by Jason D. Lazarus

Medicare Myths: What Every Trial Lawyer Should Know About the MSP & Liability Medicare Set Asides

Passage of §111 of the Medicare, Medicaid, and SCHIP Extension Act (MMSEA)[1] in 2007 and its original reporting deadline of July 1, 2009,[2] have caused a tremendous amount of confusion among insurance professionals, lawyers, and settlement planners. As a result of the MMSEA, new discovery is being sought to assist insurers in complying with the reporting requirements. Although the new discovery is proper, some changes attributed to the MMSEA are completely inaccurate. For example, some insurers are insisting on putting Medicare on the settlement check, claiming the "new law" requires it. Another example is the insistence by some insurers that Medicare set asides (MSA) are now required in all liability cases. Neither is true. The simple fact is that the MMSEA imposes a mandatory insurer reporting requirement upon responsible reporting entities (RRE). Centers for Medicare and Medicaid Services (CMS) has created a 224-page manual explaining what is required and defining terms used in the MMSEA. A discussion of all aspects of the MMSEA is beyond this article's scope. This article will briefly delve into the MMSEA to explain the act and its requirements. It will also focus on what the act does *not* require in an attempt to clear up widespread misconceptions.

Section 111 of the MMSEA

First, what is the MMSEA and what does it require? On December 29, 2007, President Bush signed into law the MMSEA.[3] Part of this act, §111, extends the government's ability to enforce the Medicare Secondary Payer Act.[4] As of April 1, 2011, an RRE (liability insurer, self-insurer, no-fault insurer, and workers' compensation carriers) shall determine whether a claimant is a Medicare beneficiary ("entitled"), and if so, shall provide certain information to the secretary of Health and Human Services when the claim is resolved.[5]

Under MMSEA, the RREs/insurers described above must report the identity of the Medicare beneficiary to the secretary and other such information as the secretary deems appropriate to make a determination concerning coordination of benefits, including any applicable recovery of claim.[6] Failure of an applicable plan to comply with these new requirements will incur a *civil money penalty of $1,000 for each day of noncompliance* on each claim.[7] A single claimant can have more than one claim, but the penalty is per claim. These new reporting requirements will make it very easy for CMS to review settlements to determine whether Medicare's interests were adequately addressed by the settling parties.

Section 111 and Resulting New Discovery Requests

As a result of the MMSEA and RREs' fear of not reporting promptly and being subjected to fines, many insurers are propounding discovery aimed at securing information to comply with the reporting. The RREs are requesting a Social Security number in order to verify whether a claimant is Medicare eligible. According to CMS, RREs may "submit a query to the COBC [Coordination of Benefits Contractor] to determine Medicare status of the injured party prior to submitting claim information for §111 reporting."[8] The query process is designed to assist RREs in determining whether the claim must be reported. The query must contain the client's Social Security number or Medicare health insurance claim number (HICN), name, date of birth, and gender. The COBC, upon submission of the information outlined above, will respond and indicate whether the individual is a Medicare beneficiary. If the injured party is a Medicare beneficiary, the HICN and other information found in the Medicare beneficiary database will be provided to the RRE. This process is done electronically with HIPAA Eligibility Wrapper software provided by CMS, but the RRE must have the Social Security number or HICN. This is the reason why the new discovery requests are being implemented.

Two recent decisions reinforce the right of a defendant insurer to compel provision of a plaintiff's Social Security number to comply with the mandatory insurer reporting required by §111 of the MMSEA. The first decision is *Seger v. Tank Connection, LLC*, Docket No. 8:08CV75 (D. Neb. 2010), in which a Nebraska federal court forced the plaintiff to answer an interrogatory requesting his Social Security number and found that the defendant "met its burden of proving the relevance of the requested information."[9] The court went on to say that:

> [a]lthough the Extension Act does not require this information be submitted

to CMS until after a final settlement or judgment is issued, there is no harm to the plaintiffs in providing the information sooner.

