

MEDICARE SET-ASIDES IN PERSONAL INJURY CASES: IS THERE A STANDARD METHOD OF PRACTICE?

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I. INTRODUCTION

A “Medicare Set-Aside,” also known as an MSA” or sometimes a “Medical Set-Aside,” is a legal tool that has grown more popular among Elder and Special Needs Law attorneys since its inception in the mid-1990s.¹ While in the workers’ compensation arena the use of MSAs has become a routine practice, it remains unclear whether MSAs are always appropriate in the context of personal injury cases. This article will explore the issues and attempt to determine whether a standard of practice for or against the use of MSAs in personal injury cases exists.

An MSA is a separately administered custodial account, which operates similarly to a trust and is created in certain situations when Medicare’s interests may be affected by a settlement. For example, pursuant to federal statute, if a plaintiff is receiving Medicare or is likely to receive Medicare within a certain period of time post-settlement or post-judgment, the parties to the settlement or judgement are required to consider Medicare’s interest as it pertains to future, injury-related expenses. An MSA may be administered by a professional fiduciary or self-administered by the plaintiff. The corpus of the MSA is comprised of a pre-determined amount of settlement proceeds allocated to cover anticipated future medical expenses specifically related to the injury that was the basis for the claim resulting in the settlement. Funds from the MSA are then used over the plaintiff’s projected lifetime in order to cover future, injury-related medical expenses so that Medicare does not have to pay for those costs. If the MSA is depleted after paying for injury-related medical expenses prior to the plaintiff’s death, then Medicare would assume payments for this care.

The MSA was developed as a tool to clearly document the projected amount of anticipated future expenses related to the injury for which compensation was received while also serving to satisfy Medicare’s interest in the settlement. The goal was to pro-

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1 “MSA” in this context should not be confused with the same abbreviation used to stand for “medical spending accounts.”

protect plaintiffs, defendants, and insurers from further liability with respect to Medicare's interest in damages for future medical payments. In the workers' compensation action it is common for the court to make or approve allocations of the settlement for future medical care. However, such allocation is not a typical practice in personal injury cases. In contrast, most personal injury settlements are negotiated to provide a global settlement of all claims to the suit, which can include, but are not limited to future medical expenses, compensatory damages, lost wages, emotional distress, and other economic damages. Thus, it becomes very difficult to allocate any specific portion of such settlements solely to address future medical expenses.

Despite the lack of any specific statute or regulation requiring the use of MSAs in workers' compensation settlements, the practice has achieved almost universal acceptance and use.² Although originally a novel concept, the MSA was quickly adopted by the Centers for Medicare and Medicaid Services (CMS) as a standard approach in workers' compensation settlements. CMS has published guidelines to help address the MSA process with respect to workers' compensation litigation.³

However, the use of MSAs to address future medical payments in personal injury cases has been a focus of serious debate for several years. Attorneys who advocate for the near universal use of MSAs in the context of a personal injury settlement present a broader interpretation of specific terms in the Medicare Secondary Payer Act⁴ (MSP Act), the controlling federal statute on the matter, and cite instances of CMS action with respect to personal injury suits that appear to support MSA use.

The predominant counter argument taken by other attorneys in the field is that universal use of MSAs is not necessary. This argument is based on a more narrow interpretation of the MSP Act and points out the lack of authority for mandatory use of MSAs in the personal injury context. What follows here is an exploration of the issue and an attempt to determine whether one can derive any standard method of practice from an examination of the arguments on each side of the issue.

II. BACKGROUND TO THE MSP ACT AND MSAs

The MSP Act was enacted as part of the Omnibus Budget Reconciliation Act of 1980.⁵ Congress enacted the MSP Act as a cost-saving measure with the primary goal of identifying circumstances when future Medicare expenditures could be reduced by forcing third parties liable for medical care to pay in place of Medicare. In essence, under the MSP Act Medicare's obligation to pay became "secondary" to that of liable third parties. The statute was subsequently amended by the Medicare Act of 2003 in order to clarify issues regarding the determination of Medicare's secondary payer role.

2 The statutory basis for Workers' Compensation Medicare Set-Asides (WCMSAs) is derived from an interpretation of 42 U.S.C. § 1395y (2011) and 42 C.F.R. §§ 411.46, 411.47, addressing lump-sum commutation of future benefits in workers' compensation matters.

3 See CMS, Medicare Secondary Payer (MSP) Manual (2011), <https://www.cms.gov/WorkersCompAgencyServices>, search for "Medicare Secondary Payer Manual."

4 42 U.S.C. § 1395y (2011).

5 42 U.S.C. § 1395 *et seq.* (2011).

The MSP Act provides general examples of when Medicare will take a secondary role as an insurer of medical expenses for an individual.⁶ The MSP Act also discusses Medicare's authority to make what are known as "conditional payments" on behalf of beneficiaries. Conditional payments are defined as medical payments made by Medicare with the condition that Medicare would hold subrogation rights to recover these conditional payments at a later time, typically from subsequent settlements or judgments received by the beneficiary from third parties.⁷ The provisions of the MSP Act regarding conditional payments and Medicare subrogation rights are relatively clear and there has been little dispute in the legal community concerning the application of these provisions in both the workers' compensation and the personal injury context.

The idea of using MSAs in any situation in which Medicare's interests may be affected by a settlement was first introduced by attorneys. However, with the publication of a policy memo directed to its regional offices, CMS publicly adopted the use of MSAs in workers' compensation around 2001. This policy memo provided that compliance with the MSP Act in most workers' compensation settlements, which included future medical expenses, required the use of MSAs.⁸ Since this policy memo was issued, CMS has created an entire application and approval process for MSAs. However, with respect to future medical payments in personal injury cases, there are ongoing divisions within the different CMS regional offices about the proper interpretation and application of certain segments of the statute and whether MSAs should be required.

