TRIAL

The uncertain future of Medicare set-asides

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Medicare set-aside requirements, which lay dormant for two decades, have recently been revived in the workers' comp arena. Personal injury cases are next, but plaintiff lawyers needn't panic. The law is on their side.

Since passage of the Medicare Secondary Payer Act (MSP) in 1980, Medicare has had a right to reimbursement of monies it paid for medical care rendered to an injury victim and to have any recovery for the victim's future medical expenses used first before Medicare secondary coverage applies.[1]

Until recently, plaintiff attorneys paid little attention to this right because the agency that runs Medicare, the Center for Medicare and Medicaid Services (CMS)—part of the Department of Health and Human Services—did almost nothing to enforce it. But for years, Medicare has been hemorrhaging red ink, and Uncle Sam is now looking closely at the MSP to help stanch the flow.

Although enforcement efforts began nearly a decade ago, personal injury claimants have, until recently, been spared because CMS focused its attention on workers' compensation claims. Workers' comp practitioners, faced with the allegedly dire consequences of failing to follow the law's confusing dictates, often erred on the side of caution and did more than the law requires. And this behavior was reinforced by the sometimes misguided counsel of a growing number of businesses (MSP vendors) claiming to offer specialized knowledge of the law's requirements.

The government's enforcement regime, which could be imported into personal injury cases from the workers' comp system, is often unfair and burdensome, and at the same time ineffective. If properly applied, the MSP is sensible and reasonable in its aim of saving Medicare dollars and preventing double recoveries. But if the law is not upheld and government overreaching is allowed, then the result will be an expensive, unreasonable burden for all parties, especially injured people.

Essentially, the obligations of parties in tort litigation under the MSP fall into two spheres: protection of Medicare program interests with respect to benefits it has already paid at the time a personal injury case is resolved, and protection of Medicare interests with respect to post-resolution medical expenses. The obligations in the first sphere are similar to those involved in health insurance subrogation claims, which most plaintiff attorneys understand and have had some experience with.

Those in the second sphere are far more complicated. They derive from a provision in the MSP that provides that to the extent that the injured party recovers from the tortfeasor for future medical expenses that are within Medicare coverage categories (for example, hospitals, doctors, and diagnostics), the recovery must be used to pay the post-settlement accident-related medical expenses of the plaintiff until it is exhausted, and only then will Medicare coverage be available.[2] Here

the law is largely undeveloped, and the amount of money involved is far greater.

According to CMS, the amount allocated to future medical expenses must be placed in a Medicare Set-Aside account (MSA). If the settling parties fail to indicate what amount represents future injury-related medical expenses, CMS insists that it will not only demand repayment of past medical expenses covered by Medicare but also treat the remainder of the settlement as money allocated to pay the plaintiff's future medical expenses. Consequently, the plaintiff will have to exhaust the entire settlement before Medicare coverage will be available.

This may be unwelcome news for plaintiff lawyers, but the MSP clearly requires an allocation for future medical expenses. This enables all concerned, CMS included, to know how much of the settlement must be spent on post-settlement medical expenses before Medicare's "secondary" (that is, excess) health coverage becomes operative. However, the law does not require a submission of the allocation to CMS for its approval.

On December 29, 2007, President Bush signed the Medicare, Medicaid, and SCHIP Extension Act of 2007 (2007 Extension Act), which will go into effect on July 1, 2009. It will require that Medicare be notified of all claims/settlements involving a Medicare beneficiary where the payer is a workers' compensation or a liability insurer, or a no-fault or self-insurance program. A failure to make a timely report can result in penalties, including a fine of $1,000 for each day of noncompliance for each individual for which the information should have been submitted.

To better understand the effect the MSP would have on personal injury litigation, consider how the law might work in hypothetical settlements.

Jasmine

Jasmine was 65 and retired when she flew to California for a vacation. Once she got there, she boarded a rental car shuttle bus.

The driver of the bus took a call on his cell phone. The call quickly turned into an argument, with the driver sometimes holding the phone at half-arm's length and shouting at it. The shuttle bus rolled through a stop sign and was hit broadside by a tractor-trailer rig.

Jasmine was thrown back-first against a stanchion. She was rendered paraplegic and suffers from impaired cognition and memory.

