

**MEDICARE LIENS AND PERSONAL INJURY SETTLEMENTS
WHAT EVERY INSURER AND SELF-INSURED COMPANY
NEEDS TO KNOW**

**AN ADAMS | NYE | TRAPANI | BECHT
WHITE PAPER**

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Introduction

Adjusting, defending and settling personal injury claims made by Medicare recipients is going to become extremely difficult next year, owing to a perfect storm of events:

- In 2003, Congress amended the federal Medicare Act, confirming that when a personal injury plaintiff receives Medicare benefits for treatment of his or her injuries, Medicare's right to recover those payments trumps everybody else's rights. Thus, under the amendments, Medicare can get its money from either the plaintiff or the settling defendants, even when those defendants have already paid the plaintiff;
- In 2006, the Center for Medicare and Medicaid Services ("CMS") contracted out its recovery process to a single contractor. Federal law prohibits that contractor from compromising any of Medicare's lien rights; and
- In 2007, Congress enacted the "Medicare, Medicaid and SCHIP Extension Act of 2007," known by the less-than mellifluous acronym "MMSEA." MMSEA imposes extensive, complex reporting requirements on insurers and self-insureds who settle personal injury claims involving Medicare-qualified plaintiffs.

While any one of these changes would be problematic, the effect of a single change would probably be predictable. But the combined effect of the three changes is just about anybody's guess. In recent months a number of law firms, TPAs and others have published papers of various kinds for companies trying to deal with the MMSEA requirements, the reimbursement obligation and the new recovery contractor. Many of these documents are excellent scholarly works containing many pages and lots of footnotes and citations to federal statutes, regulations, documents and many of the 4,411 acronyms used by The Centers for Medicare and Medicaid Services¹. Almost all of these writings, explicitly or implicitly, carry a two-part message: "You're in trouble. Hire us to help you."

While we do citations, footnotes and acronyms as well as the next law firm, we aren't going to do that here – we will save that kind of writing for the courts. The purpose of this White Paper, however, is to address a question that nobody seems to be answering: What should a company do now?

What we haven't seen in any of the articles, brochures, literature, etc. is a set of practical suggestions for dealing with the combined effect of the new onerous reporting requirements, Medicare's recovery rights and a new recovery contractor charged with recovering every last

¹ We kid you not. For a handy listing of all 4,411 of them, and a remarkable example of bureaucratic jargon run amok, see <http://www.cms.hhs.gov/apps/acronyms/>.

penny of Medicare benefits paid to persons who settle personal injury cases. We'll try to fill that void here.

The rest of this white paper has three parts. We will start with seven specific suggestions. If you are an Adams Nye client, we would be happy to discuss with you the reason for these suggestions, and help you shape a set of practices for dealing with this brave new world². The deadlines and procedures we discuss here are up to date as of CMS's last bulletin on May 11, 2009. Still, this is a moving target. As of May 21, Representative John Tanner (D. TN) has introduced legislation designed to make MMSEA at least slightly less onerous. The rules are likely to change again before we're all done with this.

In the second part, we'll talk about how we got here, specifically addressing Medicare's right of reimbursement, the new reporting requirements, and the role of the recovery contractor.

Finally, we will discuss briefly the special case of asbestos, toxic tort, pharmaceutical and other latent injury cases. We'll look at two issues that are particularly relevant to mass tort litigation. We'll discuss the importance of whether or not a plaintiff alleges or releases exposures before December 5, 1980, after that date, or both. We'll also explain why some settlements can no longer be confidential, and how that fact will change settlement strategy.