As Mr. Seger will be required to provide the requested information eventually, and as providing the information could reasonably bear on the issues in the case, the court finds Mr. Seger should respond to Interrogatories Nos. 4 and 9 to the extent he must provide identifying information along with either his Medicare Health Insurance Claim Number or his Social Security Number in order that Roundtable's insurance company may comply with the Extension Act.[10]

The second decision is *Hackley v. Garofano*, 2010 Conn. Super. LEXIS 1669. In *Hackley*, a Connecticut court followed *Seger* and found a defendant insurer, USAA, could condition settlement upon provision of his Social Security number.[11] The court said:

[t]hat there is a simple mechanism to assure that Medicare's interests are protected when a Medicare-eligible person receives a verdict or settlement in a personal injury case — the electronic "query process" — is apparent, as is the fact that both that process and USAA's confidentiality policy provide reasonable, albeit not foolproof, assurance that this personal identifying information will not be compromised.... This court, therefore, concludes that it is permissible for USAA to condition its disbursement of settlement funds on the plaintiffs' provision of their Social Security numbers.[12]

MMSEA and Conditional Payments

The stated intent of the new reporting requirements was to identify situations when Medicare should not be the primary payer and ultimately allow recovery of conditional payments. The Medicare Secondary Payer Act (MSP) prohibits Medicare from making payments if payment has been made or is reasonably expected to be made by a workers' compensation plan, liability insurance, no-fault insurance, or a group health plan. However, Medicare may make a "conditional payment" if one of the aforementioned primary plans does not pay or cannot be expected to be paid promptly.[13] These "conditional payments" are made subject to being repaid when the primary payer pays. When conditional payments are made by Medicare, the government has a right of recovery against the settlement proceeds.

Congress has given CMS both subrogation rights and the right to bring an independent cause of action to recover its conditional payment from "any or all entities that are or were required or responsible . . . to make payment with respect to the same item or service (or any portion thereof) under a primary plan."[14] Furthermore, CMS is authorized under federal law to bring actions against "any other entity that has received payment from a primary plan."[15] Most ominously, the government may seek to recover double damages via an independent cause of action.

U.S. v. Harris — A Trial Lawyer's Worst Nightmare

The government takes its reimbursement rights seriously and is willing to pursue trial lawyers who ignore Medicare's interest. In *U.S. v. Harris*, No. 5:08CV102, 2009 WL 891931 (N.D. W.Va. Mar. 26, 2009), *aff'd* 334 Fed. Appx 569 (4th Cir. 2009), a personal injury plaintiff lawyer lost his motion to dismiss against the U.S. government in a suit involving the failure to satisfy a Medicare subrogation claim.[16] The plaintiff filed for declaratory judgment and money damages against the personal injury attorney owed to CMS by virtue of third-party payments made to a Medicare beneficiary.[17] The personal injury attorney had settled a claim for a Medicare beneficiary (James Ritchea) for $25,000.[18] Medicare had made conditional payments in the amount of $22,549.67. After settlement, plaintiff's counsel sent Medicare the details of the settlement, and Medicare calculated they were owed approximately $10,253.59 out of the $25,000.[19] Plaintiff's counsel failed to pay this amount, and the government filed suit.

The motion to dismiss was denied by the U.S. District Court for the Northern District of West Virginia despite arguments from the plaintiff's counsel that he had no personal liability. Plaintiff's counsel argued that he could not be held liable individually under 42 U.S.C. §1395y(b)(2) because he forwarded the details of the settlement to the government and, thus, the settlement funds were distributed to his clients with the government's knowledge and consent. The court disagreed. The court pointed out that the government may, under 42 U.S.C. §1395y(b)(2)(B)(iii), "recover under this clause from any entity that has *received* payment from a primary plan or from the proceeds of a primary plan's payment to any entity." Further, the court pointed to the federal regulations implementing the MSPS, which state that CMS has a right of action to recover its payments from any entity, including an attorney.[20] Subsequently, the government filed a motion for summary judgment against plaintiff's counsel. The U.S. district court, in March 2009, granted the motion for summary judgment against plaintiff's counsel and held the government was entitled to a judgment in the amount of $11,367.78, plus interest.[21]

Medicare on the Settlement Check

Most trial lawyers understand their obligations under the MSP with regard to making sure conditional payments are repaid. The problem is the growing misconception among insurers that Medicare should be on the settlement check to ensure compliance with the MSP. Some insurers have even been told that the law requires Medicare be on the check. This is simply not so.