Jasmine filed suit. Under California law, the shuttle bus had a duty of "utmost care and diligence" to its passengers.[3] The rental car company had sufficient insurance, and the case was settled for $2.6 million.

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These were the key elements of Jasmine's claim for damages (stated in present value):

Past medical expenses (paid by Medicare)	$300,000
Future care expenses	$800,000
General damages	$1.5 million
TOTAL	$2.6 million

The present value of Jasmine's projected lifetime future medical expenses was calculated assuming a rated age of 75, based on an annuity issuers' evaluation of Jasmine's life expectancy.[4]

Jasmine's case was not typical in that liability was ironclad and the rental car company was well-insured. In such a case, it is fair for Medicare to obtain full reimbursement for its outlays, less a reasonable amount for the cost—mainly attorney fees—of recovery.[5]

And there would seem to be no good reason in law or policy why Jasmine should not have to spend the $800,000 recovered for future care-related expenses before turning to Medicare to tap its "secondary" coverage if it becomes necessary. This is what the law requires.[6] But although her case seems simple, it presents four issues that could require a different outcome.

The first involves the costs of Jasmine's future attendant care. Medicare doesn't cover the cost of an unskilled aide who assists with transfers, toileting, dressing, and other basic tasks. That is, treating the $800,000 as entirely for expenses that would be in Medicare-coverage categories would overstate the allocation.

The second issue involves the common use of life care plans in calculating a plaintiff's future medical expenses. Seasoned plaintiff lawyers know well how partisan and subjective life care plans can be. The difference between the defendant's life care plan and one obtained by plaintiff counsel can be hundreds of thousands of dollars or more.

Though not speculative as a matter of law, life care plans involve looking into the future. Restraint and balance about what the future holds are needed, but what standard should be used?

For years, the Workers' Compensation Review Center (WCRC)—part of CMS—took the position that an MSA set-aside should include money for a future procedure if it was a "reasonable possibility." Later, WCRC changed its position to say that the standard would be "reasonable probability," but neither standard was ever articulated in writing, let alone in a regulation.[7] The problem is aggravated by a tendency among some companies that offer MSA assistance to pad the set-aside, especially those MSP vendors that offer a guarantee (backed by their own money) that CMS will approve the Medicare set-aside they have calculated.

Third, if the subrogation recovery by Medicare is reduced by the costs of

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prosecuting Jasmine's lawsuit, why shouldn't the Medicare allocation for future care expenses also be reduced? After all, by discounting its reimbursement claim by only about 25 percent, Medicare is usually getting a better deal than the injured party, whose contingent fee is often higher. So far, in the workers' comp system, CMS's position is that the allocation for future expenses should not be reduced for any recovery costs.

The fourth issue involves the cost of administering the set-aside. CMS has conceded that the injured individual may administer his or her own set-aside, but proper administration often requires the services of a professional. Shouldn't the cost of hiring this professional be deducted from the set-aside? So far, with regard to workers' comp cases, CMS has said no.

Parties want to obtain settlements that will not be reopened by a claim that Medicare interests have not been considered. The fear of a settled case coming 'back to life' is powerful.

Karl

Karl was 47 when he lost his job. He elected to continue his health coverage under COBRA.

In April 2004, Karl was employed part-time (with no benefits) when he was involved in an auto accident while riding in a car driven by Fred. A pickup truck broadsided Fred's car. Moments before impact, Karl had released his seat belt to assist Fred's child, who was in the back seat. Karl was thrown against the inside door frame and sustained spine and skull injuries, resulting in paraplegia and slight brain damage.

At the time of the accident, 12 of the 18 months of Karl's health coverage mandated by COBRA still remained. Because he had paid FICA taxes in more than 20 of the 40 quarters before the onset of his disability, he began receiving monthly Social Security disability insurance benefits (SSD or SSDI) in the sixth month, October 2004.

Two years later, 30 months after the accident, Karl automatically became a Medicare Part A beneficiary and also enrolled in Part B and in a Part D drug plan.[8] In sum, he had private health insurance for 12 months, was self-insured for another 18 months, and then became a Medicare beneficiary.

