To Settle or Not to Settle? That Is the Medicare Question!

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I. Introduction

The Centers for Medicare & Medicaid Services (CMS) is a federal agency within the United States Department of Health and Human Services that administers the Medicare program, including the recovery of conditional Medicare payments under the Medicare Secondary Payer (MSP) Statute. 42 U.S.C. § 1395y(b). In 2010, CMS consolidated all of the functions and workloads related to MSP post-payment recoveries into one MSP recovery contract – the MSP Recovery Contractor (MSPRC). The MSPRC took over new MSP recovery claims.

Once MSPRC has been notified of a claim by a beneficiary, it will issue a “Rights and Responsibilities” (RAR) letter informing the beneficiary of his or her responsibilities to Medicare. Within 65 days from the date of the RAR letter, the MSPRC is supposed to automatically issue a “Conditional Payment Letter” (CPL), which contains the amount Medicare paid for medical claims related to the case. However, it is not until after the MSPRC receives notice that a settlement was reached that it calculates the final reimbursement amount and issues a final “Demand Letter.”

Under the current MSP system, the insurer and self insured face a dilemma because they typically do not know the amount of a Medicare reimbursement before settlement. After parties reach a settlement, any defendant or insurer that delays paying medical proceeds due to the defendant’s potential risk of a future Medicare recovery action may face civil penalties or in the case of an insurer, bad faith damages. Further compounding this dilemma is the conflicting case law on the subject.

In Zaleppa v. Seiwell, 9 A.3d 632 (Pa. Super. Ct. 2010), the Pennsylvania Superior Court held that the MSP Act “prohibits private entities from asserting the interests of the United States government in a post-trial motion or at any other phase of litigation.” At trial, the plaintiff had obtained a verdict in the amount of $15,000: $5,000 for “future medical expenses” and $10,000 for “past, present and future physical pain and suffering.” After the court entered judgment, the defendant filed a motion requesting that the court enter an order directing her to pay the verdict either by (1) naming Medicare, along with plaintiff and her attorneys, as payees on the settlement check, or (2) by paying the verdict into court pending notification from Medicare had been reimbursed for all of its conditional payments for plaintiff’s medical expenses. The defendant argued that the MSP Act requires all parties in litigation to protect Medicare’s interests when resolving claims involving conditional payments made by Medicare and that in order to protect Medicare’s interest, she was obligated to confirm that Medicare’s interest was satisfied before paying the verdict award. The court denied the defendant’s motion for post-trial relief.

The court explained that “there is no legal basis under either federal or Pennsylvania law to assert the interests of the United States government as to the reimbursement of Medicare liens.” The court distinguished a party’s statutory obligation to reimburse Medicare from Medicare’s statutory right of reimbursement. The court concluded that nothing in the MSP Act expressly authorizes a primary plan to assert Medicare’s right to reimbursement as a preemptive means of guarding against its own risk of liability; instead, only the United States government is authorized to pursue its own right to reimbursement and only after a recovery demand letter has been issued to the primary plan.
In a recent decision by a Pennsylvania state court, the court interpreted the Superior Court of Pennsylvania’s decision in \textit{Zaleppa} to mean that a defendant cannot delay paying settlement proceeds due to the fact that the Medicare’s interest is not resolved. \textit{See Mirabal v. Bard Access Systems, Inc.}, No. 2525, 2011 Phila. Ct. Com. Pl. LEXIS 147 (C.C.P. Philadelphia Jun. 10, 2011). The court explained a settling defendant is not permitted to unilaterally attach to the payment of settlement proceeds, any condition seeking to protect the interest of Medicare.

In this case and prior to the \textit{Zaleppa} decision, the defendants refused to disburse the settlement proceeds until the plaintiff either satisfied Medicare interest or advised the defendants of the amount of Medicare’s interest. The parties’ settlement agreement provided that plaintiff would be responsible for directly paying all liens, including any outstanding Medicare lien. Defendants argued that they were not required to pay plaintiff any portion of the settlement proceeds until plaintiff received a final demand letter from Medicare; otherwise, they could be subjected to penalties, interests, and the risk of double paying the monies. Plaintiff filed an Affidavit of Non-Payment of Settlement Funds pursuant to Pa. R.C.P. 2291 and requested the court to impose sanctions against Defendants for their failure to deliver the settlement funds to Plaintiff. The court denied plaintiff’s request for sanctions.