The author was asked last year by a trial lawyer to assist in a case where Medicare was put on the check despite it not being a term of settlement. The insurer moved to enforce the settlement, and plaintiff's counsel was forced to defend his position that the law did not require Medicare be on the check. The author provided an affidavit arguing why the law did not require Medicare be on the check. That case resulted in a published federal district court opinion, *Tomlinson v. Landers*, 2009 WL 1117399 (M.D. Fla. April 24, 2009), regarding the issue of whether Medicare must be on the check.

The *Tomlinson* court found definitively that the MSP did not require Medicare be on the check, and stated that "federal law does not mandate that a primary payer

(or insurer) make payment directly to Medicare."[22] The court did recognize that "an insurer may be liable to Medicare if the beneficiary/payee does not reimburse Medicare for any amounts owed to Medicare within sixty (60) days."[23] Nevertheless, the court found the defendant's decision to "list Medicare as a payee on the settlement check may have been in [defendant's] . . . best interest, however, [defendant] . . . was not required by federal law to include Medicare on the settlement check."[24] Given this fact, and the dispute concerning whether Medicare needed to be included on the check illustrated to the court, there was no meeting of the minds in terms of settlement. As a result, the settlement was not enforced, and a bad faith action could be pursued. An insurer taking a similar position in the future may open the door to similar holdings and bad faith causes of action.

Medicare Set Asides in Liability Settlements

Although "Medicare on the check" is a very problematic issue, a larger issue is the alleged connection between MSA and the MMSEA. CMS has made it very clear in numerous conference calls that the MMSEA is totally unrelated to MSA. In one such MMSEA conference call, Barbara Wright, acting director of the Medicare debt management division at CMS, stated that §111 of the MMSEA "does not mandate or specify anything about liability set asides."[25] It can't be made any clearer than that. There is no relationship between MMSEA and MSA in liability cases. However, Wright did say in that same teleconference, "We have a very informal, limited process for liability set asides."[26] She acknowledged they didn't have the "extensive" rules or procedures like the "ones [they] . . . have for workers' comp."[27] Finally, she indicated that "CMS approval of a set aside amount is not required. It is a voluntary process."[28] Each regional office sets its own policy on whether to review liability set asides.[29]

The Advent of Set Asides

Despite the lack of connection between the MMSEA and MSA, the issue is still a troubling one. For many years, personal injury cases have been resolved without consideration of Medicare's secondary payer status, even though, since 1980, all forms of liability insurance have been primary to Medicare. At settlement, by judgment, or through an award, an injury victim would receive damages for future medical expenses that were Medicare covered. However, none of those settlement dollars would be used to pay for future Medicare covered health needs. Instead, the burden would be shifted from the primary payer (liability insurer or workers' compensation carrier) to Medicare. Injury victims would routinely provide their Medicare card to providers for injury-related care.

These practices began to change in 2001 when MSA were officially recognized by CMS for workers' compensation cases.[30] Interestingly, around that same time, the General Accounting Office was studying the Medicare system and pointed out that Medicare was losing money by paying for care that was covered under the workers' compensation system.[31] Accordingly, CMS circulated a memo in 2001 to all its regional offices announcing that compliance with the secondary payer act required claimants to set aside a portion of their settlement for future Medicare-covered expenses when the settlement closed out future medical expenses.[32] The new "set aside" requirement was designed to prevent attempts "to shift liability for the cost of a work-related injury or illness to Medicare."[33] Set asides ensure that Medicare does not pay for future medical care that is being compensated by a primary payer by way of a settlement or an award. The procedures and policy for set asides have been developed through subsequent CMS memoranda known as frequently asked questions.[34]

