

27th Annual Claims Handling Seminar

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# MEDICARE SET-ASIDES AND CONDITIONAL PAYMENTS UPDATE

*Presented and Prepared by:*

**Bradford J. Peterson**

[bpeterson@heyloyster.com](mailto:bpeterson@heyloyster.com)

Urbana, Illinois • 217.344.0060

**Heyl, Royster, Voelker & Allen**

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## **MEDICARE SET-ASIDES AND CONDITIONAL PAYMENTS UPDATE**

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The cases and materials presented here are in summary and outline form. To be certain of their applicability and use for specific claims, we recommend the entire opinions and statutes be read and counsel consulted.

## **MEDICARE SET-ASIDES AND CONDITIONAL PAYMENTS UPDATE**

### **I. ARE MEDICARE SET-ASIDES REQUIRED IN LIABILITY CASES?**

The Medicare Secondary Payer Act was intended to insure that Medicare was not making payments for medical expenses when other insurance was available. In 1980 Congress also passed the Omnibus Reconciliation Act which expanded Medicare's Secondary Payer status and right to reimbursement for conditional payments to include liability, auto liability and no fault insurance. Early efforts to apply the Medicare Secondary Payer Act to liability policies were rejected by the courts, *Thompson v. Goetzmann*, 337 F.3d 489 (5th Cir. 2003), *in re Orthopedic Bone Screw Products Liability Litigation*, 202 F.R.D. 154 (E.D. PA 2001), *Fanning v. United States*, 346 F.3d 386 (3d Cir. 2003). In many instances the courts found that liability insurers were not required to "pay promptly" as required under the Act and, therefore, liability insurers were not subject to making reimbursement to Medicare.

In 2003, Congress approved the Medicare Modernization Act which deleted the "prompt payment" provision in section (A)(ii) of the Act.

Efforts to expand the scope and application of the Act to workers' compensation claims were undertaken in 2001. Previously, in 1989, the Code of Federal Regulations set forth specific regulations for the use of Medicare Set-Asides in workers' compensation claims. 42 C.F.R. §§ 411.40-411.47. Over the last 10 years the use of Medicare Set-Aside accounts (MSA) for future medical expenses has become common practice in workers' compensation claims. Pursuant to the Center for Medicare and Medicaid Services policy, the funds set aside in a MSA trust are only to be used by the workers' compensation claimant for future medical expenses related to the workers' compensation injury. Once those funds are exhausted, Medicare will then cover injury related expenses.

An entire bureaucracy was also created in order to review and approve Medicare Set-Aside accounts. Settlement amount thresholds were established in order to reduce the number of MSAs that Medicare would review. Generally, settlements involving current Medicare beneficiaries will be reviewed when the settlement amount exceeds \$25,000. Where a claimant is not currently a Medicare beneficiary, but has a reasonable expectation of enrollment within 30 months, the Center for Medicare and Medicaid Services (CMS) reviews those settlements where the settlement value exceeds \$250,000.

The issue of whether liability settlements must also protect Medicare's interests with regard to future medical expense became a focus of attention when Congress enacted the Medicare and Medicaid SCHIP Extension Act of 2007. 42 U.S.C. 1395y(b)(7)&(8) (2008). The statute created mandatory reporting requirements for claims involving Medicare eligible individuals. Although implementation has been delayed for several years, liability insurers are now required to report to CMS those liability settlements involving Medicare eligible individuals. Beginning January 1, 2012, liability insurers were required to report settlements over \$100,000. That threshold was

reduced to \$50,000 effective April 1, 2012, and will be further reduced to \$25,000 as of July 1, 2012. By October 1, 2012, there will be no threshold and, therefore, all liability settlements involving Medicare eligible claimants will be reported.

The relevance of SCHIP to the Medicare Secondary Payer Act is that Medicare will now have a mechanism in place in which to identify all liability settlements involving Medicare eligible individuals. Reporting requirements under SCHIP will specifically allow Medicare to not only identify the liability settlements and settlement amounts but also the nature of the injury for which compensation has been paid. With this information, Medicare will then be able to determine whether future medical expenses should be satisfied by Medicare or *potentially* deny future medical expenses for the injury that was the subject matter of the liability settlement.

The reporting requirements under SCHIP were implemented a year earlier in workers' compensation claims than in liability claims. The Center for Medicare and Medicaid Services is now using the SCHIP data to determine whether a beneficiary is submitting to Medicare medical expenses related to the previous workers' compensation settlement. Where CMS determines that a medical bill relates to a previous workers' compensation settlement they are denying Medicare coverage for those Medicare expenses. As Medicare continues to collect SCHIP reporting data on liability claims, it is plausible that they will take the same approach with regard to liability settlements. It is foreseeable that Medicare may deny medical treatment in the future for conditions/injuries that were the subject matter of the liability settlement or judgment as was identified and reported under SCHIP.

## **II. THE CASE FOR REQUIRING LIABILITY MEDICARE SET-ASIDE ACCOUNTS**

The Medicare Secondary Payer Act does not specifically address future medical expenses in either a workers' compensation or liability context. Ambiguity with regard to parties' obligations under the Medicare Secondary Payer Act is clarified when one looks at various pronouncements by Medicare. Although they do not have the force of law, they certainly provide insight as to CMS's interpretation of the Act. CMS Memoranda make it clear that CMS interprets the Medicare Secondary Payer Act to require parties to a liability settlement to protect Medicare's interests with respect to future medical expenses. Unlike workers' compensation, CMS has not promulgated regulations specifically raising or identifying any such duty. CMS has, however, promulgated such regulations regarding workers' compensation claims. 42 C.F.R. §§ 411.40-411.47. Although similar regulations have not been enacted with respect to liability cases, the Medicare Secondary Payer Manual was amended to include a definition for liability Medicare Set-Asides. Medicare Secondary Payer Manual, Chapter 1, § 20. The manual defines Set-Aside arrangements to include "liability and no fault cases." The manual further provides that there "should be no recovery of benefits paid for services rendered after the date of a liability settlement." Medicare Secondary Payer Manual, Chapter 7, § 50.5 (2009). Therefore, these provisions can be read to suggest that the Center for Medicare and Medicaid Services believes there is a general obligation to protect Medicare's interests with regard to future medical expenses and that such protection can be provided through the use of a liability MSA.

