The Use and Propriety of Medicare Set Asides in Liability Settlements

July 12, 2011

This White Paper analyzes the propriety of using a Medicare Set-aside Arrangement ("MSA") in liability settlements as opposed to the workers' compensation context. This memo contains the academic and legal underpinnings behind the current MSA debate as well as practical guidance/tips for dealing with situations where a settling party (perhaps misinformed about the related requirements [or lack thereof]) is demanding an MSA be funded in a liability settlement without the proper screening as to the appropriateness of an MSA based on the case specific facts.

In all settlements, compliance with Medicare rules and regulations can involve two obligations: i) the satisfaction and discharge of Medicare's reimbursement claim for injury-related care from the date of injury through the date of settlement; and ii) the evaluation of obligations associated with future costs of care that may be provided to the claimant from the date of settlement onward. In our experience, the most logical way to assure that these obligations have been satisfied is to review the relevant statutes as well as any guidance from the Centers for Medicare & Medicaid Services ("CMS")[1] interpreting those statutes and apply this information to the facts of each case. Accordingly, this White Paper is based on the currently available guidance concerning satisfaction of Medicare's future interest in liability settlements.

MSA Overview

The purpose of an MSA, in both the liability and the workers' compensation ("WC") context, is to pay for future injury-related care which would otherwise be covered by Medicare. However, the MSA obligation in a liability settlement is less definable when compared to the traditional application in a WC settlement. That is because in a WC settlement, following no fault standards, there are only three "buckets" of damages: (1) indemnity; (2) past medicals; and (3) future medicals. Because every WC settlement has a future cost of care damage allocation, the only condition left to consider is whether there is a permanent burden shift over to Medicare in the obligation to pay for that future injury-related medical care. The same is not the case in a liability settlement, as issues of comparative fault, special damages, and other, non-future medical damages are present, and serve to confound an easy application of MSA concepts. Far from being a position we take on settlements, the lack of a uniform damage allocation can be considered a truism when it comes to identifying the lack of any MSA guidance from CMS where liability settlements are involved.

Consider: if settlement involves a claimant who is entitled or soon to be entitled to Medicare, a WC settlement (indemnity and medical) has a definitive shift of future health care expenses from the WC carrier to Medicare. This shift-of-burden carries a clear obligation to protect Medicare's interest, at least when following the Memoranda issued by CMS, including the Workers'

[1] CMS is the federal agency charged by the U.S. Department of Health and Human Services with the administration of Medicare programs, including Medicare Secondary Payer ("MSP").

Compensation (Patel) Memo of July 23, 2001. In WC settlements involving Medicare beneficiaries, federal regulations provide that the liability for medical expenses incurred due to work-related injuries should not be shifted to Medicare from the responsible party.[2] However, CMS' recommended means to protect Medicare's interest involves defining that portion of a Medicare beneficiary's WC settlement which relates to future cost of care. According to CMS' Memoranda, these monies should be set aside to pay for the beneficiary's future work-related injury and/or illness.[3] Federal regulations provide that Medicare will not pay for any medical expenses for the work-related injury or illness until the amount allocated to future medical expenses is exhausted.[4]

Since liability cases often involve a mix of inter-related damages (beyond the statutorily defined silos of indemnity and medicals in the WC context), the application of the WC-oriented MSA principles (and associated guidance from CMS) is far from clear cut in the liability context. As such, WC-oriented MSA principles cannot merely be grafted onto a liability case. Instead, an independent review of damages, including an analysis intended to determine the existence of future costs of care, and the presence (or lack thereof) of a permanent burden shift over to Medicare to pay for such care is proper to determine the propriety of MSAs in liability cases.

Medicare's Recovery Rights (the law)

Medicare's right of recovery extends both to the past and the future.[5] This is the case for both liability and WC cases. As such, when we talk about Medicare Secondary Payer compliance from the reimbursement/resolution perspective, we are really talking about two separate and distinct moving parts. On the one hand, Medicare has past payments to be reimbursed (arising from date of injury through date of settlement). On the other hand, Medicare also has an incentive to not pay for future medical expenses where funds were allocated from a WC settlement to pay for such future expenses (arising from date of settlement onward). Both past and future medical payments made or to be made by Medicare become a factor in settling WC cases to ensure Medicare compliance in the reimbursement sense.[6]

In the case of past payments (date of injury to date of settlement), Section 1862(b)(2) of the Social Security Act (42 U.S.C. §1395y(b)(2)) provides that *payment may not be made under*

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[2] 42 C.F.R. §411.46.

[3] CMS has issued sixteen (16) policy memoranda, from July 21, 2001 through May 11, 2011, discussing the use of MSAs in workers' compensation settlements. These policy memoranda do not purport to discuss the use of MSAs in liability settlements. However, see Hinsinger v. Showboat Atlantic City, 2011 N.J. Super. LEXIS 96 (January 21, 2011), determining that the same regulations and directives that apply to set asides created in workers' compensation cases apply to set asides created in liability cases.

[4] 42 C.F.R. §411.46.

[5] Memorandum from Thomas L. Grissom, Director, CMS Center for Medicare Management, to All Regional Administrators, "Medicare Secondary Payer-Workers Compensation (WC) Frequently Asked Questions", question & answer No. 13 (April 22, 2003), *available at* www.cms.hhs.gov/WorkersCompAgencyServices/ (last visited June 30, 2011).

[6] While later discussion in this White Paper will include the Medicare, Medicaid and SCHIP Extension Act of 2007 ("MMSEA"), found at 42 U.S.C. §1395y(b)(8), that statute imposes a reporting obligation on certain entities and in no way alters or changes any pre-existing reimbursement obligations which are the topic of this White Paper.

Medicare for covered items or services to the extent that payment *__has been made__*, *or* *__can reasonably be expected to be made__*, *under a liability insurance policy or plan (including a self-insured plan).*[7] Thus, all past Medicare payments are conditioned on reimbursement to the Medicare program to the extent that payment with respect to the same items or services has been made, or could be made, **under a liability insurance policy** or plan (including a self-insured plan).