Unfortunately, as is often true, Karl had no chance of recovering all his damages. The pickup truck's owner/operator was uninsured and judgment-proof.[9] Karl had uninsured motorist (UM) coverage of $250,000, but Fred's UM coverage was only $15,000.

Fred's insurer tendered liability limits of $50,000 and paid medical costs of $5,000. In his 50th year, Karl settled for a total of $320,000. Just before settling, he was repeatedly hospitalized for urinary tract infections, which were covered by Medicare.

These were the key elements of Karl's claim for damages (stated in present value):

Past medical	$300,000
COBRA insurer paid $80,000	
Self-insurer paid $30,000	
Medicare paid $190,000	
Past loss of earnings	$70,000
Future medical	$1.32 million
Future loss of earning capacity (to age 65)	$460,000
General damages	$1.5 million
TOTAL	$3.65 million

The present value of Karl's lifetime future medical costs assumed an age rating of 60 that was based on an impaired life expectancy. The projected loss of Karl's earning capacity was based on a 15-year annuity certain (to age 65).

Setting aside any reduction of Karl's settlement on account of attorney fees, Karl will receive less than10 percent of the full value of his damages claim. The corollary ought to be that CMS would claim less than10 percent of its costs for Karl's care, but that is not how CMS sees it, at least in individual cases.

Rather, CMS will claim the full amount of its past medical outlays, $190,000, less procurement costs. If both the gross settlement of $320,000 and Medicare's $190,000 claim are reduced by 25 percent, *then Medicare will demand nearly 60 percent of the net recovery, or $142,500.*

Zinman v. Shalala was a class action brought to challenge the government's claim that it was entitled to recover all its Medicare expenditures whether or not the injured Medicare beneficiary obtained a full-value tort recovery. The Ninth Circuit held in 1995 that the Department of Health and Human Services (HHS) "has interpreted the MSP legislation to allow full recovery of conditional Medicare payments even when the beneficiary's settlement is for less than her total damages (that is, a discounted settlement)."[10]

The results of *Zinman* were even harsher than those in Karl's case—the Medicare subrogation recovery took the entire after-fees settlement. Yet the court ruled that the government's interpretation of the MSP statute was rational.

> [T]he injured victim alleged a variety of damages, some capable of precise computation, some not. Such allegations are not uncommon. HHS's ability to recover the full amount of its conditional payments, regardless of a victim's allegations of damages, avoids the commitment of federal resources to the task of ascertaining the dollar amount of each element of a victim's alleged damages.[11]

In 2006, a federal court in New York set a new course in *In re Zyprexa Products Liability Litigation*.[12] As part of the resolution of multidistrict mass tort litigation against a prescription drug maker, the court considered Medicare claims for reimbursement of past medical bills as well as Medicaid lien claims advanced by a number of states. Most of the government agencies claimed that they were entitled to full recovery regardless of the classification of the

settlement proceeds.

The court noted that full reimbursement to Medicare and Medicaid "deprives poor and injured individuals of needed compensation for their pain and suffering, lost wages, and other non-medical damages."[13] The court also pointed out that the full-reimbursement approach could be counterproductive for the government because it gives many injured parties little incentive to pursue valid claims, or if they do, to accept otherwise reasonable settlement offers.[14]

Finally, the court pointed to the logic of the U.S. Supreme Court decision in *Arkansas Department of Health and Human Services v. Ahlborn.*[15] In that decision, a unanimous Court rejected a full-reimbursement claim by the Arkansas Medicaid program, holding that the federal Medicaid statutes permit a state to recover its Medicaid outlays only from the portion of the settlement attributable to medical costs.

There have been efforts to obtain legislative relief from CMS's interpretation of the MSP in workers' compensation cases, but these have not yet borne fruit.

Arguably, the *Ahlborn* case should be extended from the world of Medicaid liens into the parallel world of Medicare claims for reimbursement. The *Zinman* case has not been expressly overruled, however, and the *Zyprexa Products* opinion may apply only to the facts of that case.

Finally, not a word was said in *Zinman, Zyprexa Products*, or *Ahlborn* about future medicals. How should one go about calculating the Medicare allocation, or set-aside, for future medical expenses in a discounted personal injury settlement?

