CATTIE, P.L.L.C.

A HIGHER STANDARD IN MSA COMPLIANCE

Protecting Medicare Benefits in 2019

Introduction.

Personal injury victims are fragile. Sure, some would not like to admit that. The fact is they have been injured, sometimes catastrophically. Often, they are injured through no fault of their own. They are but one person, fighting against a system which may be tilted against them. The fight to recover what they lost is physically, mentally, and emotionally draining.

They hire an attorney to represent them and achieve the justice they seek. That attorney often focuses on the big picture, how much they can get for their client. He does his best to help make the client whole again. Sometimes lost in that fight against the system, however, are minor details which, in reality, are major concerns to the victim. If only the victim realized how major those minor details are before it's too late.

Take future Medicare coverage for example. While an attorney may think about when and how to protect a client's future Medicaid benefits as part of settling a case, that same attorney seldomly thinks to protect a client's future Medicare benefits as part of settling a case. This oversight could dramatically and adversely affect the client, the attorney and the law firm. This article will: 1) describe the differences between Medicare and Medicaid benefits; 2) provide situations where a client's future Medicare benefits could be threatened; and 3) detail why working with outside counsel to protect your client's future Medicare coverage is the best choice of action. Future Medicare coverage is not a given. Personal injury attorneys must proactively address a client's future Medicare coverage to ensure the worst does not occur on their watch.

Medicare versus Medicaid.

For many practitioners, the terms "Medicare" and "Medicaid" are interchangeable. Both were created in the mid 1960s under Title XIX of the Social Security Act. Both are funded by the federal government. Both are overseen by the Centers for Medicare & Medicaid Services ("CMS") under the direction of the United States Department of Health & Human Services ("HHS") and the Secretary of HHS (the "Secretary"). Both provide health insurance coverage for vulnerable groups of individuals who may have no viable healthcare insurance options. This is where the similarities end.

In fact, Medicare and Medicaid are separate and distinct federal insurance programs. Congress created Medicare pursuant the Medicare Act. *42 U.S.C. § 1395*. Congress created Medicaid at the same time, but under an entirely different statute. *42 U.S.C. § 1396*. Medicare is an entitlement-based program while Medicaid is a needs-based program. One can become eligible for Medicare by virtue of their age, a disability or certain special qualifiers like ALS or End-

Stage Renal Disease. A person becomes Medicaid eligible when their monthly income fails to meet a certain maximum threshold.

As of October 2018, there were approximately 60,002,236 Medicare beneficiaries in our country. *https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Dashboard/Medicare-Enrollment/Enrollment%20Dashboard.html* (last visited December 1, 2018). As of September 2018, there were approximately 72,966,179 Medicaid beneficiaries in our country. *https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html* (last visited December 1, 2018). An individual can be enrolled in Medicare, Medicaid, or both programs simultaneously.

Protecting Medicaid Benefits Through a Personal Injury Case.

Many plaintiff attorneys understand that a settlement or judgment in their client's favor jeopardizes the client's future Medicaid benefits. Most settlements or judgments likely exceed the Medicaid maximum monthly income threshold ($2,250/month for single residents of Louisiana). Upon receipt of those proceeds, the client is disqualified from Medicaid eligibility. The same is true if the attorney first received those same proceeds in their client trust account. For Medicaid eligibility purposes, constructive receipt equals actual receipt. Under either scenario, the client would not be eligible for Medicaid going forward.

Prudent attorneys take proactive steps to protect a client's Medicaid card. The attorney will ask the client if they want to protect their Medicaid eligibility in the event there is a settlement or judgment in their favor. If the client says 'no', the attorney should document that in the file. The attorney should then ask the client to execute some type of Medicaid disclosure form affirming that decision. The client attests to the fact that they understand the ramifications and repercussions for the failure to take proactive steps to protect Medicaid benefits before receiving settlement proceeds (either by them or their attorney). Once signed, the attorney keeps this in the file to protect themselves in the unlikely event that the client later asks questions about why they cannot use Medicaid insurance post-settlement.

When a client does want to protect their future Medicaid benefits, the attorney has work to do. They must ensure to avoid constructive receipt of the settlement proceeds, or present the client with appropriate spend down options upon receipt of proceeds to meet eligibility requirements. To avoid constructive receipt of the settlement proceeds, the attorney has options. He should consider vehicles which would allow for the receipt of proceeds without those proceeds being attributed to the client. The most popular option in 2019 remains the Special Needs Trust.

A Special Needs Trust ("SNT") protects a client's future Medicaid eligibility. A SNT is a trust created for the benefit of a disabled individual. It contains terms and conditions recognized under federal and state laws which exempt SNT assets from being counted toward the individual's eligibility for needs-based public assistance. SNTs can be called many things, but there are three basic types: Third Party Special Needs Trusts; Non-Pooled Special Needs Trusts; and Pooled Special Needs Trusts. SNTs will have a trustee served as the administrator of the SNT, making

decisions for the benefit of the beneficiary of the SNT. For years, SNTs have been the most popular vehicle to protect a client's future Medicaid benefits.

