Do Not Settle for More: Settling a Case Involving a Medicare Beneficiary

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When settling a case, most attorneys begin by analyzing their client's liability and the potential damages before determining the amount of recoverable liens. This practice is likely to cause substantial headaches if the attorney does not first consider Medicare's right to recover conditional payments. The best practice is to immediately examine each case to determine if the plaintiff is Medicare eligible. If you determine that the plaintiff is eligible in the initial stages, then you are ahead of the game and can take appropriate measures to protect your client and yourself.

I. The Medicare Secondary Payer Act

Established in 1966, Medicare is a federally administered health insurance program that covers medical expenses for (1) people over the age of 65; (2) disabled people who qualify for Social Security Disability Insurance (SSDI); and (3) people with end-stage renal disease. The program is administered by the Center for Medicare and Medicaid Services (CMS). The Medicare Secondary Payer (MSP) statute was enacted in 1980 in an effort to control the costs of Medicare. Its purpose was to ensure that Medicare is reimbursed for medical payments it makes when a third-party primary payer is involved. Under the original MSP statute, Medicare could only seek reimbursement from group health insurance plans and insurance carriers. As a result, many companies chose to remain self-insured.

The MSP was amended in 2003 after the Eleventh Circuit permitted the recovery of a Medicare lien from a settling defendant in *United States v. Baxter Int'l*, 345 F.3d 866 (11th Cir. 2003).[1] This amendment expanded the entities that Medicare could seek reimbursement from, including creating a private right of action against self-insured parties that receive payment from a primary plan. Under the MSP, Medicare beneficiaries are required to exhaust all other available means of coverage before relying upon Medicare to pay their medical bills. Medicare accomplishes this by seeking reimbursement from the primary payer, such as insurance companies and self-insured parties who resolve a lawsuit or claim involving a Medicare beneficiary. Payment is due within sixty days of a settlement, judgment, or verdict. This is true even if the primary payer already paid the Medicare beneficiary.[2]

II. Medicare Reporting Requirements

Section 111 of the Medicare, Medicaid and State Child Health Insurance Program Extension Act of 2007 (MMSEA) imposes penalties for failure to report. Implemented in 2011, the MMSEA created an opportunity for the federal government to better monitor cases where a primary payer is available to reimburse Medicare for conditional payments. Failure to report in accordance with the MMSEA results in harsh penalties, and it is the threat of such significant penalties that has drawn so much attention to the MSP in recent years. This statute targets all insurers, including liability carriers, no-fault carriers, workers' compensation carriers, and self-insureds. The entities are collectively referred to as "Responsible Reporting Entities" (RRE). An RRE is a party that funds or pays, whether in whole or in part, a settlement, judgment, or verdict to a Medicare beneficiary. Thus, if your client pays settlements directly, then the client is the RRE. On the other hand, if your client pays the settlement but is reimbursed by the carrier, then the insurance carrier is the RRE.[3]

Under the MMSEA, Medicare reserves the right to remain a secondary payer in a civil claim where a primary health plan exists. As a result, the Medicare beneficiary or RRE must make a repayment to Medicare after the settlement, judgment, or award for all payments made by Medicare for related past medical expenses. These payments are due within sixty days of a demand letter issued by Medicare.

Medicare has a right of action to recover its payments from a beneficiary, provider, supplier, physician, attorney, state agency, or private insurer that has received a primary payment.[4] The law is still relatively new, and the liability of attorneys remains uncertain. In fact, one court recently stated that Congress never intended to make attorneys responsible for Medicare reimbursements,[5] while another court held a plaintiff's attorney personally liable after he failed to issue payment to Medicare and paid settlement funds to his client.[6]

III. Penalties

Make no mistake, the penalties for noncompliance with Medicare's guidelines are severe. Pursuant to 42 U.S.C. § 1395y(b)(8)(E)(1), failure to report a settlement to Medicare will result in a civil penalty of $1,000 per day. Under, 42 U.S.C. § 1395y(b)(3)(A), if the government files a lawsuit under the MSP, then it is entitled to double damages plus interest. Thus, all attorneys should educate their clients at the start of a case to ensure that the client is aware of the penalties associated with noncompliance. This should help when explaining the delay in resolving a case when an eventual settlement is reached.

