Setting the Record Straight

Dispelling Medicare Myths in Tort Settlements

By Kathryn Bucher, Richard L. McConnell and Katherine R. McDonald

The real scoop on the purported insurer duty to protect Medicare's interests, establish liability set-asides and pay future medical expenses.

In recent years, confusion and misinformation regarding liability insurer obligations to Medicare have complicated and in some instances delayed or obstructed settlements in bodily injury cases. There are sound reasons for caution because the Medicare Secondary Payer (MSP) statute, 42 U.S.C. §1395y(b)(2)(A), imposes significant obligations upon claimants, their counsel, and insurers, including obligations to reimburse Medicare for its payment of a Medicare beneficiary's medical expenses incurred prior to an insurance settlement, judgment, or award (known as "conditional payments"). But recently expressed concerns that liability insurers could be required to reimburse Medicare for a claimant's *future* medical expenses or to establish so-called Medicare set-asides (MSAs) to cover such expenses and thereby "protect Medicare's interests" are not well-founded. This article will separate fact from some of the swirling fiction that has enveloped the intersection of Medicare and commercial liability insurance.

In simple terms, the MSP statute provides that to the extent a group health, workers' compensation, liability, or no-fault insurance plan (including a self-insured entity) is obligated or chooses to pay the medical expenses of a Medicare beneficiary, the insurance plan is the primary payer and Medicare the secondary payer. In these circumstances, Medicare may pay such expenses conditionally if payment by the commercial insurer is delayed or in dispute, or the existence of private insurance is unknown. If an insurer subsequently pays or settles the beneficiary's claim, Medicare may recover its conditional payments from the beneficiary, any person or entity receiving any portion of the insurance payment (including plaintiff's counsel), and/or the insurer. Although the MSP statute was passed in 1980, there was only limited enforcement of these reimbursement provisions by Medicare in the ensuing years, often because Medicare was unaware of the insurer payments. In an effort to facilitate both insurer and Medicare beneficiary compliance with, as well as federal enforce-

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ment of, these MSP obligations, Congress amended the MSP statute through enactment of Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 ("Section 111" or "MMSEA"), thereby imposing tough new electronic reporting obligations on insurers and self-insured entities that settle or otherwise pay claims for medical expenses of Medicare beneficiaries.

Confusion arises in the discussion of liability MSAs because for years CMS has facilitated a structured approval process for workers' compensation MSAs.

Against the backdrop of this new reporting regime and the threat of steep statutory fines of up to $1,000 a day for noncompliance, insurers, defense counsel, and the plaintiffs' bar immediately encountered a bombardment of myths and exaggerations regarding the scope and substance of their MSP obligations, which was an interesting development given that most of these obligations had been on the books for almost 30 years. These pronouncements included emphatic declarations that Medicare's statutory right to recover its payment of pre-settlement (or past) medical expenses from insurers could be extended to the right to compel reimbursement of Medicare's payment of post-settlement (or future) medical expenses. From such statements then sprang new rhetoric that liability insurers have some amorphous obligation to "protect Medicare's interests" proactively by allocating settlement funds in most bodily injury cases to both past and future medical expenses, as well as by establishing Medicare set-aside arrangements to ensure that sufficient settlement funds are reserved to pay for future medicals. As we explain in this article, liability insurer obligations under the MSP statute simply do not extend that far. And although legislation signed into law in January of this year, and extolled by many in the insurance industry, amends the MSP statute and reforms the process through which insurers coordinate benefits with Medicare and report payments, insurer obligations under the MSP statute remain unchanged. Medicare IVIG Access and Strengthening Medicare and Repaying Taxpayers Act of 2012, Pub. L. No. 112-242, §§201–205, 126 Stat. 2374 (2013) (incorporating separate House Bill 1063, the Strengthening Medicare and Repaying Taxpayers Act of 2011, also known as the "SMART Act").

There really are only four legal obligations that a liability insurer might incur when making a payment to a Medicare beneficiary who alleges—or executes releases for—bodily injury, emotional distress, or medical expenses:

- Accepting the role of primary payer when payment to the Medicare beneficiary must be coordinated with Medicare, the secondary payer, under 42 U.S.C. §1395y(b);
- Reporting its payment through the new reporting process established by Section 111 of MMSEA, 42 U.S.C. §1395y(b)(8);
- Reimbursing Medicare for any conditional payments made for medical expenses incurred by the claimant *before* the date of settlement, judgment, or award *if* such expenses were for the treatment of bodily injuries or emotional distress alleged or released in the settlement, as required by 42 C.F.R. §411.24(i); and
- Giving formal notice to Medicare under a regulation that predates Section 111, if the insurer learns that Medicare has paid for medical expenses for which the insurer is the primary payer. Reporting under Section 111 now satisfies this obligation as well. 42 C.F.R. §411.25.

