CONSIDERING MEDICARE’S FUTURE INTEREST IN PERSONAL INJURY SETTLEMENTS

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To evaluate Medicare’s interest in future medical cost recoveries in personal injury settlements we must acknowledge the statutes and practices that have forced this issue. The pertinent legislation are the Medicare Secondary Payer (the “MSP”) statute of 1980 (42 U.S.C. § 1395y(b)(2)) and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. These laws establish Medicare as a secondary payer and provide for Medicare’s right to make conditional payments for medical treatment and seek recovery for those payments made up to the time of settlement. All Medicare payments are considered conditional as there is never a final obligation to pay. Medicare may recover a conditional payment for medical services for which another party is responsible.1 Medicare’s right of recovery does not require a finding of liability2 since many releases deny liability. Conditional payment recovery may be waived, at Medicare’s discretion, in the event of no fault by the injured party or if it would be against equity and good conscience.3 All parties are prohibited from intentionally shifting the burden of paying medical expenses to Medicare which is the catch all under which we now ponder. Historically, actual claim settling practices dealing with future Medicare interest have evolved from workers’ compensation (hereafter referred to as “work comp”) medical settlements.

Ten years have passed since settling the future medical exposure on work comp claims and the MSP earnestly started crossing each other’s path. The Center for Medicare and Medicaid Services (the “CMS”) finally began issuing internal memorandum to their district offices in July 2001 concerning their specific interest in future medical settlements on work comp. There have been many subsequent CMS internal memorandums refining the process and one went further to address cases where there was both a work comp and a third party liability claim.4 Medicare has the authority to review liability settlements5 although there have been several public question and answer sessions with CMS where they acknowledged the absence of procedures for liability cases.

3 See 42 U.S.C. § 404(b).
So what do work comp practices have to do with liability settlements? The work comp process of protecting Medicare’s future interest in settlements is being applied to liability cases on a daily basis by a host of companies and is being submitted to the CMS regional offices for approval. Since the work comp process is acceptable to CMS, plaintiff attorneys will unfortunately have to understand its background to address requirements being applied by some settling defendants. Additionally, if your liability case involves a claimant injured on the job and there is a work comp lien, the lien holder’s sophistication level has significantly increased with the use of the Medicare issue and they are pushing for the resolution of the future medical to support waiving the existing lien. The common manner of protecting Medicare’s interest in work comp future medical settlements is with a Medicare Set-Aside (the “MSA”) arrangement.

Meanwhile, the evolving liability issue is being driven by the process and mandates being adopted by self-insureds and insurance companies. Several major casualty insurance companies have published their procedures for claims staff and defense counsel to follow regarding protecting Medicare’s future interest and, in so doing, have also memorialized their procedures for resolving existing Medicare liens. Large self-insureds are expending resources on this issue and establishing procedures while others are watching the incoming storm. I have routinely seen cases settle before anything is mentioned as to defense procedures required to satisfy the future Medicare issues, so I would highly recommend to plaintiff’s counsel to request these positions in advance. One self-insured liability pool has decided that a MSA will be required on all third party settlements when the claimant is on Medicare regardless of any intervening issue such as low limits of coverage or fault. They require Medicare releases from the claimant during the discovery process to determine eligibility. I have unfortunately seen plaintiff’s counsel back pedal and try to prove that the claimant really isn’t on Medicare. Another company, a regional insurance company, now has a seven page memorandum of settlement for use at mediations that is produced once a settlement figure is agreed upon. This causes sudden grave consternation with its Medicare requirements.

The defense has routinely asked plaintiff’s counsel to hold the defense harmless in the liability settlement agreement for Medicare related issues, but this may be starting to unravel. The Board of Professional Responsibility in Tennessee issued an ethics opinion on September 10, 2010 that “requiring a plaintiff’s attorney to enter into agreement posed in the inquiry, particularly requiring that the attorney indemnify and/or hold harmless any party being released or subrogation interest holder from medical expenses or liens, creates a conflict between the interests of the plaintiff’s attorney and those of their client”. Several other state ethics opinions are referenced in this opinion, most specifically one from Arizona.

So, what is a Medicare Set-Aside? A MSA is a projection of future medical treatment related to the subject injury for the life expectancy of the claimant at an undiscounted total value. The total value is then normally broken down between funds needed immediately with the balance being annualized over the life expectancy. Since our government doesn’t deal in present value,

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6 Board of Professional Responsibility of the Supreme Court of Tennessee, Formal Ethics Opinion No. 2010-F-154.
a structured settlement annuity is routinely used to fund the annual requirement at substantial savings versus the alternative of the undiscounted lifetime total.

