Medicare Set Asides and Liability Claims Management
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Learning objectives

• Explain a liability insurer's essential obligations under the Medicare Secondary Payer Act

• Identify actions or omissions that could subject liability insurers to litigation under the Medicare Secondary Payer Act

• Establish strategies to avoid potential litigation and satisfy Medicare’s right to recover

• Outline resources for staying abreast of changes in the applicable rules and regulations
Agenda

• Industry concerns
• Federal law
• CMS memos
• Prior and current attempts
• The last five years
• MSAs in liability claims
Industry concerns
• “There is no statutory authority permitting Centers for Medicare & Medicaid Services (CMS) to impose any obligation or granting a right of recovery against an insurer or self insured with regard to future medicals.”

• “CMS lacks authority with respect to insurers and self insureds regarding future medicals.”

• “There is no current law that imposes any obligation on insurers or self insureds for medical expenses incurred after the date of a liability settlement.”
Workers’ Compensation Medicare Set-Aside (WCMSA) process is inadequate

• “The workers compensation MSA process is inefficient, ineffective, and inadequate. Using that same process would undercut the ability of insurers, self insureds, and beneficiaries to handle and timely settle claims.”

• “The WCMSA process is flawed with a current volume of less than 30,000 annually. Can anyone imagine the chaos in liability when the number of claims within the United States involving bodily injury payments is estimated in the millions annually?”
Costs and system concerns

• “Tort settlements will grind to a halt and administrative costs will increase exponentially.”
• “An already overburdened and underfunded state and federal courts system will be unable to move cases along.”
Federal law
(b) Medicare as secondary payer
(1) Requirements of group health plans
(2) Medicare secondary payer

(A) In general
Payment under this subchapter 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 a State or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance.
Federal regulations


§ 411.20 Basis and scope.
§ 411.21 Definitions.
§ 411.22 Reimbursement obligations of primary payers and entities that received payment from primary payers.
§ 411.23 Beneficiary's cooperation.
§ 411.24 Recovery of conditional payments.
§ 411.25 Primary payer's notice of primary payment responsibility.
§ 411.26 Subrogation and right to intervene.
§ 411.28 Waiver of recovery and compromise of claims.
§ 411.30 Effect of primary payment on benefit utilization and deductibles.
§ 411.31 Authority to bill primary payers for full charges.
§ 411.32 Basis for Medicare secondary payments.
§ 411.33 Amount of Medicare secondary payment.
§ 411.35 Limitations on charges to a beneficiary or other party when a workers' compensation plan, a no-fault insurer, or an employer group health plan is primary payer.
§ 411.37 Amount of Medicare recovery when a primary payment is made as a result of a judgment or settlement.
WC and Liability Federal Regulations

Subpart C—Limitations on Medicare Payment for Services Covered Under Workers' Compensation

§ 411.40 General provisions.
§ 411.43 Beneficiary's responsibility with respect to workers' compensation.
§ 411.45 Basis for conditional Medicare payment in workers' compensation cases.
§ 411.46 Lump-sum payments.
§ 411.47 Apportionment of a lump-sum compromise settlement of a workers' compensation claim.

Subpart D—Limitations on Medicare Payment for Services Covered Under Liability or No-Fault Insurance

§ 411.50 General provisions.
§ 411.51 Beneficiary's responsibility with respect to no-fault insurance.
§ 411.52 Basis for conditional Medicare payment in liability cases.
§ 411.53 Basis for conditional Medicare payment in no-fault cases.
§ 411.54 Limitation on charges when a beneficiary has received a liability insurance payment or has a claim pending against a liability insurer.
Lump sum workers compensation payments

- (a) If a lump-sum compensation award stipulates that the amount paid is intended to compensate the individual for all future medical expenses required because of the work-related injury or disease, Medicare payments for such services are excluded until medical expenses related to the injury or disease equal the amount of the lump-sum payment.

- (b) If a settlement appears to represent an attempt to shift to Medicare the responsibility for payment of medical expenses for the treatment of a work-related condition, the settlement will not be recognized and Medicare will not pay for treatment of that condition.

- (d) If the settlement agreement allocates certain amounts for specific future medical services, Medicare does not pay for those services until medical expenses related to the injury or disease equal the amount of the lump-sum settlement allocated to future medical expenses.
Apportionment of a lump sum compromise settlement of a workers compensation claim

• (1) If a compromise settlement allocates a portion of the payment for medical expenses and also gives reasonable recognition to the income replacement element, that apportionment may be accepted as a basis for determining Medicare payments.