The rationale for CMS creating an MSA is compliance with the Medicare Secondary Payer Act. The MSP is a series of statutory provisions[35] enacted in 1980 as part of the Omnibus Reconciliation Act,[36] with the goal of reducing federal health care costs. The MSP provides that if a primary payer exists, Medicare only pays for medical treatment relating to an injury to the extent that the primary payer does not pay.[37] The regulations that implement the MSP provide "[s]ection 1862(b)(2)(A)(ii) of the [a]ct precludes Medicare payment for services to the extent that payment has been made or can reasonably be expected to be made promptly under any of the following: i) workers' compensation, ii) liability insurance, iii) no-fault insurance."[38]

There are two issues that arise when dealing with the application of the MSP: 1) Medicare payments made prior to the date of settlement (conditional payments); and 2) future Medicare payments for covered services. Since Medicare is not supposed to pay for future medical expenses covered by a liability or workers' compensation settlement, judgment, or award, CMS recommends that injury victims set aside a sufficient amount to cover future medical expenses that are Medicare covered.[39] CMS' recommended way to protect future Medicare benefit eligibility is establishment of an MSA to pay for injury-related care until exhaustion.[40]

The problem is that the MSA are not required by a federal statute even in workers' compensation cases where they are commonplace. Instead, CMS has intricate "guidelines" and "FAQs" on its website for nearly every aspect of set asides,[41] from submission to administration. There are no such guidelines for liability settlements involving Medicare beneficiaries. Without codification of set asides, there are no clear cut appellate procedures from arbitrary CMS decisions and no definitive rules one can count on as it relates to MSA. Although there is no legal requirement that an MSA be created, the failure to do so may result in Medicare refusing to pay for future medical expenses related to the injury until the entire settlement is exhausted. This creates a difficult situation for Medicare beneficiary-injury victims and contingent liability for legal practitioners, as well as other parties involved in litigation involving physical injuries to Medicare beneficiaries.

Additionally, problems exist and

greater costs may be incurred in the settlement of cases involving Medicare beneficiaries due to the lack of uniformity and clarity regarding MSA.[42] The lack of uniformity and clarity comes from the fact that CMS regularly changes its procedures through publishing new memoranda in the form of FAQs that articulate policy. There have been 12 such memos since the original 2001 memo announcing set asides.[43] Submission of a set aside to CMS for review is sometimes a long process that can cause extra costs for parties to the litigation. The amount of the set aside does not take into account that the settlement amount may be lower due to other factors in the settlement apart from medicals. Fees are incurred in preparation of an allocation and submittal to CMS. The costs in creating a set aside may ultimately lower what is available to the injury victim to compensate for nonmedical damages. Delays in settlement or the inability to settle cases due to the set aside issue is another significant problem with a large impact on the tort system. The absence of any law or guidelines in the liability context is a tremendous problem. Since guidelines only exist in workers' compensation cases, those guidelines are frequently applied to liability settlements.[44] However, this creates many problems as workers' compensation cases and liability cases are two very different animals.[45] Thus, codification is vitally important from a systemic and cost perspective for both comp and liability.

A Need for Codification — LMSA

As uncertain and lacking in formal protections as the workers' compensation system is regarding MSA, it pales in comparison to the current state of affairs in liability settlements. The only known formal mention of MSA in liability settlements comes in the form of an answer to an FAQ in an April 2003 CMS memo.[46] CMS stated:

> Third party liability insurance proceeds *are also* primary to Medicare. To the extent that a liability settlement is made that relieves a Workers' Compensation (WC) carrier from any future medical expenses, a CMS approved Workers' Compensation Medicare Set-aside Arrangement (WCMSA) is appropriate. The WCMSA would need sufficient funds to cover future medical expenses incurred once the total third party liability settlement is exhausted. The only exception to establishing a WCMSA would be if it can be documented that the claimant does not require any further WC claim related medical services. A WCMSA is also not recommended if the medical portion of the WC claim remains open, and WC continues to be responsible for related services once the liability settlement is exhausted.[47]

