

Richard L. Gilbert
Judge, Retired

Richard L. Gilbert
Judge of the Superior Court, Retired
Resolution Arts Building
2630 J Street
Sacramento, Calif. 95816
Tel (916) 442-0414/Fax (916) 442-7046
www.rgilbertadr.com

Amanda C. Gilbert
Attorney at Law

Meeting the Obligation to “Consider Medicare’s Interests” in Third-party Liability Cases; Medicare Set-Asides and Beyond Panic: No/Prepare: Yes

© Richard L. Gilbert

(Originally published June 5, 2009, Substantially revised August 8, 2012; Last revision July 5, 2016)

URGENT UPDATE NOTICES

June 8, 2016: CMS has announced that it is considering expanding its "voluntary Medicare Set-Aside Arrangements (MSA)" review to include review of proposed third-party liability insurance (including self-insurance and no-fault insurance) MSA amounts. In an earlier announcement, CMS indicated the potential to include review of third party liability MSA proposals for contractors currently providing that services in the Workers' Compensation arena. (The CMS website post can be found here: (<https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Whats-New/Whats-New.html>) (Site last checked of June 29, 2016)

The announcement indicates that CMS plans to work with the "stakeholder community" with regard to implementation of this expansion. Notwithstanding the withdrawal of proposed regulations regarding third-party MSA accounts (see update below) this development, along with other recent guidance, is of great significance.

December 24, 2015: CMS has issued an important policy proclamation having potentially significant impact on third-party liability settlements where future medical expenses for Medicare beneficiaries (current or future) are implicated. Effective January 1, 2016, where an insurer (or workers' compensation entity) reports a settlement involving an obligation to provide ongoing medical care ("ORM"- "Ongoing Responsibility for Medical"), CMS will match reported ICD-9 or ICD 10 codes against future claims to determine if Medicare should pay them. (<https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Downloads/Medicare-Claim-Payments-Where-Ongoing-Responsibility-for-Medicals-is-Reported.pdf>) While this a policy pronouncement does not immediately and directly implicate lump sum settlements which include a potential amounts allocated to future medical payments, is a significant step in Medicare's utilization of reporting information and emphasizes the need to assure accurate reporting of medical conditions settled in third-party cases. It is inevitable that this matching will apply to a broader range of third-party settlements in the future.

October 8, 2014: CMS has withdrawn its proposed rules governing third-party liability MSAs

Richard L. Gilbert
Judge, Retired

Richard L. Gilbert
Judge of the Superior Court, Retired
Resolution Arts Building
2630 J Street
Sacramento, Calif. 95816
Tel (916) 442-0414/Fax (916) 442-7046
www.rgilbertadr.com

Amanda C. Gilbert
Attorney at Law

***Meeting the Obligation to “Consider Medicare’s Interests” in Third-party Liability Cases; Medicare Set-Asides and Beyond
Panic: No/Prepare: Yes***

© Richard L. Gilbert

(Originally published June 5, 2009, Substantially revised August 8, 2012; Last revision July 5, 2016)

When this article was first circulated in 2009, there were a variety of rumors and, frankly, rampant speculation whether, as a result of certain changes in Medicare Law, it had become necessary to create “Medicare Set-Aside Accounts” in third party liability (not Workers’ Compensation) Cases. The statutory amendments at issue were amendments to Federal Medicare laws effective July 1, 2009 that required reporting of claims and settlements of third party liability cases by insurers, self-insureds and others. Substantial confusion existed, and to some extent still exists, on whether the amendments required the creation of Medicare “set-aside” accounts (“MSA”) in order to “protect” Medicare’s future interests in various cases. Confusion also existed and, again, still exists to some extent, whether the changes affected the long standing rules and procedures regarding the reimbursement of Medicare payments made prior to the settlement of a third-party liability case.

With the passage of time, some settling of the dust surrounding the confusion and some additional "hints" from Medicare, it is possible to give something "resembling" an answer

to the question whether MSAs are required in third-party liability cases:

1. Neither the Medicare law nor CMS policy require the creation of Medicare Set-aside accounts in third party liability cases (“LMSA”), however;;
2. The need to "consider Medicare's interests" with respect to settlement (and even judgment) in cases involving compensation for future medical care suggests that set-aside accounts should be used in appropriate cases.
3. The more important question is how, more generally, to meet the law's obligation to "consider" Medicare's interests in third-party liability settlements.

Let me explain; from the almost beginning.

Background

To understand the issue, it is necessary to understand that Medicare paid health benefits are, by virtue of Federal law, “secondary” to other available healthcare funding sources.¹ This means that Medicare’s obligation to provide benefits kicks in only when “primary” sources of coverage are exhausted for an otherwise Medicare eligible beneficiary.

Primary sources of funding, “primary payers”, include Workers’ Compensation programs as well as insurers and self-insured entities obligated to provide payment for health care costs arising out of third party claims against the insured or self-insured entities.

Several things flow from this fundamental proposition and other specific statutory enactments:

¹ Pursuant to 42 U.S.C. §1395y(b)(2) and § 1862(b)(2)(A)(ii), Medicare is precluded from paying for a beneficiary's medical expenses when payment "has been made or can reasonably be expected to be made under a workers' compensation plan, an automobile or liability insurance policy or plan (including a self-insured plan), or under no-fault insurance."

- First, Medicare has a right to recover the cost of pre-settlement Medicare paid health care related to the third-party injury claim out of the proceeds of a judgment or settlement. This is commonly referred to as an "lien" though it is not technically a lien.²

- Secondly, Medicare requires that its interests be “taken into account” in any judgment or settlement including compensation for future health care costs.

We are fairly used to dealing with Medicare “liens” and, in that connection, CMS.³ The reimbursement right is statutory and notice of a "lien" is not required.⁴ I'll pass on further discussion about reimbursement of pre-settlement medical payments except to say this categorically:

The statutory changes that were enacted in 2007⁵ and which are the subject of this discussion, made absolutely no change in the rules or procedures for the reimbursement of Medicare for payments made before a settlement. A number of insurers and claims representatives appear to believe that new and different procedures and new and different settlement language is somehow required in the case the reimbursement to Medicare for past payments to beneficiaries. There is no basis for this belief.

² 42 U.S.C. § 1395y(b)) not only establishes that Medicare is a secondary payer to WC, but also that Medicare has a priority right of recovery over any other entity to the proceeds of any settlement. To the extent that Medicare has made any "conditional payments", Medicare recovers those payments pursuant to 42 C.F.R. § 411.47. This is the familiar Medicare “lien”. (See 42 C.F.R. 411.52 regarding third party cases.)

"Conditional payments" are Medicare payments for services for which another payer is responsible, made either on the bases set forth in 42 C.F.R. § 411 subparts C through H, or because the intermediary or carrier did not know that the other coverage existed. (42 C.F.R. § 411.21)

³ “CMS” is the “Centers for Medicare & Medicaid Services”, formerly “HCFA”, the “Healthcare Finance Administration”, which administers the Medicare program. You have dealt with CMS in working to obtain lien information and resolve liens.