IV. Protect Your Clients and Yourself

There is no absolute formula for handling a claim involving a Medicare beneficiary. Instead, the best practice is to be attentive and vigilant from an early stage. The following constitutes a recommended checklist for resolving a claim involving a Medicare beneficiary. This checklist is to be followed by plaintiffs and defense attorneys alike because Medicare treats all attorneys the same when enforcing compliance. Do not simply rely on opposing counsel to follow these steps.

(1) *Determine if the plaintiff is a Medicare beneficiary*. Verify the plaintiff's Social Security eligibility by requesting a benefit statement from the Social Security Administration. You will need the name of the plaintiff, her date of birth, and Social Security number. If you represent the plaintiff, then you can obtain this information directly from your client. If you represent a defendant, provide this statement to opposing counsel as soon as you open a new matter.

If you learn that the plaintiff is a Medicare beneficiary, then obtain a Consent to Release form. This will allow the attorneys to obtain a Conditional Payment Letter, which is vital to handling such a matter.

If you are unable to obtain a Consent to Release, you can also submit a query to CMS along with the Social Security Number, name, date of birth and gender of the plaintiff. You will then receive a response from CMS advising as to whether the plaintiff is or is not a beneficiary. If you receive a negative response from CMS, there is no guarantee that the plaintiff is not a beneficiary. In fact, a negative response from CMS is only considered to be a confirmation that the Medicare status could not be confirmed.[7] Thus, you should not rely on this negative response from CMS.

If you learn that the plaintiff is not a Medicare beneficiary, it is important to follow up with opposing counsel during the course of a litigated matter to determine if this status changes. This is especially true if the plaintiff is approaching 65 years of age or applies for SSDI. Remember, the RRE will be responsible for fines and penalties even if it is unaware that it is dealing with a Medicare beneficiary. Further, the question is whether the plaintiff is a beneficiary at the time of settlement, not when the claim or suit was initiated.[8] Thus, following up on the plaintiff's Medicare status is essential.

(2) *Open a file with the Medicare Coordination of Benefits Coordinator (COBC)*, which is the administrative arm of the CMS. An RRE does not need approval from the plaintiff to make this notice. Make sure that all communications include the beneficiary's name, Medicare identification number, date of birth, address, date of loss, and information relating to primary payers (i.e., liability insurance carriers).

(3) *Request a Conditional Payment Letter* from the Medicare Secondary Payer Recovery Contractor (MSPRC). The initial Conditional Payment Letter will most likely contain errors that will require sending a corrective letter to the MSPRC.[9] This is because Medicare does not filter through its conditional payments to determine if they are related to the plaintiff's claimed injuries. Therefore, review the letter carefully and identify all unrelated payments. If the payments are not related, then advise the MSPRC in writing.

In addition, defense counsel should use discovery tools to ensure that the alleged injuries set forth by the plaintiff encompass all the injuries related to the plaintiff's accident. For example, if a plaintiff claims a neck injury in a lawsuit but does not claim a related lower back injury, Medicare may still require reimbursement for the lower back injury. Thus, the parties must have an understanding of what Medicare expects to be reimbursed for before reaching the resolution of a case.

Expect delays, but continue to request updated Conditional Payment Letters every ninety days and review each letter to determine if the continued payments are related to the plaintiff's claims. Recently, the MSPRC started posting this information at <www.mymedicare.gov>.