After the plaintiff received a final demand letter from Medicare, he filed a motion for reconsideration of the court’s order. On October 22, 2010, the court ordered the defendants to release one half of the settlement proceeds with interest and required the plaintiff to verify Medicare’s position with regard to any future medical lien. The court mandated that the remaining settlement proceeds remain in an interest bearing escrow account until verification from Medicare was received.

After the Superior Court issued an opinion in \textit{Zaleppa}, the plaintiff filed a motion for reconsideration of the court’s October order. The court granted plaintiff’s motion and ordered defendants to immediately release the remaining settlement proceeds with the interest accrued, but denied the plaintiff’s request for additional simple interest, attorneys’ fees and costs, and Petition for Contempt/Sanctions. Plaintiff subsequently appealed the court’s refusal to impose sanctions or find defendants in contempt due to defendants’ failure to release the settlement proceeds. The court found that sanctions were not appropriate against the defendants based on a material dispute of the terms of the settlement. The parties had disputed whether defendants would be protected from any responsibility for paying Medicare’s interest. The court explained that because of the uncertainty of the law at the time, namely, whether tortfeasors were liable to Medicare in litigation cases where Medicare payments were involved, it was uncertain whether defendants could be responsible under the MSP Act for reimbursing Medicare unless plaintiff paid Medicare the conditional payment amount. The court held that based upon the legal uncertainties that existed at the time, Defendants acted appropriately and delivered the settlement proceeds to the plaintiff shortly after the \textit{Zaleppa} decision. The court further explained that defendants acted on “good faith beliefs and justified concerns related to the delivery of the settlement proceeds without assurances.”

After the decision in \textit{Zaleppa}, it appears that Pennsylvania courts will not find a defendant’s delay in paying settlement proceeds to be justified where the delay is due to the defendant’s potential risk of a future Medicare recovery action. The decision is contrary to...
decisions by district courts in other jurisdictions that have held that a defendant’s delay in paying settlement proceeds until it determined the conditional payment amount owed to Medicare due to the insurer’s potential liability for reimbursement was reasonable. See Wilson v. State Farm Mutual Automobile Insurance Company, No. 3:10-CV-256-H, 2011 U.S. Dist. LEXIS 63430 (W.D. Ky. Jun. 15, 2011).

In Wilson, the United States District Court for the Western District of Kentucky held that an insurance carrier did not act in bad faith by delaying payment of settlement proceeds until it determined the conditional payment amount owed to Medicare. This case involved a plaintiff who was injured in a collision with another vehicle. The driver of the other vehicle was at fault and uninsured. The plaintiff incurred significant medical bills, some of which were paid by Medicare. Because the driver was uninsured, plaintiff submitted an uninsured motorist claim to his automobile insurer, which agreed that plaintiff was due uninsured benefits up to the policy limits of $50,000. The insurer, however, decided not to disburse the settlement proceeds until it obtained the conditional payment amount from Medicare. In response, plaintiff sued the insurer claiming it was bad faith to delay payment of the $50,000 merely to protect itself from later liability to Medicare.

The court found that due to the insurer’s potential liability for reimbursement of the conditional payment amount to Medicare, its delay in paying the settlement proceeds was “responsible.” In its opinion, the court concluded that the insurer’s efforts to comply with federal law and to protect its own legitimate interest against overpayment were reasonable and were not in bad faith, especially because the insurer did not delay payment in order to reduce its payment or harass the plaintiff.