Although the foregoing is not on point as it addresses the question of whether a set aside is necessary when a third-party settlement extinguishes a workers' compensation obligation, it is instructive in the sense that it states CMS' position that third-party proceeds are always primary to Medicare. However, a plain reading of the MSP can provide that type of information. There have been some recent statements by CMS officials regarding liability set asides during town hall conferences, which give insight into how CMS views liability set asides.[48] These town hall conferences relate to the new Medicare mandatory insurer reporting requirements under the MMSEA, which require insurers and self-insureds to report settlements with Medicare beneficiaries to CMS.[49] Due to confusion about this law and misinformation that it somehow requires MSA in third-party liability settlements, CMS has been forced to address liability MSA during these calls.[50]

In one such call from 2008, Barbara Wright said, "I don't believe there is a General Counsel Memo that says there are no liability set asides."[51] She continued, "We have a very informal, limited process for liability set asides. We don't have the same extensive ones we have for workers' comp." Finally, she reiterated an important admission that "CMS approval of a set aside amount is not required. It is a voluntary process." In a more recent call from September 2009,[52] Wright again addressed the issue of liability set asides by stating "[t]here 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."[53]

In the most recent call, in March 2010, Wright again emphasized that the review process for liability settlements was voluntary and each CMS regional office makes its own decision whether to review.[54] When discussing whether a CMS regional office would review, she indicated that if the regional office believes there are "significant dollars at issue," they may review a proposed set aside amount for liability.[55] However, she said:

> Regardless of whether CMS has a formalized process, or regardless of whether or not you're participating in the formalized process for workers' compensation Medicare set aside, the statute has the same language in either situation. It's not parallel language. It's not similar language. It's literally the same physical sentence that we're not to make payment where payment has already been made. So where future medicals are a consideration in arriving at the settlement, etc., then appropriate arrangements should be made for appropriate exhaustion of the settlement before Medicare is billed for related services.[56]

The current version of the *Medicare Secondary Payer Manual*, revised March 20, 2009, was updated with references to set asides in the liability context. In §20, which contains definitions, set aside arrangements are defined as follows: "An administrative mechanism used to allocate a portion of a settlement, judgment or award for future medical and/or future prescription drug expenses. A set aside arrangement may be in the form of a Workers' Compensation Medicare Set-Aside Arrangement (WCMSA), No-Fault Liability Medicare Set-Aside Arrangement (NFSA) or Liability Medicare Set-Aside Arrangement (LMSA)."[57]

Clearly CMS has intentions to do something as it relates to liability settlements and set asides since this was included in the *MSP Manual*. The question is what and how will guidelines be developed? Will it be similar to workers' compensation? How will the decidedly different issues involved in liability settlements be addressed?

Given all of the foregoing, legal practitioners, Medicare beneficiary-injury victims, and insurers are left guessing as to what to do when a liability settlement is achieved. Is a

set aside necessary? If so, how do parties determine if they are necessary? Is it only "significant dollars" cases? What rules apply if you do create a set aside? Do we look to the 12 CMS memoranda[58] that have been published since 2001 on their website? What about the differences between workers' compensation cases and liability cases? Will CMS take into account policy limits in a liability case in determining the sufficiency of an allocation? What happens if policy limits are $50,000 and the future Medicare covered services are $150,000? Will CMS take into account comparative fault/contributory negligence issues that may reduce recovery? What about statutory or constitutional caps on damages? Can CMS fail to pay for Medicare covered services post liability settlement for the Medicare beneficiary-injury victim if there is no set aside created?