Recently, an alternative vehicle has gained popularity for certain cases. The Achieving a Better Life Experience ("ABLE") Act was signed in law on December 19, 2014. *26 U.S.C. § 529A*. Accounts created pursuant to the ABLE Act allow certain injured individuals with special needs to have a tax-free savings account without jeopardizing their Medicaid eligibility. *Id.* ABLE accounts may be a viable alternative to protecting a client's Medicaid eligibility so long as the client became severely disabled before they reached age twenty-six (26). *Id.* ABLE accounts made be less restrictive than SNTs, but it is more difficult to qualify for an ABLE account.

Finally, the client may choose a spend down option to preserve Medicaid eligibility. Spending down describes the process by which a Medicaid-enrolled client may use excess proceeds in order to get below the monthly maximum allowable resource limit. To ensure uninterrupted Medicaid coverage, that spend down must occur in the same month in which settlement proceeds are received. Items which are typically bought in a spend down may include but are not limited to a house (or paying off the mortgage of a then currently owned house), home furnishings/appliances, credit card debt or vehicles.

No matter whether one chooses a SNT, an ABLE account or a spend down, significant analysis and planning is needed to protect the client's future Medicaid eligibility. Thus, the question asked of the Medicaid enrolled client early on in the case is "Do you want to protect your Medicaid benefits as part of resolving your case?" It is reasonable to think that the same question is warranted with respect to future Medicare benefits, assuming that the potential exists for the Medicare enrolled client to lose their future Medicare benefits.

Future Medicare Obligations Under the Medicare Secondary Payer Act.

Far fewer attorneys think to proactively protect a client's Medicare benefits in a personal injury settlement. In reality, the client is at risk of a loss of Medicare benefits when resolving a personal injury case just as they risk losing their Medicaid benefits. The difference is that potential loss of benefits is not immediate upon receiving settlement proceeds. Instead, that loss occurs weeks, months or even years after a personal injury settlement is finalized.

The law practitioners should consider is the Medicare Secondary Payer ("MSP") Act. *42 U.S.C. § 1395y(b)(2).* The MSP Act broadly prohibits Medicare from making payment for medical expenses where payment has been made or can reasonably be expected to be made under a workers' compensation plan, an automobile plan, a liability insurance plan (including self-insurance) or a no-fault plan. *42 U.S.C. § 1395y(b)(2)(A)(ii).*

The MSP Act imposes a two-step obligation. First, Medicare is prohibited from paying for an item, service or expense when payment "has been made … under a liability insurance plan…" *42 U.S.C. § 1395y(b)(2)(A)(ii).* Second, Medicare is prohibited from paying for an item, service or expense when payment "can reasonably be expected to be made … under a liability insurance plan…" *Id.*

The concept of 'payment' in the MSP Act has dual meanings. The first half of the statute refers to Medicare making a payment. That specific payment is one Medicare makes on behalf of its beneficiary when a provider submits a bill to Medicare for reimbursement after the provider treats the client. The second half of the statute refers to situations where payments have been made or can reasonably be expected to be made. *Id.* There, the specific payment is one made by the insurance carrier or self-insured entity. That is payment of the settlement proceeds (or the judgment, if applicable). When the liability insurance carrier or self-insured has paid or is reasonably expected to pay, Medicare is barred by statute from paying medicals on behalf of the client.

There is one exception to this broad statutory prohibition known as a "conditional payment." Congress authorized the HHS and the Secretary to make a conditional payment on behalf of a Medicare beneficiary when payment has not been made and cannot reasonably be expected to be made. *42 U.S.C. § 1395y(b)(2)(B)(i).* The Secretary delegates the task of making conditional payments and running the MSP program to CMS.

All payments made by Medicare for a beneficiary's medical care come with a caveat. That caveat is the conditional payment exception to the MSP Act. Under certain circumstances, CMS has a right to recover any conditional payments made. However, this recovery right is not automatic.

Two (2) things must occur for CMS to recover a conditional payment. First, a primary plan or payer must accept responsibility for a client's medical expenses. Second, that responsibility must be evidenced by a judgment, a compromise for release, or other means. *42 U.S.C. § 1395y(b)(2)(B)(ii).* Unless both events occur, CMS has no right of recovery for conditional payments.

Personal injury settlements often trigger the conditional payment exception. The parties involved (the client and the liability insurance carrier or self-insured) will agree on a sum certain dollar amount which the defendant will pay the client. In exchange for this payment, the client will agree to provide the defendant with a general release of all claims. That general release will include all damage categories for which the client has asked or demanded compensation. Those damage categories may include medical expenses, and those medical expenses may include past and/or future medical expenses.