III. PRINCIPAL ARGUMENTS INVOLVING THE MSA

Attorneys who favor universal use of MSAs in personal injury suits argue three primary points in favor of the use: 1) an implied statutory basis of authority for MSA use; 2) evidence of MSA requirements based upon specific CMS action and action taken by its regional offices; and 3) the significant risks and potential dire consequences for failure to use an MSA in the personal injury context. Each of these arguments is addressed separately below.

A. Statutory Basis for MSAs

The MSP Act states in pertinent part:

Payment under this title [42 USCS §§ 1395 et. seq.] may not be made, except as provided in subparagraph (B), with respect to any item or service to the extent that –

- (i) payment has been made, or can reasonably be expected to be made, with respect to the item or service as required under paragraph (1), or
- (ii) payment has been made or can reasonably be expected to be made under a workmen's compensation law or plan of the United States or

6 42 U.S.C. § 1395y(b)(2)(A) (2011).

7 42 U.S.C. § 1395y(b)(2)(B) (2011).

8 Memo. from Dep. Dir., Purchasing Policy Group, Ctr. for Medicare Mgt., CMS, to Assoc. Regl. Adminstrs., Workers' Compensation: Commutation of Future Benefits (July 23, 2001), <http://www.cms.gov/Medicare/Coordination-of-Benefits/WorkersCompAgencyServices/downloads//72301Memo.pdf>.

a State or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance.⁹

It is clear, by the language of paragraph (ii) that the MSP Act references automobile and liability insurance policies, as well as self-insured or no-fault insurance plans, all of which could be available to pay damages in a personal injury suit. What is less clear is in what context this provision should apply and how this language is to be interpreted. The argument in favor of MSA use is premised on the notion that MSA guidelines and informal rules governing the process in workers' compensation, as they were derived from this statutory provision, must also apply to other types of "primary plans" identified in the MSP Act when future medical expenses are considered.¹⁰

To support this interpretation of the MSP Act, those advocating for the regular use of MSAs cite to Title 42 of the Code of Federal Regulations (CFR) §§ 411.46 and 411.47. CFR § 411.46 explains Medicare's secondary status as payer when a lump-sum compensation award or settlement stipulates that an amount paid is intended to compensate an individual for future medical benefits. The regulation provides that Medicare's coverage of related future medical expenditures is suspended under these circumstances until the allocated assets for future medical expenses have been exhausted. In the following section, CFR § 411.47, a formula is provided to use in determining which assets should be applied toward future medical expenses in allocating a workers' compensation settlement. Both of these regulations refer only to awards and settlements in the workers' compensation context and not to other awards, such as personal injury awards.

Proponents of the use of MSAs in personal injury cases (also referred to in some contexts as "liability MSAs") have also relied on more recent federal legislation to support their contention that the MSP Act intended their use in personal injury cases. In 2007, Congress passed the Medicare, Medicaid & SCHIP Extension Act of 2007 (MMSEA). Proponents of the use of MSAs in personal injury settlements used provisions of the MMSEA to reinforce their argument of statutory authority for MSA use in personal injury cases. MMSEA §111 imposed reporting requirements on statutorily defined, "Required Reporting Entities" or RREs. Included in the definition of RREs are liability insurance plans, no-fault insurance plans, and workers' compensation plans. Under the MMSEA, RREs must include information in quarterly reports to give CMS the information necessary to determine whether a claimant or plaintiff is entitled to Medicare benefits. In addition, these RREs must provide additional information to CMS upon settlement of any claim by a beneficiary or plaintiff.¹¹ The reporting requirements under the MMSEA are complex and failure to properly and timely comply could subject an RRE to a penalty of \$1,000 per day per claimant.

These reporting requirements under MMSEA § 111 did not become effective until July 1, 2009. Some attorneys argue, however, that the reporting requirements spelled out

9 42 U.S.C. § 1395y(b)(2)(A) (2011).

10 Glenn Simpson, John J. Campbell, Paul J. Masterson & Ro Baltayan, *Coordination of Medicare Set Aside Arrangements and MMSEA Section 111 Reports*, Medicare Set Aside Bull. (Issue 56, Sept. 21, 2009), <http://www.jjccelderlaw.com/MSAMMSEACoordinationMSABull.htm>.

11 *Id.*; 42 U.S.C. § 1395y(b)(8).

in the MMSEA “are surely a sign that CMS will be increasing its efforts to enforce its secondary payer status in liability settlements, similar to its enforcement efforts in workers’ compensation settlements since July 2001.”¹² While these attorneys recognize that the new MMSEA law does not impose any MSA requirements for liability settlements, they continue to argue that CMS is poised to similarly interpret the MSP Act to require MSAs in personal injury cases the very near future. This belief is reinforced by the fact that CMS is now requesting information similar to that gathered in workers’ compensation settlements.

Opponents of this statutory basis argument take a different approach. Their primary objection is that the statutory provision cited in the MSP Act is too vague to draw any definitive interpretation regarding the Act’s application to future medical benefits. In addition, they point to the fact that 42 CFR §§ 411.46 and 411.47 only provide specific reference to workers’ compensation matters and do not mention other claims. They point out that despite the regulations’ references to Medicare’s interest in future medical payments, the regulatory references are only with respect to stipulated or allocated future medical payments, which are common to settlements in the workers’ compensation field. However, there is no reference in the regulations to instances when future medical payments are not stipulated to or allocated as a portion of the settlement proceeds. Since allocation of settlement proceeds for specific damages rarely exists in a personal injury context, it is difficult to speculate that any referenced obligation within these regulations applies to personal injury settlements the same as to workers’ compensation settlements.

Opponents of the statutory basis argument also contend that the prior argument — that the enactment of MMSEA §111 is an indication that CMS will impose a strict interpretation of the MSP Act and require the mandatory use of MSAs in personal injury settlements — is only speculative of CMS’ intent. They contend that there is no definitive statute or regulation providing direct authority to support MSA use in the personal injury context.¹³ These individuals point out that if CMS wanted to mandate the use of MSAs in the personal injury context, it could only do so through considerable changes in federal statutes and regulations. The changes would require Congressional action or formal rule making procedures including adequate notice and comment periods.¹⁴ It is clear that, other than 42 CFR §§ 411.46 and 411.47, there is nothing in the statute or regulations that speaks directly to Medicare’s interest in future medical expenses and even then, these regulations only apply to workers’ compensation.