As discussed in more detail below, these requirements have been exaggerated and distorted by players inside and outside the insurance industry. This article is intended to set the record straight.

Summing Up the Law That Has Spawned So Much Confusion

When Medicare pays the medical expenses of a Medicare beneficiary because it does not know that commercial insurance coverage exists or because an insurer's payment obligations are not yet established (whether by settlement, judgment, or award) at the time Medicare pays, Medicare's payment is deemed by law to be a "conditional payment." It is considered "conditional" because if the insurer subsequently pays or settles a beneficiary's claim that arises from the same injuries for which the beneficiary received Medicare benefits, Medicare has the right under MSP law to recover its payment from the beneficiary, any "other party" that received some or all of the insurance payment, including legal counsel and medical providers, or the insurer. The law states:

> Repayment required. A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this subchapter with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means.

42 U.S.C. §1395y(b)(2)(B)(ii); *see also* 42 C.F.R. §§411.21, 411.24(g)–(i).

More specifically, both the beneficiary and any other party that received insurance proceeds have an affirmative obligation to reimburse Medicare for a conditional payment within 60 days of receiving the insurer's payment. 42 C.F.R. §411.24(h). In the event that Medicare fails to recoup its conditional payment from either, it may demand payment from the insurer "even though it [the insurer] has already reimbursed the beneficiary or other party" for the medical expenses. 42 C.F.R. §411.24(i)(1). Medicare guidance states that Medicare may recover up to the full amount of the "settlement, judgment, award, or other payment" received by the Medicare beneficiary from the insurer, regardless of the parties' allocation of damages, although Medicare typically will not try to recoup conditional payments from settlement amounts allocated to non-bodily injury damages by a jury or a court after a full hearing on the merits. 42 C.F.R. §411.37(d).

See Centers for Medicare & Medicaid Services, MMSEA Section 111: Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Workers' Compensation User Guide, Ch. III: Policy Guidance, 36 (July 3, 2012), http://www.cms.gov/Medicare/Coordination-of-Benefits/MandatoryInsRep/NGHP_User_Guides.html. Finally, Medicare can recover double damages if it must sue to recover conditional payments. 42 U.S.C. §1395y(b)(2)(B)(iii).

Section 111 requires liability, no-fault, and workers' compensation insurers (collectively referred to as "non-group health plans" or "NGHPs") to register as a Responsible Reporting Entity (RRE) with the Centers for Medicare & Medicaid Services (CMS), the agency that administers the Medicare program, when the insurer first anticipates making payment to a Medicare beneficiary that will trigger reporting. The RRE must then report the resolution of Medicare beneficiary claims above a certain monetary threshold that allege bodily injury, emotional distress, or the incurrence of medical expenses, or for which the Medicare beneficiary specifically releases the insurer from such claims. 42 U.S.C. §1395y(b)(8); Centers for Medicare & Medicaid Services, MMSEA Section 111 User Guide, *supra*, Ch. III, at 6. Under current agency guidance, RREs also are required to report the resolution of claims for which the beneficiary gives the insurer a general release of liability that would be sufficient to release unasserted claims of bodily injury, emotional distress, or incurred medical expenses. CMS argues that this reach is permissible because its Section 111 authority is necessarily broader than its right to recover Medicare payments from an insurer. NGHP Town Hall Teleconference Tr., at 21 (Feb. 9, 2011). CMS ostensibly uses this authority to determine whether the Medicare beneficiary should be spending settlement funds on future medical care before submitting claims for such to Medicare. In this situation CMS can deny Medicare benefits until the beneficiary demonstrates exhaustion of insurance funds.

Logically, CMS Cannot Make "Conditional" Payments After the Date of Settlement

By legal definition alone, Medicare's payment of medical expenses incurred *after* the date of settlement, judgment, or award cannot be a "conditional" payment. Understanding why this is true is critical to understanding why liability insurers are *not* obligated by Medicare law to pay or allocate settlement funds to future medical expenses.