Specialty firms\(^7\) prepare the MSA, which is commonly referred to as an allocation, utilizing two years past treatment history for their projection with various underlying cost basis. Prescription drugs are included and can serve to be the costliest portion. The allocation also includes whether the MSA will be funded with all cash or a structured settlement annuity and whether the ongoing claims administration of the fund will be performed professionally or by the claimant. Annual filings to CMS of future expenditures are required.

In work comp, the MSA is submitted to CMS, more specifically the coordination of benefits contractor, for approval or amendment. This approval process is the achilles heel as it can take up to 6 months for a response or may be as short as 60 days. You can take issue with the MSA vendors’ work product if you feel they have included future care or drugs that will not be utilized so please review the allocation before it is submitted to CMS. On appealing a CMS adverse amendment, a letter from the treating physician addressing the future care or prescription at issue is warranted. The claims industry has learned to wait on CMS approval before proceeding with Court or Work Comp Commission approval of the settlement. The MSA is not finalized with CMS until they are notified by submission of the court approval documents.

For the plaintiff’s attorney, the CMS approval time frame can wreak havoc on personal injury settlements with a work comp lien. If you have to negotiate the settlement of the future medical due to the size of your case, it is advisable to push the work comp carrier to be prepared. They can obtain the MSA and even submit for CMS approval at anytime. Although you may be funding the CMS approved MSA much later, you won’t be guessing as to the dollars required. Most importantly, inform the settling liability defendants as early as possible that their settlement funds may be needed to fund the work comp MSA and they may be funding a structured settlement annuity that will be paying this MSA. You can get a lot of push back here, but there is no other way to resolve the matter. The work comp is going away and the liability settlement funds must fund the MSA. You can effectively explain this in the Release and we can provide the supporting sample language. Finally, remember that there has to be a Court or Work Comp Commission Order approving the work comp side of the equation, including the MSA, so don’t let that party walk away without agreeing to cooperate. Although the work comp carrier or employer’s funds may not be used, they will be the settling party establishing the MSA!

The structured settlement annuity medical underwriters can be utilized to alter the life expectancy used by CMS via their “rated ages”. Currently, CMS refers to the United States Life Tables, 2004\(^8\) so this life expectancy figure for the claimant is used by the MSA vendor unless a

\(^7\) There are many regional firms that prepare set-aside allocations, several law firms staffed for this practice and larger well-known firms providing service to the National Workers’ Compensation Insurers. The larger firms are Gould & Lamb, PMSI and Crowe Paradis to name a few. Most are members of the National Alliance of Medicare Set-Aside Professionals Association.

\(^8\) National Vital Statistics Reports, Vol. 56, No. 9, December 28, 2007 published by the Centers for Disease Control.
rated age is obtained from your structure representative. The mean rated age is acceptable to CMS to establish the life expectancy and can serve to substantially reduce the overall allocation. The life expectancy is viewed as a static number as our government only deals in certainty. Therefore, if the life expectancy is 20 years, the set-aside is over at the end of 20 years if the funds have been depleted, even if the claimant is still living. If there are any remaining funds, they must continue to be paid on Medicare eligible expenses until exhausted or death.

MSA funds are only to be utilized to pay Medicare eligible items related to the injury. If a lump sum amount is allocated, then the claimant will spend this amount over his lifetime and when exhausted, Medicare resumes paying, assuming no other primary coverage is available. If an annual amount is allocated, with an upfront seed figure, the claimant will spend this amount on an annualized basis and Medicare will resume paying in any annual period in which the total funds are exhausted. Unspent annual funds do roll forward to the next year. Any remaining funds at death normally inure to the claimant’s estate.

The work comp MSA funds can be self-administered by the claimant or a professional administration firm can be contracted. If the claimant is self-administering and spends the funds incorrectly or frivolously, our understanding is that Medicare will never make another payment of a covered medical bill until the financial matter has been rectified. CMS will have been notified of the Court approved MSA and annual filings of expenditures are required.

Finally, CMS will not approve the MSA if it doesn’t meet certain thresholds. Some MSA vendors can provide an opinion with their evaluation whether the case is subject to CMS approval. If not subject to CMS approval, the MSA is still funded and entered in the Work Comp Order as part of the settlement. The basic guidelines are: the total settlement\(^9\) exceeds $25,000 and the claimant is currently on Medicare, or, the claimant has reasonable expectation to Medicare enrollment within 30 months of the settlement and the settlement amount is greater than $250,000. I have seen substantial MSA’s where the claimant was due to start Medicare in the immediate future because he had been awarded Social Security Disability benefits but CMS wouldn’t review the MSA because the total settlement value did not exceed $250,000. If submitted to CMS, they respond with a letter informing the MSA didn’t meet thresholds.