II. Recent Developments Impacting Settlement

A. Recent Court Decisions

A recent decision by United States District Court for the District of Arizona provided some guidance regarding CMS’s practices for recovering conditional payments made by Medicare. See Haro et al. v. Sebelius, No. 09-134, 2011 U.S. Dist. LEXIS 58036 (D. Az. May 9, 2011). In Haro, the court held that the CMS cannot require prepayment of an MSP recovery claim before the correct amount is determined where the beneficiary appeals or seeks a waiver of the MSP reimbursement claim. The court found that CMS’ application of the 60-day requirement to collect reimbursement claims from beneficiaries that seek a waiver or an appeal is not authorized by the MSP Act. The court explained that the MSP provision that interest will accrue from the notice of the settlement upon the final determination of a disputed claim is a strong incentive for beneficiaries to pay what they owe Medicare prior to the expiration of the 60-day time period, leaving only the disputed portion of the claim unpaid. See 42 U.S.C. § 1395y(b)(2)(B)(ii).

Additionally, the court held that plaintiffs’ attorneys could not be held financially responsible for disbursing settlement proceeds to their clients instead of holding the funds or immediately turning them over to CMS. The court noted that Congress never expressly made attorneys responsible for reimbursement under section 1395y(b)(2)(B)(ii), but only “an entity
that receives payment from a primary plan.” 42 U.S.C. § 1395y(b)(2)(B)(ii) (2002). The court found that there is no statutory authority, express or implied, to support a direct cause of action to recover a reimbursement claim against an attorney that has received payment from a primary plan and passed it along to the beneficiary. The court notes that CMS may have a direct action against attorneys to the extent they are end-point recipients of settlement proceeds. Therefore, it appears that CMS could still file a recovery action for double damages against a plaintiff’s attorney for up to the amount of the settlement proceeds the attorney received as a contingency fee.

This decision provided some much needed guidance on CMS’ recovery practices. While the decision provides authority to allow plaintiffs’ attorneys to disburse settlement proceeds to Medicare beneficiaries, attorneys should retain and pay CMS any undisputed reimbursement claim to avoid accruing interest. As a result of this decision, insurers and self insureds may be even more reluctant to disburse settlement proceeds until a final demand is received from CMS because they are responsible for reimbursing Medicare for its conditional payments and risk being sued in a recovery action for double damages if the plaintiff does not reimburse Medicare with the settlement proceeds.

In a recent decision by the United States Court of Appeals for the Sixth Circuit, the court ruled that CMS is entitled to a complete reimbursement of the conditional payment amount even where the beneficiary claims that the settlement required allocation based on the liability of the tortfeasor. *Hadden v. U.S.*, No. 09-6072, 2011 U.S. App. LEXIS 23289 (6th Cir. Nov. 21, 2011). In *Hadden*, the plaintiff was injured when he was struck by a utility truck. The utility truck had lost control when it was run off the road by another car that ran a stop sign. The car responsible for the accident was never identified. Medicare paid for plaintiff’s medical expenses related to the accident. Plaintiff settled his claims against the owner of the utility truck and signed a release in which he agreed to pay and satisfy all medical expenses, liens, and claims related to the incident. Plaintiff agreed to settle with the party based on what he perceived to be the fault allocation of the settling defendant. Plaintiff was ordered to pay Medicare its reimbursement even though the liable tortfeasor was never found.

The MSP Act provides:

A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this subchapter with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service.

42 U.S.C. § 1395y(b)(2)(B)(ii). According to the court, the use of the term “responsibility” clearly and unambiguously dictates that a Medicare beneficiary’s tort recovery from a tortfeasor/primary plan is subject to Medicare’s claim for reimbursement for the entire amount of Medicare’s conditional payments without regard to whether the tort recovery included full payment for the items and services paid for by Medicare. The court found that the amount the beneficiary is obligated to reimburse Medicare does not change if the beneficiary later
compromises with respect to the amount owed on the claim based on the allocation of fault attributed to the tortfeasor.

The practical import for those claims involving Medicare in the Sixth Circuit will be that CMS will be much less willing to negotiate its interest, taking the position that it is entitled to its full share regardless of equitable arguments. As a result, settlement will be less likely in cases involving a Medicare beneficiary. Beneficiaries will fear that Medicare will claim the entire settlement award, and insurance carriers will be unwilling to pay any more than what they value settlement to be in order to cover the entire Medicare lien and potential future Medicare liens. As a result, the parties will be more likely to try those cases, which will adversely impact the court system.