Under the MSP statute itself, Medicare may not pay for medical expenses to the extent that "payment has been made or can *reasonably* be expected to be made under [private insurance]." 42 U.S.C. §1395y(b)(2)(A)(ii) (emphasis added). Conversely, to avoid leaving claims of Medicare beneficiaries and their providers pending for extended or indefinite periods of time, the MSP statute allows Medicare to make "conditional payment[s]" if the primary payer "has not made or cannot reasonably be expected to make payment with respect to such item or service *promptly*." 42 U.S.C. §1395y(b)(2)(B)(i) (emphasis added). Prompt payment is defined by the MSP regulations to mean payment within 120 days of receipt of the claim. 42 C.F.R. §411.21.

When analyzing this statutory language along with its implementing regulations, one finds only three circumstances in which Medicare may make a conditional payment:

1. When the Medicare "beneficiary has filed a proper claim for liability insurance benefits, but [Medicare] determines that the liability insurer will not pay promptly," including instances in which the liability carrier has denied the claim, 42 C.F.R. §411.52(a)(1);
2. When the "beneficiary has not yet filed a claim for liability insurance benefits," 42 C.F.R. §411.52(a)(2); and
3. When Medicare does not know that liability coverage exists for the claim in question, 42 C.F.R. §411.21.

Notably, in all three circumstances, final resolution of a private insurance claim through settlement, judgment, or award would terminate Medicare's ability under the law to make a conditional payment for medical services. The first and second situations require, by definition or implication, that Medicare pay *before* settlement, judgment, or award. The third situation, which could overlap with the second situation, encompasses Medicare's payment of medical expenses without knowledge of a pending liability claim, either because (1) the beneficiary was unaware *at the time of services* of available liability coverage, or (2) neither the beneficiary (once aware of coverage), nor the carrier, nor the medical provider has informed Medicare of the available coverage. Clearly, under all three situations, a carrier's (or other party's) timely notice to Medicare of a settlement, judgment, or award would preclude Medicare from making any further conditional payments because Medicare would no longer be able to opine that a liability payment could not, *reasonably* or otherwise, be expected. 42 U.S.C. §1395y(b)(2)(A)(ii).

Notice to CMS may be achieved through a carrier's quarterly Section 111 reporting. At this time, Section 111 reporting is required for claims over $5,000, a threshold that will gradually be reduced to claims over $300 over the next few years. Carriers also can choose to give notice to CMS under 42 C.F.R. §411.25, which predates Section 111 and requires a liability carrier to give notice to CMS once it is "demonstrated" to the carrier that "CMS has made a Medicare primary payment for services for which [the carrier] has made or should have made primary payment."

This interpretation also is compelled by CMS guidance. Indeed, a chapter of the MSP Manual expressly directs Medicare contractors not to attempt recovery from liability insurers of Medicare payments made for services provided to the beneficiary after the date of settlement. Centers for Medicare & Medicaid Services, MSP Manual, Ch. 7, §50.5 (Oct. 1, 2003), available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/msp105c07.pdf (Chapter 7 is under review by CMS and not part of the current MSP Manual). Chapter 7, section 50.5, also states that "[w]hen a liability claim is pending, and Medicare made conditional payments for services rendered before settlement, and Medicare is billed after the settlement has been reached, the FI or carrier may recover Medicare's payment for the additional claims if Medicare did not have knowledge of them at the time of settlement." This statement gives further credence to the utility of giving early notice to CMS of the existence or payment of liability insurance when there is concern that CMS later may seek reimbursement of conditional payments that it may argue it made

post-settlement, albeit for pre-settlement services, because it did not timely learn of the liability claim or settlement. But in no instance does CMS have authority to expand the definition of conditional payment to include payments that fall outside the definition adopted by the MSP statute and regulations.

Although not a "conditional payment," any payment that Medicare makes to a provider for post-settlement services after receiving notice of the settlement (or judgment, award or other insurer payment) might be a deemed "mistaken payment" and thus be recoverable from the beneficiary or provider, but not the insurer. 42 C.F.R. §411.24.

> **Insurers and Medicare** beneficiaries sometimes *choose* to invest in MSAs or other structured settlement arrangements as part of their settlements.

Setting Aside Misconceptions About MSAs and Allocations for Future Medicals

There is no statute, regulation, or Medicare guidance that requires liability insurers to allocate settlement funds between future medical expenses and other beneficiary costs, nor is there any corresponding requirement for liability insurers to establish MSAs for payment of future medical expenses. In fact, Medicare guidance clearly acknowledges that such requirements do not exist.