In the case of future payments (date of settlement onward) where a lump sum compensation award stipulates that the amount paid is intended to compensate the individual for all future medical expenses required because of the work-related injury or disease, federal WC regulations provide a mechanism whereby Medicare does not pay for such expenses until the amount of the future medical expenses equals that part of the lump sum payment. Where a compromise settlement allocates a portion for future medical expenses and reasonably recognizes the income replacement element (indemnity portion), CMS can accept such apportionment as a basis for determining Medicare's future payments.[8]

__Who's Liable to CMS for What?__

Based on currently enacted law, the liability to Medicare with regards to satisfaction of its past and future payments differs. 42 C.F.R. §411.24 (Recovery of conditional payments) discusses liability for conditional payment reimbursement. 42 C.F.R. §411.24(e) sets forth that Medicare may assert a direct right of action against any entity that makes a primary payment.[9] 42 C.F.R. §411.24(g) allows Medicare to recover its conditional payment interest from any party receiving a primary payment.[10] When Medicare makes a conditional payment for injury-related care, Medicare may seek recovery from any entity that either makes or receives a primary payment. Though it has traditionally pursued claimants (and claimants' counsel in extreme circumstances)[11] to recoup that conditional payment interest, Medicare is also willing to pursue corporate defendants for conditional payments that were not made as part of a settlement program.[12] In short, Medicare can recoup its conditional payment interest from any entity that makes or receives a primary payment.

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[7] 42 U.S.C. §1395y(b)(2), *amended by* Pub. L. No. 109-171, 120 Stat. 4 (2006).

[8] 42 C.F.R. §§411.46(a), (b) and 411.47(a).

[9] 42 C.F.R. §411.24(e). "*Recovery from primary payers*. CMS has a direct right of action to recover from any primary payer."

[10] 42 C.F.R. §411.24(g). "*Recovery from parties that receive primary payments*. 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 primary payment."

[11] *U.S. v. Harris*, 2009 WL 891931 (N.D. W.Va.).

[12] *U.S. v. Stricker* (E.D. N.D. Ala. 2009) (No. CV-09-PT-2423-E). In *Stricker* (filed in December 2009, dismissed by the Eleventh Circuit court on September 30, 2010 due to statute of limitations application), the United States government filed a case in U.S. District Court to recover conditional payments and double damages plus interest under the Medicare Secondary Payer Act (42 U.S.C. §1395(b)(2)) ("MSP Act") from certain attorneys who represented individuals involved in a mass tort settlement program. Although the U.S. has brought previous actions against claimants and their attorneys to recover conditional payments (see footnote #11), the *Stricker* case represents the most recent attempt by the government to seek recovery from insurance carriers after funds were received into and distributed from a settlement account. The Court held that a three year statute of limitations applied to the

That same liability paradigm does not exist when it comes to dealing with Medicare as a secondary payer for future medical expenses. Because the reimbursement obligation under the federal regulations contemplates conditional payments made, and Medicare does not make conditional payments post-settlement once it has been reimbursed and closed its file, the language set forth in 42 C.F.R. §411.24 does not apply. As such, Medicare looks to the claimant (and claimants' counsel) if/when it asserts a future subrogation interest in those situations where a claimant has failed to properly avoid a permanent burden shift over to Medicare at the time of settlement.[13] Further, the current version of the Medicare Secondary Payer ("MSP") Manual notes that Medicare will not recover for future interests (*i.e.*, future medical expenses) in a liability settlement.[14]

Workers' Compensation Settlements (and MSAs)

While the purpose of this White Paper is to discuss the propriety of MSAs in the liability context, a discussion of WC fundamentals aids the reader in obtaining a better understanding of the underlying concepts. In the case of WC, reimbursing Medicare for conditional payments made on behalf of the Medicare enrolled beneficiary (settling the case) from date of injury through date of settlement is not the whole story. Per CMS Memoranda, Medicare's future interest should also be considered in WC settlements for which the obligation to pay future injury-related medical expenses is being permanently shifted from the WC plan to Medicare. In this regard, if a WC claimant will have future medical expenses as a result of his/her injury, the wise practitioner advises his/her client of the need to set aside settlement funds to pay for Medicare-covered expenses as a means of protecting the client's Medicare card.[15] The most accepted compliance method for this obligation is to calculate and fund an MSA when appropriate.[16]

Workers' Compensation MSA Evaluation

Based on currently enacted law and guidance provided by CMS, an MSA is needed in a WC settlement when all of the following three criteria are met: 1) the claimant is either currently enrolled in Medicare or possesses a "reasonable expectation" of Medicare enrollment within thirty (30) months of settlement; 2) the WC settlement closes future medical expenses,

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attorney defendants who did not secure a reimbursement for Medicare, and a six year statute applied to the corporate defendants, measured at the latest by the date payment was made into the settlement fund.

[13] As evidence of this, we look to the CMS website at the following link: http://www.cms.hhs.gov/WorkersCompAgencyServices/02_workerscompensationoverview.asp#TopOfPage (last visited June 30, 2011). This represents the most clear statement from CMS that it would look to those entities receiving a primary payment as opposed to those entities making/receiving a primary payment as the entities responsible and liable for considering and protecting its future interest.

[14] Medicare Secondary Payer Manual, Chapter 7, §50.5. "There should be no recovery of benefits paid for services rendered after the date of a liability insurance settlement."

[15] 42 C.F.R. §§411.46 and 411.47.

[16] Memorandum from Parashar B. Patel, Deputy Director, CMS Purchasing Policy Group, Center for Medicare Management, to All Associate Regional Administrators, "Workers' Compensation: Commutation of Future Benefits" (July 23, 2001), *available at* http://www.cms.hhs.gov/WorkersCompAgencyServices/ (last visited June 30, 2011).

effectively shifting the burden of future injury-related care from the WC carrier to Medicare going forward[17]; and 3) the claimant, in fact, requires future injury-related care that would otherwise be covered by Medicare. If a WC settlement meets these three criteria, then an MSA is appropriate.

MSAs are not needed in all WC settlements. If one of the criteria set forth above is not met, then an MSA is not necessary or appropriate for the settling parties to be Medicare Secondary Payer compliant in a WC settlement. An MSA may not be necessary when: 1) the claimant lacks the requisite Medicare enrollment status (no current Medicare enrollment at settlement and/or no "reasonable expectation" of Medicare beneficiary status within thirty (30) months of settlement); 2) future medical coverage is not being permanently settled (no burden shift exists or future medicals are left open); or 3) if the claimant's treating physician can support that no future injury-related care is necessary (no future costs of care in the first place).[18]

The CMS Policy Memoranda defines the term "reasonable expectation" as it relates to determining a person's Medicare enrollment status for MSA determination purposes. The April 2003 CMS Policy Memorandum states that a "reasonable expectation" included any injured party that has: (1) applied for Social Security Disability Income ("SSDI"); (2) been denied SSDI, but anticipates appealing the decision; (3) is currently appealing the denial of SSDI or is re-filing for it; (4) is sixty-two (62) years and six (6) months old; or (5) suffers from an end stage renal disease, but has not yet qualified for Medicare.[19]

Workers' Compensation MSA Allocation

Once it has been determined that an MSA is appropriate as part of a WC settlement, the next step is to determine the appropriate amount with which to fund the MSA. Keeping in mind that the purpose of the MSA is to avoid an improper burden shift over to Medicare with respect to future injury-related medical payments, a future cost of care review helps with that determination. From the date of settlement going forward, the total future cost of care (injury-related) should be determined. Then, those future costs of care should be divided into those costs/expenses which would be covered by Medicare and those costs/expenses which would not be so covered. At that point, the MSA Allocation amount becomes that amount of future injury-related care otherwise covered by Medicare, which is available to fund an MSA.