The *Ahlborn* case clearly points the way—not only by its outcome, but in its rationale. The Supreme Court specifically rejected the argument that using the methodology of allocation among damages categories cannot be allowed because of the danger of "settlement manipulation" by the plaintiff and the defendant:

> Even in the absence of a post-settlement agreement . . . the risk that parties to a tort suit will allocate away the state's interest can be avoided either by obtaining the state's advance agreement to an allocation or, if necessary, by submitting the matter to a court for decision.[16]

The Court noted that the state had conceded that, had a jury or judge allocated a sum for medical payments out of a larger award in the underlying case, the agency would have been limited to reimbursement only from the portion so allocated[17] and that some states had adopted rules and procedures for allocating tort settlements where, for example, a private health insurer sought subrogation recovery.[18] In the wake of *Ahlborn*, some courts have accepted this task.[19]

Because *Ahlborn* involved Medicaid, its application to Medicare expenditures is unclear. But there can be little doubt that CMS will demand that it is entitled to full reimbursement of its Medicare expenditures regardless of what an injured plaintiff is able to recover in a lawsuit.

Loretta

Loretta was also injured in an auto collision. It happened nearly three hours after she left work, on the way home from a bar. Loretta steered her vehicle into a busy intersection and started to turn left when she was hit by an oncoming car. She sustained serious head trauma resulting in brain damage.

Witnesses said that Loretta had failed to yield, but they also said that the other driver was speeding. Loretta's blood alcohol was just above the legal limit. Just before leaving work, the company nurse had given Loretta some over-the-counter medication out of a bottle in the company infirmary. The nurse had not warned her not to drink alcohol when using the medication.

Loretta filed suit. She also filed a workers' compensation claim, but the employer denied liability and paid no benefits, asserting multiple defenses.

After many months of expensive medical treatment and a year of rehabilitation, Loretta was able to walk, talk, and perform some basic tasks of daily living. However, she easily got lost and would forget to do basic things.

Three years after the accident, when Loretta was 30, there was a settlement conference at which the other driver and the employer were represented. The driver's insurer tendered its $1 million limits.

The lawyer for the employer said, "We have denied the case; we think the theory involving the medication is nonsense; but given the severity of the injuries, my client had planned to offer $50,000. However, a Medicare set-aside vendor did an analysis; they say the Medicare set-aside should be $267,000 and that any settlement must be submitted to CMS for approval. They say the personal injury settlement should have an MSA, too." Notwithstanding, the civil case and the compensation claim were settled, for $1 million and $50,000, respectively.

These were key elements of Loretta's claims:

Past medical		$300,000
Medicaid paid	$270,000	
Medicare paid	$25,000	
Loretta paid (attendant care)	$5,000	
Past loss of earnings		$120,000
Future medical		$1.25 million
Medicare medical (per vendor)	$267,000	
Other care needs	$983,000	
Future loss of earning capacity (to age 65)		$1.4 million
General damages		$1.5 million
TOTAL		$4.57 million

The present value of Loretta's lifetime future medical costs assumed an age rating of 50, based on impaired life expectancy. The projected loss of earning capacity was based on a 35-year an-

nuity certain (to age 65). The $983,000 allotted for "other care needs" included $933,000 for attendant care, which is not covered by Medicare. This projected figure is conservative.

The other $50,000 was for half the cost of Loretta's future outpatient psychotherapy (Medicare would cover the other half) and the cost of physical therapy—to preserve the fairly good recovery she made from her orthopedic injuries—that exceeds Medicare coverage limits.

If a full reimbursement for past Medicare medical expenses is deducted from the settlement and CMS insists on a set-aside of $267,000, then more than half of the net settlement will be unavailable to Loretta for her attendant care and living expenses.[20] And the gross settlement already provided only about 23 cents on the dollar. There are provisions for hardship waivers in the MSP, but they aren't of much use.

Loretta had a sufficient earnings record to qualify for SSDI and became a Medicare beneficiary a few months before the settlement. But even if she had yet to become a Medicare beneficiary, the personal injury suit should contain a reasonable Medicare allocation, based on a fair valuation of the various damages elements.