(4) *Report settlement immediately to the MSPRC and request a formal demand letter*. The settlement agreement must include a release of the plaintiff's Medicare lien. If not, the settlement is defective, and the plaintiff cannot enter judgment if the release does not contain language resolving the Medicare lien and how it will be satisfied.[10]

You must ensure Medicare is protected when drafting the settlement documents. The settlement agreement must contain a condition precedent that the parties notify Medicare of the settlement and that they will satisfy Medicare's interest prior to the disbursement of proceeds.[11] To ensure that Medicare is being properly protected, a defendant's attorney may (a) withhold all settlement funds until the final demand letter is issued by Medicare; (b) withhold a portion of the settlement funds that she anticipates being owed to Medicare until a final demand letter is issued by Medicare;[12] (c) include Medicare as a payee on the check;[13] or

(d) pay Medicare directly. Recently, a more common practice has been to create an agreement wherein the plaintiff's attorney agrees to hold all the settlement funds in a trust account until Medicare issues a final demand letter.

Indemnification language in a general release is not guaranteed to protect the RRE. This is because 42 C.F.R. § 411.24(i) requires the RRE to pay Medicare even if it has already paid the plaintiff. Thus, if the plaintiff has no money to pay Medicare directly, then the plaintiff will also be unable to pay the RRE. Further, although the plaintiff's attorney may have the funds to indemnify a defendant if Medicare is not reimbursed, the New York State Bar Association Committee on Professional Ethics issued an advisory opinion finding that New York Rules of Professional Conduct prohibit an attorney from agreeing to indemnify a client's obligations to a third party as part of a settlement of the client's claim. The opinion also stated that the Rules prohibit another attorney's participation in a settlement that requires such an indemnification.[14] Therefore, it is recommended that attorneys avoid indemnification provisions. Instead, they should protect themselves by adequately identifying the terms of the settlement and creating a contractual agreement wherein one of the parties agrees to hold settlement funds until a final demand letter is issued.

A defense attorney should avoid approving a general release that is for "pain and suffering only" because Medicare may interpret this language to indicate that the claim for medical expenses has not been resolved.[15] If that occurs, Medicare could potentially bring an action against the defendant, which would seek double damages. Instead, a defense attorney should include language that the plaintiff is responsible for reimbursing Medicare—spelling out the terms in which the plaintiff will do so. It is recommended that the language include a provision that the settlement will not be funded until a final demand letter is issued, together with a provision that any statutory deadlines relating to the payment of settlement funds be suspended.

(5) *Obtain and review Medicare's final demand letter*, which will include the lien itemization and the amount owed to Medicare (less deduction for procurement costs).[16] Review the final demand letter to ensure the payments are related. Again, if the payments are not related, then advise the MSPRC in writing.

(6) *Pay final demand* within sixty days from the date of the demand letter to avoid penalties.

V. What About Set Asides?

Although set asides are required in workers' compensation claims, there are no specific laws that govern Medicare set asides in personal injury claims. Nevertheless, Medicare has advised that its interests must be considered in every settlement where the plaintiff reasonably anticipates receiving Medicare-covered treatment after the date of settlement.[17] In fact, Medicare issued a memorandum indicating that a set aside "is our method of choice" because "it provides the best protection for the program and the Medicare beneficiary."[18] Thus, all attorneys must fully understand the medical condition and prognosis of a settling Medicare beneficiary in order to determine the necessity of a set aside. According to Medicare, some factors to consider are whether a catastrophic injury or a Life Care Plan is involved.[19]

It is not recommended that the parties select an arbitrary and inadequate set aside amount without obtaining a full analysis.[20] This could potentially expose the plaintiff and the attorneys if Medicare refuses to pay for future related medical care. If you are unsure as to whether a set aside is needed, or what the value of the set aside should be, then you should contact a third-party vendor that specializes in this area. You should also document all efforts as proof that you reasonably considered Medicare's future interests.

Plaintiffs' attorneys who face this uncertainty should take the time to advise their clients in writing of the risks involved with not funding a set aside, including the fact that Medicare may eventually deny coverage of related medical care. Educating your client about the uncertainty of the law and getting your client to acknowledge this risk is strongly recommended.