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[17] When dealing with MSA issues, it is critical to note that in some jurisdictions, such as New York and Nevada, where the WC carrier has not permanently foreclosed the payment of future medicals (instead going on a "holiday from those bills), there may be a burden shift temporarily,. During that holiday period, an MSA may be appropriate until the WC carrier resumes primary responsibility to pay future medicals.

[18] Memorandum from Thomas L. Grissom, Director, Center for Medicare Management, to All Regional Administrators, "Medicare Secondary Payer – Workers' Compensation (WC) Frequently Asked Questions," question & answer No. 20 (April 22, 2003), *available at* http://www.cms.hhs.gov/WorkersCompAgencyServices/ (last visited June 30, 2011). "It is unnecessary for the individual to establish a set-aside arrangement for Medicare if all of the following are true: a) The facts of the case demonstrate that the injured individual is only being compensated for past medical expenses (i.e., for services furnished prior to the settlement); b) There is no evidence that the individual is attempting to maximize the other aspects of the settlement (e.g., the lost wages and disability portions of the settlement) to Medicare's detriment; and c) The individual's treating physicians conclude (in writing) that to a reasonable degree of medical certainty the individual will no longer require any Medicare-covered treatments related to the WC injury."

[19] http://www.cms.hhs.gov/WorkersCompAgencyServices/Downloads/42203Memo.pdf.

Workers' Compensation MSA Proposal

After determining the appropriate amount with which to fund the MSA, questions relating to the manner of funding and the administration of the MSA need to be answered. Each question has two potential answers. Each question should be decided by the Medicare beneficiary after being fully informed.

An MSA can be funded one of two ways. First, the MSA may be funded using a lump sum amount of settlement proceeds up front. Once funded, those proceeds must be spent only on future injury-related care that would otherwise be covered by Medicare. Once those proceeds have been exhausted properly and the MSA has been spent down to zero, then the claimant may begin to bill Medicare again for injury-related medical care. The second option is to fund the MSA using an annuity or other structured settlement vehicle. Here, the MSA is funded with 'seed money' consisting of the first two years of medical expenses which would otherwise be Medicare covered plus the cost of the first contemplated surgery or procedure. Then, the annuity would pay a sum certain into the MSA for the remainder of the claimant's life expectancy to cover future injury-related care otherwise covered by Medicare. Medicare expresses no preference to one funding method or the other. There are advantages and disadvantages to each method, with a claimant making an informed decision based on the facts and circumstances of his/her case. Typically, smaller MSA accounts (*e.g.,* less than $50,000) are funded as lump sums; whereas the larger accounts, which carry with them more significant future medical expenses, benefit from being able to become exhausted following complete disbursement of the seed money, and the first year's annual payment into the MSA. At that point, with proper documentation, Medicare reclaims its position as primary payer for non-injury and injury-related medical bills until the next annual installment payment is made into the MSA.

Similarly, an MSA may be administered one of two ways. First, the MSA may be administered by the claimant. In this scenario, the claimant controls when MSA proceeds are used to pay for future injury-related care which would otherwise be covered by Medicare as opposed to when other funds should be used to pay for such expenses. In the alternative, an MSA can also be administered by a professional third party custodian/trustee. In this scenario, a custodian/trustee serves as the fiduciary of the account, determining the propriety and extent to which MSA funds are applied to pay for future injury-related care. Medical providers bill the custodian/trustee, and the custodian/trustee sorts through the bills, debiting the MSA account as appropriate. Again, both administrative methods have advantages and disadvantages. Self-administered MSAs are more simple and cost effective. However, since the goal is to preserve the claimant's Medicare card as well as protect Medicare's interest, it is imperative that the claimant has a full understanding of how the MSA proceeds should be spent and what expenses are Medicare-covered versus those that are not. Absent this understanding, a claimant runs the risk of spending the MSA proceeds inappropriately, and this jeopardizes his/her Medicare card. Professionally administered MSAs can be a more compliant solution with the right custodian/trustee, as the determination regarding when MSA funds are to be spent is left to a professional fiduciary experienced in such matters. However, professionally administered MSAs may be costly and complex. Again, the claimant should be fully advised of both options prior to being asked to make an informed decision.

CMS Submission of MSA Proposal for Review/Approval

While CMS has provided a series of guidelines to help the parties properly address the MSA issue in all WC settlements, CMS only will "review and approve" WC settlements (and associated MSA calculations) that meet certain thresholds.[20] CMS established the following workload review thresholds to help manage the number of WCMSA proposals submitted for review and approval: 1) for a claimant who is a current Medicare beneficiary, the gross settlement amount must exceed $25,000; and 2) for a claimant who is not yet Medicare enrolled but possesses a "reasonable expectation" of Medicare status within thirty (30) months of settlement, the gross settlement amount must exceed $250,000.[21]

An often misunderstood concept here is that these thresholds are **workload review thresholds, not safe harbor amounts**. Therefore, if the WC settlement involves a current Medicare beneficiary and the gross settlement is $20,000, it does not mean that an MSA is not proper to establish. Likewise, if the WC settlement involves an individual who is not yet entitled to Medicare but does possess a "reasonable expectation" of Medicare entitlement within thirty (30) months of settlement, the fact that the gross settlement is only $200,000 does not mean that an MSA is not appropriate. It merely means that if that MSA proposal was submitted to CMS for review and approval, CMS would not review it. MSAs are appropriate whenever they are appropriate, no matter what the final gross settlement amount totals.