When this occurs, a primary plan or payer (*i.e.*, the defendant) accepts responsibility (though not necessarily liability) for the client's medical expenses. The settlement release drafted and executed by the parties will then detail the terms of the settlement agreement, including the fact that the defendant is paying a gross award to the client in exchange for the client providing the defendant with a release of the claim for medical expenses. At that point, both criteria under the MSP Act are satisfied, triggering Medicare's priority right of recovery.

This diagram may be helpful to process what is happening:

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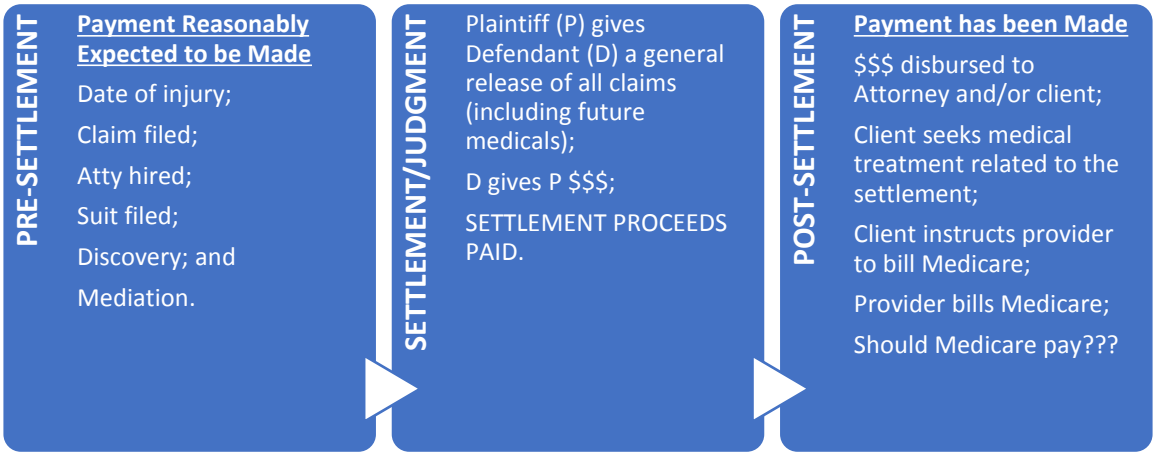


Dangers Facing Attorneys Who Ignore the Future Medicare Issue.

With respect to protecting a client's future Medicare benefits under the MSP Act, here is the applicable language to which attorneys must pay particular attention:

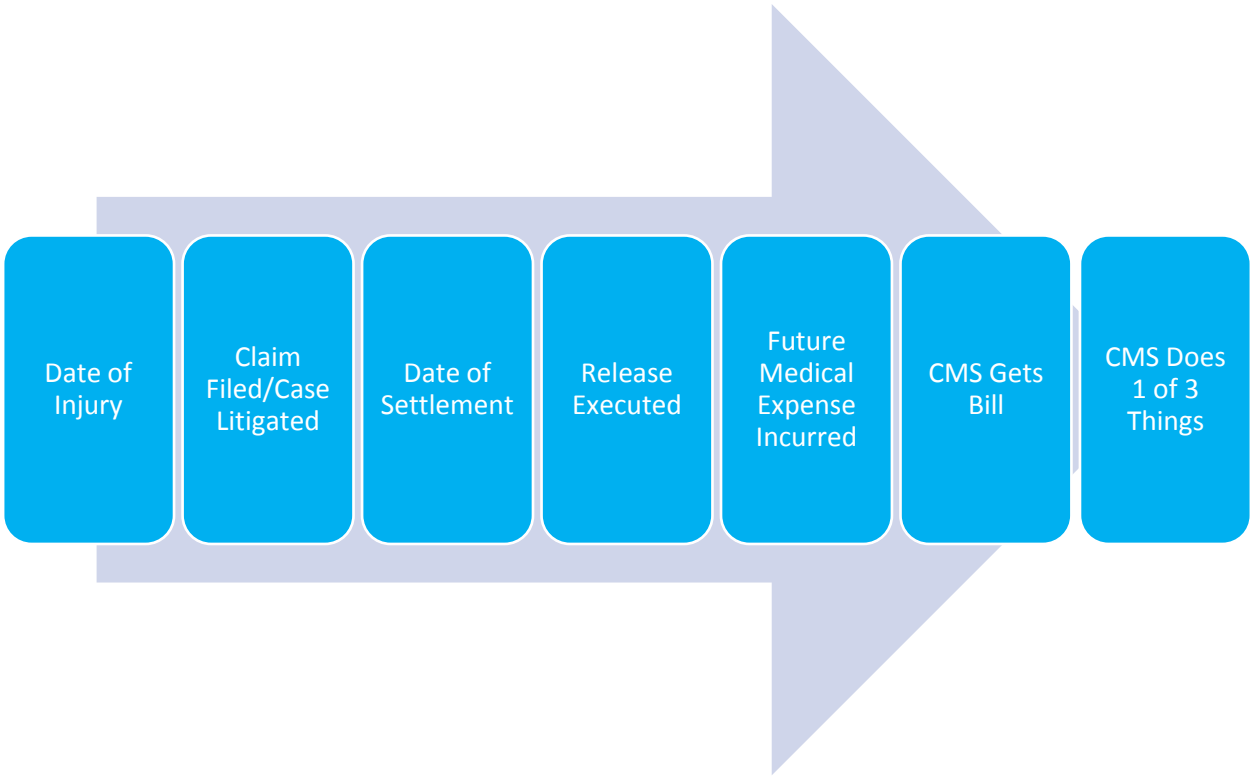
"Payment under this subchapter may not be made, except as provided in subparagraph (B), with respect to any item or service to the extent that … payment has been made … under a liability insurance policy or plan (including a self-insured plan) …" *42 U.S.C. § 1395y(b)(2)(A)(ii).*