Finally, opponents argue that if Medicare were to attempt to impose a mandatory requirement for MSAs in personal injury settlements it would be unenforceable under the “fair notice” doctrine because of the ambiguous language of the MSP Act. The fair notice doctrine was most accurately explained by the Circuit Court of Appeals for the District of

12 John J. Campbell, *New Medicare Secondary Payer Reporting Requirements*, Medicare Set Aside Bull. (Issue 43, Feb. 10, 2008), <http://www.jjcelderlaw.com/MMSEAMSABull.htm>.

13 Sally Hart, *Limits on Medicare’s Recovery Health Care Payments When the Beneficiary has Liability or Workers’ Compensation Insurance* (Sept. 17, 2009), http://www.medicareadvocacy.org/Print/2009/SecPayer_09_09.17.MedicareLimitations.htm.

14 *Id.*

Columbia in the case, *General Electric Company v. United States Environmental Protection Agency*.¹⁵ In *General Electric Company*, the court stated that “due process requires that parties receive fair notice before being deprived of property. ... In the absence of notice — for example where the regulation is not sufficiently clear to warn a party about what is expected of it — an agency may not deprive a party of property by imposing civil or criminal liability.”¹⁶ Opponents suggest that under this doctrine CMS cannot arbitrarily enforce MSA use, suing those who fail to comply, without first properly providing fair notice of its intention to apply MSAs in personal injury settings, which the agency has never formally done.

B. Actions Taken by CMS and its Regional Offices

Many advocates, recognizing the limited legal authority supporting the mandatory use of MSAs in the personal injury context, support their argument by pointing to apparent actions and statements made by CMS and its regional offices. Advocates for the use of MSAs have stated unequivocally that:

CMS interprets this language [i.e., 42 U.S.C. § 1395 (b)(2)(A)] as providing that *any* settlement that closes out future medical expenses in a claim against a primary payer represents a situation in which “payment has been made” for an item or service otherwise covered by Medicare, precluding future Medicare coverage for those items or services until the payment has been exhausted on future medical expenses related to the injury.¹⁷

This argument gains support from the detailed procedures and guidelines of CMS for future medical payments in the workers’ compensation context. Advocates of the regular use of MSAs assert that CMS’ failure to distinguish between workers’ compensation carriers and other insurers with potential liability for a Medicare recipient’s future medical expenses justifies “similar authority to require tort victims to apply damages for future medicals toward future care arising from a tort.”¹⁸

There is further evidence to suggest that CMS may, to some extent, support MSAs in the personal injury context. On April 22, 2003, CMS issued a policy statement to all CMS regional administrators. This memorandum provided that in situations involving both workers’ compensation and personal injury claims, Medicare is secondary to the personal injury proceeds. The intent of the memorandum was to clarify that Medicare’s obligation to pay benefits should be reduced if the personal injury settlement occurred and Medicare had paid or will pay benefits for care related to the underlying injury. The memorandum indicated that to the extent that a liability settlement is made relieving a

15 See *Gen. Elec. Co. v. U.S. EPA*, 53 F.3d 1324 (D.C. Cir. 1995).

16 *Id.* at 1328–1329.

17 John J. Campbell, *New Medicare Secondary Payer Reporting Requirements*, 21 NAELA News 22–24 (No. 6, 2009).

18 Lawrence A. Friedman, *Medicaid and Medicare Liens in Personal Injury Settlements*, 21 NAELA News 26–27 (No. 6, 2009).

workers' compensation carrier from any future medical expenses, a CMS-approved MSA is appropriate.¹⁹ The memorandum did not, however, address the situation in which there was no underlying workers' compensation claim.

The National Academy of Elder Law Attorneys (NAELA) established a Medicare Task Force in spring 2008 to specifically investigate and review the use of MSAs in personal injury cases. The task force found that the CMS national office is aware that some attorneys create MSA arrangements in personal injury cases and that CMS is not opposed to the use of MSAs.²⁰ Another finding indicated that the CMS regional office in Texas had been reviewing liability settlement arrangements in the past and another unnamed region was said to have been reviewing such arrangements when the settlement amount exceeded \$750,000.²¹ This empirical evidence implies that CMS, or at least some of its regional offices, have considered favorable approaches to the regular use of MSAs in personal injury settlements.

CMS, however, has not remained consistent with its approach towards mandatory MSA use in personal injury settlements. In fact, CMS takes an indifferent position to MSA use in these contexts almost as frequently, if not more often, than it appears to endorse MSAs in the personal injury context. Statements issued by CMS and past actions of CMS (or, more specifically its ambivalence on the issue) has strongly implied, if not directly indicated that CMS does not require or enforce the regular use of MSAs in the personal injury context. For example, the CMS regional office for Region IX (covering Arizona, California, Hawaii, Nevada, and several U.S. Pacific Territories) sent a letter to an advocacy group located in Arizona stating unequivocally that, "it has been long-standing Medicare policy that *Medicare* is the primary payer for accident-related medical services obtained after the Date of Settlement"²² [Emphasis supplied.] This language implies that since Medicare views itself as the primary insurer to injured parties in a personal injury suit for future medical expenses, Medicare has no interest in future medical expenses in this context and therefore, MSAs are irrelevant and unnecessary.

The CMS San Francisco Regional office went one step further and issued a memorandum in October 2009 stating, "The Centers for Medicare & Medicaid Services (CMS) has no current plans for a formal process for reviewing and approving Liability Medicare set-aside arrangements."²³ Another letter issued on May 25, 2011, by the MSP Regional Coordinator located in Dallas, Texas, representing CMS Region VI stated, "Medicare's

19 Memo. from Dir., Ctr. for Medicare Mgt., CMS, to Regl. Adminstrs., Medicare Secondary Payer—Workers' Compensation (WC) Frequently Asked Questions (Apr. 22, 2003), <http://www.cms.gov/Medicare/Coordination-of-Benefits/WorkersCompAgencyServices/downloads/42203Memo.pdf>.

