Protecting Medicare's Future Interest When CMS Declines to Review MSA Proposal:

Schexnayder and Smith

Two recent orders from the United States District Court provide new guidance on how settling parties may achieve absolute Medicare compliance when the Centers for Medicare and Medicaid Services ("CMS") chooses not to review a Medicare Set-aside Arrangement ("MSA") proposal. In both cases, the Court approved the parties' settlement absent CMS approval of the MSA (a condition precedent to final settlement of each) and ordered the MSA be funded for the amount of the MSA proposal submitted to CMS for review and approval. This Practice Tip 1) provides a brief synopsis of Schexnayder v. Scottsdale Insurance Company[1] and Smith v. Marine Terminals of Arkansas[2], 2) describes the potential impact these decisions likely will have on the submission of MSA proposals to CMS going forward and 3) demonstrates how these orders fit with CMS' stated policy about submitting MSA proposals to CMS for review and approval.

Schexnayder Procedural History

Robert Schexnayder was injured in the course and scope of his employment on June 17, 2009. Mr. Schexnayder sustained significant back injuries while driving a truck owned by his employer. Past medical expenses totaled $377,308.80. Of that amount, $151,797.20 was paid by the workers' compensation insurance carrier, which also agreed to pay an additional $43,464.04 based on the terms of the settlement agreement. The balance was privately funded, and Medicare made no conditional payments. The parties agreed to a settlement during mediation on March 22, 2011. Part of the consideration of the settlement was that Mr. Schexnayder would be solely responsible for protecting Medicare's interests under the Medicare Secondary Payer statute.[3] Additionally, Mr. Schexnayder agreed to settle the workers' compensation ("WC") claim, which was approved by the Louisiana Office of Workers' Compensation. Under the terms of that agreement, the WC insurer and the employer were given a full release.

At the time of settlement, Mr. Schexnayder was not a current Medicare beneficiary. Further, Mr. Schexnayder did not possess a "reasonable expectation" of Medicare enrollment within thirty (30) months of settlement.[4] When settling the WC claim, the parties concluded that no MSA was needed since Mr. Schexnayder lacked the requisite Medicare enrollment status warranting an MSA to be

[1] Schexnayder v. Scottsdale Insurance Company, 2011 U.S. Dist. LEXIS 83687 (July 29, 2011).

[2] Smith v. Marine Terminals of Arkansas, 2011 U.S. Dist. LEXIS 90428 (August 9, 2011).

[3] 42 U.S.C. §1395y(b)(2).

[4] According to CMS, a claimant lacks a "reasonable expectation" of Medicare enrollment within thirty (30) months of settlement if a claimant has not yet applied for Social Security Disability Income ("SSDI") benefits, is younger than age 62 ½ years old and does not possess End Stage Renal Disease.

established. As a condition of settling the liability claim, Mr. Schexnayder agreed to set funds aside to protect Medicare's interest under the MSP statute. An MSA vendor created an MSA proposal totaling $239,253.84 to address the MSA issue as part of the liability settlement. As an additional condition to settlement, this MSA proposal was to be submitted to CMS for review and approval, and final settlement was conditioned upon CMS approving the MSA proposal. Ultimately, CMS did not review the MSA proposal and provided no feedback to the parties, leading the parties to file the joint motion seeking settlement approval from the Court.

Smith Procedural History

Billy Smith settled claims brought under the Longshore and Harbor Workers' Compensation Act for injuries sustained while working as a truck driver aboard a floating barge on April 14, 2006. Prior to settlement, the defendant has engaged an MSA vendor to prepare an MSA Allocation. That allocation totaled $313,095.54 and was to be used solely for future injury-related care otherwise covered by Medicare. Mr. Smith, displeased with the amount of that MSA Allocation, wanted to engage another MSA vendor to review his case. As a condition of settlement, Mr. Smith agreed to engage the Garretson Resolution Group ("GRG") to review the MSA issues, prepare an MSA Evaluation and then submit that MSA Evaluation to CMS for review and approval. The GRG MSA Evaluation concluded that an MSA totaling $14,647 was the appropriate amount to protect Medicare's future interest. The GRG MSA Evaluation was submitted to CMS for review and approval. Ultimately, CMS decided not to review the proposal, citing its workload review threshold for its reason not to review the MSA Evaluation. The parties sought settlement approval from the Court absent CMS review and approval of the MSA Evaluation.

Case Synopses.

In both Schexnayder and Smith, CMS review and approval of the MSA proposal was a settlement condition. CMS declined to review the MSA proposal in either case. Each Court, upon reviewing the MSA proposals in light of the evidence presented, agreed that Medicare's future interest would be protected by funding the MSA in the amount set forth in each MSA proposal.

In Schexnayder, the Court found that CMS does not currently require or approve MSAs when settling a personal injury action. It also found that Mr. Schexnayder had become an "entity who received payment from a primary plan," and, as a result, was responsible as a primary payer for future medical expenses which were injury-related and otherwise covered by Medicare. Thus, the Court approved the liability MSA totaling $239,253.84.