No allocation need be applied to the settlement of the workers' compensation claim because it meets the requirements of a safe harbor clause enunciated by CMS in a memorandum it issued in 2001. The Patel Memorandum—named for its author—provides that no allocation of future medical expenses is required in disputed cases that are settled for small amounts (relative to full value) because the employer has a strong legal defense and, in reliance on the defense, has paid no benefits.[21]

In a later memorandum, CMS told all workers' comp settling parties that it wanted to review, on a case-by-case basis, every settlement valued at $25,000 or more.[22] Many workers' comp attorneys, believing that they must follow the dictates of the agency's memoranda, now routinely submit their—or their MSA vendor's—calculations to CMS for approval. Given the dire warnings that the government will soon begin enforcing the MSA provisions in personal injury cases, plaintiff lawyers are understandably concerned that soon they will have to start doing this, too.

As a matter of good public policy, it is high time that CMS was forced to promulgate regulations, not internal memos, that give guidance to parties to a settlement.

Settling parties are justifiably intent on obtaining a final settlement, one that will not be reopened by a government claim that Medicare program interests have not been adequately considered. The fear of a settled case coming "back to life" is powerful and understandable.

But unlike regulations, CMS's letters to itself do not have the force of law.[23] Consequently, there is no legal duty to submit a proposed Medicare allocation in a workers' comp case for CMS approval, regardless of the size of the case or any other factor, such as the Medicare status of the injured party.

There is no reported case of CMS attacking the reasonableness of a Medicare allocation. There is also no reported instance of CMS challenging a worker's receipt of Medicare benefits on the ground that an MSA had not been exhausted, or had been spent improperly, so that Medicare's secondary coverage is not available.

In other words, CMS has chosen to bark hard at parties who wish to settle, but so far has not tried to bite transgressors. Lack of enforcement aside, there are several reasons not to participate in the MSA review process:

- CMS continues to insist on full-value MSAs and openly admits that it will not apportion or allocate on the basis of the value of the various elements of the plaintiff's recovery.
- MSAs determined by the CMS's Workers' Compensation Review Center include money for future needs that are not reasonably probable. Sometimes there is no support in the medical reports whatever for certain items the WCRC includes.
- There is no right to appeal a WCRC determination. With no judicial oversight, submitting a case to CMS for review is like a professional football team playing an away game for a purse, with referees selected and paid for by the home team.
- The process of CMS review is expensive, and long delays (four months or more) are common.

The better course is to include a reasonable Medicare allocation in a personal injury settlement unless Medicare eligibility for the plaintiff is still many years away. If there is an opportunity at the time of settlement for a brief evidentiary hearing before a judge, to prove the factual underpinnings of the allocation, even better. It might then be worthwhile to submit the case to CMS for approval.

One cannot rule out the possibility of CMS beginning—any day now—to treat victims of personal injuries as if their settlements included 100 cents on the dollar of their future medical expenses. Therefore, plaintiff attorneys should include written Medicare allocations in their clients' settlement agreements, with an explanation of why the allocations are reasonable.

There have been efforts to obtain legislative relief from CMS's interpretation of the MSP in workers' compensation cases, but these have not yet borne fruit.[24] What is needed is a judicial remedy like the one created by *Ahlborn*, where the injured woman's determined counsel won an epochal victory that will benefit hundreds of thousands of grievously injured people.

As a matter of good public policy, it is high time that CMS was forced to promulgate regulations (not internal memoranda) that fairly apply appor-

tionment methodology and give guidance (including numerical examples) so that parties to a settlement can rest assured that they have complied with the law. ■

Notes

1. Medicare Secondary Payer Act, 42 U.S.C. §1395y(b)(2)(A) (2006); 42 C.F.R. §411.1-411.103 (2007).

2. Every person who receives monthly Social Security retirement or survivor benefits or railroad retirement benefits automatically becomes a Medicare Part A (hospital insurance) beneficiary at age 65 and has the option of enrolling in Part B (supplemental insurance). As for Medicare Part D, the prescription drug benefit, most eligible people are enrolled by virtue of their entitlement to Part A and their enrollment in Part B. About 17 percent of beneficiaries are Medicare Part C, Medicare Advantage (MA), participants. The author knows of no clear written guidance as to how the MSP affects Part C beneficiaries, but at least one court has held that an MA plan may not sue to recover its cost of providing care to an enrollee. *Care Choices HMO v. Engstrom*, 330 F.3d 786 (6th Cir. 2003).