20 Memo. from NAELA Pub. Policy Comm. and Medicare Set-Aside Task Force to NAELA Bd. of Dirs., *Task Force Report* (Oct. 27, 2010), and NAELA Medicare Set-Aside Task Force, *NAELA Medicare Task Force on the Use of Set-Aside Arrangements* (Oct. 2010), http://www.naela.org/App_Themes/Public/PDF/Home%20Page/ISSUE%20Medicare%20Set%20Aside%20TF_2%20%282%29.pdf.

21 *Id.*

22 Ltr. from Thomas Bosserman, Health Ins. Specialist, Program Integrity Branch, Div. of Fin. Mgt., Region IX, CMS, to Sally Hart, Ctr. for Medicare Advoc. (July 3, 2002), http://www.medicareadvocacy.org/InfoByTopic/MedicareSecondaryPayer/SecondaryPayer_09_06.HHSLiabilityInsuranceLetter.pdf.

23 Memo from Dept. of Health and Human Servs., Ctrs. for Medicare & Medicaid, San Francisco Regional Office (Oct. 2009). On file with author.

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.”²⁴

The American Association for Justice (a/k/a the American Trial Lawyers Association) has released a public statement directly addressing speculation as to the connection between the MMSEA § 111 and liability MSA enforcement. The statement says the following:

It has come to our attention that some defense firms and insurance providers are now claiming that CMS requires MSAs in liability cases pursuant to Section 111 reporting requirements included in the Medicare, Medicaid & SCHIP Act of 2007 (MMSEA), Public Law No. 110-173. This is **false**. Section 111 contains reporting requirements for responsible reporting entities (RREs) only. Section 111 does not impact or change the requirements for plaintiffs’ attorneys... Moreover, statements from CMS, and other federal entities, make clear that the agency does not require set-asides for liability claims.²⁵

This statement includes citations to transcriptions from CMS public meetings and a CMS Alert as support.²⁶ The May 2011 letter issued by CMS Region VI only supports this contention. In referring to the new statutory reporting provisions for liability insurers (i.e., MMSEA § 111), the May 2011 letter from CMS Region VI states: “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.”²⁷

On September 30, 2011, the Acting Director of the Financial Services Group in Medicare’s Office of Financial Management issued a memorandum providing some additional guidance, and a potential loophole for practitioners to satisfy Medicare’s interests in liability contexts. The memorandum states that when a Medicare beneficiary’s treating physician can certify in writing that treatment for an alleged injury related to the liability insurance settlement has been completed as of the date of the settlement and no future injury-related medical expenses are necessary, Medicare will consider its interest satisfied with respect to the settlement.²⁸ The impact of this memorandum is significant as it clearly indicates that there are circumstances (particularly those where maximum medical improvement of the Plaintiff can be certified by a treating physician) when CMS has

24 Memo. from Sally Stalcup, MSP Regl. Coord., Region VI, CMS (May 25, 2011), <http://www.settlementlawfirm.com/files/Stalcup%20CMS%20Memo.pdf>.

25 Ltr. From Anthony Tarricone, Pres., American Association for Justice, *Important Medicare Set Aside Information* (Aug. 11, 2009), <http://www.creative-capital.com/Section-111-MSA-Letter.pdf>.

26 CMS, Introduction to Section 111 Mandatory Medicare Secondary Payer Reporting (Feb. 23, 2009), <http://www.cms.gov/Medicare/Coordination-of-Benefits/MandatoryInsRep/downloads/RevisedSection111022309.pdf>.

27 Stalcup, *supra* n. 24.

28 Memo. from Acting Dir., Fin. Servs. Group, Off. of Fin. Mgt., CMS, *Medicare Secondary Payer — Liability Insurance (Including Self-Insurance) Settlements, Judgments, Awards, or Other Payments and Future Medicals—INFORMATION* (Sept. 30, 2011), <https://www.cms.gov/COBGeneralInformation/Downloads/FutureMedicals.pdf>.

unequivocally indicated that no further action is necessary with respect to future medical payments.

Finally, the Medicare Secondary Payer (MSP) Manual, an internal set of detailed guidelines for CMS and regional affiliates also addresses this issue. The manual specifically states, “there should be no recovery of benefits paid for services rendered after the date of a liability insurance settlement.”²⁹ Opponents of personal injury MSAs argue that these examples demonstrate that CMS policy does not require MSAs in that context or, at the very least, indicates that CMS and its regional offices have not taken a united stance on the issue.

C. Risk of Attorney Liability

One of the most common arguments for the use of MSAs in liability settlements has been the perceived risk of liability by the personal injury attorney who fails to establish an MSA for his or her client. Federal regulations promulgated in conjunction with the MSP Act indicate that Medicare holds a right to recover under the MSP Act against any entity, including a beneficiary, provider, supplier, physician, attorney, state agency, or private insurer that has received personal injury funds (i.e., a primary payment).³⁰ Despite this lone regulation discussing potential liability against attorneys under the MSP Act, MSA proponents imply that attorneys involved in personal injury suits are almost certainly exposed to liability pursuant to this regulation when future medical expenses are settled. They argue that by failing to consider Medicare’s interests with respect to future medical payments in a prescribed way (or, in other words, failing to establish MSAs), a personal injury attorney could potentially be liable for damages pursuant to 42 U.S.C. § 1395y(b)(3)(A). The argument stands that by establishing an MSA for the client, and receiving approval from Medicare for a specific set-aside amount, an attorney virtually insulates him or herself as well as all parties to the suit from any chance of liability.