⁴ Medicare has a statutory first right of recovery against all proceeds (42 U.S.C. 1395y(b)). Unlike, for example, hospital lien rights in California where notice is required to perfect the lien (Civil Code §3045.3; *Parnell v. Adventist Health* (2005) 35 Cal.4th 595, 601-602), the “right of recovery” is not a “lien” in the technical sense requiring notice.

⁵ See note 8, below.

Unless you have experience in the Worker's Compensation ("WC") field, however, you are probably not used to dealing with protecting Medicare's interests with respect to future medical care costs.

For many years, lump-sum Workers' Compensation settlements have needed to take into account the potential that the settling claimant is or will likely become a Medicare beneficiary. Where the case meets the required "threshold"⁶, an amount of money is typically "set aside" from the settlement proceeds to account for future medical costs that Medicare would otherwise have to bear.⁷ Only when that amount has been properly exhausted, will Medicare then become obligated to provide coverage as the primary payer. It is in this way that Medicare's role as the secondary payer is preserved. These MSAs take the form of bank or similar depository or investment

⁶ "It is not in Medicare's best interest to review every WC settlement nationwide in order to protect Medicare's interests per 42 CFR 411.46. (Ref: 7/23/01 Memo Q1(c)) A WCMSA is not necessary when resolution of the WC claim leaves the medical aspects of the claim open.

A WCMSA may be submitted to CMS for review in the following situations: 1. The claimant is currently a Medicare beneficiary and the total settlement amount is greater than \$25,000; OR, 2. The claimant has a "reasonable expectation" of Medicare enrollment within 30 months of the settlement date and the anticipated total settlement amount for future medical expenses and disability/lost wages over the life or duration of the settlement agreement is expected to be greater than \$250,000." (See the CMS website page concerning WC set asides: <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/msp105c01.pdf> (last visited March 16, 2015)(emphasis in original)

⁷ The burden of future medical expenses in WC cases may not be shifted to Medicare. 42 C.F.R. §§ 411.46 and .47 provide that Medicare's interest must be considered in WC settlements, when future medical expenses are a component of the settlement.

The CMS website notes, "Because Medicare does not pay for an individual WC related medical services when the individual receives a WC settlement that includes funds for future medical expenses, it is in the best interest of the individual to consider Medicare at the time of settlement. For this reason, CMS recommends that parties to a WC settlement set aside funds, otherwise known as Workers' Compensation Medicare Set-aside Arrangements (WCMSAs) for all future medical services related to the WC injury or illness/disease that would otherwise be reimbursable by Medicare."

accounts funded at the time of settlement either with cash or through periodic annuity payments to the MSA. In Workers' Compensation cases, the amounts put into the MSA in Workers' Compensation cases can and should be approved by CMS.

The notion of a MSA makes eminently good sense in the Workers' Compensation setting. In California, as in most states, workers compensation benefits are paid on a no-fault basis and are paid for life in cases of continuing injury and required ongoing medical care. Accordingly, where Workers' Compensation accepts responsibility for medical payments based on an industrial accident either with ongoing provision of medical care or through a lump-sum payment which includes amounts necessary to provide for future care, it makes logical sense and is consistent with Medicare's status as a secondary payer that provision be made to make sure the funds that are paid are devoted to their intended purpose.

The difficulty in third-party liability cases is that, while some cases have clearly identifiable value with respect to the future medical care occasioned by the conduct of a third party, many, if not most, third-party claims are settled on a compromise basis. Liability is often disputed and, even where liability is not disputed, the causation for and extent of continuing injury and future medical care is often subject to substantial debate. Moreover, third-party liability cases typically involve damage elements, such as general damages or other non-economic damages, lost income or earning capacity, that are not included in WC settlements. In third-party liability claims, unlike WC cases, compromise payments are made which cannot easily be parsed as to their component amounts.

Unfortunately, neither the statutory amendments enacted in 2007 nor Medicare's implementation of the reporting requirements has taken these critical distinctions into account. As a result of the greater complexity of third-party liability cases and the lack of clarity with respect to the need for Medicare set-aside accounts in third-party liability cases, the parties are left in somewhat of a quandary as to how to effectively settle cases without running afoul of the law and running the risk of future liability which is not

bargained for. The purpose of this paper is provide a some general background to the issue and provide some suggestions on how to approach the solution to the problem of properly considering Medicare's interests in particular cases.

What's New/ What's Not

The laws pertaining to Medicare's status as the secondary payer – "MSP" in the trade, or "Medicare Secondary Payer" – have not changed since the 1980s. Medicare has been a secondary payer with respect to Workers' Compensation since the beginning of the program in the mid-1960s. What happened in 2007, is that the Medicare law was changed to require that insurers, self-insureds and others not pertinent here, are required to report third-party liability claims and settlements involving Medicare beneficiaries to CMS.⁸ These law changes did not, however, enact requirements for MSAs in third party liability cases. "Why worry", you say. Maybe you shouldn't; but read on.

To provide context for the discussion which follows, it is helpful to have a brief understanding of what is reported to CMS.

CMS has developed an electronic information reporting program ("EDI") as mandated by statute. The details of this program are now fairly well developed. Effective at the beginning of this year (2012), "Required Reporting Entities" ("RRE") began reporting third-party liability claims and final settlement payments (TPOC) for settlements involving Medicare beneficiaries dated from and after October 1, 2011.

Reporting is being phased in based upon the amount of the total settlement obligation

⁸ 42 U.S.C. 1395y(b)(7) and (b)(8) (See, United States Code, TITLE 42 — THE PUBLIC HEALTH AND WELFARE, CHAPTER 7 — SOCIAL SECURITY, SUBCHAPTER XVIII — HEALTH INSURANCE FOR AGED AND DISABLED, PART E — MISCELLANEOUS PROVISIONS, 42 U.S.C. § 1395y. Exclusions from Coverage and Medicare as Secondary Payer.) The recent amendments are found in Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) (P.L. 110-173). You will see references to "Sec. 111" on the CMS websites cited here.

("TCOP") based on the following timeline (as of June 20,2012):

Mandatory Thresholds for Liability Insurance (including self-insurance) TPOC Settlements, Judgments, Awards or Other Payments		
Total TPOC Amount	TPOC Date On or After	Section 111 Reporting Required in the Quarter Beginning
TPOCs over \$100,000	October 1, 2011	January 1, 2012
TPOCs over \$50,000	April 1, 2012	July 1, 2012
TPOCs over \$25,000	July 1, 2012	October 1, 2012
TPOCs over \$5,000	October 1, 2012	January 1, 2013
TPOCs over \$2,000	October 1, 2013	January 1, 2014
TPOCs over \$300	October 1, 2014	January 1, 2015

The reporting process, as you might expect, is exceptionally complex. Details are found in the "Users Manuals" available on the CMS website.⁹ What is important to note at this juncture is that both the claim and settlement report require, inter alia, the following information:

- Name of the reporting party (typically, insurer, self-insured or TPA, "RRE")
- The name, address, Social Security Number and Medicare health insurance claim number for the injured party.
- The date of the incident.
- The alleged cause of the injury reported using ICD-9 codes.
- ICD-9 codes for the injury diagnoses.
- Attorney identifying information.
- An indication whether there is ongoing responsibility for future medical expenses ("ORM").
- The effective date of any final payment obligation ("total payment obligation to claimant" or "TPOC", typically the date of the settlement agreement or date of court approval, if required, of a settlement.).
- The TPOC amount.