It should be painfully obvious from the foregoing discussion that codification of set asides is imperative. Given the possible loss of Medicare benefits, as threatened by CMS, a Medicare beneficiary has significant risks when it comes to MSA with little or no corresponding legal remedies. Significant delays persist in the workers' compensation MSA process, which, in some instances, leads to settlements falling apart.[59] In addition, liability cases brought on behalf of Medicare beneficiaries may decrease due to the possibility of having to put all of the net proceeds into an MSA. As Rick Swedloff said in a 2008 law review article, it creates a classic situation of "can't settle, can't sue."[60] In the context of conditional payments, he said that the "MSP discourages Medicare beneficiaries and their contingency fee attorneys from bringing suit in simple tort disputes."[61] That statement is all the more profound today in the face of the increasing complexities of conditional payments and the confusion over MSA issues.

What To Do?

The question becomes what to do when faced with an insurer who insists on an MSA in a liability case. A trial lawyer could ask for the insurer's legal basis for mandating an MSA or ask for a cite to the federal statutes, code of federal regulations, case law, or any rules/process regarding MSA for liability cases. There are currently none; no one will find any law that directly addresses the issue of MSA for liability cases. However, this article is not suggesting that parties should ignore Medicare's interest under the Medicare Secondary Payer Act. To adequately protect counsel and a client who is a Medicare beneficiary — or reasonably expected[62] to become a Medicare beneficiary within 30 months of settlement — an MSA evaluation may be in order. As described below, this is a voluntary process, and CMS may not review the proposed set aside.

A trial lawyer may want to take the position that the insurer should bear the costs of the MSA evaluation and the costs of the set aside (including professional administration of the account). In addition, there are many non-Medicare medical expenses that must be considered in arriving at a settlement for future medical costs (*i.e.*, certain durable medical goods, custodial care, certain prescription medications, and the Part D donut hole, to name a few). If a set aside will be established, a thorough examination of non-Medicare expenses along with an allocation of future Medicare covered future services should be undertaken.

There are other options besides a formal set aside if a trial lawyer is faced with an insurer who requires addressing Medicare's interest. One option is to estimate the future Medicare covered expenses the client will potentially incur and document that amount in the settlement agreement. The estimate can be created from doctors' reports or life care plans. The client then sets aside this amount and is told to use it for future Medicare covered expenses. No submission to CMS is done if this option is exercised. However, the release provides evidence that Medicare's interests were taken into account at settlement. Since CMS admits there is no formal review process for liability settlements, and submission is voluntary, an argument can be made that all the current law requires has been done and then some.

Another option is to do the formal allocation report and again document it as previously mentioned. Since CMS does not guarantee a review of a liability set aside, a formal allocation along with documenting it in the settlement agreement provides the necessary evidence that Medicare's interests were adequately addressed. A formal allocation also gives the trial attorney a third, independent party to review the future medical expenses and determine what Medicare covers. This is an important piece of protection for the trial attorney as it provides an extra layer of error and omission protection.

Conclusion

Medicare protocols and procedures regarding the repayment of conditional payments should not change due to MMSEA. However, insurers' behaviors will and have most certainly changed. Insurance companies are fearful of all the reporting requirements under MMSEA because failure to comply is a $1,000 per day, per claimant fine. For a large insurer, that is significant exposure. Therefore, new discovery has been created to help insurers comply. Medicare may be put on the settlement check, and, unfortunately, some insurers are insisting on MSA in liability cases. Federal law does not require Medicare be placed on the check, a fact confirmed by *Tomlinson*. Federal law does not contain any codification of the obligation to create an MSA in liability cases. However, trial lawyers will have to interpret the MSP laws and deal with the insurers on these issues to protect the client as well as their practices. There are many unanswered questions that persist with little clarity or law to help guide lawyers.❑

[1] 42 U.S.C. §1395y(b)(8)(C).

[2] This date has been pushed back several times and is now slated for April 1, 2011.

[3] Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110-173). This act was passed by the House on December 19, 2007, and by a voice vote in the Senate on December 18, 2007.

[4] Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110-173).