Opponents argue that in reality, risk of attorney liability is minimal, pointing out that, “the MSP provisions of the statute never specifically identify attorneys as individuals against whom CMS recovery rights are created....”³¹ Medicare’s private cause of action to collect damages under 42 USC § 1395y(b)(3)(A) appears to only apply to a primary plan that fails to provide for primary payment (or other appropriate reimbursement).³² The statute defines a primary plan as a workers’ compensation law or plan, an automobile or liability insurance policy or plan (including a self-insured plan), or no fault insurance plan.³³

A careful reading of the federal regulations shows that Medicare ultimately holds “primary payers” responsible in the personal injury context. Support for this is found at 42 CFR § 411.24(i)(1), which states in pertinent part:

29 CMS, *supra* n. 3, ch. 7, § 50.5.

30 42 C.F.R. § 411.24 (2011).

31 Sally Hart, *The Myth of the Superlien: Medicare as Secondary Payer Law Clarified*, 5 NAELA J. 101 (2009).

32 *Id.*

33 42 U.S.C. § 1395y(b)(2)(A) (2011).

In the case of liability insurance settlements...the following rule applies: If Medicare is not reimbursed as required...of this section, the primary payer must reimburse Medicare even though it has already reimbursed the beneficiary or other party.

This provision is important because it references primary payer liability without any reference to attorney liability and it appears to only apply to recovery by Medicare for conditional (i.e., past) payments. This section of the CFR does not appear to reference future medical payments. Thus, opponents strongly believe that liability for attorneys in personal injury cases has only minimal authoritative support.

The MSP Act does not specifically reference attorneys as primary payers, and while some federal regulations allude to attorney liability, this liability has been argued to arise only if the attorney has actually received, and still possesses, settlement proceeds. If an attorney has never received or no longer possesses settlement proceeds subject to the referenced statute and regulation, the argument holds that it would be difficult for Medicare to hold such personal injury attorney liable for recovery for either conditional payments or future medical payments.

Opponents to mandatory MSAs in personal injury actions acknowledge that Medicare has only pursued recovery against attorneys in a handful of published cases and therefore there is little precedent to indicate that such liability exists.³⁴ It is important to recognize that in each of the cases in which Medicare pursued recovery the attorney had possession of settlement funds, thereby allowing Medicare to file its claim against the attorney. Furthermore, in each of these cases, Medicare's claim was based on the recovery of past medical payments (i.e., conditional payments) and was not a claim for estimated future medical payments or for any failure to use MSAs. Opponents argue that federal provisions logically conclude that, except for primary payers, recovery actions actually pursued by CMS indicate the agency will likely pursue recovery of funds either directly from a defined "primary payer," or from one individual or entity to the next depending on who possesses the funds at that point in time and that such recovery shall be solely for conditional payments made by Medicare.³⁵

IV. STANDARD OF PRACTICE

There are many unresolved questions with respect to the use of MSAs in personal injury settlements. Thus, it does not appear that there is a standard method of practice with respect to MSAs in the personal injury context. Nor is it clear whether attorneys, when negotiating a personal injury settlement, should always use MSAs. What is clear is that the answers to these unresolved questions appear to depend upon the circumstances of each case and require a case-by-case and cost-benefit analysis for the parties involved.

As previously mentioned, NAELA created a Medicare Task Force in spring 2008 with the specific mission to investigate and report on the use of set-aside arrangements

34 See *U.S. v. Sosnowski*, 822 F. Supp. 570 (W.D. Wis. 1993); *U.S. v. Weinberg*, 2002 U.S. Dist. LEXIS 12289 (E.D. Pa. July 1, 2002); *U.S. v. Harris*, 2009 U.S. Dist. LEXIS 23956 (N.D.W. Va. March 26, 2009), *aff'd*, *U.S. v. Harris*, 2009 U.S. App. LEXIS 23394 (4th Cir. October 23, 2009).

35 Hart, *supra* n. 31.

in the context of personal injury settlements involving third party liability for Medicare-covered expenses. The task force was comprised of a diverse group of attorneys experienced in the subject. The official report was issued in October 2010.

The primary findings of the Task Force were:

- CMS acknowledges that there is no Medicare requirement to establish MSAs in any context;
- CMS national office has indicated that it is not likely to issue further clarification with respect to requiring MSA arrangements for future medical expenses in liability cases;
- CMS acknowledges that some attorneys create MSA arrangements and is not opposed to such arrangements;
- Various CMS regional offices appear to differ with respect to enforcement of MSAs in liability cases and the set parameters for review of such cases;
- Although CMS believes the MSP Act applies to tort cases, the agency has not set a formal procedure with respect to protection of Medicare's future interests; and
- Attorneys should counsel their clients to consider setting aside funds they receive from a settlement that could be covered by Medicare in the future or the attorney may be vulnerable to future client claims.³⁶

The recommendations of the NAELA Medicare Task Force that followed also appeared indefinite. The most notable recommendations to attorneys were:

- Advise personal injury (PI) clients to establish self-administered MSAs designated for settlement amounts equal to future medical expenses that would otherwise be covered by Medicare similar to workers' compensation cases with the caveat that the requirement for MSAs in tort cases is not as clear as it is in workers' compensation cases;
- Inform clients that the MSP Act applies to all tort cases and that CMS considers PI plaintiffs to hold an obligation to protect Medicare's future interests with the caveat that the requirement for MSAs in tort cases is not as clear as it is in workers' compensation cases; and
- Advise PI clients to consider MSAs and apply to CMS for approval with the caveat that some CMS regional offices will not consider MSAs in tort cases.³⁷

Despite issuing several recommendations with respect to use of MSAs in personal injury cases, the task force was unable to issue definitive statements without significant caveats attached. As a result, it is difficult to derive a method of practice from this study. At a minimum, the task force strongly recommends that attorneys discuss the potential use of MSAs with their clients. It also appears that the task force generally encourages the use of MSAs in personal injury settings. However, the task force did not and could not conclude that MSAs are mandatory or enforceable by CMS in any way.

The task force did not report finding any risk of liability by attorneys to Medicare for failure to establish MSAs for their client. The task force did, however, advise attorneys to fully inform their clients of the applicability of the MSP Act in liability cases in order to mitigate malpractice liability.