The Center for Medicare and Medicaid Services has made several pronouncements over the years that clearly assert that there is a general duty to protect Medicare's interests with regard to future medical expenses in liability settlements. In what is commonly referred to as the "Stalcup" Memo, CMS's position is clearly set forth. (See Appendix 1). Therein, Sally Stalcup, MSP Regional Coordinator, stated:

Medicare's interests must be protected; however, CMS does not mandate a specific mechanism to protect those interests. The law does not require a "set-aside" in any situation. The law requires that the Medicare Trust Funds be protected from payment for future services whether it is a Workers' Compensation or liability case. There is no distinction in the law.

Set-Aside is our method of choice and the agency feels it provides the best protection for the program and the Medicare beneficiary.

The Stalcup Memorandum further states:

Anytime a settlement, judgment or award provides funds for future medical services, it can reasonably be expected that those monies are available to pay for future services related to what was claimed and/or released in the settlement, judgment, or award. Thus, Medicare should not be billed for future services until those funds are exhausted by payments to providers for services that would otherwise be covered and reimbursable by Medicare. If the settlement, judgment, award are not funded there is no reasonable expectation that third party funds are available to pay for those services.

\* \* \*

The fact that a settlement/judgment/award does not specify payment for future medical services does not mean that they are not funded. The fact that the agreement designates the entire amount for pain and suffering does not mean that future medicals are not funded. The only situation in which Medicare recognizes allocations of liability payments to nonmedical losses is when payment is based on a court of competent jurisdiction's order after their review on the merits of the case.

More recently, the position of CMS was set forth in a Memorandum authored by Charlotte Benson, Acting Director, Financial Services Group, Office of Financial Management, Center for Medicare and Medicaid Services. (See Appendix 2). The Memorandum purported to provide additional information and guidance with regard to "proposed Liability Medicare Set-Aside Arrangements (LMSA) amounts related to liability insurance . . ." The Memorandum provides that Medicare will consider its interests protected with regard to future medical expense in liability settlements where the treating physician certifies that treatment has been completed and future medical services for that injury will not be required. (See Appendix 2).

Although substantial ambiguity exists under the Medicare Secondary Payer Act with regard to liability insurers obligations to protect Medicare in liability settlements, it cannot be said that CMS's position is similarly ambiguous. CMS has repeatedly asserted that its interpretation of the Medicare Secondary Payer Act requires that liability insurers protect Medicare's interests with respect to future medical expense. Furthermore, the Medicare Secondary Payer Manual now defines liability Set-Asides. Until the courts further define the obligations with regard to future medical expense, some degree of deference must be afforded CMS's interpretation as to the liability insurers obligations.

### **III. THE CASE THAT LIABILITY MEDICARE SET-ASIDES ARE NOT REQUIRED**

The Medicare Secondary Payer Act does not specifically impose a duty on liability insurers to protect Medicare with regard to future medical expense. Neither the Act itself nor the Code of Federal Regulations specifically require that parties to a liability settlement address, identify or allocate any settlement proceeds as compensation for future medical expense.

The Medicare Secondary Payer Act does provide that Medicare is secondary to other insurance including liability insurance. 42 U.S.C. §§ 1302, 1395 (2000 & Supp. 2004). This statutory provision falls far short of imposing an obligation on liability insurers to act affirmatively to protect Medicare with respect to future medical expenses. Although Medicare is not to make payment to the extent that payment has been made, or can reasonably be expected to be made, under a liability policy or plan, 42 U.S.C. § 1395y(b)(2), this is a statutory obligation as to Medicare's duty with regard to making payment and not a defined statutory obligation on liability insurers with regard to future medical expense.

Furthermore, Medicare's interests will be protected with the information to be provided under the Medicare and Medicaid SCHIP Extension Act. CMS will become aware of liability settlements including the terms of those settlements. They will also be aware of the injuries at issue in the underlying liability claim. With that information, Medicare may then deny coverage for future medical care related to that injury. To that end, Medicare's interests are protected. For this reason, claimants and their attorneys may have a much greater interest in creating a liability MSA than the insurers will.

Although SCHIP reporting just began in January 2012, the reporting of workers' compensation claims began a year earlier. Now that CMS has a database of reported workers' compensation claims, they have begun denying Medicare coverage for bills submitted related to treatment at issue in the underlying workers' compensation claim. In some instances, Medicare Set-Aside accounts were established but claimants failed to pay medical bills out of their Set-Aside account as opposed to submitting them to Medicare. In other instances, Medicare Set-Aside accounts were not established and claimants are attempting to secure payment of post-settlement medical treatment by Medicare. As the liability settlement database grows, it is plausible that CMS will take the same approach, that is, to deny post-settlement Medicare coverage for treatment related to the injury at issue in the liability claim.

#### **IV. MEDICARE'S REFUSAL TO COMPROMISE CONDITIONAL PAYMENTS RUNS CONTRARY TO THE PUBLIC POLICY IN FAVOR OF SETTLEMENTS**

*Bradley v. Sebelius*, 621 F.3d 1330 (11th Cir. 2010) – A potentially important decision concerning Medicare conditional payments (liens) was handed down on September 29, 2010 by the United States Court of Appeals for the Eleventh Circuit (California). Medicare (CMS) occasionally takes the position that it will not compromise its conditional payments – even if the end result would be Medicare taking all of the settlement (minus attorney's fees). In *Bradley v. Sebelius*, 621 F.3d 1330 (11th Cir. 2010), CMS took just such a position. The court of appeals, however, took exception and affirmed a substantial reduction in the conditional payments lien.