Because of these workload review thresholds, it cannot be said that parties are required to submit MSA proposals to CMS for review and approval. CMS approval of the set-aside calculation is voluntary, not mandatory.[22] Though voluntary, CMS approval of the MSA proposal ensures that only a predefined portion of the settlement, rather than the entire settlement, must be spent before Medicare resumes payment of future injury-related medical expenses.[23] Nevertheless, CMS review and approval of the MSA proposal remains the one proven method to ensure Medicare will not challenge the set aside calculations later on. Therefore, as part of installing a Medicare Secondary Payer compliance program in your practice, seeking CMS review and approval whenever a WC case meets the workload review thresholds established at

[20] Social Security Act §1862, *as amended*, 42 U.S.C. §§ 1395y(b)(2), 1395y(b)(5)(d), 1395y(b)(6), *amended by* Pub. L. No. 109-171, 120 Stat. 4 (2006); *see also* Memorandum from Gerald Walters, Director, CMS Financial Services Group, Office of Financial Management, to All Regional Administrators, "Medicare Secondary Payer (MSP) – Workers' Compensation (WC), Additional Frequently Asked Questions", question & answer No. 2 (July 11, 2005), *available at* http://www.cms.hhs.gov/WorkersCompAgencyServices/ (last visited June 30, 2011); *amended by* Memorandum from Gerald Walters, Director, Financial Services Group, Office of Financial Management, to All Regional Administrators, "Workers' Compensation Medicare Set-Aside Arrangements (WCMSAs) and Revision of the Low Dollar Threshold for Medicare Beneficiaries" (April 25, 2006), *available at* http://www.cms.hhs.gov/WorkersCompAgencyServices/ (last visited June 30, 2011).

[21] http://www.cms.gov/WorkersCompAgencyServices/04_wcsetaside.asp#TopOfPage (last visited June 30, 2011).

[22] Memorandum from Charlotte Benson, Acting Director, Financial Services Group, Office of Financial Management, to Consortium Administrator for Financial Management and Fee-for-Service Operations, "Medicare Secondary Payer – Workers' Compensation -- INFORMATION, (May 11, 2011), *available at* http://www.cms.hhs.gov/WorkersCompAgencyServices/. "There are no statutory or regulatory provisions requiring that a WCMSA proposal be submitted to CMS for review."

[23] If CMS approves the set-aside, you can be certain Medicare will resume primary coverage after the claimant demonstrates that the set-aside proceeds were properly depleted. While such certainty gives some peace of mind, obtaining it often comes at a price of additional time and money. Parties are forced to accept CMS' methodologies for calculating the set-aside without any right of appeal, and the agency may take six months or longer to review and approve the calculations submitted.

the time of your settlement may become the final step to ensure Medicare Secondary Payer compliance.

Taking the above mentioned guidance one step further, submitting a zero dollar MSA allocation to CMS for review and approval is also voluntary. CMS advises the settlement community that it lacks the time and resources to review all MSA proposals. Thus, the workload review thresholds are in place. However, if the attorney does not seek CMS approval, following client input, it is imperative to document the file and memorialize the comprehensive efforts that were undertaken to properly consider and protect Medicare's future interest, to use Medicare's vernacular. Examples include obtaining letters from treating physicians supporting the analysis, MSA evaluations prepared by independent third parties and claimant education regarding the proper use and accounting of the MSA funds.

Liability Settlements (and MSAs)

The fundamental statutory principle requiring settling parties to consider and protect Medicare's future interest in WC settlements already exists and appears to apply to liability settlements as well. The MSP provisions state Medicare is always secondary to WC and other insurance, including no-fault and liability insurance.[24] Again, under the Social Security Act, payment "*may not be made under Medicare for covered items or services to the extent that payment has been made, or can reasonably be expected to be made, under a liability insurance policy or plan.*"[25] Also, Medicare's authority to review liability settlements arises under the same statute as does its authority to review WC settlements.[26]

While the statutory principle to consider/protect Medicare's past and future interests in liability settlements is uncontroverted, the extent of the MSA obligation in a liability settlement remains unclear. Unlike the use of MSAs in WC settlements, which can be supported explicitly by specific regulations and administrative announcements, the same cannot be said for using MSAs in liability settlements. When the various individual factors are viewed in their totality, one cannot conclude that the process for determining the extent of the MSA obligation in a liability settlement equals that of a WC settlement at this time.

Differences Between WC & Liability Settlements

The composition of a liability settlement is much more complex than a WC settlement. A WC settlement contains a finite number of potential recovery buckets: 1) indemnity; 2) past medical expenses; and 3) future medical expenses. On the other hand, a liability settlement contains many more potential recovery buckets when both economic damages (*i.e.*, past medical expenses, future medical expenses, loss of earning capacity, loss of household services, etc.) and non-economic damages (*i.e.*, pain & suffering, mental anguish, loss of independence, loss of society, etc.) are considered. Typically, these settlements also differ in the fact that settlement proceeds are often allocated specifically in a WC settlement while settlement

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[24] 42 U.S.C. §§1302, 1395w-101 through 1395w-152, 1395hh (2000 & Supp. 2004); *see also* 42 C.F.R. §411.40.

[25] 42 U.S.C. §1395y(b)(2), *amended by* Pub. L. No. 109-171, 120 Stat. 4 (2006).

[26] Social Security Act §1862, *as amended,* 42 U.S.C. §§1395y(b)(2), 1395y(b)(5)(d), 1395y(b)(6), *amended by* Pub. L. No. 109-171, 120 Stat. 4 (2006).

proceeds are not often allocated specifically in a liability settlement.[27] These distinctions are critical; so much so that merely "bootstrapping" the WC rules to liability settlements is hardly compliant. The question ultimately arising in a liability settlement is the following: "How much of the undifferentiated sum of gross settlement proceeds is being paid for future medicals versus other damages components pled and released?"

Currently Enacted Law re: MSAs in Liability Settlements

A fact often lost in the MSA debate is that the MSA obligation is not one specifically imposed by the MSP statute. The MSP statute itself does not discuss MSAs. In fact, a review of **all** currently enacted federal statutes and regulations may lead one to the conclusion that there is no currently enacted law imposing an MSA obligation on settling parties. Current law does not even provide the settlement community with a statutory definition of "MSA" or "Medicare Set-aside Arrangement", and currently enacted law makes no mention of those terms.

The closest currently enacted law comes to the "set-aside" concept may be found at 42 C.F.R. §411.46. This was one of several federal regulations enacted in support of the MSP Act.[28] 42 C.F.R. §411.46(d)(1) sets forth that Medicare will generally pay for future injury-related care when a lump-sum compromise settlement forecloses the possibility of future payment of workers' compensation benefits. The exception to that basic rule is found at 42 C.F.R. §411.46(d)(2), when a portion of the settlement agreement allocates certain amounts to future medical expenses. In those limited cases, Medicare will not pay for future injury-related care until those amounts allocated to future medical expenses have been exhausted. While there currently is no statutory definition of 'Medicare Set-aside Arrangement' or 'MSA', this section is as close as current law comes to telling the settlement community that MSAs are appropriate under certain circumstances.

[27] See 42 C.F.R. §§411.46 and 47.