As discussed below, this reporting requirement has significant implications on how Medicare's interests should be considered and how settlements ought to be

⁹<http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Non-Group-Health-Plans/NGHP-User-Guide/NGHP-User-Guide.html>

consummated in fairness to the parties and the Medicare law.

So-called Medicare set-aside accounts are one way of addressing the need to consider Medicare's interests in connection with settlements that implicate payments for future medical care in order to maintain Medicare's secondary payer status. Those of you into legal research will not find a specific statutory or regulatory basis for requiring MSAs in Comp cases; yet they are common and expected/required by Medicare.¹⁰ Industry experts note that the evolution of MSAs in WC cases stems in great part from the insurance industry's reaction to the requirement that Medicare's interests be considered in WC settlements including future medical care. Fearing their potential liability to Medicare by not specifically earmarking dollars for future care and setting them aside, the industry began the practice of demanding set asides. This practice became enshrined as part of the Workers' Compensation settlement process in cases involving lump-sum payments including future medical expenses when Medicare issued a memorandum in July, 2001 indicating that creation of a MSA would satisfy the requirement to consider Medicare's interests in connection with Workers' Compensation settlements including amounts for future medical expenses. This is the infamous "Patel Memorandum."¹¹

This leads to the inevitable question of whether, despite the absence of specific statutory or regulatory mandate, set-asides should be considered as a requirement to meet the obligation to consider Medicare's interests in some or all third party liability cases involving compensation or potential compensation for future medical expenses

¹⁰ See note 7, supra.

¹¹ The memorandum, in its current form, can be found at:

<http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Workers-Compensation-Medicare-Set-Aside-Arrangements/WCMSA-Memorandums/Downloads/July-23-2001-Memorandum.pdf>. (Last visited March 16, 2015) The original memorandum has been amended to

include substantial detail with regard to the submission and review process. Remember that this memorandum applies only to Workers' Compensation cases.

related to the underlying claim or injury.

When you peruse the CMS website, as, indeed, you must (thrilling romantic, etc.....), you will see that CMS is hosting a series of telephonic "Town Hall Meetings" to receive input, answer questions and disseminate information on the policy and technical EDI aspects of the program. Transcripts of the sessions are posted on the CMS site. A review of the transcripts of several Town Hall sessions over the last several years may reveal a certain evolution of Medicare's thinking with respect to the need for set-aside accounts in third party liability cases most recently hinting that their use may be "expected". During an early session on October 29, 2008 session, the following question and answer were exchanged:

"Next question comes from (Loren F.). Thank you. Your line is open.

(Loren F.): Hi I'm a lawyer. And my question - and this may not be the right forum for it but the most recent General Counsel Memoranda that I saw talked about the coordination of benefits and Medicare (certified) and so on only applies to worker's comp. And then, of course, you had the SCHIP Extension Act which extended the information reporting to the third party liability claims and so on.

And it seems informally that in some cases they're seeking to do coordination of benefits with third party claims that aren't worth (their) time. And sometimes they're not. Do you guys have any insight on that as to whether we need to make set aside arrangements and coordination of benefits for ordinary auto accident or medical malpractice or so on...

(Barbara) Wright: First of all, excuse me, first of all I don't believe there is a General Counsel Memo that says that there are no liability set asides. We, in brief, we have a very informal, limited process for liability set asides. We don't have the same extensive ones we have for worker's comp.

In either case CMS approval of a set aside amount is not required. It is a voluntary process.

(Loren Friedman): Right.

(Barbara) Wright: And lastly Section 111 does not mandate or specify

anything about liability set asides. So no that isn't really a topic for right now."¹²

When I originally wrote this article in June of 2009, I concluded that, while set-aside accounts were not "required" in third-party liability cases, a careful evaluation of individual cases may lead to the conclusion that a set-aside is the most appropriate vehicle to meet the legal obligation to "consider" Medicare's interests in connection with a settlement that includes compensation for future medical expenses for a Medicare beneficiary or potential beneficiary. That remains my view.

Note the exchange below which occurred during the March 24, 2009 Town Hall session. Because I believe this discussion is quite revealing as to Medicare's thinking, I am including substantial excerpts.

"John's question about worker's comp set-asides and liability set-asides, we'll repeat what we said over and over is that the worker's compensation set-aside process first of all that is not a required process; it's a voluntary process that's highly recommended.

Secondly CMS for liability set-asides does not have the same formal review process although our regional offices will consider review of proposed liability set-aside amounts depending on their particular work load and whether or not they believe significant dollars are at issue.

Last but not least...

(John Albert): But again none of them are required.

(Barbara Wright): Well the point is the set-aside process is totally separate from the Section 111 reporting process. As we've said in more than one call we don't anticipate changing our routine recovery processes. When there is a TPOC amount typically what we're doing is pursuing recovery against the beneficiary's settlement, judgment award or other payment; we are not - the fact that you're reporting to us doesn't change any other obligations or eliminate any other obligations."¹³

¹² The original link for this transcript, <http://www.cms.hhs.gov/MandatoryInsRep/Downloads/TeleconfOct2908.pdf>, is inactive and no new link could be found as of March 16, 2015 (FTS-HHS HCFA Moderator: John Albert 10-29-08/12:00 pm CT, Confirmation # 1211627, pages 17-18,(emphasis added.)

¹³ March 24, 2009 Town Hall: (<http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Non-Group-Health-Plans/Archive/Downloads/MMSEA111March24NGHPTranscript.pdf>)

A similar discussion took place during the October 22, 2009 the session:

“And from my perspective Medicare’s interests can’t possibly have been reasonably considered under that approach. So because CMS hasn’t officially stated that set asides or a claim settlement allocations are recommended in liability settlements and they haven’t published any procedures as such. I was wondering if you could advise me as to the best way a party settling a liability case especially a self insured like my company to ensure that Medicare’s interests are being quote/unquote reasonably considered.

(Barbara Wright): Actually I saw your question come in and I meant to address it in the ones at the beginning. If you go back on some of the earlier transcripts we’ve done short points on liability set asides. The AAJ is correct in that Section 111 does not require liability set asides as we said at the beginning of this call 111 is a new and separate reporting requirement.

And all it is a reporting requirement but we also said Section 111 doesn’t change any preexisting obligations. The idea of set asides is based on the fact that Medicare is prohibited from making payment where payment has already been made.

So that if you have a settlement judgment or other payment that takes into account in any way future medicals that settlement judgment award or other payment should be exhausted or appropriately before Medicare is billed for the associated services.

We do not have the same formal process for liability set asides that we have for worker’s comp set asides. The worker’s comp one is a recommended process. It’s not a required process and keep in mind we’re talking about a recommended process not the fact of whether or not you should or shouldn’t have a set aside in a particular case.

For liability we don’t have the staffing or resources right now to do that type of program for every single liability settlement or even with certain dollar thresholds what we’ve told our regional offices is if they believe there are significant dollars at issue in a particular case and the workload of that particular regional office permits.