In *Bradley*, the probate court was asked to apportion the settlement amount between Medicare and non-Medicare beneficiaries. The settlement amount was substantially less than the potential full value of the claim. The probate court effectively reduced the Medicare lien from \$38,875.08 to \$787.50. Medicare refused to accept the probate court's ruling. After the estate exhausted administrative remedies, the decision was appealed to the federal district court. The district court reversed, relying, in part, upon arguments by Medicare that pursuant to the Medicare Field Manual, its conditional payment lien was not subject to compromise based on allocation of fault.

On appeal, the Eleventh Circuit reversed the district court, noting "[h]istorically, there is a strong public interest in the expeditious resolution of lawsuits through settlement." *Bradley*, 621 F.3d at 1339. The court stated:

The Secretary's position would have a chilling effect on settlement. The Secretary's position compels plaintiffs to force their tort claims to trial, burdening the court system. It is a financial disincentive to accept otherwise reasonable settlement offers. It would allow tortfeasors to escape responsibility.

*Id.*

The court further found that Medicare's reliance on its field manual was unpersuasive, pointing out that Medicare policies and manuals are not "law" and would not be given deference under the *Chevron* Doctrine.

The *Bradley* case is particularly noteworthy because the Eleventh Circuit stated that Medicare cannot take an unreasonable position with regard to their liens that would thwart the public policy in favor of settlements. This case will likely be widely cited in future efforts seeking compromise of Medicare conditional payments.

The public policy analysis used by the court in *Bradley* could also be extended to civil cases where the parties choose to use a Medicare Set-Aside for future medical care. If a defendant wants to use a Medicare Set-Aside to protect itself from further claims by Medicare under the Medicare Secondary Payer Act, this case could provide a basis upon which to formulate a

compromise value of the MSA. If, for example, the plaintiff reasonably appears to be 30 percent at-fault and the case is settled for 70 cents on the dollar with an MSA for future medical expense, the MSA could reasonably be reduced by 30 percent under the analysis employed in *Bradley*. Under that scenario, a good faith hearing should be held requesting the court to enter an order apportioning/compromising the MSA to a reasonable amount given the facts and circumstances of the case.

While we are in uncharted territory with regard to use of Medicare Set-Aside accounts in civil cases, the *Bradley* decision suggests that the judiciary will not hesitate to impose practical solutions to facilitate equitable settlements. In other words, this holding is a very positive development since it may result in more prompt resolution of compromised claims.

#### **V. SIXTH CIRCUIT FAILS TO APPLY COMPARATIVE FAULT PRINCIPLES TO CMS'S CONDITIONAL PAYMENTS CLAIM**

*Hadden v. United States*, 661 F.3d 298 (6th Cir. 2011) – In this case the plaintiff, Vernon Hadden, was struck by a utility vehicle belonging to Pennyrile Rural Electric Cooperative that swerved to avoid a vehicle that ran a stop sign. The driver of the vehicle that ran the stop sign was never identified. Hadden brought suit against Pennyrile for bodily injury. Ultimately, Hadden and Pennyrile settled the case for \$125,000. Hadden's counsel asserted that the settlement amount was approximately 10 percent of the total value of the claim and that the missing driver of the vehicle that ran the stop sign was 90 percent negligent.

The Center for Medicare and Medicaid Services asserted a conditional payments claim for \$62,338.07. Hadden's counsel sought a compromise and waiver or reduction of the conditional payments amount from CMS. CMS refused to compromise the amount of its claim. Plaintiff's counsel argued that Hadden's recovery was reduced under applicable comparative fault principles and that CMS' claim for conditional payments should be similarly reduced. CMS and the Department of Health and Human Services rejected the request for compromise and waiver. CMS pointed out that recoveries under the Medicare Secondary Payer Act did not account for state tort law. Hadden's counsel exhausted administrative appeals and ultimately filed suit in the federal district court for the Western Division of Kentucky.

The district court rejected Hadden's arguments and noted that the underlying personal injury claim against Pennyrile Rural Electric had not proceeded to trial and accordingly the allocation of fault was purely speculative.

On appeal the Court of Appeals for the Sixth Circuit affirmed the district court. The Court of Appeals for the Sixth Circuit allowed Medicare to recover 100 percent of its claimed conditional payments demand relying upon what the court deemed to be the "plain language" of the Medicare Secondary Payer Act. The Medicare Secondary Payer Act provides in part:

A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this subchapter with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service . . .

42 U.S.C. 1395y(b)(2)(B)(ii).

The *Hadden* court found that a settlement through a primary plan (liability policy) demonstrates “responsibility” under the Medicare Secondary Payer Act thereby entitling Medicare to recover its full conditional payment amount notwithstanding that a settlement is for a compromised or reduced amount. The court concluded that since Hadden received the full amount of his medical expenses from the defendant, he was therefore responsible to reimburse Medicare for the full amount of the conditional payments.

The court further rejected Hadden’s argument that the conditional payment amount should be reduced based on equitable allocation principles. Hadden argued that principles of comparative fault resulted in a compromise settlement and those same principles should be equitably applied to the conditional payments amount. Such principles had previously been applied by the U.S. Supreme Court in *Arkansas Department of Health and Human Services v. Ahlborn*, 547 U.S. 268 (2006), in the context of a lien by Medicaid.