The conditional payment exception can apply post-settlement just as it does pre-settlement. When a client resolves a personal injury case involving future medical expenses and receives dollars from the defendant paying them for certain future medical expenses, Medicare is prohibited by statute from making payment for those same future medical expenses for which the client received compensation. There, if: 1) the plaintiff receives treatment; 2) the provider bills Medicare; and 3) Medicare mistakenly pays the bill, then an overpayment situation would be created. Some other party, not Medicare, is responsible for that overpayment. The law provides Medicare the ability to seek recovery of that overpayment.

Ignoring minor details can lead to major problems in the future. Attorneys who fail to address future Medicare eligibility with a client endanger the client, the attorney, and the firm. Take the hypothetical example of Attorney Tucker Jackson and his client, John Anson.

Mr. Anson was injured in a motor vehicle accident. Due to the negligence of another driver, he tore his rotator cuff. Anson hired Jackson after seeing his TV ad where Jackson promises, "We will get the justice you deserve."

By all accounts, Jackson gets a great result for Anson. Anson agrees to settle his case for $600,000. Anson and the insurance carrier execute a general release of all claims, including Mr. Anson's future medical claim. Jackson however failed to speak with Anson about Anson's future Medicare benefits. He disburses funds to Anson. About three (3) months later, Anson visits the doctor for treatment on his torn rotator cuff. Anson, now a Medicare beneficiary, tells his doctor to bill Medicare for the visit.



Three (3) potential scenarios arise when a former client like Anson instructs a medical provider to bill Medicare for future medical care related to the former client's settlement. First, Medicare receives the bill from the medical provider and pays that bill, no questions asked. That scenario has occurred for years, and will likely continue until HHS provides CMS with proper funding to track and police this activity fully. Second, Medicare gets the bill from the medical provider, but rejects the bill. Here, Medicare is able to identify that someone else is responsible for the bill. It rejects the bill, and instructs the provider to collect payment from the patient (a/k/a former client). Third, Medicare gets the bill, Medicare pays the bill and later realizes that it was not

responsible for payment of the bill. That bill was someone else's responsibility. It is this overpayment scenario which should most concern the attorney.

In that overpayment scenario, Medicare would have a right of recovery under the MSP Act against the party responsible for the bill. *42 U.S.C. § 1395y(b)(2)(A)(ii)*. The party responsible for that bill, based on the terms of the settlement agreement previously agreed to by the former client, is the former client. CMS has a right of action to recover its payments from any entity, including a beneficiary or attorney who has received a primary payment. *42 C.F.R. § 411.24(g)*. Thus, Medicare would have the right to seek repayment from the former client for the amount of the overpayment as well as that former client's attorney. *Id.* That repayment may also come with interest. *Id.*

The MSP Act also authorizes Medicare to collect up to double the amount of the overpayment. *42 U.S.C. § 1395y(b)(2)(B)(iii)*. This is the "double damages" provision of the MSP Act. The federal government may bring an action against any entity that is responsible to make payment for that medical expense which is the subject of the overpayment. *Id.* The MSP Act goes on to grant the federal government the right to collect double the amount of the medical expense. *42 U.S.C. § 1395y(b)(3)(A)*. Therefore, the exposure for a client who fails to ensure that Medicare is not billed prematurely for future injury-related care could total double the amount of the bill itself (plus interest). *Id.* The MSP Act provides Medicare with broad discretion to recover conditional payments from former clients and attorneys when it makes those payments post-settlement.

To recover that overpayment, Medicare would send the former client a letter. In that letter, Medicare would advise the former client that it paid certain medical bills in error, that the former client was responsible for those bills due to a personal injury settlement, and Medicare is seeking to recover against the former client. For the former client, this will come out of left field. He will be confused, frightened and angry. He will seek answers. He will call his personal injury lawyer.