The Hadden decision is at odds with the decision by the United States Court of Appeals for the Eleventh Circuit decision in Bradley v. Sebelius et al., No. 09-13765, 2010 U.S. App. LEXIS 20091 (11th Cir. Sept. 29, 2010), which held that Medicare was not entitled to a full recovery of the conditional payment amount in a wrongful death action. In Bradley, the Court of Appeals determined the interplay between the Florida Wrongful Death Act (FWDA) and the federal MSP Act. Under Florida law, in a recovery for wrongful death action, children may recover for lost parental companionship, instruction, and guidance and for mental pain and suffering from the date of injury. Fla. Sta. § 768.21(3). It is a well-settled principle under Florida law that proceeds from a wrongful death action are not for the benefit of the estate, rather, they are the property of the survivors and compensation for their loss.

In Bradley, the decedent was hospitalized for three months for injuries resulting from the negligence of the nursing home of which he was a resident. Medicare paid $38,875.08 for the decedent’s medical care during his hospital stay. Without filing suit, Carvondella Bradley, the personal representative of decedent’s estate, settled a wrongful death claim for $52,000, the full amount of the nursing home’s liability insurance policy limits. Bradley notified CMS of the settlement and associated legal fees and costs. CMS refused to recognize that the medical expense claim had been settled for less than the Medicare’s conditional payment amount, and asserted that Medicare had the authority to claim the total amount of medical expenses, $38,875.00, less procurement costs, or a net amount of $22,480.89.

Bradley filed an application with the probate court to adjudicate the rights of the estate and the rights of the children with respect to the settlement. Bradley notified Medicare of the probate court proceedings, but Medicare refused to appear or participate. The state probate court ordered that Medicare could recover $787.50, after determining the total value of the claims of the decedent’s surviving children.

CMS refused to accept the probate court’s determination, contending that the court’s decision was advisory in nature and/or superseded by federal law. Relying on language contained in its field manual, CMS refused to recognize the probate court’s allocation of liability payments to non-medical losses unless and until payment was based on a court order issued on the merits of the controversy. The surviving children appealed Medicare’s final decision to district court. The district court, also relying heavily on the language contained in the Medicare
field manual, determined that Medicare was entitled to the reimbursement of $22,480.89, not $787.50, for conditional medical expense payments made on behalf of the decedent.

The Court of Appeals reversed the district court, holding that Medicare was only entitled to the sum of $787.50, as determined by the allocation of the probate court. The Court recognized that the $52,000 settlement consisted of medical expenses and costs recovered by the estate (subject to the MSP Act) and non-medical, tort property claims of the surviving children (not subject to the MSP Act) and concluded that Medicare was not entitled to any share of the surviving children’s claim. The Court held that the district court’s reliance on the Medicare field manual was misplaced. Further, the Court noted that Medicare’s position would have a “chilling effect on settlement” by “compelling plaintiffs to force their tort claims to trial, burdening the court system.”

As a result of the decisions in *Hadden* and *Bradley*, an obvious conflict exists among the United States Courts of Appeals with respect to whether Medicare must be willing to adjust the amount it seeks to recover in cases where the parties reach settlement, which may only be resolved by the Supreme Court of the United States.

**B. New CMS Regulations and Recent Alerts**

CMS has recently taken steps to make the MSP system more efficient and to relieve some of the administrative burden for CMS, which suggests that Medicare recognizes some of the concerns with the MSP Act and potential recovery actions. In September of 2011, CMS implemented a $300 threshold for certain liability insurance settlements. Medicare will not seek recovery against a liability insurance settlement if all of the following criteria are met:

1. the settlement, judgment, award or other payment is for a Total Payment Obligation to Claimant (TPOC) of $300.00 or less;
2. the settlement releases a physical trauma-based injury (This does not include alleged ingestion, implantation or exposure-based injuries);
3. there are no additional settlements related to the same alleged incident; and
4. a demand issue has not been issued.