The *Hadden* decision will potentially have a chilling effect on settlements. Settlement may be particularly problematic where Medicare pays a substantial sum in medical expense yet the settlement value of the claim is substantially compromised based upon issues of liability and comparative fault. Similar difficulties may be encountered where there are substantial medical bills and a \$100,000 liability limit under the liability policy. In such instances, litigants should argue that the principles of *Bradley v. Sebelius*, 621 F.3d 1330 (11th Cir. 2010), justify a reduction and compromise in the conditional payments amount. The Eleventh Circuit’s decision in *Bradley* and the Sixth Circuit’s decision in *Hadden* stand in partial conflict and undoubtedly additional circuits will be weighing in.

## **VI. COURT ACCEPTS AS REASONABLE PROPOSED MEDICARE SET-ASIDE ALLOCATION IN LIABILITY SETTLEMENT**

In *Schexnayder v. Scottsdale Ins. Co.*, No. 6:09-CV-1390, 2011 WL 3273547 (W.D. La. July 29, 2011), the plaintiff Robert Schexnayder was injured in the course of his employment as a result of an auto accident. His workers’ compensation claim was settled but no Medicare Set-Aside account was established as a part of that settlement. The plaintiff brought suit against the operator of the semi that struck his vehicle as well as the semi driver’s employer. Through mediation, a settlement was reached. A condition of settlement included that a Medicare Set-Aside account would be established to protect Medicare’s interests under the Medicare Secondary Payer Act. It is important to note that the plaintiff was not a Medicare beneficiary nor

was there a reasonable expectation of Medicare enrollment within 30 months. As such, the plaintiff would not have been considered a Class 1 or Class 2 beneficiary which would trigger the need for a MSA in the workers' compensation context. Notwithstanding, the parties allocated a sum of \$239,253.84 for future medical expense as a part of the civil settlement. Said funds were to be placed into a Medicare Set-Aside account. A condition of settlement further included that the MSA allocation would be submitted to CMS for approval and settlement was contingent upon such approval. The Center for Medicare and Medicaid Services, however, refused to evaluate the MSA proposal and, hence, did not provide approval. The parties then sought declaratory relief in the federal court. They asked that the Medicare Set-Aside amount be deemed reasonable and a further finding that it protected Medicare's interests under the Medicare Secondary Payer Act.

Neither the Department of Health and Human Services nor CMS appeared before the court. They did, however, submit a handout from the MSP Regional Coordinator for CMS in Region 6 (Stalcup Memo) (See Appendix 1).

The U.S. District Court for the Western Division of Louisiana noted that Medicare does not currently require or approve Medicare Set-Asides when personal injury lawsuits are settled. He further pointed out that Medicare does not currently have a policy of procedure in effect for reviewing or providing an opinion regarding the adequacy of the future medical aspect of a liability settlement.

The court found that the payment of future medical expense, as an element of settlement, would constitute a receipt of payment from a "primary plan" and therefore the plaintiff would be responsible as a primary payer for future medical items or services which would otherwise be covered by Medicare and related to what was claimed and released in his lawsuit. As such, the court then found that the Medicare Set-Aside allocation was reasonable and adequately protected Medicare's interests.

The court further recognized the strong public policy in favor of settlements citing *Bradley v. Sebelius*, 621 F.3d 1330 (11th Cir. 2010).

What this case does not state is perhaps more important than what is stated in the opinion. The *Schexnayder* case does not address on the merits the issue of whether the Medicare Secondary Payer Act requires liability insurers to protect Medicare's interest with regard to future medical expense. That simply was not a litigated issue before the court. Furthermore, the Department of Health and Human Services did not appear and argue that the MSA allocation was insufficient. As such, the court's decisions were based essentially upon stipulations of the parties.

**VII. NO ALLOCATION FOR FUTURE MEDICAL EXPENSES NECESSARY UNDER MSPA WHERE PLAINTIFF COVERED BY GROUP HEALTH INSURANCE**

*Finke v. Hunter's View, Ltd.*, No. 07:4267, 2009 WL 6326944 (D. Minn. Aug. 25, 2009) – The United States District Court for Minnesota was asked to approve a personal injury suit and specifically address whether the settlement adequately protected Medicare's interests with regard to future medical expenses. Plaintiff Darus Finke was paralyzed from the chest down after falling from a deer stand manufactured by Hunter's View and sold at Wal-Mart. The plaintiff brought suit against both Hunter's View and Wal-Mart. The case was settled for \$1.5 million. The district court approved the settlement and did not require any form of allocation of settlement proceeds to cover future medical expenses. The court specifically found that the parties had adequately considered Medicare's interests, and it was not reasonably foreseeable that Medicare would be responsible for such future expenses. The court reasoned that the plaintiff was covered under group health insurance and that benefits available through the group policy were more than adequate to cover all reasonably anticipated medical expenses for the foreseeable future. The court pointed out that the group policy would continue to be primary to Medicare. The court approved the settlement and did not require any form of Set-Aside. In its order the court provided that:

The parties have reasonably and adequately considered the interest of Medicare in this settlement, and Plaintiffs Darus Finke and Shea Finke and Defendants Wal-Mart and Hunter's View will not be subject to any claim, demand or penalty from Medicare, Medicaid, or any other party, as a result of its settlement payments in this matter.

*Finke*, 2009 WL 6326944 at \*4.

**VIII. COURT ESTABLISHES STATUTE OF LIMITATIONS UNDER MEDICARE SECONDARY PAYER ACT OF THREE YEARS FOR ACTIONS ARISING OUT OF TORT AND SIX YEARS FOR ACTIONS ARISING OUT OF CONTRACT**

*U.S. v. Stricker*, CV-09-BE-2423-E, slip op. (N.D. Ala. Sep. 30, 2010) – On September 30, 2010, the United States District Court for the Northern District of Alabama, Eastern Division, clarified the applicable statute of limitations with regard to government actions for violations of the Medicare Secondary Payer Act. In December 2009, the United States sued numerous defendants, including plaintiff's lawyers, law firms, corporations and insurance carriers alleging a violation of the Medicare Secondary Payer Act with regard to conditional payments to Medicare beneficiaries for treatment related to PCB chemical contamination. In 2003 the Medicare beneficiaries, among others, reached a global settlement for \$300 million with the defendants, including Monsanto, Pharmacia and Solutia. In what is commonly known as the *Abernathy* settlement, the defendants initially funded the settlement with a payment of \$75 million in 2003. Future payments were also required as a part of funding the settlement, including \$2.5 million annual installments from 2004 to 2013.