The structured settlement professional has to coordinate all necessary language in documents, to support income tax-free annuity payments, with all parties including verifying the CMS approval matches the submission, or forces the amendment of releases and structure terms. We are truly stuck in the middle of the process. In 2010, my office processed 48 structures for MSA’s on work comp cases and 5 structures for liability set-aside funds. The structured settlement annuity simply allows more settlement dollars to be available for other uses. Further, the structure can take advantage of the best rated age available, not just the mean rated age used by CMS, and on work comp cases the annuity is priced for the “temporary” life. The temporary life period is the life expectancy approved by CMS in the MSA submission. The

\(^9\) Total settlement includes all past costs, including previous settlement amounts, attorney fees and all future annuity payments.
annuity pays only for that period, if the claimant is living, and not longer regardless if they are living.

To the inexperienced, the whole MSA work comp process can be unnerving. From 2006 through 2009, United States Representative Clay Shaw (R-FL) submitted legislation in H.R. 5309 and Representative John S. Tanner (D-TN) twice submitted legislation in H.R. 2549 and 2641 to address what some consider a mess but the bills never made it out of committee.

Then there are the additional expenses. The MSA allocation can cost from $1,500 to $4,500. If too much time elapses between the date of the MSA and submission to CMS, the MSA must be updated with current two years prior medical data. What if you want the MSA fund professionally administered by a firm whose contracted duties will be to perform custodian services and pay medical expenses, provide a prescription drug card service and file reports to Medicare? These services are normally priced in an annual component for the life of the claimant and funded with a structured settlement annuity with prices ranging from $5,000 to $50,000. In addition, the claimant absolutely should have purchased Medicare’s Coverage D prescription plan when they became eligible. If they didn’t, they will have to pay premiums back to their eligibility date, including a hefty penalty. Currently Coverage D premiums in Alabama run around $42 per month from Blue Cross. In the alternative, one of the new Advantage Plans could be purchased, only in open enrollment at the end of the year, which provides comprehensive medical plan options that should provide more benefits than Medicare Coverage A, B and D combined and supposedly avoid the back premiums and penalty for Coverage D.

Some MSA vendors are doing all they can to convince defendants and insurers that they must obtain a liability MSA allocation albeit without any specific guidelines to follow. Gould & Lamb’s current liability document reads as follows: “The attached Claim Settlement Allocation has been produced in full accordance with all medical requirements of Medicare and in compliance with the Medicare Secondary Payer Statute. The allocation adequately protects Medicare’s interest...” signed by their medical director.

I watched the MSA process start in workers’ compensation claims in the late 1990’s and thought it would never develop as there were too many problems. I was dead wrong. So here we are again and we’re just one CMS memorandum away from some procedure to take hold on liability cases.

The MSA vendors have no real duty to the plaintiff attorney, the claimant or the defense. They attempt to only deal in factual medical expense projections to protect Medicare. You can appeal to them on the data utilized or get a second MSA as that industry has proven the process is subjective, although on work comp it shouldn’t be. I have recently seen a work comp case where the defense MSA was half the amount of the plaintiff MSA. We have had cases approved by CMS but amended in amounts three to four times greater than was submitted. I have also seen a new MSA obtained on a work comp case, when the original MSA vendor was no longer being used, that was double the amount from the one previously
completed. Can you pick and choose? On work comp there is a final acceptance from CMS if the MSA meets thresholds, but currently, odds are you won’t be getting an acceptance from CMS on a liability MSA to support your choice.

The liability MSA has traction since they are being required in settlements by the defense and they are being submitted to the CMS office in your applicable region. Some CMS offices respond to the submission with a letter that they do not have the resources or procedures to review liability cases. The Atlanta office is responding to some submissions with an approval letter but we can’t document a pattern. It appears they are responding to large MSA’s over $1 million and sometimes on amounts over $500,000. Furthermore, the Atlanta CMS office wouldn’t have the resources to dispute the MSA amount submitted so it is my understanding that the amount submitted is simply accepted. This implicit process could be considered a contradiction to the Medicare manual, which states that “there should be no recovery of benefits paid for services rendered after the date of a liability settlement.”

Remember, there are no written procedures yet from CMS but this process is simply an attempt to not shift the burden to Medicare.

There are issues for the plaintiff attorney obtaining an MSA allocation in a liability case. If the allocation is substantial and the settlement is ultimately less, the defense may request the whole net settlement be used to fund the MSA. Also, if the allocation is disproportionate relative to the settlement, the claimant may not pocket much. Can you apportion settlement dollars to lessen the impact of setting aside settlement dollars for Medicare’s future interest? The only place to find guidance is from litigated cases involving existing Medicare liens. There are quite a few court cases but one recent case on apportionment is Hadden v. United States, which is currently under appeal in the Sixth Circuit. The government’s appeal brief filed on January 13, 2010 is thorough. Does the logic on Medicare liens transcend to Medicare’s future interest? If so, you could conclude that the future medical projection may not be apportioned for fault, or otherwise, by settlement agreement and “the only situation in which Medicare recognizes allocations of liability payments to nonmedical losses is when payment is based on a court order on the merits of the case.”