MSAs are structured accounts that "set aside" a portion of settlement funds for payment of anticipated future medical costs. Confusion arises in the discussion of liability MSAs because for years CMS has facilitated a structured approval process for workers' compensation MSAs (WCMSAs). CMS will review and approve WCMSAs when (1) the claimant is 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 is expected to be greater than $250,000. Centers for Medicare & Medicaid Services, Workers Compensation Medicare Set-Aside Arrangements (WCMSAs), http://www.cms.gov/Medicare/Coordination-of-Benefits/Workers-Compensation-Medicare-Set-Aside-Arrangements/Whats-New/Whats-New.html. But even with this facilitation by CMS, and as we explain below, the WCMSA process is entirely voluntary for both insurers and Medicare beneficiaries; this is true even though workers' compensation law may require carriers to pay future medical expenses and the regulations governing workers' compensation settlements make it clear that settlement funds intended to cover future medical expenses must be exhausted before Medicare will pay benefits related to that workplace injury. 42 C.F.R. §411.46(a). Perhaps for this reason the use of WCMSAs has become widespread, which also may explain why many in the industry have incorrectly assumed the law requires them.

Despite some lingering counsel by lawyers and structured settlement companies that MSAs are required in settlements of any kind with Medicare beneficiaries who are likely to incur significant future medical expenses, neither insurers nor Medicare beneficiaries are required to allocate any portion of settlement funds, whether under workers' compensation plans or liability policies, to future medical expenses. No such obligation is imposed by the MSP statute, Section 111, or any other laws, regulations, or Medicare guidance, and CMS has unmistakably confirmed this fact in recent court filings, CMS Regional Office communications, and periodic Section 111 Town Hall Teleconferences. *See* Defendant's Mot. for Summ. J., *Protocols v. Leavitt*, Civ. Action No. 05-cv-01492-BNB, at 3–4 (D. Colo. June 1, 2009) ("[T]here is no legal requirement that the WCMSA [workers' compensation Medicare set-aside] process be utilized by a claimant."); May 25, 2011 CMS Region VI Public Service "Handout" ("Medicare's interests must be protected; however, CMS does not mandate a specific mechanism to protect those interests. The law does not require a 'set-aside' in any situation."). For example, during Town Hall teleconferences recorded by CMS, the agency has advised as follows:

> What we [have] said over and over is that the worker's compensation set-aside process… is not a required process; it's a voluntary process that's highly recommended.

NGHP Town Hall Teleconference Tr., at 23 (Mar. 24, 2009).

> Liability set-asides; both of them, worker's comp and liability, neither one of them has ever been required to participate in a CMS review process.

Id. at 61.

> CMS has [a] formalized process to review proposals for workers' compensation, Medicare set aside amounts. It does not have the same formalized process for liability Medicare set aside arrangements. The process for workers' compensation is voluntary. We have a process for an informal process on the liability side that if a plaintiff's attorney or insurer, et cetera, wishes to attach [sic] the appropriate CMS regional office and the regional office has the ability to do so workload or otherwise, that they can choose to review a proposed set aside amount if they believe there is significant dollars at issue. Again, it's not the same extensive process that we have for worker's compensation. But regardless… the statute has the same language in either situation… It's literally the same physical sentence that we're not to make payment where payment has already been made.

NGHP Town Hall Teleconference Tr., at 41 (Mar. 16, 2010).

> [Medicare set-asides are] not tied to [Section 111] reporting despite allegations by some entities that Section 111 mandates liability set-asides… Section 111 has no such requirement.

NGHP Town Hall Teleconference Tr., at 50 (Dec. 11, 2008).

Further, CMS has made statements in other workers' compensation contexts that confirm that MSAs and allocations are not required under either the MSP statute or Section 111, although the decision not to allocate settlement funds between past and

future expenses may affect Medicare's payment of future medical services received by the beneficiary:

> **Question:** How does Medicare determine its interests in WC cases when the parties to the settlement do not explicitly state how much of the settlement is for past medical expenses and how much is for future medical expenses?
>
> **Answer:** A settlement that does not specifically account for past versus future medical expenses will be considered to be entirely for future medical expenses once Medicare has recovered any conditional payments it has made. This means that Medicare will not pay for medical expenses that are otherwise reimbursable under Medicare and are related to the WC case, until the entire settlement is exhausted.

See Mem. from Centers for Medicare & Medicaid Services Purchasing Policy Group to "All Associate Regional Administrators" (July 23, 2001), Exhibit A-1 to Defendant's Mot. for Summ. J., *Protocols v. Leavitt*, Civ. Action No. 05-cv-01492-BNB, at 3–4, (D. Colo. June 1, 2009). The Secretary of Health and Human Services also has stated that

> there is no legal requirement that the WCMSA process be utilized by a claimant. However, if a *claimant* does not engage in the process and fails to set aside funds to protect Medicare's interests, the Medicare program may refuse to pay for future medical expenses related to the workers' compensation injury until the entire workers' compensation settlement is exhausted.