Thus, the task force report concludes that the MSP statute appears to apply to personal injury cases, a conclusion that is widely supported amongst attorneys in the field.

36 NAELA Pub. Policy Comm. and Medicare Set-Aside Task Force, *supra* n. 20.

37 *Id.*

Unfortunately, the task force did not produce a definitive explanation as to the Act's specific application to future medical payments and this issue remains unresolved to date.

This issue has not gone unnoticed by the American Bar Association (ABA). In February 2011, the ABA House of Delegates adopted Resolution 108A, which was intended to send a clear message to members of Congress regarding the ambiguity of MSA use in personal injury contexts. The Resolution, in part, asked Congress to enact new legislation to accomplish 10 specific goals. The most pertinent were:

- Acknowledge that there are no statutory and regulatory requirements for determining Medical Set Aside payments and the process for approving claims subject to the Medicare Secondary Payer Act for third party liability claims;
- Exempt from review by CMS all settlements in which there are no legal obligations to pay medical benefits;
- Establish an appeals process that must be completed by CMS within 90 days of request by the claimant, insurer, or their representative;
- Prohibit CMS from seeking additional moneys from the settlement proceeds after review and/or appeals processes have been concluded;
- Prohibit recovery thresholds for MSASP (Medical Set Aside Settlement Proposals) that are linked to predetermined economic indices;
- Establish a statute of limitations for MSP claims;
- Prohibit the "certification" or claim of specialization by any private individual or person or government entity of a process, practice or individual in the determination of MSASP.³⁸

Resolution 108A was sent to Congress along with a report authored by the chair of the Tort Trial and Insurance Practice Section of the ABA. The report again requested additional regulatory clarification on the matter indicating that, "Because of the uncertainty and lack of regulatory specification with respect to the determination of Medical Set Asides, there continues to be considerable delays in the settlement process, no rules governing the process...and justified significant concern on the part of parties, insurers and their legal representatives."³⁹

The ambiguity surrounding this issue continues however, and has reached a significant level of concern among attorneys involved in all aspects of personal injury suits. Resolution 108A and its accompanying report appear to align with several of the points made in the NAELA Task Force Report. While it is clear that the MSP Act applies to personal injury suits, how the Act applies directly in such suits remains unresolved and requires further clarification from either Congress or CMS.

The lack of authority mandating the use of MSAs in the personal injury context does not necessarily mean that MSAs should never be considered a useful tool for personal injury settlements to reasonably address Medicare's interests. It merely indicates that MSAs are a possible solution, not the only solution. Of course, MSAs have proven to be very

38 Am. Bar Assn., Res. 108A, Feb. 14, 2011.

39 Am. Bar Assn. Tort Trial and Insurance Practice Section, Rpt., Res. 108A, February 2011.

useful and are a frequently applied tool in the workers' compensation arena. However, the dogmatic approach taken by some who swear to their use in most, if not all, circumstances appears to be unsupported by authority and is inappropriate.

While the protection afforded by an MSA has its merits, the costs associated with the creation, implementation, and administration of such tools must also be reasonably balanced. When considering the use of MSAs in personal injury cases it is important to determine whether the MSA process could prove to be more financially detrimental than beneficial to plaintiffs. It appears more than coincidental that individuals most in favor of a universal approach to MSA use are the same individuals advertising their own services to prepare and establish MSAs or to provide professional administrative services for MSAs. Over the last several years, the MSA business has boomed. More and more companies offer fee-based, professional MSA administrative services despite the fact that MSAs can be self-administered. Others offer high-priced MSA training courses to provide "MSA certification" for such administrators. However, the question still remains whether these businesses and attorneys always consider the plaintiff's best interests.

There is evidence that MSA use in personal injury cases can sometimes hamper settlements and increase costs. As previously mentioned, CMS has no formal policy in place for review and approval of MSAs in personal injury cases and it appears each regional office has set its own internal guidelines for review. As a result, inconsistency abounds resulting in significant delays to the settlement process for the parties involved. As an example, in a recent case, *Smith v. Marine Terminals of Arkansas*,⁴⁰ a longshoreman reached a settlement in a civil suit with his employer regarding an injury. As part of the settlement agreement, the parties agreed that the settlement required a self-administered MSA and that it would be submitted to CMS for approval. CMS, however, decided for unknown reasons not to review or approve the MSA submission. Thus, resolution of the case was significantly delayed and the settlement was placed in jeopardy. These circumstances resulted in additional time and expenses for the parties in seeking court approval of the MSA as well as a declaratory judgment that they properly considered Medicare's interests. Even so, it is unclear whether Medicare would agree that this process fully satisfies their interest in the settlement.

Until recently, CMS and Congress have provided little help to clarify the statutory ambiguity surrounding the application of the MSP Act and future medical expenses. Under these circumstances it would be logical to examine whether any precedent can be drawn from the common law. Unfortunately, common law has also yielded little guidance. Since the inception of MSAs, no cases have been decided in which the court expressly stated that MSAs are the preferred, much less required, method with which to address Medicare's interest in future medical expenses under the MSP Act. Until 2011, there were no notable cases in which a court ever directly addressed or attempted to address the direct application of the MSP Act to future medical expenses in personal injury cases.