If the plaintiff’s attorney must protect Medicare’s interest in cases where future medical damages have been pled and will be recovered, the defense is driving toward some resolution. What do you do if the defense obtains a MSA? Do you take a proactive stance and inform all parties that your client is or isn’t on Medicare and what your plans are? If the claimant is on Medicare, should you consider a bifurcation of pled damages from the outset and propose to apply that percentage to any net settlement? How would you then apply this or another approach to a judgment that is only partially collected? What position do you take if the claimant is not on Medicare today but the injury is subject to lifelong treatment and they will definitely become eligible for Medicare in the future? If your solution involves a proration of

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10 See Medicare Secondary Manual, Ch. 7 § 50.5 (February 22, 2008).
12 See Medicare Secondary Manual, Ch. 7 § 50.4.4 (February 22, 2008).
damages or determination of fault or equity, do you seek a court finding? Must that be in Federal Court? Do you address how the funds will be set aside to be spent on future medical that would have been paid by Medicare, especially if you file your plan with your regional CMS office and it is accepted?

If you want to attempt to protect Medicare’s future interest in your plaintiff practice, would you not set a minimum settlement amount and establish a methodology to determine an amount to be set aside to pay future medical and identify the related injury? Do you initiate a subjective basis to determine which claimants, not already on Medicare, to which your procedures will apply? If you leave the ongoing responsibilities to spend the set-aside funds with the claimant, how do you explain their duties to Medicare? On work comp MSA’s, CMS sends a letter with the approval specifying the claimant’s duties. You could copy this format and deliver it to your client. Should you insist the funds be placed in a protected account? Trusts are normally too expensive for anything but the larger accounts so the industry has been using custodial accounts with the professional administration vendors. Whatever you establish for your practice shouldn’t you be consistent among all your cases?

A methodology for the plaintiff’s side to protect Medicare’s future interest should be put forth if the MSA method isn’t acceptable. The proposed solution will have to be either fact based or some sort of fault or no fault methodology. If CMS ever publishes a liability case memorandum, they most likely will only deal in a factual basis, like historical medical review, and legislation will be needed for any other method to be accepted. The only alternative is a Federal court finding the MSP doesn’t apply to liability settlements.

I have seen several cases settle with a structured settlement annuity where the plaintiff attorney evaluates the amount to be set aside immediately after the settlement and we bifurcate the periodic payments in the release with some being assigned to protect Medicare’s future interest. Hopefully someday Congress and our industry will restore structures’ primary value in that you could not undo them. Unfortunately, today the structure can be partially undone with the claimant selling a number of their future checks at ridiculous discounts. The unscrupulous industry that buys the future checks has proven they have no concerns whatsoever on the basis of the original claim or payments or whether their transaction is contrary to the law i.e., payments that were allocated for Medicare eligible expenses.

To resolve this matter our company has resurrected an old tool. We have set up a trust with Midwest Trust, Overland Park, Kansas, to issue structured settlements backed by United States Treasury Bonds. Every payee is given secured creditor status and a “Keep Well Agreement” pledges the assets held in the trust may not be used for any purpose other than paying the payee. The trustee should never allow a payee to sell his future “checks”.

The Treasury Funded Structured Settlement™ brings back what made structured settlements commonplace; they cannot be undone. You trade stability, certainty and income tax-free earnings for the lack of liquidity and the claimant cannot mess it up. It should be noted that the rates of return developed by Treasuries never match those provided by the annuity companies.
and the maximum term is 30 years. So why not use this structure in your settlements for annual periodic payments to protect Medicare’s future interest? Provide a document specifying your claimant’s duties to spend the periodic payments on Medicare eligible expenses. If they do not follow the advice, at least they will have multiple years of annual payments as opposed to blowing a single cash allocation. The only variation from a standard annuity structure is the Treasury Funded Structured Settlement™ would provide benefits for the estimated life expectancy term, not to exceed 30 years, on a guaranteed basis versus life contingent.

There are no hard and fast answers to the Medicare liability issues at this time. Unfortunately, we only have the work comp procedures for guidance, which could be argued, doesn’t even apply. If CMS does develop formal procedures for liability settlements, structured settlements will have a prominent role especially if life expectancy is involved. There is no better way to address and price mortality risk than with a structure and thus maximize available settlement funds. Your structure representative will continue to be stuck in the middle.