See Defendant's Mot. for Summ. J., *Protocols v. Leavitt*, at 3–4 (emphasis added). *See also* Centers for Medicare & Medicaid Services, Workers' Compensation Medicare Set-Aside Arrangements (WCMSAs), http://www.cms.gov/Medicare/Coordination-of-Benefits/Workers-Compensation-Medicare-Set-Aside-Arrangements/Whats-New/Whats-New.html.

In summary, although Medicare beneficiaries may have a personal obligation or interest in certain circumstances to use some or all of the commercial insurance payments that they receive to pay for future medical expenses, the agency record provides no support for the position that insurers are required to allocate funds to future medicals or, more specifically, to offer MSAs to claimants. Of note, several federal and state courts also have confirmed that MSAs are not required by law or regulation, and we anticipate that the number will only grow as judges become more familiar with insurer obligations under the MSP statute and Section 111. *See, e.g.*, *Bertrand v. Talen's Marine & Fuel LLC*, No. 6:10-CV-1257, 2012 WL 2026998, at *3 (W.D. La. June 4, 2012) ("CMS does not currently require or approve Medicare set-asides when personal injury lawsuits are settled."); *Bruton v. Carnival Corp.*, No. 11-21697, 2012 WL 1627729, at *3 (S.D. Fla. May 2, 2012) ("There is no legal requirement that the settlement in this personal injury lawsuit include a Medicare set-aside trust account[.]"); *Hinsinger v. Showboat Atl. City*, 18 A.3d 229, 231 (N.J. Super. Ct. Law Div. 2011) ("Although there is no statutory or regulatory requirement to create a Medicare set aside when future medical expenses are awarded, it is recommended by the Center for Medicare [and Medicaid Services] and has become standard practice, particularly in workers' compensation cases, to create a set aside to protect the future interests of the injured individual and Medicare.").

With that said, insurers and Medicare beneficiaries sometimes *choose* to invest in MSAs or other structured settlement arrangements as part of their settlements. As discussed below, there are advantages and disadvantages associated with these tools.

Looking Practically at Medicare Set-Asides and Allocations

In some circumstances, liability MSAs can provide financial protection and certainty for injured Medicare beneficiaries and facilitate settlement. In many cases, however, MSAs increase the costs of settlement and raise complicated and divisive issues between the parties. Any decision to allocate a portion of settlement funds to future medical expenses or to utilize an MSA must take these considerations into account.

As a practical matter, and as noted above, CMS regional offices typically will not review liability MSAs, except in limited circumstances and only if scarce agency resources are available. Utilizing structured arrangements therefore usually offers no protections that are associated with official agency approval. And CMS has stated repeatedly that it is not required to respect allocations unless established by a special verdict returned by a jury or by a judgment on the merits from the bench.

Although it is unclear whether claimants would be able to protect other insurance proceeds from Medicare by allocating only a portion of the proceeds to future medical expenses, allocation issues are sometimes divisive and can impede settlement. Some claimants may attempt to minimize the portion of the settlement amount allocated to future medical expenses by aggressively pursuing an allocation that does not fairly reflect projected medical expenses. Insurers should be wary of agreeing to unreasonable allocations, because Medicare conceivably could use such an allocation as a basis for arguing that an insurer aided or conspired with the claimant to defraud the federal government and the Medicare Trust Fund, particularly if there appears to be a pattern of deficient allocation to future medical expenses. The transaction costs of arguing with claimants about such allocations, the consequent delays in settlement negotiations, and the potential risk created by allocation deficiencies have led some liability insurers to avoid allocations in settlement agreements. MSAs also may unreasonably drive up settlement costs by giving undue attention to projected future medical expenses and ignoring weaknesses in the plaintiff's liability case, uncertainties in the damages evidence, and the compromise nature of settlements.

> **CMS has stated** repeatedly that it is not required to respect allocations unless established by a special verdict returned by a jury or by a judgment on the merits from the bench.