[28] 42 C.F.R. §411.46 (Lump-sum payments). "(a) *Lump-sum commutation of future benefits*. If a lump-sum compensation award stipulates that the amount paid is intended to compensate the individual for all future medical expenses required because of the work-related injury or disease, Medicare payments for such services are excluded until medical expenses related to the injury or disease equal the amount of the lump-sum payment. (b) *Lump-sum compromise settlement*. (1) A lump-sum compromise settlement is deemed to be a workers' compensation payment for Medicare purposes, even if the settlement agreement stipulates that there is no liability under the workers' compensation law or plan. (2) 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. For 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. (c) *Lump-sum compromise settlement: Effect on services furnished before the date of settlement*. Medicare pays for medical expenses incurred before the lump-sum compromise settlement only to the extent specified in §411.47. (d) *Lump-sum compromise settlement: Effect on payment for services furnished after the date of settlement*-(1) *Basic rule*. Except as specified in paragraph (d)(2) of this section, if a lump-sum compromise settlement forecloses the possibility of future payment of workers' compensation benefits, medical expenses incurred after the date of the settlement are payable under Medicare. (2) *Exception*. If the settlement agreement allocates certain amounts for specific future medical services, Medicare does not pay for those services until medical expenses related to the injury or disease equal the amount of the lump-sum settlement allocated to future medical expenses."

Even here, this regulation does not support the conclusion that MSAs are **required** in liability settlements, but that MSAs may be appropriate under certain circumstances. First, this is a workers' compensation regulation, not a third party liability regulation. The provisions related to third party liability settlements are set forth in Subpart D – Limitations on Medicare Payment for Services Covered Under Liability or No-Fault Insurance beginning at 42 C.F.R. §411.50. After comparing Subpart C (Workers' Compensation) to Subpart D (Liability or No Fault), it becomes obvious that Subpart D does not contain the same language as is found in Subpart C at 42 C.F.R. §411.46. In fact, Subpart D contains no language discussing the effect on payment for services furnished after the date of settlement. Second, even in workers' compensation settlements, the basic rule is that Medicare will pay for future injury-related care, with the exception being those cases where there is an allocation for future medical expenses. Applied to the third party liability context, Medicare generally pays for future injury-related care except those liability settlements where there is an allocation for future medical expenses. Absent this allocation for future medical expenses, federal law would allow Medicare to pay for future injury-related care.

Current Guidance from CMS re: MSAs in Liability Settlements

The liability MSA obligation, such that it is, is one imposed by CMS Policy Memoranda as opposed to currently enacted law. As a result, any discussion regarding the use of an MSA in liability settlements stems from published guidance related specifically to WC settlements. Currently, there are sixteen (16) policy memoranda from CMS about the use of MSAs in WC settlements. The reason for the guidance in the WC situation is that CMS is interpreting the MSP statute, namely 42 U.S.C. §1395y(b)(2) and its associated regulations.

While CMS continues to release memoranda formalizing MSA procedures for WC cases, it has yet to release a memorandum formalizing standards or guidance for the review of liability insurance settlements for MSA obligation purposes.
Simply put, to date, CMS has not chosen to expand its MSA guidance to specifically include liability settlements without a WC component. That is not to say CMS cannot make such an extension, and we fully expect CMS to issue such guidance prior to the end of 2011. However, the fact the CMS has not yet given the settlement community the "rules of the game" does not mean parties settling a liability case can ignore Medicare's future interest (which is explicitly contemplated in the MSP Act). Having said that, we submit that, regardless of characterization, unless a settlement has an allocation (defined or undefined) for future medical expenses otherwise covered by Medicare, the elements that would even permit us to recommend MSAs in the liability context do not exist.

The Proper Use and Application of MSAs in Liability Settlements

The MSA obligation in a liability settlement is only clear (on its face) in the specific case where a definitive allocation for future injury-related medical expenses exists for an injured Medicare beneficiary. For example, a liability MSA would be properly considered in the case where a liability action proceeds to trial, results in a judgment in favor of a Medicare beneficiary, and the trier of fact determines that a specific portion of the judgment is to be applied to pay for future medical expenses. In that fact pattern, there would be an identifiable portion of the judgment against which to apply future medicals. Prior to concluding an MSA may be in the best interest of the Medicare beneficiary, the parties would also need to identify whether there also exists a burden shift by reason of the lack of any primary payer (other than Medicare) to make such

payments. If both of these queries result in an affirmative determination, establishing an MSA and seeking CMS approval may be the best, but not only, way to ensure compliance.

A second, albeit more rare, example would be a settlement release containing a definitive allocation for future medical expenses. This allocation could relate either to a specific future treatment (such as a surgery contemplated by the parties) or to generally anticipated future medical expenses for which the settling parties have agreed to a certain dollar amount and specifically listed on the settlement documents to ensure no future liability exists for those anticipated future medical expenses. We further submit that certain large settlements wherein damage elements other than future medicals are capped (such as pain and suffering) or non-existent (such as other economic damages, like lost wages) may fit this same unique mold in isolated circumstances when the liability settlement, by virtue of these caps and/or limited recovery buckets, looks more like a WC settlement.

On the other hand, in the majority of settlements where the parties settle liability claims using a broad, general release of all claims and do not specify or otherwise allocate settlement proceeds to particular damages, whether due to policy limitations or other confounding factors, the ability to determine the propriety of an MSA becomes much less clear. When settling a liability case in which payment for future medical expenses is not specifically negotiated, if a general release is implemented that uses broad language (for example, referring to "all claims past and future"), that future medical expense component is not readily identifiable. The mere fact that a claimant has pled for future medical expenses as part of the claim or the insurance carrier is being released (under the terms of the settlement) from the obligation to pay for future medical expenses going forward does not necessarily mean the gross recovery contains proceeds for future medical expenses. Also, the mere presence of a life care plan does not mean that the gross recovery contains proceeds for future medical expenses. While a claim may contemplate future medical expenses, that in and of itself does not guarantee the gross recovery contains proceeds for future medical expenses, even if the release makes reference to "all claims past and future."

Typically, when a liability claim is resolved, whether through a jury verdict or a settlement agreement, if the claimant will incur future medical expenses as a result of the injuries pled in the case, settling parties should take steps towards Medicare Secondary Payer compliance to determine IF an MSA is appropriate under the case specific facts and then **document the file** accordingly. By screening every case and having a formalized approach to verifying, resolving and satisfying MSA obligations (by means of documenting the file), you ensure the following: 1) Medicare's future interest has been considered and protected appropriately; 2) the settling parties are fully compliant with the Medicare Secondary Payer Act (statute and regulations); and 3) the claimant's Medicare benefits are protected going forward.