[5] *Id.*
[6] *Id.*
[7] *Id.*
[8] Centers for Medicare and Medicaid Services, *MMSEA Section 111 Medicare Secondary Payer Mandatory Reporting, Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Workers' Compensation User Guide* at 17 (July 31, 2009), *available at* http://www.avizentrisk.com/downloads/NGHPUserGuideV2.0.pdf.
[9] *Seger*, Docket No. 8:08CV75 (D. Neb. 2010).
[10] *Id.*
[11] *Hackley v. Garofano*, 2010 Conn. Super. LEXIS 1669.
[12] *Id.*
[13] 42 U.S.C. §1395y (2007).
[14] *Id.*
[15] *Id.*
[16] *Harris*, No. 5:08CV102, 2009 WL 891931 (N.D. W.Va. Mar. 26, 2009), *aff'd* 334 Fed. Appx 569 (4th Cir. 2009).
[17] *Id.* at *1.
[18] *Id.*
[19] *Id.*
[20] *See* 42 C.F.R. §411.24 (g).
[21] *Harris,* No. 5:08CV102, 2009 WL 891931 at *5.
[22] *Tomlinson v. Landers*, 2009 WL 1117399 at *5.
[23] *Id.*
[24] *Id.* at *6.
[25] Centers for Medicare and Medicaid Services, NGHP Transcript, *Town Hall Teleconference* at 18 (Oct. 29, 2008).
[26] *Id.*
[27] *Id.*
[28] *Id.*
[29] Centers for Medicare and Medicaid Services, NGHP Transcript, *Town Hall Teleconference* at 26 (Sept. 30, 2009).
[30] *See* Parashar B. Patel, *Medicare Secondary Payer Statute: Medicare Set-aside Arrangements*, Centers for Medicare and Medicaid Services Memorandum (July 23, 2001).
[31] Edward M. Welch, *Medicare and Worker's Compensation After the 2003 Amendments,* WORKERS' COMPENSATION POLICY REVIEW at 5 (March/April 2003).
[32] Parashar B. Patel, *Medicare Secondary Payer Statute: Medicare Set-aside Arrangements*, Centers for Medicare and Medicaid Services Memorandum (July 23, 2001).
[33] *Id.*
[34] Centers for Medicare and Medicaid Services, Workers Compensation Agency Services, http://www.cms.gov/WorkersCompAgencyServices.
[35] The provisions of the MSP can be found at §1862(b) of the Social Security Act. 42 U.S.C. §1395y(b)(6) (2007).
[36] Omnibus Reconciliation Act of 1980, Pub. L. No. 96-499 (Dec. 5, 1980).
[37] 42 CFR §411.20(2) Part 411, Subpart B, (2007).
[38] *Id.*
[39] *See* 42 U.S.C. §1395y(b)(2) and §1862(b)(2)(A)(ii) of the Social Security Act; *see also* Centers for Medicare and Medicaid Services, Workers Compensation Medicare Set Aside Arrangements, http://www.cms.gov/WorkersCompAgencyServices/04_wcsetaside.asp#TopOfPage.
[40] Centers for Medicare and Medicaid Services, Workers Compensation Medicare Set Aside Arrangements, http://www.cms.gov/WorkersCompAgencyServices/04_wcsetaside.asp#TopOfPage.
[41] Centers for Medicare and Medicaid Services, Workers Compensation Agency Services, http://www.cms.gov/WorkersCompAgencyServices.
[42] Eric J. Oxfeld, *Congress Must Reform Medicare Set Asides*, FLA. UNDERWRITER at S-9 (May 2006).
[43] *See* Centers for Medicare and Medicaid Services, Workers Compensation Agency Services Overview, http://www.cms.gov/WorkersCompAgencyServices.
[44] For example, the April 2003 CMS memo gives us guidelines of when an MSA is not necessary. *See* Thomas Grissom, *Medicare Secondary Payer — Workers' Compensation (WC) Frequently Asked Questions*, Question 20, Centers for Medicare and Medicaid Services Memorandum (April 22, 2003). Another example is the July 2001 CMS memo, which sets up review thresholds for WCMSAs. *See* Parashar B. Patel, *Medicare Secondary Payer Statute: Medicare Set-aside Arrangements*, Centers for Medicare and Medicaid Services Memorandum Question 1(c) (July 23, 2001).