Seven Suggestions For Settling Claims With Medicare Beneficiaries

1. Every insurance company and self-insured company involved in personal injury litigation should require its counsel to use formal or informal discovery in every case to determine whether any plaintiff qualifies for Medicare benefits and, if so, to obtain that plaintiff's Social Security Number (while taking all appropriate steps to keep the latter information confidential and secure). Remember: senior citizens are not the only ones who qualify for Medicare. While Medicare benefits are most commonly paid to citizens and legal residents 65 and over, they are also available to some younger persons who have been drawing social security disability payments for two or more years, and to persons on dialysis.
2. Until it has been determined that the Medicare electronic query system is functioning, counsel should be directed to use all available efforts to obtain from each plaintiff an authorization permitting written inquiry to the Centers for Medicare and Medicaid Services ("CMS") as to whether that plaintiff is receiving Medicare benefits.
3. For toxic tort / latent exposure cases, counsel and client must make a determination whether any exposure on or after December 5, 1980 has been alleged. If no post-December 5, 1980 exposure is alleged, the settling company must determine if a release that does not include any exposures after that date is adequate and acceptable.
4. Companies should determine now who is going to manage their MMSEA reporting obligations. A number of TPA's and other contractors are holding themselves out as having expertise in this field. Since nobody has ever undertaken this reporting before, there is no way to know whether any of these services will be satisfactory, or whether companies are better off leaving this to their own IT departments. Medicare has estimated that the set-up process will

² If you are not a client, please see our disclaimer, which appears at the end of this White Paper. And feel free to contact us if you wish – our contact information is also at the end of this White Paper.

require 375 man hours. We think this is wildly optimistic. Furthermore, MMSEA makes the reporting obligation a non-delegable duty. If the contractor drops the ball, the self-insured company or insurer faces the penalties and other consequences. So if companies use outside contractors, those contractors should be required to indemnify the companies against errors

5. As soon as the system is operational, such self-insured companies and insurers should register as Responsible Reporting Entities, or "RRE's." Once registered, they should get started on the testing process with the understanding that they will now be responsible for electronically reporting live settlement data no later than January 1, 2010.

6. Whenever there is reason to believe that a plaintiff (or a decedent) may be a Medicare recipient, no RRE should complete a settlement without obtaining firm, clear and certain confirmation as to whether the plaintiff (or decedent) has received Medicare benefits.

7. Once it has been determined that a plaintiff is Medicare-eligible, the settling insurer or self-insured defendant must not settle a claim with that plaintiff without providing specific protection for itself against a Medicare reimbursement claim. A general representation by the settling plaintiff that "there are no liens" and he will "indemnify and hold harmless" the defendant against liens is wholly inadequate. The settling plaintiff and the plaintiff's attorney should be offered whichever of the following options are suitable under the circumstances of the claim:

- The plaintiff and his attorney will make a specific representation concerning the amount that has been paid by Medicare for injury-related treatment and diagnosis, the defendant will exercise due diligence in comparing this information against medical bills obtained in discovery, and, in addition,
- The plaintiff and his attorney, jointly and severally, will agree to indemnify the self-insured defendant and/or its insurer against lien claims by Medicare or its contractor, MSPRC³; or
- The settlement check will be made payable to the plaintiff, his attorney and Medicare; or
- Plaintiff will receive two checks, one payable to him and his attorney, and a second payable to Medicare for the amount of the reasonably confirmed Medicare benefits; or
- The settling company will hold a sufficient amount of the settlement proceeds in trust pending resolution of the Medicare reimbursement claim; or
- Some combination of these.

Many plaintiff attorneys are ignorant of the changes in the Medicare landscape. Furthermore, from 2003 to the present, many plaintiff attorneys have simply ignored Medicare's reimbursement right. Since the recovery contractors had no way of knowing what cases were out there and what settlements were being reached except in the highest profile cases, there was limited danger in ignoring the reimbursement right. Since the recovery contractors weren't often coming after insurers or self-insureds either, these settling companies simply relied on

³ "Medicare Secondary Payer Recovery Contractor."

generic indemnification language in settlement agreements requiring the settling plaintiff to indemnify the settling defendant against "any and all liens."

Now that those days are over, it is time to start educating the plaintiffs' attorneys. Otherwise, they and their clients will arrive at the settlement table unprepared, and cases which would simply be very difficult to settle will, instead, become impossible to settle.