They may review a proposed set aside amount for liability. The fact that they declined to review in a particular case does not create any type of safe harbor. So you’re back to an obligation that has existed essentially since 1980.

And if an entity has not been taking this into consideration and taking steps whether it’s to do a set aside or some how else take care of it. It’s something they now need to be documenting and taking care of. Simply it is a - it’s an obligation that existed far in advance of Section 111.

(Ryan Proser): Okay and just as a follow up. So should the regional office not have the resources to formally review a set aside or a claims settlement

) (Last visited March 16, 2015)Pages 23-24 (Emphasis added.).

allocation that I would want to put together in one of my releases and I go out to a third, independent third party an agent or an independent physician or whomever.

They do an independent analysis. And either a zero dollar amount or some small portion of the total settlement award is dedicated as a set aside and plaintiff's counsel is agreeable to that. We attach that as an exhibit or an amendment to the assigned release upon settlement. In CMS' eyes is that going to be sufficient?

(Barbara Wright): We as I said we don't have any formal process. I can't give you an answer on that. It does sound like one way to appropriately document what you've gone through and that you've made a reasonable consideration. Can we say more than that? No.

(Ryan Proser): Okay thanks.

(Barbara Wright): I mean I can't give you any bright line rule to help you out here.

(Ryan Proser): All right well, you know, I guess we'll just adopt those steps and, you know, see how things turn out. But we just wanted to create a paper trail to show CMS that we're, you know, taking the necessary steps in case they, you know.

Some times subsequent to our settlement come back and try to, you know, seek an over payment from us because we're the primary payer of the self insured. So we're just trying to come up with ways to insulate yourself in case that happened.

(Barbara Wright): But that's what I - goes back to what I just said. You need to at least think about having a process in place where you're documenting why or why not there are future medicals and how you took care of that. And our anecdotal experience is a lot of entities were simply not even considering the possibility of future medical.

(Ryan Proser): Okay I think you've answered my question. I appreciate it." ¹⁴

Also of interest is a February 2010 e-mail exchange between a San Francisco CMS regional office manager and a Sacramento law office which clearly indicated that at least the San Francisco regional CMS office was not prepared to review or approve MSAs. Moreover, as of February 2010, the San Francisco CMS office had published the following policy memorandum, which was included in the e-mail exchange:

¹⁴ October 22, 2009 Town Hall: (<http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Non-Group-Health-Plans/Archive/Downloads/Oct2209NGHPTranscript.pdf>) (Last visited March 16, 2015) pages 63-66 (Emphasis added.).

The Centers for Medicare & Medicaid Services (CMS) has no current plans for a formal process for reviewing and approving Liability Medicare Set-aside Arrangements. However, even though no formal process exists, there is an obligation to inform CMS when future medicals were a consideration in reaching the Liability settlement, judgment, or award as well as any instances where a Liability settlement, judgment, or award specifically provides for medicals in general or future medicals.

I have communicated with CMS concerning their MSA review policy. In August 2012, the SF Regional Office confirmed the policy quoted above. In February 2013, responding to rumors that one or more CMS regions had adopted specific policies regarding review, I contacted each CMS Region asking for a policy statement. SF affirmed the above. Additionally, I received a call from a CMS representative on behalf of all regions – it seems they talk to one another and discussed my inquiry. I was informed that CMS national policy is to review MSA proposals in third party liability cases on a case-by-case basis depending on resources. I was told, emphatically, that there is no different “policy” of any specific region.¹⁵ This is entirely consistent with the “Town Hall” information noted in this article.

No discussion of the use of set-aside accounts in third-party liability cases involving potential future Medicare entitlement would be complete without considering the potential consequences where Medicare's interests are not considered. First, remember that the beneficiary (the client if you are a plaintiff's attorney) can lose entitlement to benefits.¹⁶ If you are a plaintiff's lawyer, who do you think the client will call first when he or she finds out his or her benefits are cut off because settlement proceeds weren't applied to offset future Medicare covered health care costs? Additionally, insurers and other third party payers need to be concerned about potential liability for not considering Medicare's

¹⁵ A staff member of the Dallas region authored a paper seeming to express some “guidance”. This document was described as a “pamphlet” providing “information”.

¹⁶ See 42 C.F.R. 411.50 regarding limitation of benefits where primary payer source available.

interests as well.¹⁷ In light of the now effective reporting process, these considerations are not purely theoretical.

Let me restate the conclusions that I think ought to be drawn at this point:

1. The 2007 amendments to the SCHIP law that became effective in 2009 did not change the long-standing obligations with respect to the reimbursement of pre-settlement Medicare payments.
2. The sole effect of the 2007 amendments was to create a reporting mechanism which will enable Medicare to better track the existence of claims and settlements, including the details about payment in consideration of related future medical services.
3. While MSAs are not required in third-party liability cases, even those involving compensation for potential future medical expenses that might be Medicare eligible, consideration should be given to the use of set-aside accounts as a vehicle to discharge the settling parties' obligations under the Medicare law in some cases.

What To Do

The first panic I experienced when hearing of the possibility of needing MSAs in third party liability cases was that the fear that the requirement could make it very difficult to expeditiously settle major loss cases with Medicare involvement during the mediations I conduct. If the parties were not prepared to address the issue, I feared the negotiations would inevitably stall. Even if the parties were ready, the notorious non-responsiveness and delays in dealing with CMS appeared as a possible show stopper. This need not be the case. Here are some thoughts on how to approach the problem on a case by case basis.

¹⁷ There are specific statutory penalties for not reporting (42 U.S.C. 1395y(b)8(E)). Additionally, pursuant to 42 C.F.R. 411.24 (e), Medicare has the right to recover "primary payments" from parties that received those payments, including beneficiaries, providers and attorneys, and also from the entities that make the primary payments ("primary payer"), meaning insurers and self-insurance where Medicare made conditional payments and should have been the secondary payer. This section is referring to pre-settlement Medicare payments which are subject to Medicare's reimbursement right and which are typically paid to Medicare at the time of settlement. There does not appear to be an articulated basis for recovery of Medicare expenditures from an RRE where there was no set aside and Medicare pays future costs that could have been paid through an MSA. Query, however, how long before CMS finds the deep pocket?

A substantial aspect of rationally dealing with this difficult area is pre-settlement preparation. Additionally, a primary key to managing the issue successfully is early communication among the players.

What everyone needs to think about.

The first step that everyone needs to take is to make at least a preliminary assessment whether the case is or is not one which implicates the need to consider Medicare's interests, with or without a MSA, in the first instance.

Remember, reporting is made to CMS only for payments to Medicare beneficiaries and only where medicals are claimed and/or released:

“Information is to be reported for claims related to liability insurance (including self-insurance), no-fault insurance, and workers’ compensation where the injured party is (or was) a Medicare beneficiary and medicals are claimed and/or released or the settlement, judgment, award, or other payment has the effect of releasing medicals.”¹⁸

This first consideration, obviously, is whether the plaintiff is a current Medicare beneficiary or may become one in the relevant future. If the answer to this question is in the negative, then there is no need for further consideration of Medicare's future interests. No MSA, no special agreement language.