42 C.F.R. § 411.47
Apportionment of a lump sum compromise settlement of a workers’ compensation claim

• (2) If the settlement does not give reasonable recognition to both elements of a workers' compensation award or does not apportion the sum granted, the portion to be considered as payment for medical expenses is computed as follows:

• (i) Determine the ratio of the amount awarded (less the reasonable and necessary costs incurred in procuring the settlement) to the total amount that would have been payable under workers' compensation if the claim had not been compromised.

• (ii) Multiply that ratio by the total medical expenses incurred as a result of the injury or disease up to the date of the settlement. The product is the amount of the workers' compensation settlement to be considered as payment for medical expenses.
Apportionment of a workers’ compensation lump sum compromise example

• As the result of a work injury, an individual suffered loss of income and incurred medical expenses for which the total workers' compensation payment would have been $24,000 if the case had not been compromised.

• The medical expenses amounted to $18,000. The workers' compensation carrier made a settlement with the beneficiary under which it paid $8,000 in total. A separate award was made for legal fees.

• Since the workers' compensation compromise settlement was for one-third of the amount which would have been payable under workers' compensation had the case not been compromised ($8,000/$24,000= 1/3), the workers' compensation compromise settlement is considered to have paid for one-third of the total medical expenses (1/3 × $18,000 = $6,000).
Liability and No-Fault Insurance

• (a) Limits on applicability. These provisions do not apply to any services required because of accidents that occurred before December 5, 1980.

• (b) Definitions.
  Liability Insurance.
  No Fault Insurance.
  Self Insured Plan
  Underinsured Motorist Insurance.
  Uninsured Motorist Insurance.

42 C.F.R § 411.50
Medicare payments in liability cases

- (a) A conditional Medicare payment may be made in liability cases under either of the following circumstances:
  - (1) The beneficiary has filed a proper claim for liability insurance benefits but the intermediary or carrier determines that the liability insurer will not pay promptly, including cases in which the liability insurance carrier has denied the claim.
  - (2) The beneficiary has not filed a claim for liability insurance benefits.

§ 411.52
If beneficiary has received payment

• (a) Benefits Payable but Recoverable. Medicare benefits are payable notwithstanding potential liability insurance payments, but are recoverable in accordance with §411.24.

• (b) Applicability. This section applies when a beneficiary has received a liability insurance payment or has a claim pending against a liability insurer for injuries or illness allegedly caused by another party.
The CMS memos
• “Medicare's interest must always 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 worker's compensation or liability case. There is no distinction in the law.”

• “Set aside's are the method of choice and the agency feels they provide the best protection for the program and the Medicare beneficiary.”
• “The fact that a liability settlement, judgment, or award does not specify payment for future medical services does not mean that they are not funded. The fact that the liability agreement designates the entire amount for pain and suffering does not mean future medicals are not funded.”

• “The only situation in which Medicare recognizes allegations of liability payments for non-medical losses is when payment is based on a court of competent jurisdiction's order after a review of the merits of the case.”
“If plaintiff counsel determines that the settlement includes future medicals, they should see to it that those funds are used to pay for Medicare covered services related to what is claimed or released in the settlement, judgment, or award.”

“If defense counsel/insurer determines that the settlement includes future medicals, they should document that the settlement funds future medicals which obligates them to report it to Medicare through mandatory insurer reporting and obligates them to protect the Medicare trust funds.”
• “When beneficiary’s treating physician certifies in writing that treatment for the injury related to the liability insurance settlement, judgment, award, or payment has been completed, and that future medical items and/or services for that injury will not be required, Medicare considers its interest, with respect to future medicals satisfied.”

• “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.”
Prior and current attempts
Advance Notice of Proposed Rulemaking (ANPRM)

- Published by CMS on June 14, 2012
- Solicits comments to protect Medicare's interest with respect to MSP claims involving automobile and liability insurance (including self-insurance), no-fault insurance, and workers' compensation when future medical care is claimed or released in a settlement, judgment, award, or other payment
- Voluntarily withdrawn in 2014 after comments were received and reviewed
Expanding MSA announcement

• Published by CMS on June 8, 2016

• CMS is “considering expanding its voluntary MSA amount review process to include the review of proposed liability insurance (including self-insurance) and no-fault insurance MSA amounts.”