Thus, in every case where Medicare may be involved, self-insureds, insurers and their counsel must let the plaintiff's attorney know as early as possible that the rules have changed. Long before the settlement process starts, the plaintiff attorneys must understand that if they are going to settle the case, the parties must be mindful that Medicare will be looking for reimbursement of 100% of the benefits it has paid, with a reduction allowed only for attorneys' fees. And no defendant is going to enter into a settlement that leaves it vulnerable to a subsequent reimbursement claim.

**The Perfect Storm: The Right of Reimbursement,
The Reporting Obligation and
The New Secondary Payer Recovery Contractor**

The Right of Reimbursement

Medicare's right of reimbursement is not new. In 1980, Congress enacted the Medicare Secondary Payer Act, 42 U.S.C. §1395y, and following. Most people understood this Act to mean that Medicare providers, suppliers or beneficiaries must submit claims to applicable primary health insurers before submitting them to Medicare. Only after the primary health insurer had failed to pay would Medicare step in as the "secondary payer."

Twenty years later, Medicare decided that it had the same rights against tort defendants as against health insurers, and the Department of Justice began suing tort defendants for benefits it had paid. These suits met with little success until one of them got to the 11th Circuit in *United States v. Baxter International, Incorporated*, 345 F.3d 866 (11th Cir., 2003). This case involved Medicare's attempt to recover Medicare payments made to claimants against a 400,000 class-member settlement involving breast implants, even though the government was unable to identify any of the class members by name. The decision drones on for some forty-five stultifying pages, but the upshot is this: Medicare was a secondary payer, and not just as compared to health insurers. It was also a secondary payer as to self-insured tort defendants, and entitled to recover benefits paid by those defendants.

Soon, Congress codified the *Baxter* decision in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, confirming that Medicare can recover payments from settlement proceeds. It can get them from the plaintiff. Or it can get them from the defense side, even if the plaintiff has already been paid. The result is that the insurer or self-insured can end up paying at least twice: once to the plaintiff and once to Medicare.

In fact, if the government goes to court to recover, the company can actually end up paying three times. If Medicare (or its recovery contractor) sues to recover from the defendant or insurer, it can be awarded twice the benefit amount. So potentially, the company can end up paying the plaintiff once and Medicare twice more.

Furthermore, Medicare does not allocate its reimbursement right based on comparative fault or questionable liability. Consider the case with \$25,000 in medical bills, a total verdict value of \$100,000 (including medical bills, other “special damages” and pain and suffering), but a strong likelihood of a defense verdict and an even stronger likelihood of a high percentage of comparative fault on the part of the plaintiff, co-defendants or absent parties. It would not be unusual to see such a case settle for less than the medical bills. However, if the plaintiff’s bills were paid by Medicare, Medicare will demand the entire settlement, less a share for the plaintiff attorney’s fees and costs. Under these circumstances, such “nuisance value” or “cost of defense” settlements will become difficult, if not impossible. Over the long haul, plaintiff attorneys will be less likely to accept such cases when the clients are Medicare beneficiaries.

Until the plaintiff attorneys become educated, however, such cases will either have to be abandoned or tried. Plaintiffs will have no motivation to settle. Medicare refuses to be bound by allocation agreements between the settling parties, and assumes all settlement payments go toward medical bills until the settlement exceeds Medicare’s payments. For any settlement less than the medical bills, the plaintiff gets nothing.

While Medicare will not accept allocations agreed to by the parties, it will accept such allocations by a court. So in cases such as our hypothetical, if the plaintiff attorney can avoid an out-and-out defense verdict, he may be better off with a verdict than a settlement. Suppose a jury has found that the total damages, including medical bills and pain and suffering, are \$100,000, that the defendant is liable, but that the plaintiff was 75% at fault. In California, this would, result in a \$25,000 net verdict. Medicare will abide by the jury’s verdict, and only seek 25% of its lien. As in the previous examples, even the reduced lien will be reduced further by a share of the plaintiff attorneys’ fees. So in a high comparative fault case, the plaintiff could theoretically be better off trying the case and winning only a fraction of the damages than settling it (although the real-life economics of a twenty-first century jury trial make it unlikely that there would be much left for the plaintiff in this hypothetical).