On the other hand, if the case involves a Medicare beneficiary or an individual

¹⁸ MMSEA Section 111, Medicare Secondary Payer Mandatory Reporting Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Workers’ Compensation USER GUIDE, Chapter III: POLICY GUIDANCE (Version 3.4 July 3, 2012), Page 33 (See: <http://www.cms.gov/Medicare/Coordination-of-Benefits/MandatoryInsRep/Downloads/NGHPUserGuideVer34Ch3Policy.pdf>)

who may become so in the “relevant future”, the next question is whether the settlement involves compensation for future medical expenses that may be covered by Medicare. As noted earlier in this discussion, because third-party liability cases are settled for a myriad of reasons and do not often involve a mere accounting of various undisputed damage numbers, it is not easy to determine what component of a settlement amount is attributable to future medical expenses even when they are on the table as part of the claim.

There are cases, however, where there are no claims for continuing medical care as a result of the underlying liability action or where there is no evidence to support a claim for future medical expenses related to an accident or injury. These cases do not require set-asides or any consideration of Medicare's future interests. Medicare recognizes that there are cases where no future medical expenses are implicated in the settlement. In fact, there is specific Medicare policy guidance indicating that where there is a certification from a treating physician that future medical care will not be required as a result of the underlying claim, Medicare will consider its interests with respect to future medical expenses satisfied.¹⁹ Again, any related past payments need to be reimbursed.

If, however, both of the two initial threshold conditions are met - beneficiary or potential beneficiary status and a settlement implicating or arguably implicating payment for future medical expenses, a more detailed consideration of how to account for Medicare's interests needs to be made.

Some thoughts regarding “Beneficiary Status”. Obviously, if the plaintiff is

¹⁹ The policy memorandum can be found here: <http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Non-Group-Health-Plan-Recovery/Downloads/Future-Medicals.pdf>. (Last visited March 16, 2015). Note that other language in the memorandum assumes that CMS is otherwise reviewing proposed Medicare set-asides in liability cases, referred to as “LMSA” in the document.

actually a Medicare beneficiary as of the time of the settlement, an analysis needs to be made of how to handle proper consideration of Medicare's interests in a settlement that does or may involve compensation for future medical treatment. A more difficult question is when such considerations should be made for someone who is not currently a Medicare beneficiary. As noted above with respect to Workers' Compensation cases, set-asides are not needed unless certain stated criteria are met: a lump sum payment of \$25,000 or more for current beneficiaries or a \$250,000 lifetime total payment where beneficiary status is likely within 30 months.²⁰ A similar bright line threshold is not necessarily appropriate in third party cases. As discussed above, unlike in WC, third party cases do not by definition involve a payer's lifetime obligation for medical care relating to the adjudicated injury as does WC in most states (including California). A rational approach to the problem seems to be to consider the claimant's age in the context of the nature of the claimed or compensated future medical condition, including the amounts involved. For example, in a clear liability case involving a 50-year-old plaintiff who, in the relatively near future, will require only a single future surgery to resolve a continuing medical problem related to the incident being settled, it can be concluded that Medicare's interests are not implicated at all and, accordingly no special consideration may be undertaken, certainly not a set-aside account.

On the other hand, the case of a 65-year-old settling plaintiff with a similar potential future surgery may be a case where something more needs to be done to properly consider Medicare's interests. This may or may not involve the creation of set-aside account.

Remember, also, that Medicare entitlement also arises from qualification for Social Security Disability. This is not an age-related test.

²⁰ See note 6, supra.

The nature of third party cases suggests a test for "beneficiary status" where "active" consideration of Medicare's interests should be undertaken that looks like this:

Where the plaintiff either is a current Medicare beneficiary, has an application for beneficiary status pending or may become a beneficiary during the period that encompasses the duration of the claimed ongoing medical condition (or during which a discreet probable future medical treatment will take place) and if the settlement arguably includes consideration for such future treatment, active consideration of Medicare's interests should be undertaken as part of the settlement process.

It should be noted that this test may result in measures to consider Medicare's interests, including creation of an MSA, in cases which do not meet the threshold applicable if the case were a Workers' Compensation case. Also, this test could yield the conclusion that some active measure to accommodate Medicare's interests is not required in cases that would be subject to the threshold in an "analogous" Workers' Compensation situation. While it may be controversial, I believe this conclusion is reasonable and consistent with the significant differences between third-party liability cases and Workers' Compensation cases and is adequate to reasonably consider Medicare's interests with respect to settlements that may implicate compensation for future medical costs.

"Medicare's Interest." The next step should be to consider the extent to which the settlement actually implicates Medicare's future interest in remaining secondary payer. This analysis also results in consideration of the extent to which the settling parties and payers may be at risk for failing to take Medicare's interests into consideration through other than lip service, such as by creating a MSA. In the absence of statutory or regulatory guidance from Medicare, there are no specific rules or detailed guidelines to decide what to do when. In my view, each case should be considered on its own merits, having appropriate regard for the required consideration of Medicare's secondary payer status, but also reasonably considering the distinct nature of third party liability

compromise settlements.

A small settlement, whether or not involving future medical care, by definition has minimal implications for Medicare's interests and, at the same time, poses less risk of future liability to Medicare for the parties. The larger the case, and the larger the component of future medical expenses involved in the value, the more Medicare's interests are implicated and the greater the risk. Also, the availability of other coverage for future medical expenses is a reasonable factor to consider.

I believe that this general approach is consistent with Medicare's stated philosophy, to the extent it can be determined.

Here are two excerpts from statements made by a Medicare representative at the Town Hall Meeting of October, 2010 cited at length above which I believe are consistent with this approach:

“We’ve told our regional offices is if they believe there are significant dollars at issue in a particular case and the workload of that particular regional office permits.

They may review a proposed set aside amount for liability.”

...

You need to at least think about having a process in place where you’re documenting why or why not there are future medicals and how you took care of that.”

Read in context, and in light of the distinctions between third-party liability cases and the bases for payments in those cases compared to Workers’ Compensation cases, it appears that Medicare is prepared to recognize that not all cases require set-asides and that they will look at the parties reasonable efforts to consider Medicare's interests on a case-by-case basis when considering whether to seek to recover post settlement Medicare payments. Note, also, the comment about CMS workload and settlement size.

At the end of this paper is a chart entitled "Medicare Interest Consideration Analysis

Matrix". The purpose of the Matrix is to suggest one rational approach to determining if consideration of Medicare's interest in connection with the settlement is required and how to accommodate that interest. The Matrix includes the concept of documenting the nature of the consideration taken. The Matrix should not be read as "the answer". It is not endorsed by CMS or Medicare; it has no specific statutory or regulatory basis and it should only be used as a method to raise issues rather than as a pattern approach to the final answer. There are likely many other, perhaps much better, approaches to the problem. The Matrix is intended as a tool to promote the thoughtful consideration of how to meet the parties obligation to consider Medicare's interests when those interests are implicated. Finally, the Matrix should be used in connection with the threshold criteria for consideration of Medicare's interests as discussed above.