• Indicated that “CMS plans to work closely with the stakeholder community to identify how best to implement this potential expansion.”

• Informed that “CMS will provide future announcements of the proposal and expects to schedule town hall meetings later this year.”
MSP Clarification and update

• Published by CMS on December 18, 2018
• Medicare does not currently provide beneficiaries with “guidance to help them make appropriate choices regarding their future medical care expenses and their need to satisfy their MSP obligations.”
• The proposed NPRM would “produce Code of Federal Regulations (CFRs) to provide beneficiaries options for meeting future medical obligations that fit their individual circumstances, while also protecting the Medicare Trust Fund.”
• Expected to be published October 2019.
The last five years
• The United States District Court, Southern District of Florida, Miami Division, published its opinion on Early v. Carnival Corporation, refusing to render an advisory opinion as to whether an MSA was required in this liability case.

• The Court finds that it may not rewrite the terms of parties’ private settlement agreement or render advisory opinions. Therefore, the Court concludes that the parties do not in fact have a settlement agreement and orders the case back on the Court’s trial docket.
On February 26, 2013, the United States District Court for the Southern District of Mississippi published its opinion on *Welch v. American Home Assurance*.

In order to comply with MSP on this liability claim, since CMS has provided no procedure for protecting Medicare's interests for future medical needs and/or expenses, the Court determines the necessity of the MSA and the amount of the MSA.

The Court concludes that the interests of Medicare have been reasonably considered and protected by all parties through the creation, funding, and maintenance of the MSA.
• On April 17, 2013, the United States District Court of Louisiana published its opinion on Benoit v. Neustrom.

• Court finds that since the net settlement proceeds after reimbursement of conditional payments to Medicare was $55,707.98 and the mid-point range of the MSA projections was $305,512.50, the net settlement is 18.2% of the MSA.

• Using that percentage applied to the net settlement proceeds, the Court concludes that the sum of money to be set aside in trust for future medical expenses is $10,138.00.
• On October 16, 2015, the United States District Court for the District of Arizona published its opinion on Aranki v. Burwell.

• Court concluded that this case is not ripe for review because no federal law mandates CMS to decide whether Plaintiff is required to create a MSA.

• “There may be a day when CMS requires the creation of MSAs in personal injury cases, but that day has not arrived.”

• Court concludes that although it is sympathetic to the uncertain predicament that CMS has placed upon Plaintiff, judgment in favor of the Defendants is proper.
• On August 6, 2018, the United States District Court for the District of South Carolina, published its opinion on Humana Insurance Company v. Bi-Lo, LLC.

• Humana filed declaratory judgment to recover double damages pursuant to the MSP Act in the amount of $32,754.02 despite the existence of a settlement agreement in which the Medicare beneficiary and her counsel agreed to be responsible for such reimbursement.

• However, because the Medicare beneficiary did not reimburse the Medicare payments advanced by Humana, Humana sought reimbursement from Bi-Lo.
MSAs in liability claims
Medicare beneficiary

• Is claimant a current Medicare beneficiary?
  – 65 years of age or older
  – Receiving SSD benefits for more than 24 months
  – Diagnosed with ESRD or Lou Gehrig's Disease

• If not, is there reasonable expectation that he/she will become a Medicare beneficiary within 30 months of settlement of the liability claim?
  – 62 ½ years of age or older
  – Applied, denied, appealed, or awarded SSD benefits
CMS and LMSA allocations

- Voluntary but considered best practice by CMS to assure compliance
- CMS does not advise when an LMSA is necessary or what should be included
- No CMS internal team or outside contractor to review LMSAs and provide approval
- However, current WCRC’s contract includes provisions to review LMSAs
Liability Medicare Set Asides (LMSA)

• Settlement includes future medical needs related to liability claim

• Liability Medicare Set Aside
  – Anticipated future medical and prescriptions based on treating physician’s opinion, not IME’s medical opinions
  – Medical treatment priced at U&C fee schedule, not Medicare fee schedule
  – Prescriptions priced at AWP per Red Book
  – Based on claimant’s life expectancy, with permitted rated age
Liability Issues in MSA Allocations

- Policy limits
- Contributory negligence
- Comparative negligence
- Statutory caps
- Jury/Judicial findings and decisions
Thank you
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