum, April 25, 2006.

[20] *Id.*

[21] Reasonable expectation of becoming a Medicare beneficiary is defined by CMS as the individual has applied for Social Security Disability Benefits; the individual has been denied Social Security Disability Benefits but anticipates appealing that decision; the individual is in the process of appealing and/or re-filing for Social Security Disability Benefits; 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 the individual has an End Stage Renal Disease (ESRD) condition but does not yet qualify for Medicare based upon ESRD. Thomas Grissom, *Medicare Secondary Payer – Workers' Compensation (WC) Frequently Asked Questions*, Question 2, Centers for Medicare and Medicaid Services Memorandum, April 22, 2003.

[22] Parashar B. Patel, *Medicare Secondary Payer Statute: Medicare Set-Aside Arrangements*, Question 1, Centers for Medicare and Medicaid Services Memorandum, July 23, 2001. In order to decide whether a settlement has reached the $250,000 dollar threshold one must calculate it by adding together settlement proceeds for "wages, attorney fees, all future medical expenses (including prescription drugs), and repayment of any Medicare conditional payments". *See* Gerald Walters, *Workers' Compensation Medicare Set-Aside Arrangements (WCMSAs) and Revision of the Low Dollar Threshold for Medicare Beneficiaries*, Centers for Medicare and Medicaid Services Memorandum, April 25, 2006. CMS requires that the total payout of an annuity, if a structured settlement is used, be calculated and used to determine whether the dollar threshold has been reached. *Id.* The following example is given by CMS to demonstrate how to calculate the threshold when an annuity is utilized, "a settlement is to pay $15,000 per year for the next 20 years to an individual who has a "reasonable expectation" of Medicare enrollment within 30 months. This settlement is to be funded with an annuity that will cost $175,000. The RO will review this settlement because the total settlement to be paid is greater than $250,000 ($15,000 per year x 20 years = $300,000). It is immaterial for Medicare's purposes that the PDV or cost ($175,000) to fund this settlement is less than $250,000." Thomas Grissom, *Medicare Secondary Payer – Workers' Compensation (WC) Frequently Asked Questions*, Question 17, Centers for Medicare and Medicaid Services Memorandum, April 22, 2003.

[23] Thomas Grissom, *Medicare Secondary Payer – Workers' Compensation (WC) Frequently Asked Questions*, Question 20, Centers for Medicare and Medicaid Services Memorandum, April 22, 2003.

[24] *Id.* at Question 22.

[25] *Id.* at Question 12. In question 22 of the same memo, the question is posed "[w]hat happens if one of the parties settling a WC case refuses to involve CMS, even though Medicare has an interest in the case?". *Id.* at Question 22. According to CMS, "[i]n these situations, the "cooperative" settling party should notify the appropriate CMS RO. Where the RO believes it is appropriate, the RO will then send the "uncooperative" part a letter (via certified mail) conveying that Medicare's interests must be considered in the WC settlement. The RO should inform the "uncooperative' settlement party that: "Pursuant to 42 CFR 411.24(g), 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 third party payment. Moreover, pursuant to 42 CF 411.25, CMS is subrogated to any individual, provider, supplier, physician, private insurer, state agency, attorney, or any other entity entitled to payment by a third party payer. Therefore, pursuant to 42 CFR 411.24(b), CMS may initiate recovery against the parties listed under 42 CFR 411.25 as soon as it learns that payment has been made or could be made under workers' compensation." *Id.*

[26] Defendant's Motion for Summary Judgment and Supporting Brief at 3, Protocols, LLC v. Leavitt, 549 F.3d 1294 (10th Cir. Dec. 2008).

[27] Protocols, LLC v. Leavitt, 549 F.3d 1294 (10th Cir. Dec. 2008).

[28] *Id.*

[29] Edward M. Welch, *Medicare and Worker's Compensation After the 2003 Amendments*, WORKERS' COMPENSATION POLICY REVIEW, at 5 (March/April 2003).