Managing Reporting: Maybe the Biggest Issue

In almost every scenario on the Matrix, you will see the recommendation to "Confirm RRE reporting; consider as element of the settlement agreement". This may be both the most important and most neglected aspect of managing the parties' obligations to deal with Medicare.

As you know, many third party cases involve initial claims for a variety of injuries including claims of the need for future related medical care which, by the time of settlement or trial, are not substantiated and may be withdrawn or substantially compromised. If the paying carrier ("RRE") reports a settlement based on all of the initially claimed ICD-9 codes, Medicare will have been informed that that any subsequent Medicare claim for reimbursement of medical services reflecting one of those diagnosis or treatment codes was implicated in the final settlement payment ("TPOC"). Accordingly, Medicare may erroneously conclude that post-settlement Medicare claims relating to these codes should have been paid from settlement

proceeds and may seek reimbursement.

Of the many issues the parties need to consider in connection with their legal obligations in connection with Medicare secondary payer status, I believe that this issue may be the biggest practical issue we are facing and may be a ticking time bomb. I say this because in the small, but not insignificant number, of cases where I have raised the issue and discussed it with carrier representatives attending mediations, those responsible for making the settlement decisions were uninformed with respect to the carriers reporting process and not "in the loop" in creating the final TPOC report to CMS. This is an issue which should concern carriers and plaintiffs alike. There needs to be a reporting and feedback mechanism connecting settlement evaluation and finalization with the newly required Medicare reporting. Accordingly, I suggest that this be an active consideration in settlements where Medicare's interests may be implicated. Assuring accurate TPOC reporting is an important adjunct of managing the issue.

August, 2013 "Reporting Update": I continue to believe the "reporting issue" remains critical and under-attended at the "trench" level in connection with settlements. The prospect of Beneficiary claim denial is very real. Moreover, the topic is one that is the subject of ongoing discussion with CMS. Note this exchange during a July 25, 2013 "Town Hall" discussion:

"The next thing I'd like to mention along that similar in line is the issue of denied claims. We continue to see some reports of denied claims and one thing we have not stressed in the past that I would make clear is anytime a beneficiary actually has its claim submitted for payment and it's denied because of an MSP record, they have the ability to appeal that denial. You know, if it's the denial because they happen to have GHP insurance that's primary, they're not going to successful because it's still going to remain denied under that. But if you have a situation as sometime you've been alleged where it's obvious that the claim is not related.

For instance, someone is being treated for leukemia and their injury on the record is a broken ankle. If they appeal that denial on that basis, I would expect that they will win an appeal. There is – it shouldn't be needed to go all the way through but there is a complete administrative appeal process with several levels including ultimately judicial review if the amount of controversy is met.

The second related issue along that line is denied services where a beneficiary is telling you that they've been actually denied services. It's not that Medicare denied payment for the services, they've – they've had the physician or other entity refused services. We don't have an absolute fix for that for you but certainly it would be worthwhile to make sure the beneficiary has access to or has a copy of the Med

Learn articles we have told you about related to that that they could show to their physician or hospital. And the other thing I don't know if anyone has tried. Again, we can't guarantee it as a solution is whether or not if you gave the beneficiary a letter stating that you have reported this open record but then the open record, the ORM, is specific to X, Y, Z injury. That's something you might wish to try. That's all I have on that right now." (The speaker is CMS representative Barbara Wright; <http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Non-Group-Health-Plans/Archive/Downloads/NGHP-Town-Hall-Teleconference---July-25-2013.pdf>) (Last visited March 16, 2015) - Page 14-15)

July, 2016 “Reporting Update”: The importance of accurate reporting of the injuries involved in the settlement of cases was emphasized, again, in a December 24, 2015 policy statement from CMS. The CMS policy statement issued on that date reads, in full:

“CHANGES TO MEDICARE CLAIM PAYMENTS WHERE ONGOING RESPONSIBILITY FOR MEDICALS (ORM) IS REPORTED

Effective January 1, 2016, in situations where an insurer or workers' compensation entity has reported to CMS that it has ORM for specific care or an injury, CMS' claims processing contractors will use the information provided by the insurer or workers' compensation entity to determine whether Medicare is able to make primary payment for those claims. Insurers and workers' compensation entities that notify Medicare that they have ORM are strongly encouraged to report accurate ICD-9 or ICD-10 codes. Medicare's claims processing contractors will use this information to pay accordingly.”

“Ongoing Responsibility for Medicals” (“ORM”) describes the circumstances such as in resolution of a Workers' Compensation case with “open medicals” and potentially applies to similar settlements in third-party liability cases. While this is essentially unheard of in California, the significance of this policy statement is to recognize that, as has been emphasized in this article since its first publication 2009, one of the most serious impacts of the requirement for reporting claims and settlements is the ability for CMS to match post-settlement claims against reported ICD-9 and ICD-10 codes and potentially deny payment of those claims in cases where there has been a reported third party settlement for injuries matching the ICD-9 or ICD-10 code reported by the paying carrier or business.

Together with the June, 2016 announcement by CMS that it is considering expanding its capacity to review Medicare Set-Aside Arrangements (MSA) in third-party cases that, it must be concluded that CMS is clearly working towards a system whereby it will be able to match post-settlement claims against reported settlements and will have the opportunity to deny payment of claims where the settlement may have included payment for future medicals.

These developments emphasize the significance of taking care in making claims to include only those injuries which are truly pertinent to the case and, on settlement (or disposition by trial or arbitration) to assure that the settlement report accurately reports only the injuries which were compensated.

Additionally, while CMS continues to refer to MSA arrangements as “voluntary”, these policy steps also emphasize the need to consider Set-Aside accounts more in otherwise appropriate third-party cases.

Settlement Preparation for Defense Counsel and Claims Adjusters:

- Be aware of the carrier/self-insured (both, “carrier” for convenience hereafter) policies concerning provision for MSA in third party cases.
 - does the carrier ever require a set aside?
 - does the carrier have in-house or contracted vendor relationships to analyze future health care costs, set up MSAs and/or seek CMS review and approval?
 - what is the carrier viewpoint on the use of annuities to fund MSA?
 - does the carrier have a preferred annuity broker or carrier if needed?
 - will the carrier pay the cost of analyzing future care costs, setting up an MSA and seeking CMS review?

- Do you have all current medical records?

- Consider a “pre-review” of projected future medical costs.

There are several approaches to estimating future medical costs.²¹

If you have prepared a life care plan in the case already, the calculations can be made from that base. There are also services that can adapt the life care plan to a future cost estimate with a

²¹ This calculation should also include analysis of which of the future costs are covered by Medicare.

covered v. non-covered breakdown. If there is no life care plan, existing medical records and reports will need to be analyzed and an estimate prepared. Here, again, there are services available to do this, either stand alone or as a package with other MSA related activities.

- Be sure plaintiff's counsel is aware of carrier expectations in advance of settlement discussions/mediation.
- Find out the plaintiff's Medicare status- current beneficiary? Eligible? Do you have the plaintiffs Social Security number to check SSI, etc., status? Will Plaintiff's counsel provide that information for that purpose?
- If an MSA is in the picture, is an annuity a good way to go? If so, get cost estimates and consider having a broker at the mediation; coordinate with plaintiff's counsel.