Settling parties should take four steps towards Medicare Secondary Payer compliance to "SAVE" a beneficiary's Medicare card and the Medicare program (relative to future medicals):

1) **Screen** to validate a claimant's candidacy for an MSA;
2) **Assess** damages to determine gross recovery;
3) **Value** future medicals for the claimant's case; and
4) **Educate** and administer the MSA results properly.

Screen - Every case deserves to be screened when making this determination in order to validate a claimant's candidacy for needing an MSA. MSAs are not appropriate in every single

case. Only after finding a claimant to be a candidate for needing an MSA (based on claimant's Medicare enrollment status plus determining if claim resolution results in future medicals being closed such that Medicare becomes the primary payer of future injury-related medicals going forward) can it be said that an MSA may be warranted. Any MSA allocation created without first determining a claimant's candidacy for an MSA has missed a critical threshold issue, and may be creating an obligation which would not otherwise exist for the settling parties.

Assess - Upon finding a claimant to be an MSA candidate, it must be determined if the gross recovery contains sufficient dollars to fund any MSA obligation which is warranted. To do this, parties should assess the damages sustained, compare those to the gross recovery and conclude whether the gross recovery actually contains dollars for future medicals (or whether due to the case specific facts, the claimant is not being compensated for future medicals despite the fact that future medicals are a damage component being pled and released and/or a life care plan may be in existence, evidencing the claimant's need for future injury-related care).
Parties should rely on a standardized method by which this determination is made, ensuring a consistent application of these principles if challenged at a later date. As part of our standard MSA Evaluation process, we apply an alleged damages analysis to determine if a portion of the gross recovery provides sufficient proceeds to compensate for future injury-related care and then further determine the amount of future injury-related care for which Medicare would otherwise be responsible once we have identified a claimant as a candidate for an MSA.
Our liability MSA methodology is the state-of-the-art gold standard. Based on all currently enacted statutes, regulations, administrative guidance and case law, GRG has the ability to determine what part of an undifferentiated sum of money in a liability settlement is really intended to compensate the claimant for future medicals. While the methodology is the same that we have employed during the previous ten (10) years in pioneering the LMSA compliance field, the position is current and fully supported by all directives (statutes, regulations, administrative guidance and caselaw). We currently employ this methodology in all liability cases we review for MSA determination purposes in our capacity as an independent, neutral third party whose focus is on Medicare Secondary Payer compliance as opposed to favoring either a plaintiff-oriented or defense-oriented analysis.

Value -After assessing the damages, if a reasonable person would determine that an actual allocation for future injury-related medical expenses exists in the settlement such that the claimant voluntarily chooses to pursue a set aside arrangement to protect his/her Medicare benefits, two options exist: i) identify the appropriate allocation and educate the claimant to ensure that those proceeds are spent down on future injury-related care (for which Medicare would otherwise pay)[29]; and/or ii) contact the appropriate Medicare regional office, share the

[29] Settling parties have different means at their disposal by which to determine the actual amount of this allocation. One method would be to rely on an independent neutral third party experienced in this area to assist. Alternate means would be to approach the court system for a court-approved allocation. In Big R Towing v. Benoit, 2011 WL 43219 (W.D. La. Jan. 5, 2011), this is exactly what the settling parties did. After agreeing to settle the Jones Act claims asserted for a gross recovery amount of $150,000, the settling parties consented to the court making findings of fact and conclusions of law, and issuing an order determining the amount of the allocation within the $150,000 for future medical expenses. After making certain findings (based on the record, evidence presented and parties' stipulation) and conclusions of law, the court ordered the claimant: 1) to promptly reimburse Medicare for any conditional payments made (which were none in this case); and 2) to set aside $52,500 to consider and protect Medicare's future interests. In securing a court-approved allocation based on the merits of the case, the question of how much of the award was allocated for future meds was removed. The results of this case are consistent with what the authors of this White Paper have been teaching the settlement community since 2006 – namely, that: 1) all settlements involving Medicare beneficiaries have to verify, resolve and satisfy any conditional payments made,

fact pattern of the case to determine whether he/she elects to review and approve the allocation. In order to identify the appropriate MSA allocation, a future injury-related care plan should be created. This plan would identify all future injury-related care services/expenses and then divide those between Medicare-covered expenses and non-Medicare covered expenses. The resulting future cost of care figure would then be compared to the future medical allocation identified previously. Based on this comparison, the MSA would be fully funded for the lesser of the future medical allocation and the future cost of care review. Once finalized, the parties should determine how the MSA results will be memorialized and implemented.

Educate – At this point, the claimant faces the same funding and administrative decisions presented in the WC context. Liability MSAs may be funded either with a lump sum dollar amount up front or with the purchase of an annuity or other structured settlement vehicle. Liability MSAs may either be self-administered or administered by a professional custodian. What differs greatly from the WC context at this point is the ability to submit the MSA proposal to CMS for review and approval. While WCMSAs are submitted to a central CMS office and CMS has a formalized approach to the review of WCMSAs, liability MSAs are submitted to the appropriate CMS regional office. The regional offices make choose to review liability MSAs based on unpublished workload review thresholds and those thresholds are subject to change without notice. Simply put, CMS does not have the same formal review process for liability MSA proposals as it does for WCMSA proposals, and it may prove difficult to get CMS to review and approve a liability MSA proposal.[30] Nevertheless, parties should continue to address these issues as part of settling a liability claim, from initial screening via a formalized process to determine a claimant's candidacy for an MSA to an evaluation to determine actual presence of settlement proceeds paid for future medicals to the claimant's actual future injury-related care needs and finally to the appropriate means by which to set up and administer the MSA. Utilizing a formalized process in this manner and document your file to evidence the steps taken along the way, parties can ensure Medicare Secondary Payer compliance on the issue of future medicals.

The New MMSEA Statute Does Not Require MSAs

Despite considerable urban legend, the Medicare, Medicaid and SCHIP Extension Act of 2007 ("MMSEA")[31] does not contain any new guidance or requirements related to MSAs. The relatively new MMSEA statute has nothing to do with MSAs. The MMSEA statute requires defendants/insurers to **report** certain information regarding settlements with Medicare beneficiaries to the Secretary of Health and Human Services when appropriate.[32] In fact, the sole purpose of the MMSEA is to ensure that settling parties fully comply with the previously

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whether arising in the workers' compensation or liability context; and 2) Medicare's interests in remaining a secondary payer after settlement needs to be evaluated in each case. While obtaining a court-approved allocation for future medical expenses is not feasible in every case (less our court system would grind to a halt), settling parties should have a formalized process that starts early; verifies, resolves and satisfies conditional payments made by Medicare; and asks the right questions to ensure future costs of care are not improperly shifted over to Medicare.