In December 2009 the United States brought suit claiming that conditional payments were made subsequent to the initial 2003 global settlement and were not reimbursed upon funding of the future periodic payments. The corporate defendants argued that the government's action to recover conditional payments was based in tort and subject to a three-year statute of limitations under the Federal Claims Collection Act. 28 U.S.C. § 2415 (2008). In its decision, the court distinguished between the corporate defendants (manufacturers and insurers) and the attorney/law firm defendants. The court held that the three-year statute of limitations for claims founded upon tort applied to the corporate defendants and, therefore, the government's action was time barred.

As to the attorney/law firm defendants, the court concluded that the six-year statute of limitations applied, since an attorney's responsibility for reimbursement of conditional payments is founded upon the contractual relationship between attorney and client. The court nevertheless ruled that the government's action against the attorney defendants was also time barred because the limitations period began running no later than October 29, 2003, when the initial \$275 million settlement payment was made. The court rejected the government's argument that the statute would not begin to run until the settlement funds were distributed to the plaintiffs. The court further rejected the government's argument that the limitation had been tolled.

## **IX. FEDERAL DISTRICT COURT APPROVES MEDICARE SET-ASIDE AND LIABILITY SETTLEMENT**

The question of whether Medicare Set-Aside accounts for future medical expense need to be established in liability cases under the Medicare Secondary Payer Act is subject to debate. A recent Federal District Court Order from the Western District of Louisiana has been frequently cited (and often mis-cited) with regard to this very issue.

In *Big R Towing, Inc. v. Benoit*, No. 10-538, 2011 WL 43219 (W.D. La. Jan. 5, 2011), David Benoit was injured while working as the captain of a towboat owned by Big R Towing, Inc. He was paid maintenance and cure benefits pursuant to general maritime law. When a dispute arose as to additional medical treatment, Big R filed a declaratory judgment action as to whether maintenance and cure benefits were owed for the procedure. Benoit filed a counter-claim seeking damages under the Jones Act as well as under general maritime principles. Ultimately, pursuant to a settlement conference with the federal court, a settlement was reached in the amount of \$150,000. Consideration for that settlement included Benoit agreeing to be responsible to protect Medicare's interests under the Medicare Secondary Payer Act. 42 U.S.C. § 1395(y). The parties consented to allow a U.S. Magistrate Judge to decide the issue of future medical expenses under the Medicare Secondary Payer Act. The magistrate's order pointed out that Medicare does not currently have a policy or procedure in effect for reviewing or providing an opinion regarding the adequacy of future medical expenses of liability settlements. After a hearing on the merits, the magistrate ordered that \$52,500 be set aside to protect Medicare under the Medicare Secondary Payer Act. The sum reflected the cost associated with a future

back surgery and left hip replacement. No consideration was made for the ancillary expenses one would anticipate with such surgical procedures, such as post-operative follow-up and therapy.

The court specifically found that the amount was sufficient to protect Medicare's interests under the Medicare Secondary Payer Act. The court's order will effectively preclude CMS from later claiming that its interests are not protected.

Some vendors of Medicare Set-Aside allocation services are promoting this decision as a federal court ruling 'recognizing' the need for a Medicare Set-Aside in liability cases in order to protect Medicare's interests under the Medicare Secondary Payer Act. Such representations are misleading. First of all, it is unclear whether the U.S. Department of Health & Human Services was provided notice of the settlement terms and provided an opportunity to object. Secondly, the court simply adopted the terms of settlement proposed by the parties during a settlement conference with the court. Practically speaking, the *Big R Towing* case simply represents an example of a liability case in which the parties, by mutual agreement, agreed to use a Medicare Set-Aside and the court acquiesced to their proposed allocation.

#### **X. CMS GIVEN A PRIORITY RIGHT OF RECOVERY IN UNDERINSURED MOTORIST CLAIM**

*Farmers Ins. Exchange v. Forkey*, 764 F. Supp. 2d 1205 (D. Nev. 2010) – The United States District Court for the District of Nevada granted summary judgment in favor of CMS with regard to the government's claim of entitlement to a portion of underinsured motorist benefits. CMS claimed \$10,070.22 of a \$35,000 underinsured motorist policy. The policy holder was deceased; however, his spouse claimed entitlement to the underinsured benefits under the Nevada wrongful death statute. She argued that her claim had a value of \$500,000 and that Medicare's claim of \$10,070.22 merely represented about two percent of all potential claims and, therefore, should be limited in recovery to approximately \$200 (two percent). The court indeed ruled that CMS was entitled to the full \$10,070.22. The court held that the government's direct right of reimbursement from proceeds of the liability insurance payment took precedence over all other claims, including the state law of wrongful death claim.

The decision in *Farmers Ins. Exchange v. Forkey* illustrates that a split remains with regard to apportionment of settlement proceeds. The *Farmers* case appears to be contrary to the Court of Appeals for the Eleventh Circuit decision in *Bradley v. Sebelius*, 621 F.3d 1330 (11th Cir. 2010) in which the court applied principles of apportionment to reduce the CMS claim based upon public policy favoring settlements.