[45] *Zinman v. Shalala*, 67 F.3d 841, 846 (Ninth Cir. 1995). The *Zinman* court recognized how different workers' compensation settlements are from liability. The court pointed out that "[a]pportionment in workers' compensation settlements therefore involves a relatively simple comparison of the total settlement to the measure of damages allowed for individual components of the settlement, pursuant to a prescribed formula. Tort cases, in contrast, involve noneconomic damages not available in workers' compensation cases, and a victim's damages are not determined by an established formula. Apportionment of Medicare's recovery in tort cases would either require a factfinding process to determine actual damages or would place Medicare at the mercy of a victim's or personal injury attorney's estimate of damages."
[46] Thomas Grissom, *Medicare Secondary Payer — Workers' Compensation (WC) Frequently Asked Questions*, Question 19, Centers for Medicare and Medicaid Services Memorandum (April 22, 2003).
[47] *Id.* (emphasis added).
[48] *See* Centers for Medicare and Medicaid Services, NGHP Transcript, *Town Hall Teleconference* at 18 (Oct. 29, 2008); Centers for Medicare and Medicaid Services, NGHP Transcript, *Town Hall Teleconference* at 25 (Sept. 30, 2009); Centers for Medicare and Medicaid Services, NGHP Transcript, *Town Hall Teleconference* at 64 (Oct. 22, 2009); Centers for Medicare and Medicaid Services, NGHP Transcript, *Town Hall Teleconference* at 41 (March 2010).
[49] Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110-173). This act was passed by the House on December 19, 2007, and by a voice vote in the Senate on December 18, 2007. It was signed into law by President Bush on December 29, 2007.
[50] *See* Centers for Medicare and Medicaid Services, NGHP Transcript, *Town Hall Teleconference* at 18 (Oct. 29, 2008); Centers for Medicare and Medicaid Services, NGHP Transcript, *Town Hall Teleconference* at 25 (Sept. 30, 2009); Centers for Medicare and Medicaid Services, NGHP Transcript, *Town Hall Teleconference* at 64 (Oct. 22, 2009); Centers for Medicare and Medicaid Services, NGHP Transcript, *Town Hall Teleconference* at 41 (March 2010).
[51] Centers for Medicare and Medicaid Services, NGHP Transcript, *Town Hall Teleconference* at 18 (Oct. 29, 2008).
[52] Centers for Medicare and Medicaid Services, NGHP Transcript, *Town Hall Teleconference* at 25 (Sept. 30, 2009).
[53] *Id.*
[54] Centers for Medicare and Medicaid Services, NGHP Transcript, *Town Hall Teleconference* at 41 (March 2010).
[55] *Id.*
[56] *Id.* at 41-42.
[57] MEDICARE SECONDARY PAYER MANUAL (Rev. 65, March 20, 2009).
[58] *See* memos at Centers for Medicare and Medicaid Services, Workers Compensation Agency Services Overview, http://www.cms.gov/WorkersCompAgencyServices.
[59] Eric J. Oxfeld, National Issues Impacting Workers' Compensation, https://www.riskinstitute.org/peri/component/option,com_bookmarks/Itemid,44/catid,35/navstart,0/task,detail/mode,0/id,766/search,*.
[60] Rick Swedloff, *Can't Settle, Can't Sue: How Congress Stole Tort Remedies from Medicare Beneficiaries*, 41 AKRON L. REV. 557 (2008).
[61] *Id.*
[62] Reasonable expectation is defined as an individual that has applied for Social Security disability insurance (SSDI) benefits, been denied SSDI but anticipates appealing that decision, is in the process of appealing and/or refilling for SSDI, is 62 years and six months old (*i.e.*, may be eligible for Medicare based upon his/her age within 30 months), or has end stage renal disease condition, but does not yet qualify for Medicare based upon the condition.

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