The personal injury lawyer fielding that phone call has few options. He did not ask the former client if he wanted to protect his future Medicare benefits as part of the personal injury settlement. He did not advise the former client of the potential for Medicare to seek recovery of medical payments made on his behalf post-settlement. He did not get written acknowledge from the former client that the former client understood the ramifications and repercussions of the failure to proactively protect his future Medicare benefits. For the personal injury lawyer, he faces two (2) likely scenarios: 1) a legal malpractice action files by the former client; or 2) being reported to the state bar ethics committee by the former client. Either way, it seems certain that any adverse actions will ultimately land back in the attorney's lap.

False Claims Act: Medicare's Nuclear Option.

Medicare has one more statute it could leverage to achieve repayment. Medicare, through the United States Department of Justice ("USDOJ"), could allege violation of the federal False Claims Act ("FCA"). *31 U.S.C. §§ 3729, et seq.* Though it's uncommon, Medicare is choosing this option with more regularity. Plaintiff practitioners must understand how a Medicare overpayment situation could morph into an FCA case. More importantly, they must know how to avoid that catastrophic possibility.

The FCA is a statute which deters bad actors from perpetrating fraud against Medicare. Liability under the FCA arises, in part, from an actor's attempt to conceal or avoid an obligation to pay the federal government. The FCA defines a false claim like this: "any person who … knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000 … plus three times the amount of damages which the Government sustains because of the act of that person." *31 U.S.C. § 3729(a)(1)(G).* Pursuant to Section 701 of the Bipartisan Budget Act of 2015, revising prior provisions of the Federal Civil Monetary Penalties Inflation Act of 1990, FCA penalties in 2018 rose to between $11,181 and $22,363 per false claim. *28 U.S.C. § 2461.*

The FCA permits private persons known as relators to file civil actions known as qui tam actions to recover damages on behalf of the United States from any person who: (1) knowingly presents, or causes to be presented, to an officer or employee of the United States government … a false or fraudulent claim for payment or approval; (2) Knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the government." *31 U.S.C. § 3729(a)(1)-(2).*

Now recall reimbursement obligations under the MSP Act. The statute mandates that a plaintiff "shall reimburse …for any payment made … with respect to an item or service if it is demonstrated that … [a] primary plan has … responsibility to make payment with respect to such item or service." *42 U.S.C. § 1395y(b)(2)(B)(ii).* The knowing avoidance by a practitioner of any obligation to repay Medicare for conditional payments constitutes a false claim under the FCA. Specific to the "knowing" or "scienter" element under the FCA, knowledge may include reckless disregard or deliberate ignorance. *31 U.S.C. § 3729(b).* Certainly, it could be said that some practitioners demonstrate reckless disregard and/or deliberate ignorance when it comes to protecting a client's future Medicare benefits.

Recently, Medicare chose this avenue to recover conditional payments from an attorney. A plaintiff personal injury law firm in Pennsylvania (the "Firm") did not adhere to the MSP Act and its statutory obligations. According to the USDOJ, the Firm was settling cases for Medicare enrolled clients without addressing MSP reimbursement obligations. . https://www.justice.gov/usao-edpa/pr/philadelphia-personal-injury-law-firm-agrees-start-compliance-program-and-reimburse (*last visited December 4, 2018*).
Over time, Medicare discovered these debts. It then asserted its recovery rights against the beneficiary and/or Firm for those conditional payments. *42 U.S.C. § 1395y(b)(2)(B)(ii).* Ultimately, Medicare referred the matter to USDOJ when the debt remained unresolved. *42*

U.S.C. § 1395y(b)(3). From there, it was a matter of time before the USDOJ used all possible avenues to get the Firm to pay.

The Firm and the USDOJ ultimately agreed to the following: 1) the Firm repays Medicare a lump sum amount of $28,000; 2) the Firm has one person internally in charge of paying all MSP debts on behalf of the Firm's clients; 3) the Firm trains that employee so that all MSP debts are handled in a timely manner; and 4) the Firm reviews any outstanding debts with that designated employee every six months or less to ensure MSP compliance. If the Firm erred again, the USDOJ reserved the right to use the FCA to penalize the firm. https://www.justice.gov/usao-edpa/pr/philadelphia-personal-injury-law-firm-agrees-start-compliance-program-and-reimburse (*last visited December 4, 2018*).

The press release from the USDOJ makes clear the serious nature of these offenses. Of note and concern to attorneys should be the amount of the settlement. Here, the USDOJ appears willing to use the FCA against the Firm when it has settled for $28,000. In the grand scheme of things, $28,000 is not a large amount for a Medicare conditional payment obligation, especially considering the amount is intended to resolve more than one debt owed. Some readers will think about those cases where they had one case where the debt owed was $28,000 or more. Application of the FCA to MSP debts does not appear to be limited to only the "big ones."