The Reporting Requirement

Of course, up until now, Medicare and its recovery contractors would have no way of knowing about routine, garden-variety personal injury settlements. A settlement involving 400,000 breast implant patients would likely come to their attention; a single personal injury case likely would not. At least until January 1, 2010. Because that is the date when every liability insurer and self-insured company in the United States will be deputized as a member of the recovery army⁴. Between now and September 30, each such company must electronically register as a “responsible reporting entity,” or “RRE.”

What, exactly, are RREs responsible for? Well, first of all, they are responsible for knowing whether any plaintiff with whom they settle a case is a Medicare beneficiary. Supposedly, they can find that out by making an electronic inquiry utilizing the plaintiff’s social security number and additional information. Supposedly, the CMS will respond within forty-five days to an inquiry with either a “no” or a “yes” and the plaintiff’s Health Identification Number, which the RRE must use for further reporting. The CMS’s inability to get many of its on-line

⁴ MMSEA’s reporting requirement actually has a start date of July 1, 2009 (“the first day of the first calendar quarter beginning after a date 18 months after . . . enactment. . .”). Nonetheless, CMS issued a bulletin last month delaying the start by six months.

services related to MMSEA requirements up and running in a timely fashion raises considerable doubts as to whether and when this system will work. In any event, CMS will probably take the position that it responds to these inquiries as a service to RREs, but is not bound by the results. A false negative response will not relieve the RRE of either the reporting requirement or the reimbursement obligation.

Beginning January 1, 2010, when an RRE settles a personal injury or wrongful death case with a Medicare beneficiary or the beneficiary's heirs, the RRE must almost always report the settlement electronically, providing the CMS with data in more than 125 fields. These reports will be due no later than the quarter after each settlement. The CMS predicts that it will get 2.7 million reports in the first year of the system's operation.

The only exception to the reporting requirement is for total settlements of less than \$5,000 between January 1, 2010 and December 31, 2010, less than \$2,000 in 2011 and 2012 and less than \$600 in 2013. This is only an exception to the reporting requirement, not to the reimbursement obligation.

A number of TPAs and other companies are setting up business units to manage the reporting requirement. However, just as nobody knows how effective the CMS's reporting system will be, nobody knows how effective the commercial compliance systems will be, either. MMSEA provides that the reporting requirement is a non-delegable duty, meaning that the RRE will be held responsible for its contractor's non-compliance. And, there is a \$1,000 per day penalty for failing to comply. So at a minimum, this will be an area for both vigilance and contractual indemnification.

The Recovery Contractor: Is There A New Sheriff In Town?

Until recently, CMS used five regional contractors to assert its reimbursement claims. However, effective October 1, 2006, CMS contracted exclusively with CNI, LLC, a subsidiary of Chickasaw Nations, Inc., which is owned in turn by the Chickasaw Indian Tribe. The contractor is very strictly constrained as to how it undertakes collections (e.g., regulations set out the text of letters it is to send, the sequence of these communications, etc.). It has no authority to compromise claims. Making matters worse, it seemingly lacks the authority to even to deal with the plaintiff, his counsel or the RRE in any meaningful way until the parties settle the claim.

As mentioned above, next year the contractor is expected to receive 2.7 million reports of settlements or other events creating potential reimbursement situations. We expect that the contractor will show a fair amount of aggressiveness in pursuing those among the 2.7 million settling companies who have not ensured that CMS gets its share. We also expect that both the CMS and the contractor will be very, very slow in responding to inquiries from parties to tort claims who are trying to get some closure. The contractor can be expected to claim reimbursement for all post-injury Medicare payments, tort-related or not. The plaintiff (or whomever is trying to reduce reimbursement) has the burden of showing payments are not related. All-in-all, it is likely that the process of resolving reimbursement claims with the contractor will last many months after the parties have settled their own dispute.