The threshold would cover a situation where a Medicare beneficiary slips and falls in a store and is compensated with a small payment or gift card to the store. The threshold does not apply to no-fault insurance or workers’ compensation settlements. This is the first time that Medicare has implemented a threshold related to its rights of reimbursement under the MSP Act.

On November 7, 2011, CMS implemented a new payment option for beneficiaries who receive certain types of liability insurance settlements of $5,000 or less to resolve Medicare’s recovery claim. A beneficiary who elects this option will be able to resolve Medicare’s recovery claim by paying Medicare 25% of his/her total liability insurance settlement instead of using the traditional recovery process. In order to qualify for this option, the following criteria must be met:
1. The liability insurance (including self-insurance) settlement is for a physical trauma based injury. (This means that it does not relate to ingestion, exposure, or medical implant); and
2. The total liability settlement, judgment, award, or other payment is $5000 or less; and
3. The beneficiary elects the option within the required timeframe and Medicare has not issued a demand letter or other request for reimbursement related to the incident, and
4. The beneficiary has not received and does not expect to receive any other settlements, judgments, awards, or other payments related to the incident.

Beneficiaries may not be willing to pay a quarter of a small settlement to Medicare, especially where the beneficiary is represented by an attorney and will have to pay attorney’s fees from those settlement proceeds. This option does not provide a reduction for procurement costs.

In a recent memorandum, CMS issued its first guidance with respect to the use of Liability Medicare Set-Aside Arrangements (LMSA) amounts related to liability insurance settlements. CMS advises that where the beneficiary’s treating physician certifies in writing that treatment for the alleged injury related to the liability insurance settlement has been completed as of the date of the settlement and that future medical items and/or services for that injury will not be required, Medicare considers its interest, with respect to future medicals for that particular settlement, satisfied. Further, CMS provides that when the treating physician makes such a certification, there is no need for the parties to submit the certification for review and approval. Therefore, the parties can rely on such certifications to demonstrate that Medicare’s future interest has been considered and satisfied. While the scope of the memorandum is limited to cases where a treating physician is able to opine that no future injury-related care is needed, the memorandum serves as the first official notice regarding CMS’s position on the use of LMSAs.

Conversely, CMS is also trying to dispel the notion that LMSAs are not going to be required in liability claims. Obviously, if CMS is exempting certain types of cases, it will be looking at the other types to determine if a good faith effort has been made to address Medicare’s future interest.

In cases where the plaintiff’s potential for future medical care is uncertain or the amount of the plaintiff’s future medical treatment is at issue, the parties should seek court approval of the settlement amount and the decision of whether to set up an LMSA. The court may be willing to issue an advisory opinion in these situations. If the court believes an LMSA is necessary to protect Medicare’s interest, it may be willing to approve the amount of the LMSA. For example, in *Smith v. Marine Terminals of Arkansas et al.*, No. 3:09-00027, 2011 U.S. Dist. LEXIS 90428 (E.D. Ark. Aug. 9, 2011), the United States District Court for the Eastern District of Arkansas approved the parties’ LMSA amount to cover the plaintiff’s future medical treatment for accident-related injuries that would otherwise be covered by Medicare. The proposed LMSA was submitted to CMS for approval, but CMS refused to review it due to “workload issues.” Instead, the parties filed a motion with the court to review and approve the proposed LMSA. The court approved the proposed LMSA finding that the parties had reasonably considered and
protected Medicare’s interest in the settlement and that the LMSA amount fairly and reasonably took Medicare’s interest into account. By having a court review and approve a proposed LMSA, parties can obtain some assurance that the amount set aside is sufficient and meet their good faith obligations.

Over the last year, proposed legislation to reform the MSP Statue has been introduced in the United States Senate and House of Representatives: The Strengthening Medicare and Repaying Taxpayers Act (SMART Act). The goal of the proposed legislation is to make the MSP system more efficient and effective so that parties know the amount of the reimbursement before settlement.