In January 2011, however, a New Jersey state trial court, issued an opinion (pub-

40 *Smith v. Marine Terminals of Ark.*, 2011 U.S. Dist. LEXIS 90428, No. 3:09-CV-00027-JLH (E.D. Ark. Aug. 9, 2011); See also The Lien Resolution Group, *Liability Medicare Set-Aside Approval Hampers Settlements* (Oct. 7, 2011), <http://lienresolutiongroup.com/liability-medicare-set-aside-approval-hampers-settlements/print>.

lished in May 2011) in the case of *Hinsinger v. Showboat Atlantic City* that found MSAs in third party liability cases to be synonymous with those in workers' compensation matters. One of the court's conclusions was that "the statutory and policy reasons for creating both [liability and workers' compensation MSAs] are the same: to protect the government, and the Medicare system in particular, from paying medical bills for which the beneficiary has already received money from another source."⁴¹ The court justified this analysis with a reference to a transcript published by CMS of a teleconference from October 2008.⁴²

Hinsinger appears to be the first case of its kind and could lead to a broader interpretation of the application of the MSP Act in personal injury cases. A closer reading of the case, however, indicates that the holding is likely not as influential as one might think. The primary issue of the case was whether an attorney could, without prior court direction, pay a portion of procurement costs from a liability settlement out of funds voluntarily allocated to an MSA. The court was not asked to interpret the application of the MSP Act to liability settlements nor was it asked to determine the validity of the MSA that had been established. Further, in its opinion the court acknowledged that no statutory or regulatory requirements existed to create an MSA when future medical expenses were awarded.⁴³ The opinion appears to be an example of the court's attempt to find previously established rules and regulations that would apply to the case before them. By applying those rules and regulations that already apply to MSAs in workers' compensation suits, the court was able to support its decision regarding an ancillary issue involving payment for procurement costs. One should also note that as a lower state court decision, the *Hinsinger* case is not a controlling decision, and a single court opinion does not constitute a pattern worthy of establishing common law practice. It will be important, however, to see if other courts engage in similar analyses when confronted with similar issues in the future.

Surprisingly, CMS has recently taken what appears to be a significant step forward to establish a clearer policy with respect to future medical expenses and MSAs. On June 15, 2012, CMS released newly proposed rule changes in the form of an "advanced notice of proposed rule-making" (ANPRM).⁴⁴ The ANPRM proposes rule changes to 42 CFR, Parts 405 and 411. CMS indicates in the ANPRM that it is soliciting comment on:

standardized options that [CMS is] considering making available to beneficiaries and their representatives to clarify how they can meet their obligations to protect Medicare's interest with respect to Medi-

41 See *Hinsinger v. Showboat A. City*, 2011 N.J. Super. LEXIS 96 (Jan. 21, 2011); See also The Lien Resolution Group, <http://www.lienresolutiongroup.com/hvs.pdf>.

42 See *Hinsinger v. Showboat A. City*, 2011 N.J. Super. LEXIS 96 (Jan. 21, 2011).

43 *Id.* at 3.

44 See Fed. Reg., Vol. 77, No. 116 (June 15, 2012), www.gpo.gov/fdsys/pkg/FR-2012-06-15/pdf/2012-14678.pdf, Mark Popolizio, Esq., CMS Releases Advance Notice of Proposed Rulemaking in "Future Medical" Situations, Workers' Compensation Law Community Blog, LexisNexis Communities, June 27, 2012, <http://www.lexisnexis.com/community/workerscompensationlaw/blogs/workerscompensationlawblog/archive/2012/06/27/cms-releases-advance-notice-of-proposed-rulemaking-in-future-medical-situations.aspx>.

care Secondary Payer (MSP) claims involving automobile and liability insurance (including self-insurance), no-fault insurance, and workers' compensation when future medical care is claimed or the settlement, judgment, award or other payment releases (or has the effect of releasing) claims for future medical care.

CMS continued by indicating that the ANPRM issuance was in direct response to affected parties' requests for clarity on the matter.

CMS stated in the ANPRM that while there is a formal, yet voluntary MSA process in workers' compensation situations to address future medical costs, it has not yet recognized nor established a similar process in liability settings. Thus, it appears that one purpose of the ANPRM was to determine whether and how Medicare should implement an MSA process in liability cases as well as determine whether alternative options could or should be available to current and future Medicare beneficiaries.

CMS proposed seven options to address Medicare's interest in future medical costs arising from liability cases. Options one through four would apply to current as well as potential Medicare beneficiaries while options five through seven would apply only to current Medicare beneficiaries. The options listed were as follows:

Option 1

Medicare will not pursue future medical expenses if the plaintiff assumes responsibility for the entirety of his or her injury-related medical expenses until his or her settlement is exhausted. Under this option, Medicare would not formally or routinely review any documentation under these circumstances. Informal review would still be possible.

Option 2

Medicare would not pursue future medical expenses if the beneficiary meets all of the requirements under either of two sets of circumstances:

- a. The amount of liability insurance (including self-insurance) "settlement" is a *defined amount* or less and the following criteria are met:
 - The accident, incident, illness, or injury occurred on year or more before the date of "settlement;"
 - The underlying claim did not involve a chronic illness/condition or major trauma;
 - The beneficiary does not receive additional "settlements;" and
 - There is no corresponding workers' compensation or no-fault insurance claim.

Or,

- b. The amount of liability insurance (including self-insurance) "settlement" is a *defined amount* or less and all of the following criteria are met:

- The accident, incident, illness, or injury occurred on year or more before the date of “settlement;”
- The individual does not expect to become a beneficiary within 30 months of the date of “settlement;”
- The beneficiary does not receive additional “settlements;” and
- There is no corresponding workers’ compensation or no-fault insurance claim.

Option 3

Medicare will not pursue future medical expenses in most instances if the plaintiff is able to provide an attestation of completion of future medical care from his or her physician. Medicare recovery rights will be adjusted based upon the timing of such physician’s attestation.

Option 4

Medicare will not pursue future medical expenses if the plaintiff submits proposed Medicare Set-Aside Arrangement (MSA) amounts for CMS’ review and obtains approval.

Option 5

Medicare will not pursue future medical expenses if the plaintiff (who would have to be a current Medicare beneficiary) participates in one of three newly developed monetary recovery options outlined in the ANPRM.

Option 6

Medicare will not pursue future medical expenses if the plaintiff makes an upfront payment to Medicare for estimated future medical expenses.

Option 7

Medicare will not pursue future medical expenses if the plaintiff obtains a compromise or waiver of recovery.