It cannot be said that the USDOJ's potential use of the FCA in the MSP context comes without warning. According to former Assistant U.S. Attorney Robert Trusiak, in an open letter written to the Western New York bar, the words of the MSP statute provide that Medicare "shall be reimbursed for the medical expenses upon a tort settlement involving a Medicare beneficiary." *Letter, Trusiak: State courts not an out on MSP, Robert Trusiak, Assistant U.S. Attorney, dated March 25, 2010.* The federal government's "commencement of suit for the failure to secure an administrative adjudication from CMS concerning the existence and/or amount of the repayment obligation" shares the two important litigation goals of "deterrence and punishment." *Id.* As explained by Trusiak: "It may be necessary for the United States to pursue its double damage remedy in federal court to vindicate these litigation goals of deterring MSP misconduct by others and punishing MSP violations for the continued recklessness in failing to pursue an administrative adjudicatory. It is important to recognize any federal double damages suit will address the panoply of MSP misconduct by the practitioner rather than address only a single case." Attorneys are advised to head the warnings from CMS about MSP debts so the USDOJ does not use them as a national example for the sake of deterrence and punishment.

How to Protect a Client's Future Medicare Benefits in a Personal Injury Settlement.

The penalty potential for attorneys is concerning, but a simple remedy exists. ***Ask the client if they want to protect their future Medicare benefits as part of resolving the personal injury case***. We ask that question of clients receiving Medicaid. There's absolutely no reason not to ask the same question when it comes to Medicare.

> *"Do You Want to Protect Your Medicare Benefits?"*

When you ask the client that critical question, the client will respond either affirmatively ("yes, I want to protect my future Medicare benefits") or negatively ("no, I do not want to protect my future Medicare benefits"). When the client says they do not want to protect their future Medicare benefits, you need to get that in writing. Create an MSP Future Medicals Disclosure Form that you review with the client at the disbursement conference. It should contain a bullet point list of the ramifications and repercussions of the failure to take steps to protect their future Medicare benefits. You should include discussion of the penalties and sanctions mentioned above. Have the client sign the form and keep it in the file. If they do lose Medicare coverage in the future due to improper billing to Medicare, you are likely to get a call from the then former client. This executed form becomes your best evidence of counseling the client appropriately when you face a legal malpractice action or inquiry from your state bar's ethics committee. If you do not want to re-create the wheel and create a form, feel free to email me at jcattie@cattielaw.com and my firm will provide you with a complementary template form you can modify to fit your case-specific facts. **We consider incorporating discussion of this form into your disbursement conference an MSP best practice tip for personal injury attorneys**.

"Do You Protect Future Medicare Benefits or Do You Seek Outside Help?"

When the client wishes to protect their future Medicare benefits, the next question you must answer is critical. The question is "Will you take steps to protect those benefits yourself or will you seek outside help to protect your client's Medicare benefits?" If you decide to handle the issue yourself, understand the delicate balance you must strike in protecting those benefits.

On one hand, you cannot rely solely on a nurse's calculation of future medical costs anticipated to be incurred by the client post-settlement. That calculation assumes recovery of 100 cents on the dollar for the client's damages. Certainly, that never happens when you settle a personal injury case. You always recover anywhere between a penny ($0.01) and ninety-nine cents ($0.99) on the dollar for those damages. The only time it can be said that you may recover full value for a client's future medicals is when a case proceeds to trial, and a trier-of-fact renders a verdict in your favor. Just because a client might need certain future medical care does not mean he is compensated for that care as part of the settlement.

On the other hand, you cannot say automatically that your client was not compensated anything for future medicals within the lump sum settlement award. In a case where: 1) you pled for future medicals; 2) the client will need future medicals post-settlement; and 3) future medicals are a damage component being released, the lawyer would need some evidence that, in fact, he was not receiving compensation for future medicals.

To address this issue on your own for your client, you need to answer two (2) questions. First, has payment been made for Medicare covered future medicals within the settlement/judgment/award? Maybe it has, maybe it hasn't. In the event of a policy limits settlement or a case with highly disputed liability, perhaps you can get to a conclusion that finds no payment is being made. However, you will want to be able to prove that conclusion quantitatively. You'll need the numbers in your case to back that conclusion if it stands a chance of passing muster at a later date if challenged by CMS. No matter how good of an attorney you are, telling Medicare, a judge, or a state bar's ethics committee that "your gut told you so" simply won't suffice.

The second question is if payment is being made for future medicals within the settlement, then how much is that? Again, to answer this question, the numbers make all the difference. What amount represents full value for your client's damages? Think about what full value of your case might be if you had your best day in court. What would a jury award and how would they get to that conclusion? Now, how much are you settling the case for? What are your past medical expenses? Of that, what needs to be reimbursed in the form of liens for past medicals? Does the case have any wage loss or loss of earning capacity component? What about non-economic damages? Most states permit the recovery of non-economic damages such as pain & suffering, mental anguish, loss of enjoyment of life, etc. as part of a personal injury case. What about your fees, costs and expenses? The MSP regulations provide for a procurement cost offset to Medicare's recovery under certain circumstances. *42 C.F.R. § 411.37.* Also remember that not all medical expenses are covered by Medicare. *See 42 U.S.C. § 1395(y)(a) and 42 C.F.R. § 411.15.* All of these factors and more are relevant to how you answer that second question.