## **XI. MMSEA SECTION 111 REPORTING**

The Medicare/Medicaid and SCHIP Extension Act of 2007 imposed a duty on insurers to report to Medicare payments made to Medicare beneficiaries. Collectively, these are referred to as Non-Group Health Plans (NGHP). Such Non-Group Health Plan insurers "are obligated to notify Medicare about 'settlements, judgments, awards, or other payment from liability insurers (including self insurers), no fault insurers, and workers' compensation' received by or on behalf of Medicare beneficiaries," MMSEA Section 111 Mandatory Insurer Reporting, Quick Reference Guide, Version 1, January 19, 2012. The reporting requirements became effective May 1, 2009. However, due to software difficulties, reporting of workers' compensation claims did not commence until 2011 and the reporting of liability settlements began January 1, 2012.

When a liability or workers' compensation case is settled involving a Medicare beneficiary, the insurer is obligated to report that settlement to the Center for Medicare and Medicaid Services (CMS). The insurers are identified as "responsible reporting entities" (RRE's) as are self insureds. The RRE's are to report information when the insurer assumes an ongoing responsibility for medicals (ORM) or after paying the total payment obligation to the claimant (TPOC) in the form of a settlement, judgment, award or other payment. Simply stated, the trigger for reporting is the issuance of payment to the claimant or satisfaction of medical expense.

Numerous data elements must be submitted to CMS as a part of the section 111 reporting. Data includes, but is not limited to, evidence of insurance coverage, applicable settlements, judgments, awards, or other payments regardless of whether there is an admission or determination of liability. Additional information to be submitted includes the Medicare health insurance claim number or Social Security number, claimant's name, date of birth, gender, and other information including the International Classification of Diseases, 9th Version (ICD-9) diagnosis codes.

As a result of section 111 reporting, CMS will become aware of workers' compensation and civil settlements involving Medicare beneficiaries. The purpose is, in part, to identify insurers and self insureds that may have "primary" responsibility for payment under the Medicare Secondary Payer Act.

In the field of workers' compensation, Medicare Set-Asides have been used for several years to provide funds to satisfy future medical expenses that are closed out under a workers' compensation settlement. Those funds are to be used for future medical expense as opposed to submitting bills to Medicare. Now that CMS is aware of settlement details under section 111 reporting they have begun denying Medicare coverage to beneficiaries where bills are submitted that relate to the workers' compensation injury. It is plausible that the Center for Medicare and Medicaid Services may take the same approach with regard to liability settlements and judgments. Whether they will limit such action to cases where there is a specific allocation for future medical expense in the settlement or judgment is to be determined. The insurance industry and litigants are watching closely for the next indication from CMS as to how they may respond once provided the section 111 reporting data.

**XII. SECTION 111 REVISED REPORTING TIMELINE**

On September 30, 2011, CMS issued an alert revising the timeline for section 111 reporting of claims involving liability insurance. In the first quarter of 2012, settlements exceeding \$100,000 will be reported where the settlement payment (TPOC) was issued on or after October 1, 2011. On July 1, 2012, the threshold falls to \$50,000 and on October 1, 2012, the threshold is reduced to \$25,000. As of January 1, 2013, all such payments (TPOCs) must be reported. Set forth below is the table as published in the September 30, 2011, Memorandum:

<b>TPOC Amount</b>	<b>TPOC Date On or After</b>	<b>Section 111 Reporting Required In The Quarter Beginning</b>
TPOCs over \$100,000	October 1, 2011	January 1, 2012
TPOCs over \$50,000	April 1, 2012	July 1, 2012
TPOCs over \$25,000	July 1, 2012	October 1, 2012
All TPOCs over min. threshold	October 1, 2012	January 1, 2013

**XIII. MEDICARE OFFERS FIXED PERCENTAGE SETTLEMENT OPTION TO RESOLVE MEDICARE’S REIMBURSEMENT RIGHTS**

In a Memorandum of September 30, 2011, the Center for Medicare and Medicaid Services introduced a new payment option to resolve Medicare’s reimbursement rights (conditional payments). Liability settlements involving Medicare beneficiaries after November 7, 2011, can elect this option of a fixed percentage settlement. The requirements for this option are:

- The underlying injuries must be physical, trauma-based (rather than exposure or ingestion-based);
- The total amount of settlement, judgment or other payment does not exceed \$5,000;
- The option is elected within a specified time frame;
- Medicare has not issued a final demand letter or made any request for reimbursement prior to the election being made; and
- The beneficiary has not received, and does not expect to receive any further payments or judgment related to the trauma-based incident.



DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
**Division of Financial Management and Fee for Service Operations, Region VI**

1301 Young Street, Room 833  
Dallas, Texas 75202  
Phone (214) 767-6441  
Fax (214) 767-4440

This specific handout was prepared as a service to the public and is not intended to grant rights or impose obligations. It may contain certain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. Readers are encouraged to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. It is intended to provide consolidated guidance to those attorneys, insurers, etc., working liability, no-fault and general third party liability cases for any Medicare beneficiary residing in Oklahoma, Texas, New Mexico, Louisiana and Arkansas and is not to be considered a CMS official statement of policy.

If the Medicare beneficiary involved in your case is not a resident of one of these states, please contact the appropriate Centers for Medicare & Medicaid Services' (CMS) Medicare Secondary Payer Regional Office (MSP RO). If you do not have that information please contact Sally Stalcup (contact information below) for that information.

Medicare's interests must be protected; however, CMS does not mandate a specific mechanism to protect those interests. The law does not require a "set-aside" in any situation. The law requires that the Medicare Trust Funds be protected from payment for future services whether it is a Workers' Compensation or liability case. There is no distinction in the law.

Set-aside is our method of choice and the agency feels it provides the best protection for the program and the Medicare beneficiary.