C. Proposed Legislation

Under the SMART Act, the Secretary of the U.S. Department of Health and Human Services would have 65 days from the receipt of a request to provide the Medicare reimbursement amount. After the Secretary’s initial failure to respond to the request for the reimbursement amount, the applicable plan must provide an additional notice to the Secretary of its failure to respond. The Secretary would have 30 days from the additional notice to provide the reimbursement payment before the applicable would not be liable for or obligated to reimburse the reimbursement payment, except where the Secretary’s failure to respond was justified due to exceptional circumstances. The enactment of the SMART Act would help facilitate settlements because parties would know the amount owed to Medicare during their settlement negotiations. The SMART Act’s amendments also include: (1) a three-year statute of limitations for MSP recovery actions from receipt of the Section 111 report; (2) discretionary penalties instead of mandatory penalties; and (3) the development of safe harbor provisions for meeting the mandatory reporting requirements (i.e., good faith efforts to identify a beneficiary).

While awaiting further guidance from CMS and MSPRC on complying with the MSP Act, counsel for both parties, insurers and self insureds should ensure that they adequately consider and protect Medicare’s interest when settling with Medicare beneficiaries.

III. Settlement Scenarios and Potential Strategies to Address Them

Given the state of flux with regard to addressing Medicare’s interest, the parties to any settlement involving a Medicare beneficiary must act in good faith to address Medicare’s interest. The following are common scenarios that we may all face in the future and suggested actions to satisfy the good faith efforts. By the time of this seminar, we may have additional case law or guidance from CMS, which may require a further refinement of the suggested approaches.

Scenario One: Confirming whether a claimant is a Medicare beneficiary at the beginning, middle and resolution of your case.

Issue: Settlement without this information creates too great of a risk. Making an improper payment could result in a recovery action by Medicare along with civil penalties, interests and the risk of double payment of the reimbursement amount.
Options:

Pre-suit:

Request authorization from the claimant to confirm whether the claimant is a Medicare beneficiary. If the investigation continues for a period of time, make another inquiry. Before finalizing any settlement, put the onus on the claimant, if the claimant is represented, by informing the claimant that you need confirmation of his/her Medicare status before finalizing any settlement by paying the settlement monies. Be careful how you word your authorization.

If the claimant is unrepresented, you must inform the claimant that he/she is not required to provide the information but that you need the information in order to pay the settlement proceeds. Do not use that authorization to obtain additional information (i.e., a background check) without first obtaining permission.

During Litigation:

Where the claimant has filed suit, use discovery requests as a tool to determine whether he/she is currently a Medicare beneficiary, is eligible for Medicare or is a potential beneficiary.

It is important to remember that a person who is under the age of 65 is eligible for Medicare if he/she: (1) has received Social Security disability benefits for 24 continuous months; or (2) has End-Stage Renal Disease (kidney failure requiring dialysis or transplant) or Lou Gehrig’s disease (amyotrophic lateral sclerosis).

A potential beneficiary is a person that has a “reasonable expectation” of Medicare entitlement within the next 30 months. Reasonable expectation includes where the individual: (1) is 62.5 years of age or older; (2) is currently receiving Social Security Disability Benefits (SSD); (3) has applied for SSD benefits; or (4) has been denied SSD benefits, but anticipates appealing that decision.

If the plaintiff refuses to provide the requested Medicare information, a court will likely grant a motion to compel plaintiff’s responses to discovery requests. See, e.g., Seger v. Tank Connection, LLC, No. 8:08CV75, 2010 U.S. Dist. LEXIS 49013 (D. Neb. Apr. 22, 2010).

Use “Safe Harbor” Language

If an individual refuses to furnish either an HICN or SSN, CMS will consider the reporting entity compliant for purposes of its next Section 111 file submission if the insurer obtains a signed copy of the model language (even if the individual is later discovered to be a Medicare beneficiary) and the individual re-signs and dates the model language at least once every 12 months in cases where ongoing responsibility for medicals (ORM) applies.
The model language provided by CMS can be obtained at: http://www.cms.gov/MandatoryInsRep/Downloads/RevisedHICNSSNForm081809.pdf

If settlement proceeds are paid before confirming the Medicare status of the claimant, the insurer or self insured risks a recovery action from Medicare for reimbursement of double the amount due under 42 U.S.C. § 1395y(b)(2)(B)(iii).