[30] *Id.*

[31] *Id.*

[32] *Id.*
[33] *See* 42 U.S.C. § 1395ff(b)(1); Fanning v. United States, 345 F.3d. 386, 400-401 (3d Cir. 2003).
[34] Eric J. Oxfeld, *Congress Must Reform Medicare Set Asides*, FLA. UNDERWRITER, May 2006, at S-9.
[35] *Id.*
[36] *Id.*
[37] Thomas Grissom, *Medicare Secondary Payer – Workers' Compensation (WC) Frequently Asked Questions*, Question 19, Centers for Medicare and Medicaid Services Memorandum, April 22, 2003.
[38] *Id.* (emphasis added)
[39] Medicare, Medicaid and SCHIP Extension Act of 2007 (P.L. 110-173). This Act was passed by the House on December 19, 2007, and by a voice vote in the Senate on December 18, 2007. It was signed into law by President Bush on December 29, 2007.
[40] Barbara Wright, MMSEA October 29,2008 NGHP Transcript at P. 18
[41] Barbara Wright, MMSEA September 30, 2009 NGHP Transcript at P. 25
[42] Barbara Wright, MMSEA October 22, 2009 NGHP Transcript at P. 65
[43] *Id.*
[44] *Id.*
[45] Medicare Secondary Payer (MSP) Manual (Rev. 65, 03-20-09).
[46] Eric J. Oxfeld, *National Issues Impacting Workers' Compensation*
[47] Rick Swedloff, *Can't Settle, Can't Sue: How Congress Stole Tort Remedies from Medicare Beneficiaries*, 41 AKRON L. REV. 557 (2008).
[48] *Id.*
[49] James K. Carroll, ABA, Tort Trial and Insurance Practice Section, (February 2005).
[50] *Id.*
[51] *Id.*
[52] *Id.*
[53] *Id.*
[54] *Id.*
[55] *Id.*
[56] ABA Resolution No. 109B (Adopted by the House of Delegates on February 14,2005)
[57] *Id.*
[58] *Id.*
[59] *Id.*
[60] *Id.*
[61] *Id.*
[62] *Id.*
[63] Govtrack.us at http://www.govtrack.us/congress/bill.xpd?bill=h109-5309; Medicare Secondary Payer and Workers' Compensation Settlement Agreements Act of 2006, H.R. 4309, 109th Cong. (2006).
[64] Congressional Research Service (5/2006)
[65] *See* John J. Campbell, *New Federal Legislation Regarding Medicare Set-Aside is Introduced in the House of Representatives*, THE MEDICARE SET ASIDE BULLETIN, May 9, 2006.
[66] "Sessions of Congress last two years, and ad the end of each session all proposed bills and resolutions that haven't passed are cleared from the books." Govtrack.us at http://www.govtrack.us/congress/bill.xpd?bill=h109-5309
[67] Govtrack.us at http://www.govtrack.us/congress/bill.xpd?bill=h111-2641; Medicare Secondary Payer and Workers' Compensation Settlement Agreements Act of 2009, H.R. 2641, 111th Cong. (2009).
[68] *Id.*
[69] *Coalition Hopes Bill will Resolve Medicare Set-Aside Delays, Confusion,* RISK & INSURANCE (2009).
[70] *Id.*
[71] *Id.*
[72] Complaint, Count Two at 13, Protocols, LLC v. Leavitt, 549 F.3d 1294 (10th Cir. Dec. 2008).
[73] *See* Mathews v. Eldridge, 424 U.S. 319, 332-33 (1976).
[74] Lawrence v. Reed, 406 F.3d 1224, 1233 (10th Cir. 2005).
[75] *See* Board of Regents v. Roth, 408 U.S. 564, 571-572 (1972).
[76] Plaintiff's Motion for Summary Judgment at 26, Protocols, LLC v. Leavitt, 549 F.3d 1294 (10th Cir. Dec. 2008) (citing Matthews v. Eldridge, 424 U.S. 319 (1976)).

[77] Roth, 408 U.S. at 571-572
[78] Plaintiff's Motion for Summary Judgment at 33, Protocols, LLC v. Leavitt, 549 F.3d 1294 (10th Cir. Dec. 2008). *See also* Thomas Grissom, *Medicare Secondary Payer – Workers' Compensation (WC) Frequently Asked Questions*, Question 14, Centers for Medicare and Medicaid Services Memorandum, April 22, 2003. "14) If Medicare rejects a proposed Medicare set-aside arrangement, how can the parties to a WC settlement appeal this rejection? Answer: The [sic] CMS has no formal appeals process for rejection of a Medicare set-aside arrangement." *Id.*
[79] Plaintiff's Motion for Summary Judgment at 28, Protocols, LLC v. Leavitt, 549 F.3d 1294 (10th Cir. Dec. 2008).
[80] Plaintiff's Motion for Summary Judgment at 28, Protocols, LLC v. Leavitt, 549 F.3d 1294 (10th Cir. Dec. 2008) (citing Lawrence v. Reed, 406 F.3d 1224, 1233 (10th Cir. 2005) (quoting Eldridge, 424 U.S. at 33)).
[81] *Id.* At 30
[82] *Medicare, A Primer 2010,* at Introduction (The Henry J. Kaiser Family Foundation 2010).
[83] *Id.* at 3
[84] *Id.*
[85] *Id.*
[86] *Id.* at 14
[87] *Id.* at 16
[88] *Id.* at 18
[89] *Id.*
[90] *Id.*
[91] *Id.*
[92] Hinda Chaikind, *Medicare Secondary Payer: Coordination of Benefits*, CRS REPORT FOR CONGRESS (March 6, 2008).
[93] *Id.*
[94] Letter from Herb B. Kuhn, Acting Deputy Administrator of CMS, to Honorable John Tanner (Aug. 9, 2007) (on file with author).
[95] *Id.*
[96] Norma S. Schmidt, *The King Kong Contingent: Should the Medicare Secondary Payer Statute Reach to Future Medical Expenses in Personal Injury Settlements?*, 68 U. PITT. L. REV. 469, 484 (2006).
[97] Arkansas Dept. of Health and Human Services v. Ahlborn, 126 S.Ct. 1752 (2006).
[98] Medicare Secondary Payer and Workers' Compensation Settlement Agreements Act of 2009, H.R. 2641, 111th Cong. (2009).