In Smith, the Court reviewed the "comprehensive and detailed analysis by the Garretson Resolution Group supporting its determination of this MSA." It also found that it was reasonable for Mr. Smith to engage GRG to provide "a professional analysis and determination of the projected Medicare Set Aside allocation. The court finds that the Garretson Resolution Group's determination of the MSA of $14,647.00 and the supporting rational are reasonable."

Potential Impact

Schexnayder and Smith support the fact settling parties may fund an MSA and adequately protect Medicare's interest without obtaining CMS approval of the MSA proposal. The cases also reinforce the fact that submission of an MSA to CMS for review and approval, both in the WC context as well as the liability context, is voluntary and not mandatory, following CMS' guidance from its policy memorandum dated May 11, 2011. Further, both cases remind us to take notice of the well-

established precedent that the judiciary is hesitant to disturb a settlement agreed upon by the parties unless required to do so.

However, these cases should also serve as cautionary tales to the settlement community. Parties should understand that having CMS approval of an MSA as a settlement condition is likely to lead to settlement delays (at best) and failure to meet a condition to settlement (at worst). While obtaining CMS approval of an MSA proposal remains the only guaranteed method by which to ensure CMS agrees with the MSA evaluation, Schexnayder and Smith remind us that asking for, but not receiving such approval, will further complicate the settlement process. What should not be lost in these case analyses is the role a third party can play to ensure absolute Medicare compliance.

Schexnayder and Smith provide excellent litmus tests for how involving neutral third parties to assess and lend guidance on the MSA issues can ensure such compliance. Each court's ratification of the MSA evaluations proves the point – CMS and even court approval may not be needed if the settling parties adopt a formalized process to address Medicare compliance issues, including MSAs. At the same time, seeking court approval of a settlement where CMS does not review an MSA allocation has the potential to further clog judicial dockets. Unless the settling parties have a contingency plan in effect to take into account the possibility (or perhaps even the likelihood) that CMS will not review an MSA proposal in their settlement, the parties may find themselves in the same precarious position as did the parties in Schexnayder and Smith.

MSA Takeaway

Following court decisions in the Fall of 2010, this year we continue to see the judiciary adding its input to the MSA debate. In both state[5] and federal[6] courts, we have seen the judiciary taking a more active role where MSA questions are involved because the parties cannot seem to agree, in some cases, on what is required of them to achieve MSP compliance. While seeking judicial guidance on liability issues provides a measure of certainty to the parties, it also represents an untenable solution going forward for all cases, as federal and state court dockets across the country may not have the bandwidth to address these Medicare compliance issues.

So what should the settling parties do? In settlements (or litigations leading to judgments) a key question for all parties to ask is the following: Is an MSA needed to protect the Medicare beneficiary's card under the case specific facts? Typically, when a claim is resolved, whether through jury verdict or settlement agreement, if the plaintiff will incur future medical expenses as a result of the injuries pled or claimed in the case, the parties should determine whether an MSA would be appropriate. It is important that the parties complete a good faith analysis of this issue. By making this determination and then documenting the file accordingly, three things result:

i. Medicare's future interest is considered and protected appropriately;
ii. The parties are compliant with the MSP and all associated regulations; and
iii. The beneficiary's Medicare benefits are protected going forward.

[5] Hinsinger v. Showboat Atlantic City, 2011 N.J. LEXIS 96 (January 21, 2011).

[6] See Schexnayder and Smith. See also Big R. Towing v. Benoit, Civ. Action No. 10-538, 2011 WL 43219 (W.D. La. Jan. 5, 2011) and Finke v. Hunter's View, Ltd., 2009 WL 6326944 (D. Minn. Aug. 25, 2009).

Every case (liability, workers' compensation or no-fault) needs to be screened to identify which Medicare interests need to be resolved. Following screening, for those cases that qualify, the parties should evaluate damages to identify whether there is a future cost of care component (allocation) to the settlement, and a burden shift of the payment and management of that future care over to Medicare. As part of developing an absolute Medicare Secondary Payer compliance mindset, each settling party should know what role is to be played for three distinct obligations, two of which arise on the part of plaintiffs and one the defendant:

Plaintiffs / Claimants

- Verify, resolve and satisfy any past conditional payments made by Medicare; and
- Consider how best to address any future interests Medicare would have in not paying for future injury-related care.

Defendants / Insurers

- Electronically report liability settlements or judgments to Medicare starting Oct. 1, 2011 (following Section 111 of the MMSEA).

The Garretson Resolution Group continues to closely monitor how decisions such as Schexnayder and Smith affect settlements and future cost of care issues such as MSAs. Please see our website at www.garretsongroup.com for resources such as White Papers, articles and other practice tips related to Medicare Secondary Payer. To view a copy of the Schexnayder decision, click here. To view a copy of the Smith decision, click here.