Pre-settlement Preparation for Plaintiff's Lawyers:

- What is the client's Medicare status – current beneficiary? Eligible? Receiving SSI?
- Be sure you know what alternate health insurance payer sources, if any, are available to the client.
- Be sure you have all medical records.

- If you might do a “life care plan”, consider doing it earlier rather than later so that future health care costs can more readily be identified.
- Find out what the carrier’s position is on MSA.
- Consider having future care costs analyzed in advance of mediation by a suitable service to determine Medicare coverage and care costs at Medicare rates who.
- If an MSA is in the picture, is an annuity a good way to go? If so, get cost estimates and consider having a broker at the mediation; coordinate with defense counsel. The MSA account can either be self-administered or managed professionally by a service. The key here is to assure and have evidence that the funds are directed to health care costs that would otherwise be covered by Medicare so that, when the funds are properly exhausted, Medicare will agree that their interests have been considered and they will step in as primary payer and resume coverage.²²

The Options to Satisfy MSP Requirements; Not Just Set-sides

With as much information as possible in hand, consider whether, how and to what extent Medicare's interests need to be considered. As the attached Matrix shows, the answer can range from doing nothing to establishing a substantial or even a professionally managed MSA.

There are a couple of additional options which are not set out in the Matrix. In cases where a MSA is established, you might consider whether to seek formal

²² There are lots of details about this, including, for example, the accounting periods for exhaustion and expectations for fund replenishment in annuity funded MSA arrangements.

approval of the MSA from the CMS. There is a possibility, however slight, that a MSA will receive CMS review and approval, providing the desired comfort level for the settling parties. It has also been suggested that submitting the MSA for CMS review, even if CMS makes no response, may provide some protection to the parties in case of a later claim by Medicare for reimbursement of post settlement medical care payments. I question whether submission without actual CMS review will provide a defense to any subsequent claim. Moreover, because CMS does not have an established procedure for the review of MSA proposals and there is no timeline for review or response or even any assurance that CMS will acknowledge receiving the proposal and declining to review it, requiring such a step could place a settlement in unnecessary limbo. Nonetheless, I have encountered carriers who stubbornly insist on submission of a MSA to CMS. It may not be worth "blowing" a settlement to fight this requirement but if this is done, the settlement agreement should identify the party responsible for seeking the review, set a reasonable timeline by which review is to be sought and set a time limit for receipt of a response from Medicare such that, if no response is received within the stated time, the settlement goes forward without a CMS response.

Another way to deal with the potential implications of Medicare beneficiary status with respect to future medical costs may be to provide an alternative means of paying for medical care outside of a MSA and outside the Medicare program. Some plaintiffs will have available private medical insurance and will not need to rely on Medicare funded care. The settlement agreement could include the obligation to keep private medical insurance in place and could include a covenant not to seek Medicare funded care in the future. This could be backed up by some form of trust fund or similar method of ensuring the commitment. Note, however, that certain Medicare entitlements are automatic on achieving eligibility age. I understand, though have not independently researched, that it is

possible to petition Medicare to opt out of coverage such that any claim which may be inadvertently submitted to Medicare would be rejected. The option to provide future medical care through private insurance or even cash acquisition of care in cases involving very large settlements is something which should, at least, be considered as an option where the creation of an MSA may prove too restrictive with respect to the plaintiff's future financial planning.

Considerations for Cases That Are Tried

As you will see from the statutory and regulatory citations above, accounting for Medicare's interest is required both respect to settlements and judgments. Accordingly, strategies need to be considered to manage the issue in applicable cases that go to trial.

All of the preparatory steps discussed above should be on your radar. The end game, however, is a bit different. To consider Medicare's interests with respect to future medical care costs awarded as a part of judgment will require that, in some fashion, the portion of the judgment amount representing Medicare covered future costs be identified. An obvious first instinct would be to present specific evidence of the break-out at trial and have a corresponding special verdict completed by the jury. This sounds awfully distracting and cumbersome to me, however.

Another thought is that the issue be dealt with in a post-judgment hearing akin to a post-verdict *Greer/Howell*²³ determination. In that setting, the court can be presented with the future medical care costs and the Medicare-covered cost breakout and issue a

²³ *Greer v. Buzgheia* (2006)141 Cal.App.4th 1150 (2006) 46 Cal.Rptr.3d 780. *Greer* held that a plaintiff may produce evidence of the reasonable value of medical care costs before the jury, even if paid medicals were less and that the defense can move, post-verdict, for a reduction based on proof of the write-downs. *Howell v. Hamilton Meats, etc.* (2011) 52 Cal.4th 541 (2011) 257 P.3d 257, 129 Cal.Rptr.3d 325. *Howell* also discusses post-judgment determinations. These cases are cited only in that they suggest a role for the trial court in making apportionment of damages like those that would be required here.

judicial determination. That determination can form the basis of an MSA or other provision for “Medicare’s interests”. Even if an MSA is not established because the case does not materially implicate Medicare’s interests and is “low risk”, the process may be sufficient proof that Medicare’s interests were considered. If there is not an MSA, however, be sure the plaintiff knows what his or her obligations as a beneficiary are with respect to the value of Medicare covered future health care costs included in a judgment. For the reasons discussed above, doing something along these lines should be a common interest of both the plaintiff and defense.

Conclusions

The comments above should convince you that the world has not ended. The simple message is this: be aware of the issue and prepare, in advance, to deal with it. The preparation suggested here, all to be done in advance of settlement discussion, particularly mediation, and before trial are likely things you would want to do in any event. A final thought: continue to keep your eyes and ears open for changes on the horizon.

**Medicare Interest Consideration
Analysis Matrix**

Medicare Status	Case Issue Consideration (e.g. extent of contest regarding liability and/or causation of future care claim)	Injury Status	Action Options to Consider
Not Medicare Beneficiary and no potential for beneficiary status within relevant time.	Any	Any	No action required re Medicare future interests.

**Medicare Interest Consideration
Analysis Matrix**

Medicare Status	Case Issue Consideration (e.g. extent of contest regarding liability and/or causation of future care claim)	Injury Status	Action Options to Consider
Beneficiary or potential future beneficiary within relevant time.	Any	No ongoing medical expense claimed.	<ol style="list-style-type: none"> 1. Recite fact that no future care claim made and no amount allocated in settlement agreement. 2. Obtain certification from treating doctor, if possible. 3. Attach available expert reports, if available; reference in settlement agreement. 4. Include acknowledgement of Medicare responsibility in settlement agreement. 5. Confirm RRE reporting; consider as element of the settlement agreement.

**Medicare Interest Consideration
Analysis Matrix**

Medicare Status	Case Issue Consideration (e.g. extent of contest regarding liability and/or causation of future care claim)	Injury Status	Action Options to Consider
	Liability and causation uncontested	Minimal ongoing or discreet, relatively small future procedure (e.g. anticipated outpatient arthroscopic surgery)	<ol style="list-style-type: none"> 1. Generally describe future medical compensation in agreement. 2. Set out allocation of the total settlement amount attributed to future care. 3. Incorporate expert information re need and cost. 4. Include acknowledgement of Medicare responsibility in settlement agreement. 5. Confirm RRE reporting; consider as element of the settlement agreement.