**Scenario 2:** Parties have reached an agreement about the settlement amount. Plaintiff has not received conditional payment demand letter from Medicare, so parties do not know amount of Medicare’s interest.

**Issue:** How to address Medicare’s potential interest in the settlement agreement and be able to make a payment of settlement proceeds and close the file.

1. Request conditional payment letter from MSPRC. You may not receive it within 60 days.

2. Examine plaintiff’s medical bills to estimate the gross amount of the bills. Assuming Medicare’s interest will not exceed this amount, set that amount of money aside to be distributed according to Medicare’s interest provided that there are no future medicals contemplated.

3. In the release, include a hold harmless provision where plaintiff and plaintiff’s counsel agree to hold defendants harmless from any cause of action, including an action by Medicare to recover Medicare benefits. Obviously, a risk exists that Medicare could pursue the plaintiff, plaintiff’s counsel or the primary plan (you) for any deficiency.

One simple procedure to avoid this scenario is to instruct plaintiff’s counsel to request the conditional payment demand letter early on in the litigation (i.e., discovery requests).

**Scenario 3:** Parties have reached an agreement about the settlement amount. Plaintiff has received a conditional payment demand letter but disputes the amount of Medicare’s conditional payment.

**Issue:** This scenario presents many difficulties for insurers in particular. State statutes often have unfair practice regulations that require prompt payment of settlement proceeds upon the execution of the release. Case law has also been developed to provide bad faith exposure for failure to pay settlement proceeds in cases involving a Medicare beneficiary.

One possible resolution is to pay the settlement amount minus the amount owed to Medicare. It would also be a good practice to insure that the undisputed portion, if any, of Medicare’s interest is paid. With regard to the disputed portion, the insurer or self insured should put those monies in escrow pending a final decision by Medicare.

1. Include the following in the release:
a. acknowledge that Medicare must be paid within 60 days of receipt of the settlement proceeds;
b. that within 45 days of the receipt of the settlement funds, Plaintiff is to provide Medicare’s final notice of Medicare’s claim and Defendant insurer will pay Medicare directly to satisfy Medicare’s lien; and
c. if plaintiff fails to provide written notice and written confirmation of Medicare’s final lien within 45 days of receipt of the settlement funds, then the undersigned authorizes defendant insurer to forward a draft in the full amount of the Medicare lien made payable to Medicare.

2. In the release, also include a hold harmless provision where plaintiff and plaintiff’s counsel agree to hold defendants harmless from any cause of action, including an action by Medicare to recover Medicare benefits. Obviously, a risk exists that Medicare could pursue the plaintiff, plaintiff’s counsel or the primary plan (you) for any deficiency.

Scenario 4: Parties have reached an agreement about the settlement amount. Plaintiff or plaintiff’s counsel demands full payment of the settlement proceeds.

Issue: How to make a good faith effort to protect Medicare’s interest in order to avoid a future recovery action by Medicare.

Options:

1. Pay the full settlement amount. In the release, acknowledge that Medicare must be paid within 60 days of receipt of the settlement proceeds. Also include a hold harmless provision in the release where plaintiff and plaintiff’s counsel agree to hold defendants harmless from any cause of action, including an action by Medicare to recover Medicare benefits. A risk exists that Medicare could pursue the plaintiff, plaintiff’s counsel or the primary plan (you) for any deficiency. This option involves the greatest risk of being named in a future recovery action by Medicare.

2. Petition the court to review the issue and enter an order addressing the payment of Medicare’s conditional payments.

3. Notify CMS of the issue and request that CMS provide the final amount of Medicare’s interest.

4. Pay the undisputed amount.

5. Refuse to settle and allow litigation to be instituted or allow the matter already in litigation to proceed to trial.

6. Try to schedule a settlement conference with the trial judge to allow him or her to get involved in the process.
Scenario 5: The Liability Medicare Set-Aside

A. Satisfying Medicare’s interest and protecting the parties where the beneficiary will not require future medical care.

The easiest solution is to have the plaintiff and plaintiff’s treating physician sign a document that plaintiff will not require any future medical care from any injuries sustained as a result of the incident at issue in the litigation. In third-party liability settlements, CMS has recently advised that where the beneficiary’s treating physician certifies in writing that treatment for the alleged injury related to the settlement has been completed as of the date of the settlement and that future medical items and/or services for that injury will not be required, Medicare considers its interest to be satisfied. Therefore, the parties can rely on such certifications to demonstrate that Medicare’s future interest has been considered and satisfied.