[30] http://www.cms.hhs.gov/MandatoryInsRep/07_NGHP_Transcripts.asp#TopOfPage (last visited March 9, 2010).

[31] 42 U.S.C. §1395y(b)(8).

[32] GRG regularly updates the dedicated MMSEA section of our website. See www.garretsongroup.com for further information regarding MMSEA and related practice tips.

existing Medicare Secondary Payer requirements – that is, past Medicare payments must be verified and resolved in all liability, workers' compensation and no-fault settlements. In this regard, if plaintiff's counsel is already verifying and resolving Medicare's reimbursement claim in all settlements, as far as MMSEA is concerned, it is business as usual for plaintiff's counsel and his/her clients. This new law (to date) has nothing to do with identifying Medicare-covered future costs of care, which leads to MSA issues and analysis.

In fact, CMS, in town hall teleconferences related to the MMSEA implementation, has informed the legal community that CMS' routine recovery processes have not changed. Specific examples of these statements may be found in teleconference call transcripts dated March 24, 2009, October 22, 2009 and January 28, 2010.[33] Based on the CMS town hall teleconference transcripts, we see that the set-aside process (whether it is for WC or liability) is: 1) voluntary, not mandatory; and 2) the same as it has been in the past.

Perhaps more persuasive to this point is the Congressional Research Service ("CRS") analysis of the MMSEA statute.[34] This comprehensive analysis of the new legislation (and its intent) does not mention, at any point, the concept of Medicare Set Asides in liability cases. Certainly if such purpose (*i.e.*, requiring MSAs in liability settlements) were part of the Congressional intent of MMSEA, one would reasonably expect it would have been in the CRS analysis (after all it would be a rather notable revenue-generating component of such new law if it were a part of it).

Though off-topic from the stated intent, these same CMS town hall teleconferences have provided indicia from CMS officials as to the appropriate methods for considering and protecting its future interest. During the October 22, 2009 call, a call participant asked for the best way a party settling a liability case can ensure that Medicare's future interest was being reasonably considered and protected. Ms. Barbara Wright (Technical Advisor, Division of Medicare Debt Management) responded by saying that parties should be taking Medicare's future interests into account, whether by setting up an MSA or documenting what steps have been taken to consider and protect Medicare's future interest.[35] During the March 16, 2010 call, a call participant asked

[33] During the March 24, 2009 CMS town hall teleconference related to MMSEA Section 111 reporting implementation, CMS officials said, "…As we've said in more than one call, we don't anticipate changing our routine recovery processes…The fact that you are reporting to us doesn't change any other obligations or eliminate any other obligations." During the October 22, 2009 CMS town hall teleconference, CMS officials said, "We continue to get questions about Medicare Set-Asides and the Section 111 process…What we will reiterate again is that Section 111 is a new and additional requirement for MSP…It doesn't change any preexisting obligation…It has nothing to do with set-asides." During the January 28, 2010 CMS town hall teleconference, CMS officials said, "In terms of reporting requirements, again, with respect to recovery, various entities seem to be confusing the Section 111 process with the preexisting and ongoing recovery process for conditional payments once there's been a settlement, judgment, payment, award or other payment…we have a multistep process that establishes a potential recovery…to start collecting conditional payment information. This process is not the same as the Section 111 process and does not eliminate any Section 111 requirements."

[34] See http://opencrs.com/ (last visited March 9, 2010).

[35] During the October 22, 2009 teleconference call, the following exchange took place: (Call Participant): "I was wondering if you could advise me as to the best way a party settling a liability case especially a self insured like my company to ensure that Medicare's interests are being quote/unquote reasonably considered."; (Barbara Wright): "The idea of set asides is based on the fact that Medicare is prohibited from making payment where payment has already been made. So that if you have a settlement, judgment or other payment that takes into account in any way future medicals that settlement, judgment, award or other payment should be exhausted …before Medicare is billed for the associated services…if an entity has not been taking this into consideration and taking steps, whether it's to

if MSAs were ever going to be something that enters the liability world. Ms. Wright responded that the obligation is the same, no matter whether the claim involves WC or liability, and that when future medicals are a consideration as part of a settlement, arrangements should be made to exhaust those future medicals prior to billing Medicare for related services.[36] These comments support our long-standing position that parties should be reviewing MSA issues as part of a liability settlement and then either establishing an MSA for an appropriate amount (if necessary) or documenting the file with the reasons why an MSA was not appropriate based on the case-specific facts in light of the currently enacted law and guidance provided by CMS. MSP compliance on the MSA issue cannot be achieved without at least documenting the reasons why an MSA was not appropriate under the case specific facts.

In sum, the obligation under the MSP statute is to ensure Medicare remains a secondary payer by considering and protecting Medicare's interests, not to set up MSAs in every single liability settlement. An MSA could be the appropriate way to consider and protect Medicare's future interest, but only after arriving at that conclusion based on an evaluation of the case specific facts in light of the current law and guidance. To that end, the appropriate standard to be applied to MSA analysis in liability settlements is "good faith effort at substantial compliance", appreciating the fact that there is neither a statutory requirement nor guidance for the use of MSAs in liability settlements. While MSAs are not recommended in every liability settlement, it is recommended that the settling parties analyze the MSA issues in liability settlements, and then document their files accordingly. In most liability settlements, Medicare Secondary Payer compliance can be achieved short of establishing an MSA so long as those conclusions and reasoning supporting those conclusions have been documented in the file.

Practical Guidance (How to Document the File)

The above is intended to help an attorney sift through the confusion surrounding MSAs and emerge with a better understanding of the appropriateness of MSAs in liability settlements. However, no analysis would be complete without a discussion of what to do if the settling parties cannot agree on an appropriate Medicare Secondary Payer compliance standard for MSAs, and

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do a set aside or somehow else take care of it, it's something they now need to be documenting and taking care of…"; (Call Participant): "So should the regional office not have the resources to formally review a set aside or a claims settlement allocation that I would want to put together in one of my releases and I go out to an independent third party…they do an independent analysis, and either a zero dollar amount or some small portion of the total settlement award is dedicated as a set aside and plaintiff's counsel is agreeable to that. We attach that as an exhibit or an amendment to the assigned release upon settlement. In CMS' eyes, is that going to be sufficient?"; (Barbara Wright): "We don't have any formal process…It does sound like one way to appropriately document what you've gone through and that you've made a reasonable consideration…You need to at least think about having a process in place where you're documenting why or why not there are future medicals and how you took care of that."

