



April 7, 2011

MSAs and Liability Settlements—Recent Updates from the Liability Industry and Medicare

On April 14, 2010, PMSI issued a Legal Bulletin regarding liability settlements and the need to consider Medicare's interests as to future medicals. This bulletin will provide recent updates regarding the resistance by the liability industry to consider the protection of Medicare's future interests and the more recent trend of communication by Medicare that Medicare Set-Asides (MSAs) should in fact be considered under the Medicare Secondary Payer Act (MSP).

The American Bar Association (ABA) recently passed a resolution at its mid-year meeting urging The Centers for Medicare and Medicaid Services (CMS) and lobbying Congress to conclusively state that Medicare Set-Asides are not required in liability cases. While some clarity from CMS regarding the need for liability set-asides has been very much desired by the industry, this resolution appears to be flawed and short-sighted in numerous ways. Let us examine the first two principles sought by the ABA.

The first principle states that it "urges Congress to acknowledge that there is no regulatory or statutory basis for Medical Set Asides for third party liability settlements, judgments, or awards under the Medicare Secondary Payer Act." While there is no specific statutory mandate regarding establishment of a Medicare Set-Aside, clearly, this resolution does not address 42 USC §1395(y) (b) (2) of the MSP Act, which states plainly that payment shall not be made by Medicare and that Medicare shall be secondary wherein a primary payer exists. Primary payers are listed within the MSP Act as: workers' compensation law or plan, an automobile or **liability insurance policy or plan**, or no fault insurance.

Medicare has been clear in its memoranda, town hall conferences, Medicare Secondary Manuals and the like that Medicare's interests must be protected both through compromise (resolution of Medicare conditional payments) as well as commutation (set-asides for future Medicare covered expenses). While CMS has admitted that its memoranda have only been published in regard to workers' compensation cases, they have been very clear that this does not exempt the liability arena from the requirement to protect Medicare's future interests and consider liability Medicare Set-Asides to be the appropriate method by which to do so.



Please consider the following from the Non Group Health Plan (NGHP) Transcript dated September 30, 2009 page 25: "...there is not the same formal process for liability set asides that there is for workers' compensation set asides. However, *the underlying statutory obligation is the same.*" (Emphasis added).

The second principle of the resolution also seeks to "(e)xempt from review by CMS all settlements in which there are no legal obligations to pay medical benefits." It appears the resolution seeks to not allow CMS to review any liability cases, including \$0 allocations. Essentially CMS would not have the ability to review any settlements in which the carrier states that liability is denied. It is easy to see where this is going since most, if not all of these cases "deny" liability and MSAs would never be considered or needed. Medicare's interests would be ignored in virtually every settlement and we would be back to the same issue of the persistent shifting of the burden to Medicare in settlements that precipitated the passage of the MSP in 1980.

The Resolution also further seeks the following principles, which seem to have relatively similar goals of the proposed Medicare Bill H.R. 1063 namely: to prohibit recovery thresholds for liability MSAs that are linked to predetermined economic indices; the establishment of a statute of limitations for MSP claims; the establishment of a 30-day deadline by which CMS must respond in writing of its acceptance of the liability MSA; and to prohibit the certification or claim of specialization by any individual person or government entity of a process, practice or individual in the determination of the liability MSA.

In November of 2010, CMS issued an alert that it was delaying the reporting of liability TPOC (Total Payment Obligation to Claimant) settlements to January 1, 2012. However, any TPOC liability settlements occurring after October 1, 2011 would still need to be reported come January 1, 2012. This delay was greatly applauded and welcomed by many, as there remained many questions unanswered by CMS. Insurers and other self-insured RREs indicated that it would be unfair to face a \$1000 per claim per day penalty when CMS had not provided adequate guidance in many areas. Questions such as what if a Plaintiff refuses to provide his/her SSN or how to report a mass tort settlement were posed to CMS. These were good questions which still remain unanswered and certainly warranted a delay in reporting. However, it appears that there is much confusion, or perhaps purposeful ignorance that the delay of reporting of liability settlements also similarly delays any requirement to comply with the Medicare Secondary Payer Act. The delay of the reporting requirements for liability settlements is not to be confused with any obligations required pursuant to the Medicare Secondary Payer Act.

Several regional offices of CMS have admitted that they are reviewing liability MSAs on a case-by-case basis, such as Boston, New York, Philadelphia, Chicago and Dallas. If you call any of the above Medicare Regional Offices and ask whether that particular office is reviewing liability MSAs, the Regional Office will tell you the general procedures in regard to the types of



settlements in which it has an interest in reviewing a liability MSA. However, the Regional Office generally will not provide any liability MSA review guidelines in writing. It can be assumed that the Regional Offices have declined to or are not allowed to provide guidelines in writing, as their offices could probably not handle the influx of workload it would bring. Clearly though, the fact that numerous regional offices are reviewing liability MSAs is a direct indication that Medicare does feel that MSAs should be required pursuant to the Medicare Secondary Payer Act, or Medicare would not be spending the time to review them.

It is unlikely that this ABA resolution will have any direct impact on reform by Medicare; however, the insight into the desires by the liability arena is interesting and certainly warrants continued attention. As to the issue of the requirement of MSAs in liability settlements, it is still in flux and unlikely that CMS will issue any formal requirements any time soon. At this juncture, whether a liability MSA should be obtained and established in a liability settlement can ultimately be decided on a case-by-case basis and should depend on the appetite for risk of the parties. Clearly, the higher dollar settlements should strongly consider a liability MSA. Further, the parties to a liability settlement in which there is a Medicare Beneficiary Plaintiff (or the Plaintiff is reasonably expected to be a Medicare beneficiary within 30 months of the settlement) should keep in mind that the lack of a liability MSA could subject the Plaintiff to a loss of Medicare benefits, at least up to the entire amount of the settlement.

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