It's important to understand that amount must be something less than full value of your client's future medicals. A medical record review (such as those contained in life care plans, medical cost projections, etc.) are great tools to build your case value and drive a higher settlement figure overall. But they are much less effective at predicting accurately what portion of a settlement is payable for future medicals versus other damages pled. It simply does not (nor should it) account for confounding factors to full recovery such as disputed liability, disputed causation or policy limit scenarios.

Even once you identify that amount, more questions remain. What vehicle is best to ensure that Medicare is not billed prematurely? What are the possible funding options? What are the possible administrative options? Do you need to ask Medicare to review/approve your conclusions? Is there a way to obtain a judicial allocation on the merits that would bind Medicare to your conclusions with certainty? The client is likely to ask these and other questions when you tell them a certain portion of their settlement proceeds must be spent on their future medical needs otherwise covered by Medicare.

As your client's attorney, your job is to provide them sound legal advice on which they can rely. In fact, your state likely has an ethics rule similar to Rule 1.4(b) of the Model Rules of Professional Conduct. "A lawyer shall explain a matter to the extent reasonably necessary to permit the client to make informed decisions regarding the representation." https://www.americanbar.org/groups/professional_responsibility/publications/model_rules_of_professional_conduct/rule_1_4_communications/ (*last visited* December 4, 2018). In the context of protecting a client's future Medicare benefits, you must be able to counsel them upon receipt of an offer to settle. How can the client understand the potential impact on their future Medicare benefits of accepting the offer unless you advise them of that potential impact? The client won't know, and should not be expected to ask the question himself.

Finally, for those of you willing to counsel the client yourself about this issue, be prepared to revisit the issue with the client years later. Given the issue at hand, it is likely that if the client will need to speak with you about this again, it will be months or years down the road. It will come in the form of a letter they receive from Medicare about repayment of certain bills or denial of coverage for certain medical expenses. As counsel of record, you must be prepared to

address that issue on behalf of your then former client. That includes counsel in the face of an action by the federal government against your former client. Said another way, you must be willing to stand behind the legal advice you provided your client at the time of settlement. Are you willing to do that?

The alternative to handling the issue yourself is to seek outside help. Given the specialized focus of protecting a client's healthcare benefits and the number of factors going into how to advise the client, ego might be the only thing standing in the way of the prudent practitioner from seeking outside help.

> *"When You Seek Outside Help, Will That Help be Legal Advice from a Lawyer or Non-Legal Advice from a Vendor?"*

If the personal injury attorney does decide to seek outside help, one question remains. "Will that outside help consist of legal advice from a lawyer or non-legal advice from a vendor?" That answer could have profound effects in the short term and long term.

When you hire a law firm to obtain legal advice about any issue (healthcare coverage or otherwise), that relationship bestows certain protections. For example, attorney-client privilege applies to communications between that law firm and the client seeking the firm's legal advice. Also, work product privilege applies to the documents, reports and opinions prepared by the law firm on behalf of the client. Vendors can provide clients with neither attorney-client privilege nor work product privilege as part of the engagement. As a result, communications and reports are discoverable. That could be an issue for a plaintiff attorney seeking justice for the client.

Clients seeking legal advice may rely on that legal advice going forward. If the client relies on that legal advice to their future detriment, the client has recourse against the firm providing that legal advice. They may sue the law firm providing the erroneous advice for legal malpractice or may report the attorney/firm providing the erroneous legal advice to the appropriate state bar. Justifiably, law firms providing bad legal advice face consequences.

The same cannot be said for vendors. Some vendors say they will stand behind their conclusions in this area. Some will offer insurance-type products that purport to protect the client from adverse decisions and actions by CMS in the future. Some might even follow through with those promises when push comes to shove. If you choose to obtain vendor advice in this area, ask them to put in writing their willingness to back their conclusions. What will it do if Medicare seeks additional future medical dollars from the client in the future? Legal advice from lawyers provides stronger and more consistent protection for those who seek outside assistance in protecting a client's future Medicare benefits.