Plaintiffs will likely want the insurer or self insured to pay for the additional cost of the certification, which may be comparable to the cost of an independent medical examination.

B. Plaintiff’s potential for future medical care is uncertain.

Example: Plaintiff has stopped treating for a long period of time, but plaintiff’s prognosis is guarded. There is potential that plaintiff will seek future medical treatment.

1. Include the following in the release:
   a. plaintiff’s injuries are permanent and that plaintiff believes that he has reached maximum medical improvement;
   b. defendant’s doctors reports in which it was concluded that plaintiff is fully recovered and/or has reached maximum improvement and does not need any future medical treatment related to the accident;
   c. acknowledge that release is not intended to shift to CMS the responsibility for payment of medical expenses for the treatment of injury related conditions;
   d. it is not anticipated that plaintiff will need any future medical treatment; and
   e. plaintiff warrants that he/she will use settlement proceeds received to pay for any future medical treatment and will not submit the bills for future medical treatment for injuries relate to the accident.

2. CMS will not review or approve a settlement agreement or proposed LMSA submitted by the parties.

3. Seek court approval of the settlement amount and the fact that there is no need for an LMSA. Depending upon the jurisdiction, the court may be willing to review the settlement and opine on its reasonability, including that no LMSA is

C. Plaintiff has future medical needs and agrees to establish an LMSA.

1. In order to create an LMSA, the parties need an estimated value of future medical care.

2. Request information from plaintiff’s physician or life care planner regarding plaintiff’s future medical treatment and costs.

3. Evaluate reports of defendant’s doctors and life care planners.

4. Calculate the present value of plaintiff’s future medical treatment to fund the LMSA.

5. Consider setting up an LMSA account through a third party.

6. Submit the proposed LMSA to CMS for approval.

7. If CMS refuses to review the proposed LMSA, seek court approval.

D. Plaintiff requires future medical care.

Issue: Defendant wants to set up an LMSA in order to protect Medicare’s interest and comply with the MSP Act; however, plaintiff refuses because the law does not specifically require an LMSA in third-party liability settlements.

Addressing this issue:

1. Educate plaintiff and plaintiff’s counsel regarding value of LMSA – present value of future medical treatment may be less than they anticipate

2. Have an independent third-party review case and determine whether an LMSA is appropriate, and if so, the amount that should be set aside.

3. Defense counsel or the insurer should include in the release or at least document that they notified plaintiff’s counsel and the Medicare beneficiary that the settlement proceeds fund future medicals and plaintiff is obligated to protect Medicare’s interest.

4. Include the following in the release:

   a. plaintiff’s injuries may be permanent and progressive and recovery therefrom is uncertain and indefinite;

   b. plaintiff may require and undergo future medical treatment of injuries allegedly sustained in the accident;
c. plaintiff hereby warrants and agrees that he/she will set aside $_____ of the settlement proceeds in a restricted account to be used solely to pay for any future medical treatment that he/she may undergo for injuries arising out of the accident, even though he/she may be a Medicare beneficiary at the time of such treatment; and

d. plaintiff warrants that, to the extent that he/she is prohibited, by Federal law or regulation, from seeking payment from Medicare for treatment of accident-related injuries, he/she will not submit to Medicare any bills for future medical treatment for injuries arising out of the accident.

IV. Conclusion

Medicare presents unique issues when trying to resolve cases. Because of its relative recent impact, the case law and CMS guidance are still developing, especially concerning liability settlements. This paper was intended to highlight some of these issues, as they impact liability settlements and provide possible means of addressing them.

It is no stretch of the imagination to state that the subject matter is in a state of flux. When settling a case with a Medicare beneficiary, use caution and act in good faith to address Medicare’s interest.