Section 1862(b)(2)(A)(ii) of the Social Security, Act [42 USC 1395 y(b)(2)], precludes Medicare payment for services to the extent that payment has been made or can reasonably be expected to be made promptly under liability insurance. This also governs Workers' Compensation. 42 CFR 411.50 defines the term "liability insurance". Anytime a settlement, judgment or award provides funds for future medical services, it can reasonably be expected that those monies are available to pay for future services related to what was claimed and/or released in the settlement, judgment, or award. Thus, Medicare should not be billed for future services until those funds are exhausted by payments to providers for services that would otherwise be covered and reimbursable by Medicare. If the settlement, judgment, award, y are not funded there is no reasonable expectation that third party funds are available to pay for those services.

The new provisions for Liability Insurance (including Self-Insurance), No-Fault Insurance, and Workers' Compensation found at 42 U.S.C. 1395y(b)(8) add reporting rules and do not eliminate any existing statutory provisions or regulations. The new provisions do not eliminate CMS' existing processes if a Medicare beneficiary (or his/her representative) wishes to obtain interim conditional payment amount information prior to a settlement, judgment, award, or other payment. The new provisions do NOT require a set-aside when there is a recovery for future medicals, in fact this legislation does not address that subject. This legislation is unofficially known as "Mandatory Insurer

Reporting” because it does just and only that. It specifies the entity mandated to report a settlement/judgment/award/recovery to Medicare and addresses specifics of that issue.

There is no formal CMS review process in the liability arena as there is for Worker’ Compensation. **However**, CMS does expect the funds to be exhausted on otherwise Medicare covered and otherwise reimbursable services related to what was claimed and/or released before Medicare is ever billed. CMS review is decided on a case by case basis.

The fact that a settlement/judgment/award does not specify payment for future medical services does not mean that they are not funded. The fact that the agreement designates the entire amount for pain and suffering does not mean that future medicals are not funded. The only situation in which Medicare recognizes allocations of liability payments to nonmedical losses is when payment is based on a court of competent jurisdiction’s order after their review on the merits of the case. A review of the merits of the case is a review of the facts of the case to determine whether there are future medicals - not to determine the proper allocation of funds. If the court of competent jurisdiction has reviewed the facts of the case and determined that there are no future medical services Medicare will accept the Court’s designation.

While it is Medicare’s position that counsel should know whether or not their recovery provides for future medicals, simply recovers policy limits, etc, we are frequently asked how one would ‘know’. Consider the following examples as a guide for determining whether or not settlement funds must be used to protect Medicare’s interest on any Medicare covered otherwise reimbursable, case related, future medical services. Does the case involve a catastrophic injury or illness? Is there a Life Care Plan or similar document? Does the case involve any aspect of Workers’ Compensation? This list is by no means all inclusive.

We use the phrase “case related” because we consider more than just services related to the actual injury/illness which is the basis of the case. Because the law precludes Medicare payment for services to the extent that payment has been made or can reasonably be expected to be made promptly under liability insurance, Medicare’s right of recovery, and the prohibition from billing Medicare for future services, extends to all those services related to what was claimed and/or released in the settlement, judgment, or award. Medicare’s payment for those same past services is recoverable and payment for those future services is precluded by Section 1862(b)(2)(A)(ii) of the Social Security Act.

“Otherwise covered” means that the funds must be used to pay for only those services Medicare would cover so there is a savings to the Medicare trust funds. For example, Medicare does not pay for bathroom grab bars, handicapped vans, garage door openers or spas so use of the funds for those items is inappropriate. We include the designation of “otherwise reimbursable” because Medicare does not pay for services that are not medically necessary even if the specific service is designated as a covered service and Medicare does not pay primary when Group Health Plan insurance has been determined to be the primary payer.

At this time, the CMS is not soliciting cases solely because of the language provided in a general release. CMS does not review or sign off on counsel’s determination of the amount to be held to protect the Trust Fund in most cases. We do however urge counsel to consider this issue when settling a case and recommend that their determination as to whether or not their case provided recovery funds for future medicals be documented in their records. Should they determine that future services are funded, those dollars must be used to pay for future otherwise Medicare covered case related services.

CMS does not review or sign off on counsel's determination of whether or not there is recovery for future medical services and thus the need to protect the Medicare Trust Funds and only in limited cases do they review or sign off on counsel's determination of the amount to be held to protect the Trust Funds.

There is no formal CMS review process in the liability arena as there is for Worker' Compensation, however Regional Offices do review a number of submitted set-aside proposals. On occasions, when the recovery is large enough, or other unusual facts exist within the case, this CMS Regional Office will review the settlement and help make a determination on the amount to be available for future services.

We are still asked for written confirmation that a Medicare set-aside is, or is not, required. As we have already covered the "set-aside" aspect of that request we only need to state that IF there was/is funding for otherwise covered and reimbursable future medical services related to what was claimed/released, the Medicare Trust Funds must be protected. If there was/is no such funding, there is no expectation of 3<sup>rd</sup> party funds with which to protect the Trust Funds. Each attorney is going to have to decide, based on the specific facts of each of their cases, whether or not there is funding for future medicals and if so, a need to protect the Trust Funds. They must decide whether or not there is funding for future medicals. If the answer for plaintiff's counsel is yes, they should see to it that those funds are used to pay for otherwise Medicare covered services related to what is claimed/released in the settlement judgment award. If the answer for defense counsel or the insurer, is yes they should make sure their records contain documentation of their notification to plaintiff's counsel and the Medicare beneficiary that the settlement does fund future medicals which obligates them to protect the Medicare Trust Funds. It will also be part of their report to Medicare in compliance with Section 111, Mandatory Insurer Reporting requirements.