To summarize the thought process you must follow when thinking about protecting a client's future Medicare benefits in a personal injury settlement, those are containing in the following flow chart:

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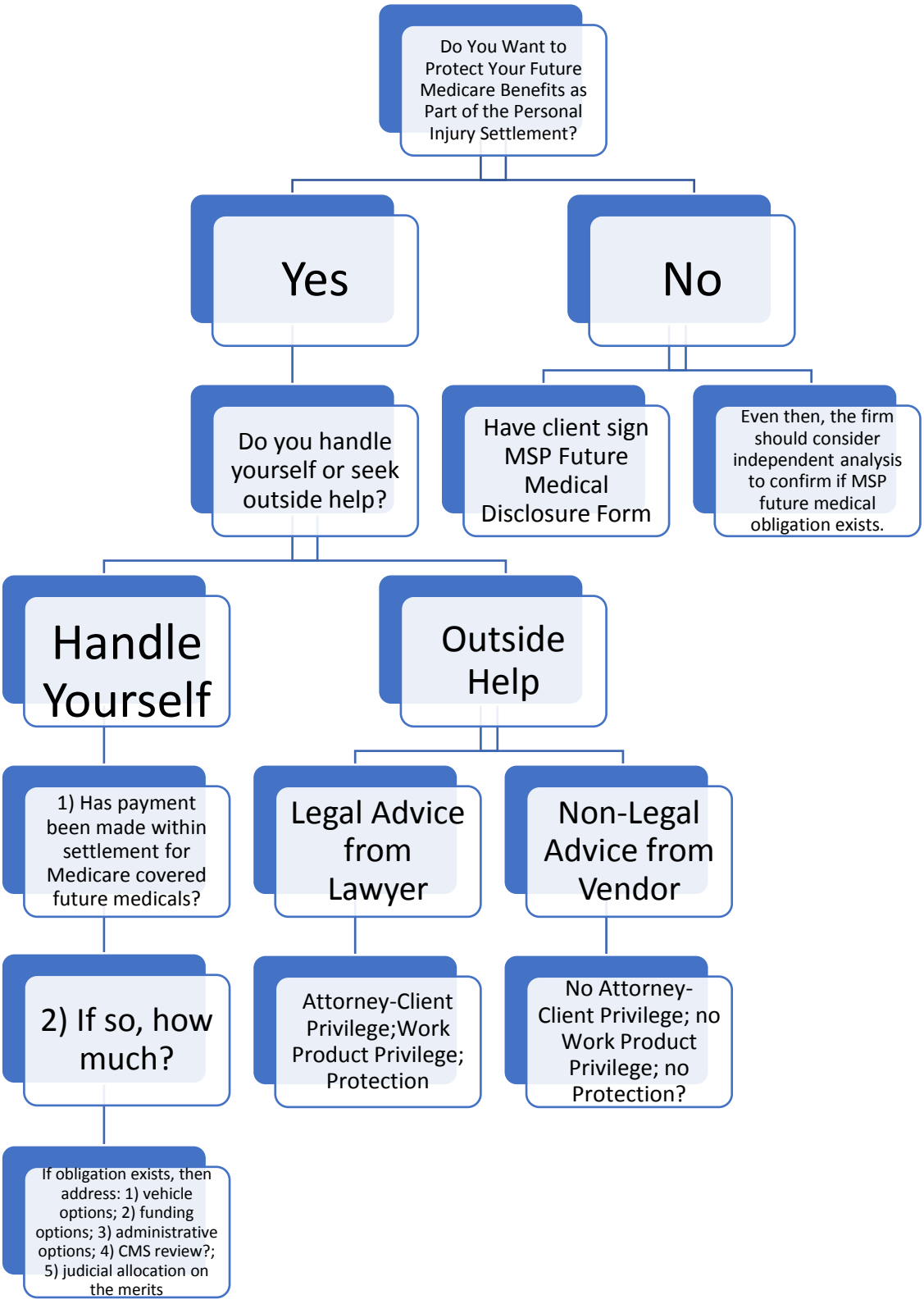

Conclusion.

Discussions about healthcare and payment for healthcare coverage dominate the national news cycle. More individuals become Medicaid and Medicare enrolled every day. With each passing year, chances increase that the plaintiff in your personal injury case is Medicaid and/or Medicare enrolled.

When representing Medicaid enrolled clients, standard operating procedure is to ask them if they want to protect their Medicaid benefits as part of resolving their personal injury case. The same should be true with respect to Medicare. Lawyers should ask every client if they want to protect their future Medicare benefits as part of resolving their personal injury case. Then, the lawyer should take appropriate steps if the client directs them to protect future Medicare benefits. Those steps must include a fact specific analysis in light of the laws and regulations in effect at the time of settlement. That analysis must take care to not overestimate or underestimate the future medical obligation. Working with outside parties to preserve a client's future Medicare benefits might make the most sense. If seeking outside help, there are distinct advantages to procuring legal advice from a lawyer about how to protect a client's future Medicare benefits.

Medicare beneficiaries represent some of our nation's most vulnerable individuals. After the rigors of a personal injury case, the last thing they should be worried about is if Medicare will pay their medical bills in the future. What's worse is when that denial of benefits come post-settlement with no warning at all. As zealous advocates of our client's best interests, the personal injury attorney should take affirmative steps to remove that concern from our client's mind. Asking them up front if they want to protect their future Medicare benefits as part of settling their personal injury case is a step in the right direction.