3. *See* Cal. Civ. Code §§2100, 2102 (West 2008).

4. The settlement totals in this article imply a cost to the defendant of a certain sum expressed in present value. Most large settlements will employ structured payments.

5. CMS will reduce the amount of the Medicare reimbursement claim by its pro rata share of the beneficiary's reasonable attorney fees and costs in obtaining payment, provided payment is made as a result of a judgment or settlement of a disputed claim and the costs are paid by the beneficiary. CMS usually defines "reasonable" as 25 percent. 42 C.F.R. §411.37.

6. 42 U.S.C. §1395y(b)(2)(A)(ii).

7. The author asked a WCRC representative about the "reasonable possibility" standard by posing this hypothetical example: "Suppose you have 100 settlements in which the worker has a particular industrial injury and it is established in the medical literature that the particular injury will require, within the next four years, a certain procedure (say, a surgery) in 10 out of 100 cases. Would you require that the set-aside include the full budget for the procedure in all 100 cases?" In other words, was a 10 percent chance a reasonable possibility? The answer: Yes. The representative later said the standard had changed to reasonable probability.

8. 42 U.S.C. §§423, 1395y.

9. Recovery from an uninsured natural person probably is not recovery from a "self-insured plan." Whether payments other than insurance payments by a corporate or other non-natural defendant are made by a self-insured plan (so that Medicare is secondary) has been the subject of considerable controversy. *See e.g. U.S. v. Baxter Intl., Inc.*, 345 F.3d 866 (11th Cir. 2003); *Mason v. Am. Tobacco Co.*, 346 F.3d 36 (2d Cir. 2003); *Thompson v. Goetzman*, 315 F.3d 457 (5th Cir. 2002); *U.S. v. Philip Morris*, 116 F. Supp. 2d 131, 145 (D.D.C. 2000).

10. 67 F.3d 841, 843 (9th Cir. 1995).

11. *Id.* at 845.

12. 451 F. Supp. 2d 458 (E.D.N.Y. 2006).

13. *Id.* at 470.

14. *Id.* If it makes sense for an injured person who has a justified fear of a defense verdict to settle the case for 50 cents on the dollar, why doesn't it make sense for the health care subrogor to do the same?

15. 126 S. Ct. 1754 (2006).

16. *Id.* at 1765.

17. *Id.* at n. 11.

18. *Id.* at n. 17.

19. *See e.g. Lugo v. Beth Israel Med. Ctr.*, 819 N.Y.S.2d 892, 897-98 (Sup. N.Y. Co. 2006); *Chambers v. Jain*, 839 N.Y.S.2d 432 (Sup. Queens Co. 2007) (table).

20. The gross settlement is $1.05 million. Assuming a blended contingent fee of one-third and costs of $50,000, there is $650,000 left before Medicaid and Medicare are considered. Using the rule of *Ahlborn*, the Medicaid lien would be resolved for $46,526 because the case settled for about 23 cents on the dollar of full value, and there would be a 25 percent reduction on account of Medicaid not having to pay attorney fees and costs. A full reimbursement for Medicare's past expenses claim, less 25 percent, is $18,750. Finally, deduct the full Medicare set-aside of $267,000. The remainder is $317,723, which is less than half of $650,000. It is less than 13 percent of the full value of lost earnings and other care needs.

21. Memorandum from Deputy Director, Purchasing Policy Group, Center for Medicare Management, CMS, to All Associate Regional Administrators (July 23, 2001), www.cms.hhs.gov/WorkersCompAgencyServices/Downloads/72301Memo. pdf.

22. Memorandum from the Director, Financial Services Group, Office of Financial Management, CMS, to All Regional Administrators (Apr. 25, 2006), www.cms.hhs.gov/WorkersCompAgencyServices/Downloads/42506Memo.pdf.

23. *Christensen v. Harris Co.*, 592 U.S. 576, 587 (2000).

24. Medicare Secondary Payer and Workers' Compensation Settlement Agreement Act of 2007, H.R. 2549, 110th Cong. (May 24, 2007).

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