Medicare educates about laws/statutes/policies so that individuals can make the best decision possible based on their situation. This is not new or isolated to the MSP provisions. Probably the best example I can give is the 2008 final rule adopting payment and policy changes for inpatient hospital services paid under the Inpatient Prospective Payment System. That final rule also adopted a number of important changes and clarifications to the physician self-referral rules sometimes known as the Stark provisions. The physician self-referral law prohibits physicians from referring Medicare and Medicaid patients to certain entities with which the physician or a member of their immediate family has a financial relationship. Exceptions apply. Requests for determinations as to whether or not the physician met the exception criteria, or whether or not their situation was covered by this prohibition poured in. CMS/Medicare did not and continues to make no such determinations. It is the responsibility of the provider to know the specifics of their situation and determine their appropriate course of action.

**Sally Stalcup**  
MSP Regional Coordinator  
CMS  
Medicare Fee for Service Branch  
Division of Financial Management  
and Fee for Service Operations  
1301 Young Street, Room 833  
Dallas, Texas 75202  
(214) 767-6415  
(214) 767-4440 fax



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MEMORANDUM

**DATE:** September 29, 2011

**FROM:** Acting Director  
Financial Services Group  
Office of Financial Management

**SUBJECT:** Medicare Secondary Payer—Liability Insurance (Including Self-Insurance)  
Settlements, Judgments, Awards, or Other Payments and Future Medicals --  
INFORMATION

**TO:** Consortium Administrator for Financial Management and Fee-for-Service  
Operations

The purpose of this memorandum is to provide information regarding proposed Liability Medicare Set-Aside Arrangement (LMSA) amounts related to liability insurance (including self-insurance) settlements, judgments, awards, or other payments (“settlements”).

Where the beneficiary’s treating physician certifies in writing that treatment for the alleged injury related to the liability insurance (including self-insurance) “settlement” has been completed as of the date of the “settlement”, and that future medical items and/or services for that injury will not be required, Medicare considers its interest, with respect to future medicals for that particular “settlement”, satisfied. If the beneficiary receives additional “settlements” related to the underlying injury or illness, he/she must obtain a separate physician certification for those additional “settlements.”

When the treating physician makes such a certification, there is no need for the beneficiary to submit the certification or a proposed LMSA amount for review. CMS will not provide the settling parties with confirmation that Medicare’s interest with respect to future medicals for that “settlement” has been satisfied. Instead, the beneficiary and/or their representative are encouraged to maintain the physician’s certification.

The above referenced guidance and procedure is effective upon publication of this memorandum.

  
Charlotte Benson



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MEMORANDUM

**DATE:** September 30, 2011

**FROM:** Acting Director  
Financial Services Group  
Office of Financial Management

**SUBJECT:** Medicare Secondary Payer—Liability Insurance (Including Self-Insurance)  
Settlements, Judgments, Awards, or Other Payments and Future Medicals --  
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The above referenced guidance and procedure is effective upon publication of this memorandum.

A handwritten signature in cursive script that reads "Charlotte Benson".

Charlotte Benson



## Bradford J. Peterson

- Partner

After passing the Bar in 1987, Brad joined the Urbana office of Heyl Royster and has spent his entire career there. His practice focus is divided between workers' compensation and civil litigation, where he is experienced in the defense of products liability, construction, motor carrier and insurance coverage. In recent years, Brad has had a special interest in Medicare Set-Aside Trusts and the Medicare Secondary Payer Act, and has written and spoken extensively on those issues. In fact, Brad was one of the first attorneys in the State of Illinois to author a published article regarding the application of the Medicare Secondary Payer Act to workers' compensation claims: "Medicare, Workers' Compensation and Set-Aside Trusts," *Southern Illinois Law Journal* (2002).

Brad is a member of the Champaign County, Illinois State, and American Bar Associations. He served a number of terms in the Illinois State Bar Association Assembly. Brad has also been a member of the ISBA Bench and Bar Section Council and served as its Chair in 2000-2001. Currently, he serves as Vice Chair of the ISBA Workers' Compensation Section Council; Brad will become Chair in June 2012 at the ISBA Annual Meeting. He is a past editor of the Workers' Compensation Section Newsletter. Brad currently serves as the contributing editor of the Workers' Compensation Report for the *Illinois Defense Counsel Quarterly*.

### Significant Cases

- *Johnson v. Daimler Chrysler Corporation, Blane Warren and Aladdin Electric* - Obtained favorable settlement (structured settlement with cost in low seven figures) in negligent entrustment and product liability action involving death of an accountant with wife and two children.
- *Tracy Green v. Freitag-Weinhardt* - Obtained favorable settlement of workers' compensation claim and third-party liability claim against petitioner/plaintiff's employer. Plaintiff suffered from fractures to the T11-T12 vertebra with resulting paraplegia. Seven figure settlement reached with primary defendants and third-

party liability claim as well as workers' compensation claim resolved through workers' compensation lien waiver and partial satisfaction of future medical expense.

### Publications

- "When is a Purely Personal Deviation a Departure from the Course of Employment," *Illinois Defense Counsel Quarterly* (2011)
- "Appellate Court Resurrects 8(j)(2) Credit Related to Compensation Paid by the Employer," *Illinois Defense Counsel Quarterly* (2011)
- "Workers' Compensation Procedural Reforms to Impact Downstate Practice," *Illinois Defense Counsel Quarterly* (2011)

### Public Speaking

- "Medicare Set-Aside Trusts" Heyl Royster 26th Annual Claims Handling Seminar (2011)
- "Mock Trial Participant" ISBA Workers' Compensation Section Council (2010)

### Professional Associations

- Champaign County Bar Association
- Illinois State Bar Association (Vice Chair, Workers' Compensation Section Council)
- American Bar Association
- The National Association of Medicare Set-Aside Professionals
- Illinois Association of Defense Trial Counsel

### Court Admissions

- State Courts of Illinois
- United States District Court, Central District of Illinois
- United States Court of Appeals, Seventh Circuit
- United States Supreme Court

### Education

- Juris Doctor, Southern Illinois University, 1987
- Bachelor of Science (with honors), Illinois State University, 1984