The ANPRM did not identify whether CMS would consider incorporating one, several or all of these options into the new rules. The agency consistently implied that the rule making process and solicitation for comment was an opportunity for those interested to help shape the proposed rules themselves. Thus, it is a strong signal that currently, CMS has no firm policy or approach to future medical costs and acknowledges that MSAs are not mandatory to meet its interests in such cases. CMS’ request for outside input appears relatively obvious — some of the proposed options did not have predetermined settlement threshold amounts and summaries included in the ANPRM specifically identified these omissions and requested comment on these issues. More specifically, requests were made

for input as to whether current thresholds adopted for workers' compensation settlements should be used or whether alternative thresholds should be employed.

While CMS has taken a significant first step to clarify (and likely codify) a position with respect to these issues, it is clear by the ANPRM that there still remain a number of glaring ambiguities that requiring its attention. The issuance of such proposed rule changes does clarify one matter – that the MSP Act does, in fact apply to personal injury cases. Other than this, the information seems to support the argument of a more balanced approach with MSA use in these circumstances rather than a mandatory use of such instruments. One can hope that once the comment submission period ends on August 14, 2012, CMS will likely review any and all comments to help develop greater clarity on the matter for practitioners.

V. CONCLUSION

Currently, there is no clearly identifiable best practice with respect to the use of MSAs in personal injury cases. The decision whether to use an MSA is case specific and will depend on the attorney's examination of the issues, including an in-depth cost-benefit analysis of the plaintiff's circumstances. It is clear that MSAs are not a mandatory means by which to satisfy Medicare's interest in personal injury contexts. Even though CMS has adopted a detailed MSA approval process in the workers' compensation context, CMS still acknowledges self-imposed limitations to its enforcement of MSAs. Of course, new revisions to federal regulations could easily change this fact. At this time, in the workers' compensation context, CMS requires the use and approval of MSAs only when the plaintiff is a current Medicare beneficiary and the total settlement amount is greater than \$25,000, or when the plaintiff has a reasonable expectation of enrolling in Medicare within 30 months from the settlement date and the anticipated total settlement amount is expected to be greater than \$250,000.⁴⁵ It is reasonable to assume that if an attorney chose to advise his or her client to use an MSA in a personal injury settlement, these same CMS limitations, at a minimum, would also apply, especially since CMS chose to omit specific figures from its proposed rule changes.

It is clear that the size of the settlement, as well as the plaintiff's Medicare eligibility status, should always be taken into consideration when weighing whether to use MSAs in personal injury settlements. It is reasonable to expect that the larger the negotiated settlement in a personal injury case, the greater interest CMS may hold in future medical payments arising from the injury. The fact that personal injury settlements generally cover a wide variety of damages and typically fail to allocate amongst these damages creates additional problems for CMS. Workers' compensation settlements, on the contrary are, by their nature, more structured with respect to allocation of settlement proceeds for future medical expenses. This makes Medicare's alleged interest in the settlement more clearly defined and easily enforceable.

Even though MSAs are not directly mandated by any authority, attorneys are still

45 Memo. from Dir., Ctr. for Medicare Mgt., CMS, to Regl. Adminstrs., *supra* n. 19.

obligated to ensure that they have fully informed their clients of the issues related to future medical expenses and taken measures to consider Medicare's interest in the settlement. At a minimum, this could be interpreted to mean that attorneys should discuss the potential use of MSAs in personal injury contexts with their clients and all parties involved, but they can refrain from insisting upon their use in all matters. The best way to accomplish this is by clearly explaining the issues involving the MSP Act and consideration of Medicare's interest in a letter to the client. Written correspondence to one's client should outline the various options available for the client to choose in addressing Medicare's interest and the costs and benefits associated with each option. If an MSA appears to be the vehicle of choice by the client, it would also be advisable to have a predetermined allocation of settlement proceeds for future medicals, and if possible, request a court order to ratify the allocation. Notice should be given to CMS under such circumstances. Ultimately, it is the client's choice as to what strategy to take and proper measures taken by the attorney to demonstrate that the client was fully informed is best to avoid any future risk of a malpractice suit.

At this time, there is no published history of any suit by Medicare against any party in a personal injury suit for the failure to establish an MSA. For this reason attorneys and their clients must continue to weigh the risks of using or not using MSAs in these contexts. It would appear that for a reasonable cost, the MSA could provide all parties with the piece of mind that Medicare's interests are satisfied, avoiding the risk of potential future litigation with Medicare. This is especially true if the settlement in question is a significantly large sum compared to a relatively small estimated amount for lifetime future medical expenses. However, as explained earlier, the MSA process could just as easily cause significant delays and added costs to clients if the settlement is relatively small and insignificant. As has been reported, Medicare may choose not to approve an MSA or MSAs may be established when CMS policies and practices make them entirely unnecessary. Further, there is nothing to indicate that Medicare's interests could not be otherwise satisfied when a plaintiff received all settlement proceeds from a personal injury suit after being fully informed that Medicare may not pay for certain injury-related future medical expenses.

The situation is similar to others in which the parties weigh the risk against the cost of protection. Every homeowner risks facing a multi-million dollar personal liability suit by a slip and fall victim on their property but the calculated risk of such a suit is relatively low for most individuals. Thus, it does not necessarily mean that every homeowner should pay for an exorbitantly high liability insurance policy that will never be used. A homeowner who resides on property with more treacherous conditions may have greater exposure than a typical homeowner and this is what should guide the choice to purchase insurance coverage. Similarly, in the arena of personal injury settlements the attorney and client must weigh the level of risk of Medicare's interest against the cost to the plaintiff of establishing and maintaining an MSA before determining whether an MSA is warranted.

While the proposed rule changes by CMS are a proactive step to establish more clarity as to future medical expenses, until CMS or Congress provides firm authority regarding the application and enforcement of the MSP Act in personal injury settlements, there will continue to be uncertainty regarding MSA use in these contexts. The risks and

benefits involved with MSA use in personal injury cases should always be considered, especially the direct impact on the plaintiffs' interests, but only after first examining the size of the settlement proceeds, whether any of the settlement has been allocated to address future medical payments, whether such an allocation should be made under the circumstances, and whether the plaintiff's current or future Medicare eligibility falls within statutory and regulatory guidelines.