Finally, if your client does not want a set aside, it is a good idea to obtain proof that the client does not require future related treatment. This is because Medicare issued an alert indicating that its interests are fully considered when the beneficiary's treating physician certifies in writing that the future related treatment is not required.[21]

VI. Conclusion

Medicare's right to reimbursement does not accrue until a settlement, verdict, or judgment is reached. That, however, does not mean that you should wait until the end of a case to consider Medicare's involvement. Settling a case involving a Medicare beneficiary can be tedious and time consuming. This is why all attorneys should make their lives easier by quickly filing a notice with Medicare and keeping up to date on the status of related conditional payments. This will help all parties understand where they stand long before settlement negotiations. Following the above-mentioned suggestions will prevent a more expensive settlement and reduce the element of surprise once a resolution is reached.

Endnotes

1. Thomas C. Regan and Seamus M. Morley, *The Revised Medicare Secondary Payer Act*, For The Defense, Jan. 2005, p. 50.
2. *See* 42 C.F.R. § 411.24(i).
3. Roy A. Franco, Jeffrey J. Signor, and Thomas S. Thornton, III, *Resolution of a Case with a Medicare Claimant*, For The Defense, May 2009, p. 9; John J. Campbell, *Mandatory Insurance Reporting Under the MMSEA*, Medicare Set Aside Bulletin, May 18, 2009, Issue No. 54, http://www.jjcelderlaw.com/MMSEA2MSABull.htm.
4. *See* 42 C.F.R. § 411.24(g); *see* also 42 C.F.R. § 411.26(a).
5. *Haro v. Sebelius*, 789 F. Supp. 2d 1179, 1192 (D. Ariz. 2011).
6. *United States of America v. Harris*, 08 CV 102, 2009 U.S. Dist. LEXIS 23956 (N.D. W. Va. Mar. 26, 2009).
7. John J. Campbell, *Mandatory Insurance Reporting Under the MMSEA*, Medicare Set Aside Bulletin, May 18, 2009, Issue No. 54, available at http://www.jjcelderlaw.com/MMSEA2MSABull.htm.
8. David M. Melancon, *Mediating a Case Involving a Medicare Beneficiary*, For The Defense, June 2012, p. 32.
9. *Id*. at p. 11.
10. *Torres v. Hirsh Park, LLC*, 91 A.D.3d 942, 943, 938 N.Y.S.2d 145, 146 (2d Dep't 2012); *Liss v. Bringham Park Coop. Apartments Sec. No. 3, Inc*., 264 A.D.2d 717, 718, 694 N.Y.S.2d 742, 742743 (2d Dep't 1999).
11. Roy A. Franco, Jeffrey J. Signor, and Thomas S. Thornton, III, *Resolution of a Case with a Medicare Claimant*, For The Defense, May 2009, p. 12.
12. David M. Melancon, *Mediating a Case Involving a Medicare Beneficiary*, For The Defense, June 2012, p. 34.
13. *Id*.; Thomas C. Regan and Seamus M. Morley, *The Revised Medicare Secondary Payer Act*, For The Defense, Jan. 2005, p. 50.
14. NYSBA, Committee on Professional Ethics, Formal Op. [852, Feb. 10, 2011].
15. Thomas C. Regan and Seamus M. Morley, *The Revised Medicare Secondary Payer Act*, For The Defense, Jan. 2005, p. 51.
16. *See* 42 C.F.R. ¶ 411.37(c)(3).
17. John V. Cattie, Jr., *Medicare Secondary Payer and "Future Medicals": A Movement Toward a Standardized Process*, June 14, 2012, available at http://www.dritoday.org./post/Medicare-Secondary-Payer-and-e2809cFuture-Medicalse2809d-A-Movement-Toward-a-Standardized-Process.aspx.
18. Department of Health & Human Services, Centers for Medicare & Medicaid Services, Division of Financial Management and Fee for Service Operations, Region VI, May 25, 2011, p. 2.
19. *Id*.
20. *CMS Region 6 Memo on Liability Medicare Set Asides – A Must Read!*, July 24, 2011, available at http://www.settlementlawfirm.com/post-detail.php?id=185.
21. David M. Melancon, *Mediating a Case Involving a Medicare Beneficiary*, For The Defense, June 2012, p. 33.

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