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Medicare Secondary Payer Statutes, Part II: Liability Settlement Issues

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David E. Schweighoefer

Background

As discussed in a previous alert, self-insured health care providers face the same compliance requirements and challenges as do those primary payers that qualify as Required Reporting Entities ("RRE") under Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (42 U.S.C. 1395y(b)(7) & (8)).

To date, the Center for Medicare and Medicaid Services ("CMS") has put forth a formidable effort to establish reporting procedures for Liability Insurance, including Self-Insurance, No-Fault Insurance and Workers' Compensation claims. Readers are encouraged to visit the CMS webpage for the most recent updates. (*See* www.cms.hhs.gov/MandatoryInsRep.) This webpage contains all new alerts and announcements, as well as the dates for upcoming teleconferences and transcripts of previous teleconferences.

As the reporting process matures and CMS continues to develop and refine both policy and technical aspects of compliance, third party liability insurers continue to settle claims. The following is a sampling of some of the questions we have encountered in counseling clients in the claims settlement process.

How can we demonstrate that we have acted to protect Medicare's interests in liability settlements?

For many years, parties involved in the settlement of workers' compensation claims have created Medicare Set Aside Accounts ("MSA's") in order to protect themselves and the interests of Medicare. These MSAs were created based on an evaluation of the claimant/plaintiff's past treatment together with an estimation of the need for future Medicare-covered treatment expenses.

Failure to create a sufficient MSA has implications for the "responsible" party.[1] If Medicare concludes that the parties failed to adequately account for Medicare's future interests, it reserves the right to disregard the settlement and fine the "responsible" party. If Medicare concludes the MSA is insufficient, Medicare may not pay for future treatment expenses or, Medicare may pursue an action against the parties for failure to consider Medicare's interests.

While CMS has yet to mandate the creation of MSAs as a requirement of the settlement process for liability settlements, Medicare's interests must nonetheless be protected. The notification process is not only an important step, it is now required. During the investigation of a liability claim, if the claimant is a Medicare beneficiary, the RRE must place the CMS coordination of benefits contractor on notice of the loss.[2] An RRE does not need approval from the Medicare beneficiary to make this notice. The trigger to report involves whether there is an expectation of making a payment.

While the settlement is being negotiated, we have reminded clients that the Medicare secondary payer recovery contractor will not issue a demand for reimbursement until the case is settled. The Medicare beneficiary is required to supply the information regarding the specific settlement terms, including, if

appropriate, attorney's fees and expenses. Upon receipt of this information, the Medicare beneficiary will be informed of CMS's subrogation rights as of that date. This right of subrogation interest must be satisfied, consistent with the CMS demand, and/or an amount equal to the settlement payment, if the amount is less the CMS's subrogation assertion.[3]

As a result of this inherent difficulty in constructing the appropriate settlement, we advise the client to:

1. Continuously verify Medicare eligibility throughout the processing of the settlement.
2. Report to CMS as required.
3. If medical needs are immediately present, or reasonably foreseeable, document them and allocate funds accordingly.
4. Carefully monitor the calculation of any interest claimed by Medicare.
5. Review all CPT codes that Medicare asserts are related to the claim.
6. Maintain settlement funds in a separate account.
7. Maintain accurate records.

The CMS demand may be reduced through a hardship petition, as well as procurement costs. However, clients must be aware that the minimum threshold for settlements for personal injury claims with a Medicare beneficiary could increase to effectively equal the reimbursement amount. A nuisance value settlement will have to equal an amount in excess of Medicare's subrogation right as of the date of the settlement, regardless of admission or assessment of liability for the personal injury claim. Otherwise, why would a Medicare beneficiary accept a settlement in which he or she receives no money?[4]

Insurers and TPA clients have expressed considerable concern over the value of settlements that must be reported, especially those settlements which the industry knows as "nuisance" settlements. CMS has announced that it would impose an interim reporting threshold in 2010 for liability claims of $5,000, below which claims need not be reported to the new system. In 2011, the threshold will reduce to claims greater than $2,000, and greater than $600 for the year 2012. These thresholds are based on the RRE's Total Payment Obligation to the Claimant ("TPOC"). Further, multiple TPOCs to the same claimant/plaintiff must be bundles in determining the reporting obligation of the RRE.[5]

Will a two-party check protect us, the insurer, from subsequent collection action from CMS?