The Special Circumstances of Latent Exposure Cases

The Importance of December 5, 1980

Diseases caused by asbestos exposure or other exposures to chemicals or substances typically involve a long latency (the time from first exposure to manifestation of the disease). Such claims may be exempt from both reporting and reimbursement when all the exposure to the settling defendant's product occurred before December 5, 1980, when the Medicare Secondary Payer act was enacted. Latent exposure cases often involve exposures thirty or more years in the past, so this exception window at first blush seems fairly significant.

We think the exception will have very limited application for two reasons. First, the exception does not refer to first exposure but to all exposure to a particular defendant's chemicals or other products. If some exposure is before December 5, 1980 and some after, there is a reporting requirement and an obligation to reimburse. Second, CMS states the exemption as follows:

. . . [T]his means that there was no exposure on or after December 5, 1980 **alleged, established and/or released**. If any exposure for December 5, 1980 or a subsequent date was **claimed and/or released** then Medicare has a potential recovery claim and the RRE must report . . . ⁵

Plaintiffs typically allege more and broader facts than they can prove, and it would not be unusual for a complaint to allege exposures to a particular defendant's products on or after December 5, 1980 even when all the exposures were actually before. Moreover, settling defendants typically insist on the broadest releases allowable by law. A defendant paying thousands of dollars or more to settle a latent injury claim would not likely be willing to limit the release to some exposures. So whether the initial claim is overly broad or the release is appropriately broad, the MMSEA reporting requirement will probably be triggered.

The Effect Of Lost Confidentiality On Settlement Strategy

In California, the following scenario is common in multi-party mass tort litigation: the plaintiff attorney names twenty (or forty, or fifty) defendants in a single plaintiff's case, and settles with all but a handful as the case progresses. All settlements are kept confidential to keep pressure on the remaining defendants, who, without knowledge of the settlement amounts, cannot meaningfully evaluate their trial exposure because they do not know the potential offsets. Some settlements are truly secret, because they are reached with defendants who are never sued, or who never appear in the case.

However, once settlement information is provided to Medicare, it should become subject to a request under the Freedom of Information ("FOIA"). While the FOIA is a subject beyond the scope of this White Paper, there are not many exceptions to its scope, and MMSEA requests aren't among them. Thus, a plaintiff attorney who enters into a settlement for a Medicare beneficiary client should know that the settlement will remain confidential for no more than six to

⁵ The emphasis is ours.

nine months (taking into account the time lag between settlement and reporting, and between reporting and processing of the FOIA request.)

We think this loss of confidentiality in cases involving Medicare beneficiaries will result in bunching of settlements at the end of the case, “agreements to agree,” and other tactics to keep non-settling defendants in the dark about settlements for as long as possible. But in such cases, non-settling defendants should routinely make appropriate FOIA requests.

Conclusion, and One More Suggestion

CMS has published a lengthy User Guide, available at

www.cms.hhs.gov/MandatoryInsRep/Downloads/NGHPUserGuide031609.pdf.

This user guide is required reading for every RRE and every person employed by an RRE who may be involved in the reporting and recovery processes. Sad to say, it’s also mandatory reading for the attorneys involved in the process of defending such cases. The landscape may have changed for plaintiffs, but it has changed for the defense as well, Everyone involved needs to know where the hills, valleys, rocks and potholes are located.

Contact Information:

Bruce Nye, bnye@adamsnye.com Blog: www.calbizlit.com Twitter: @CalBizLit	Adams Nye Trapani Becht LLP 222 Kearny Street, Suite 700 San Francisco, CA 94108-4521
Barbara Adams, badams@adamsnye.com	Tel: 415.982.8955
Thomas Trapani, ttrapani@adamsnye.com	Fax: 415.982.2042

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