We recognize that there may be benefits to utilizing liability MSAs in certain

circumstances. Such arrangements may facilitate settlement with a claimant who believes that an MSA is in his or her best interest. In these situations, liability insurers should be careful not to acquiesce in an allocation that could be seen as unreasonable, for the reasons described above. Requiring the claimant or claimant's counsel to hire the MSA consultant or otherwise to establish the MSA, rather than taking on that responsibility itself, will decrease the risk that the liability insurer is seen as responsible for the allocation and also decrease the insurer's administrative costs. The best alternative may be for liability insurers to avoid any involvement in allocation or the establishment of an MSA, and instead settle with a claimant for a lump sum amount. The claimant and claimant's counsel are then free to set up the MSA independently of the insurer, after settlement and reimbursement of any Medicare conditional payment amounts. In this case, any administrative fees associated with the liability MSA should come out of the total settlement amount, and the insurer should remain uninvolved in any allocation of funds determined by the claimant.

Debunking the Alleged Duty to Protect Medicare's Interests

Despite the various reporting and reimbursement obligations discussed above that the MSP statute, including Section 111, expressly imposes on insurers, it does not levy a broader, undefined duty on liability insurers "to protect Medicare's interests," and thus one potentially vulnerable to evolving agency interpretation. It is only because CMS and others have so often used this expansive language that some in the industry now believe that such an amorphous or expansive duty actually exists. The references to a "duty to protect" likely originated in the workers' compensation arena, where, we believe, the statements were directed toward the notice and repayment obligations imposed upon Medicare beneficiaries rather than insurance companies. Examples of these references include the following agency statements:

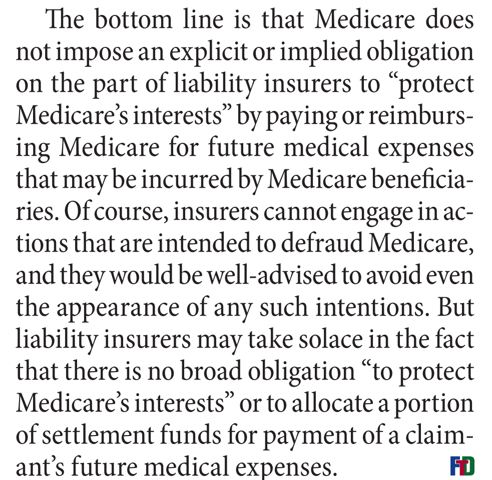
> Under the Medicare Secondary Payer provisions, Medicare is always secondary to workers' compensation and other insurance such as no-fault and liability insurance. Accordingly, *all beneficiaries and claimants must consider and protect Medicare's interest* when settling any workers' compensation case; even if review thresholds are not met, Medicare's interest must always be considered.

See Letter from Gerald Walters, Director, Financial Services Group, Office of Financial Management, CMS, to All Regional Administrators (July 11, 2005) (emphasis added), http://www.cms.gov/Medicare/Coordination-of-Benefits/WorkersCompAgencyServices/downloads/71105Memo.pdf.

> WC insurers, agencies, and attorneys have significant responsibilities under the MSP provisions of the Social Security Act to protect Medicare's interests when resolving WC cases. Because Medicare does not pay for an individual's WC-related medical services and/or prescription drugs when the individual receives a WC settlement, judgment or award that includes funds for future medical and/or prescription drug 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, known as WC Medicare Set-Aside Arrangements (WCMSAs) for all future medical and/or prescription drug services related to the WC injury or illness/disease that would otherwise be reimbursable by Medicare.

See Medicare Secondary Payer Manual, Pub. 100-05, Ch. 1, §10.4.1 (Mar. 20, 2009) (emphasis added).

Recommendations, of course, are not legal requirements. As discussed above, the MSP statute, including Section 111, and its regulations only impose obligations on liability insurers to report to CMS certain payments they make to Medicare beneficiaries and, in some circumstances, to reimburse Medicare for conditional payments made on behalf of those beneficiaries. Medicare's mistaken payment of medical expenses incurred *after* the date of settlement, judgment, or award, for whatever reason, is not "conditional payment" and cannot create new statutory obligations of liability insurers "to protect Medicare's interests" by reimbursing Medicare in that circumstance.



The bottom line is that Medicare does not impose an explicit or implied obligation on the part of liability insurers to "protect Medicare's interests" by paying or reimbursing Medicare for future medical expenses that may be incurred by Medicare beneficiaries. Of course, insurers cannot engage in actions that are intended to defraud Medicare, and they would be well-advised to avoid even the appearance of any such intentions. But liability insurers may take solace in the fact that there is no broad obligation "to protect Medicare's interests" or to allocate a portion of settlement funds for payment of a claimant's future medical expenses. FTD