Insurers, after settlement and payment to the claimant, wish to insulate themselves from subsequent enforcement and collection action on the part of CMS should the claimant not satisfy any Medicare reimbursement demand.[6] The statute was amended in 1984, giving CMS the right to recover Medicare payments from liability insurers without regard to whether the insurer has already made a liability insurance payment. If the liability insurer does not properly pay Medicare, Medicare has the right to take legal action against the insurer and to collect double damages.[7]

Typically this strategy has been attempted through the use of a two-party check. While Medicare has procedures outlining the use of two-party settlement checks, their use is not mandatory, and in the limited case law to date, insurers may not demand to seek refuge in their use.

In Tomlinson v. Landers, 2009 WL 1117399 (M.D. Fla. 2009), the Plaintiff's attorney rejected a settlement check from the Defendant's insurance company that listed Medicare as a payee and requested that the settlement check be reissued without the identification of Medicare as payee. The Plaintiff's attorney assured the insurance company that Medicare would be reimbursed and agreed to hold the insurance company harmless for any Medicare claims. Fearing that the Plaintiff would not reimburse Medicare and that they would be held liable under the MSP regardless of whether they paid the Plaintiff, the insurance company refused to remove Medicare as a payee from the check. The United States District Court for the Middle District of Florida held: 1) federal law does not mandate that a primary payer or insurer make

payment directly to Medicare; 2) the insurance company would not have violated federal law if it omitted Medicare from the settlement check; and 3) an insurer may be liable to Medicare if the beneficiary/payee does not reimburse Medicare for any amounts owed within 60 days.

Must we notify the claimant of their option of having an attorney review the proposed release?

Insurers have sought our advice on the advisability of including such language in their settlement release documents. Such language, it is believed, may delay the timeliness of the settlement and in some situations lead the claimant to seek additional settlement dollars.

Our review of applicable regulations, insurance law and common law yields three different areas that should be considered when a client is making a decision to include such language in a settlement release: (i) Medicare Secondary Payer Recovery policies and procedures; (ii) model legislation drafted by the National Association of Insurance Commissioners and adopted in whole or in part by approximately forty states; and (iii) in common law, the fiduciary obligation of an insurance company to its insured, grounded in an insurance contract and founded upon an implied covenant of good faith and fair dealing.

CMS communicates with the beneficiary/claimant in a variety of ways during the MSP claims settlement process, and the communications from the Recovery Contractor will include inquiries as to whether or not counsel has been retained. These communications may serve to successfully prompt the claimant to seek counsel regardless of the notice (or absence thereof) in the insurer's release. In this regard, it is useful to review sections 50.4.3 and 50.5.2.1 in the Medicare Secondary Payer Manual, Chapter 7.

The National Association of Insurance Commissioners has prepared model legislation known as the Unfair Claims Settlement Practices Act ("UCPSA"). The essential provisions of this Act have been widely adopted either in whole or part. There are thirteen key provisions in the Act, and it is not inconceivable that a determined Plaintiff's attorney could fashion an argument that the insurer's failure to provide notice or recommendation to the claimant constitutes an unfair settlement practice. Note as well that Ohio has adopted a similar rule, which can be found at O.A.C. § 3901-1-54 - Unfair Property/Casualty Claims Settlement Practices.

Lastly, the common law defenses to contract formation and enforcement include duress and procedural and substantive unconscionability. It is arguable that the omission of notice constitutes either duress or substantive unconscionability. A claimant could argue in this regard that it is not acceptable public policy for the insurer's release to be seen as unreasonably favorable to them as the omission of notice may result in a less favorable outcome for the claimant.

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[1] Responsibility is established not by liability but simply through any payment by the accused tortfeasor. The claimant/plaintiff's potential comparative fault is not taken into consideration nor is the nuisance value of a claim. (42 U.S.C. § 1395y(b)(2)(A)(ii)(2002)).
[2] *See* 42 C.F.R. § 411.25(a).
[3] *See* Resolution of a Case with a Medicare Claimant, by Franco, Signor and Thornton, Medical Liability and Health Care Law, May, 2009.
[4] *Id*.
[5] Centers for Medicare and Medicaid Services, ALERT for Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Workers' Compensation, Mar. 20, 2009, available at http://www.cms.hhs.gov/MandatoryInsRep/04_whats_new.asp.
[6] *See* 42 C.F.R. § 411.24(i).
[7] Medicare Secondary Payer (MSP) Manual, Chapter 7, Contractor MSP Recovery Rules, Section 50.5.3 - Recovery From Liability Insurers