**Medicare Interest Consideration
Analysis Matrix**

Medicare Status	Case Issue Consideration (e.g. extent of contest regarding liability and/or causation of future care claim)	Injury Status	Action Options to Consider
	Liability and causation uncontested	Moderate ongoing care issues or significant anticipated discreet future care; amount not a substantial portion of total settlement.	<ol style="list-style-type: none"> 1. Generally describe future medical compensation in agreement. 2. Set out allocation of the total settlement amount attributed to future care. 3. Incorporate expert information re need and cost. 4. Include acknowledgement of Medicare responsibility in settlement agreement. 5. Consider self-administered MSA based on reasonably estimated cost of services. 6. Confirm RRE reporting; consider as element of the settlement agreement.

**Medicare Interest Consideration
Analysis Matrix**

Medicare Status	Case Issue Consideration (e.g. extent of contest regarding liability and/or causation of future care claim)	Injury Status	Action Options to Consider
	Liability and causation uncontested	Significant ongoing care or major future medical procedure.	<ol style="list-style-type: none"> 1. Obtain "life-care" plan and Medicare coverage and cost analysis of future care. 2. Set out allocation of the total settlement amount attributed to future care. 3. Consider professionally administered MSA. 4. Consider annual or monthly MSA funding using annuity. 5. Include MSA details in settlement agreement. 6. Include acknowledgement of Medicare responsibility in settlement agreement. 7. Confirm RRE reporting; consider as element of the settlement agreement.

**Medicare Interest Consideration
Analysis Matrix**

Medicare Status	Case Issue Consideration (e.g. extent of contest regarding liability and/or causation of future care claim)	Injury Status	Action Options to Consider
	<p>Liability relatively <u>uncontested</u>; causation and/or cost of future care <u>highly contested</u>; minimal portion of total settlement attributable to future care claim.</p>	<p>Minimal ongoing or discreet, relatively small future procedure (e.g. anticipated outpatient arthroscopic surgery) claimed.</p>	<ol style="list-style-type: none"> 1. Recite contested nature of causation and/or cost of future care claim. 2. Incorporate and attach available defense reports on liability and/or causation. If not complete or exchanged as of settlement, consider detailed recitation of position, attached defense mediation or settlement conference statement if available. 3. Recite that defense not acknowledging material value of future care claim. 4. Include acknowledgement of Medicare responsibility in settlement agreement. 5. Confirm RRE reporting; consider as element of the settlement agreement. Query; can the RRE report no TPOC amount for future care - i.e. no ICD-9 for future care in TPOC amount.

**Medicare Interest Consideration
Analysis Matrix**

Medicare Status	Case Issue Consideration (e.g. extent of contest regarding liability and/or causation of future care claim)	Injury Status	Action Options to Consider
	<p>Liability relatively <u>uncontested</u>; causation and/or cost of future care <u>highly contested</u>; minimal portion of total settlement attributable to future care claim.</p>	<p>Moderate ongoing care issues or significant anticipated disreect future care; amount not a substantial portion of total settlement.</p>	<ol style="list-style-type: none"> 1. Recite contested nature of causation and/or nature of contested issues regarding cost of future care claim. 2. Incorporate and attach available defense reports on liability and/or causation. If not complete or exchanged as of settlement, consider detailed recitation of position, attach defense mediation or settlement conference statement if available. 3. Recite that defense not acknowledging material value of future care claim. 4. Consider self-administered MSA based on reasonably estimated cost of services; MSA amount reduced proportionally to reflect causation and/or cost compromise. 5. Include acknowledgement of Medicare responsibility in settlement agreement. 6. Confirm RRE reporting; consider as element of the settlement agreement. Query; can the RRE report no TPOC amount for future care - i.e. no ICD-9 for future care in TPOC amount.

**Medicare Interest Consideration
Analysis Matrix**

Medicare Status	Case Issue Consideration (e.g. extent of contest regarding liability and/or causation of future care claim)	Injury Status	Action Options to Consider
	<p>Liability relatively <u>uncontested</u>; causation and/or cost of future care <u>highly contested</u>; minimal portion of total settlement attributable to future care claim.</p>	<p>Significant ongoing care or major future medical procedure.</p>	<ol style="list-style-type: none"> 1. Obtain "life-care" plan and Medicare coverage and cost analysis of future care. 2. Set out allocation of the total settlement amount attributed to future care; provide for reduction commensurate with reduction based on compromise of issue. 3. Consider professionally administered MSA. MSA amount reduced proportionally to reflect causation and/or cost compromise. 4. Consider annual or monthly MSA funding using annuity. 5. Include MSA details in settlement agreement. 6. Include acknowledgement of Medicare responsibility in settlement agreement. 7. Confirm RRE reporting; consider as element of the settlement agreement.

**Medicare Interest Consideration
Analysis Matrix**

Medicare Status	Case Issue Consideration (e.g. extent of contest regarding liability and/or causation of future care claim)	Injury Status	Action Options to Consider
	<p>Liability highly contested; causation of future care claim or care costs <u>relatively uncontested</u>. Settlement reflects reduction in "potential full value" for associated risks. Significant settlement amount (Not a hard line , but In excess of plus or minus \$250,000.00)</p>	<p>Significant ongoing care or major future medical procedure.</p>	<ol style="list-style-type: none"> 1. Recite contested nature of liability. 2. Incorporate and attached available defense reports on liability. If not complete or exchanged as of settlement, consider detailed recitation of position, attached defense mediation or settlement conference statement if available. 3. Recite that defense not acknowledging material value of liability claim, but acknowledging risk of special damages. 4. Consider self-administered MSA based on reasonably estimated cost of services; MSA amount reduced proportionally to reflect liability compromise. 5. Include acknowledgement of Medicare responsibility in settlement agreement. 6. Confirm RRE reporting; consider as element of the settlement agreement.

**Medicare Interest Consideration
Analysis Matrix**

Medicare Status	Case Issue Consideration (e.g. extent of contest regarding liability and/or causation of future care claim)	Injury Status	Action Options to Consider
	<p>Liability highly contested; causation of future care claim or care costs relatively uncontested. Settlement reflects reduction in "potential full value" for associated risks. Relatively small settlement amount (Not a hard line , but less than plus or minus \$250,000.00)</p>	<p>Moderate or minor future treatment.</p> <p style="text-align: center;">Considering Medicare's Interests in Third Party Liability Cases</p>	<ol style="list-style-type: none"> 1. Recite contested nature of liability. 2. Incorporate and attached available defense reports on liability. If not complete or exchanged as of settlement, consider detailed recitation of position, attached defense mediation or settlement conference statement if available. 3. Recite that defense not acknowledging material value of liability claim, but acknowledging minimal risk of special damages. 4. Include acknowledgement of Medicare responsibility in settlement agreement. 5. Note that, although future medical are claimed, defense disputes liability for payment. 6. Confirm RRE reporting; consider as element of the settlement agreement. <p style="text-align: center;"><i>Page 10</i></p>