[36] During the March 16, 2010 teleconference call, the following exchange took place: (Call Participant): "Do you have any thoughts or any expectation that doing Medicare set asides is ever going to be something that enters the world of the liability and casualty payers?"; (Barbara Wright): "It has already entered. As we've said on many calls, CMS has a formalized process to review proposals for workers' compensation Medicare set aside amounts. It does not have the same formalized process for liability Medicare set aside arrangements. The process for workers' compensation is voluntary…regardless of whether CMS has a formalized process…the statute has the same language in either situation. It's not parallel language. It's not similar language. It's literally the same physical sentence that we're not to make payment where payment has already been made. So where future medicals are a consideration in arriving at the settlement, et cetera, then appropriate arrangements should be made for appropriate exhaustion of the settlement before Medicare is billed for related services."

out of an abundance of caution, discuss using MSAs as a condition of settlement. In these situations, it becomes critical to break any settlement impasse by adopting a formalized Medicare Secondary Payer compliance process.

To that end, settling parties might consider the following, which we have successfully used in thousands of single event and mass tort settlements, alike:

- Educate. Make sure the settling parties know who is responsible to do what. Sharing key information, such as this White Paper, as well as other articles, including "Act II: Reporting Obligations for Settling Insurers where Medicare is a Secondary Payer: The Medicare, Medicaid and SCHIP Extension Act of 2007" (see www.garretsongroup.com), is a key first step towards educating the settling parties about Medicare Secondary Payer compliance action steps;
- Evaluate. Every case, regardless of liability or workers compensation, needs to have a damage evaluation performed to determine whether any portion of the settlement (or judgment) proceeds were paid to cover future medical expenses otherwise payable by Medicare. For example, we have been engaged by plaintiffs and defense alike to provide settling parties with an MSA Evaluation, which provides a fact-specific analysis of the case given the then current law and guidance about using MSAs in liability settlements. Settling parties can then use the MSA Evaluation to document their files and memorialize the fact that they have considered and protected Medicare's future interest at the time of settlement, thus meeting their statutory obligation under the MSP statute;
- Agree (on Medicare Secondary Payer compliance language in the release). As Medicare Secondary Payer compliance issues are resolved, the parties need to properly document the steps taken as part of the release language in the settlement/release agreement, keeping the focus on the law as opposed to the conjecture surrounding Medicare Secondary Payer compliance. In this regard, the release language should set forth each of the parties' duties with respect to Medicare Secondary Payer compliance (*i.e.,* claimant and counsel have verified, resolved and will satisfy past payments made by Medicare; insurers/their insureds will electronically report to Medicare). The release language should also set forth certain representations and warranties and is likely to include language that the claimant (but not the claimant's attorney, to avoid ethical traps) will indemnify the releasees from any and all injury-related obligations/Medicare rights (past, present or future) arising out of 42 U.S.C. §1395y(b)(2). As part of the MSA Evaluation process, we provide sample Medicare Secondary Payer compliance release language for settling parties to incorporate, following their own due diligence review, into their master release; and
- MSA Report/CMS Submission. Following the above compliance phases, one final piece of the implementation puzzle is to develop, in the appropriate fact pattern, a future cost of care analysis by obtaining an MSA report from a qualified Medicare Set Aside allocation provider, and consider submitting such report (including a damages/recovery allocation performed by the qualified resource) to the appropriate Medicare Regional Office ("R.O."). Based on our extensive experience, it is quite possible the response received will be that the R.O. is not reviewing/approving such submissions in liability settlements, but that the parties should do what is appropriate in order to consider/protect Medicare's future interest. At that point, having a well-documented file depicting the steps taken to that end becomes critical.

Finally, regardless of the outcome of the four action steps above, we recommend always disclosing to the injured claimant the analysis above to ensure he/she is fully informed about why an MSA is or is not being established. An example of such a disclosure statement is contained in the booklet entitled "Medicare, Medicaid & Private Health Insurance Plans: Important Information about Healthcare Liens in Personal Injury Settlements" which can be accessed at http://www.garretsonfirm.com/garretson/resources/?pageID=49.

Final Thoughts – MSAs as Part of the Medicare Compliance Puzzle

While the above is intended to help an attorney and/or claims adjustor identify the situations when MSAs may need to be part of the discussion in settling liability claims, MSAs are but one part of the overall Medicare Secondary Payer compliance puzzle. Earlier in this White Paper, we discussed Medicare's reimbursement rights as consisting of past interests (date of injury to date of settlement) and future interests (date of settlement going forward). Therefore, determining if an MSA is needed really only solves one half of the Medicare Secondary Payer compliance puzzle. MSA analysis should be the final step in the settling parties' Medicare Secondary Payer compliance initiatives. A properly compliant settlement should accomplish three goals: 1) affirmatively verify and resolve any conditional payments made by Medicare from date of injury to date of settlement; 2) ensure the appropriate data points are reported to Medicare to satisfy any reporting obligations under the MMSEA[37] statute; and 3) appropriately consider and protect Medicare's future interest by determining if an MSA is needed and if so, the appropriate amount with which to fund the MSA.

Conclusion

The use of MSAs is a topic of nationwide debate. The lack of any statutory requirement complicates the debate. While the legal community can follow guidance about how to use MSAs in WC settlements, no similar guidance exists about how to use MSAs in liability settlements. As a result, any entity professing that MSAs are now routinely required in all liability settlements absent: 1) a true good faith analysis, such as that discussed above; 2) specific guidance published by CMS; and/or 3) a bill passed by Congress and signed into law regarding the use of MSAs in liability settlements may, in fact, be improperly promoting a cost recovery mechanism that has no legal foundation, thus needlessly costing the insurance industry millions of dollars annually.

This White Paper is based on our company's many years of experience with Medicare Secondary Payer compliance issues. While our analysis is subject to interpretation, having specifically addressed this issue in both single event and mass tort settlement programs with CMS, we submit that until actual statutory guidance or any type of CMS guidance is provided, the question whether an MSA is required in liability settlements will be extremely fact-intensive.

We submit this White Paper to assist settling parties to better understand the use of MSAs in a liability settlement context. At the same time, hopefully, we have provided some practical guidance/tips for dealing with situations where the settling parties are confused about their

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[37] 42 U.S.C. §1395y(b)(8). Though reporting for MMSEA Section 111 purposes is outside the scope of this White Paper, please see www.garretsonfirm.com/mmsea for detailed practice tips, alerts and articles on our dedicated MMSEA Compliance webpage.

Medicare Secondary Payer compliance obligations, especially with respect to the related requirements (or lack thereof) concerning MSAs in liability settlements. The authors of this White Paper may be contacted as follows:

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