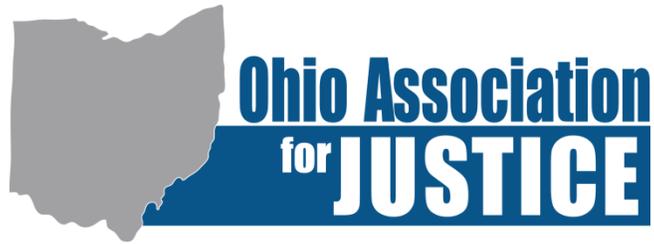


Healthcare Lien Resolution

2011 Annual Convention

Friday, May 13, 2011

Hilton at Easton, Columbus, Ohio



Ultimate 2011 Update- Private Healthcare & ERISA Liens

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Post-Longaberger: Recent Decisions Regarding ERISA Liens and Claims Against Plaintiff Counsel

In the wake of the Sixth Circuit's 2009 decision of *Longaberger v. Kolt*, 586 F.3d 459 (6th Cir. 2009) (discussed in GRG Practice Tip: [What You and Your Clients Should Learn From the Longaberger Case](#)), there has been great consternation and debate regarding the scope of a self-funded ERISA plan's claim for reimbursement under ERISA¹ Section 502(a)(3) and whether the attorney representing a plan participant in a third-party tort action is liable under ERISA. Simply stated, in *Longaberger*, a self-funded ERISA plan was permitted to recover a portion of its reimbursement claim against the participant's attorney where the attorney had already disbursed a portion of a third-party recovery for his own fee. During the past year-and-a-half, we have seen self-funded ERISA plans and their third party recovery agents utilize the logic and arguments of the *Longaberger* decision to pursue similar rulings outside of the Sixth Circuit. Now, we are left with a perceived split among the Sixth, Fourth, and Ninth Circuits on whether a plaintiff's attorney's fees are within reach of an ERISA plan's grasp. The purpose of this piece is to provide you with the latest decisions on this topic and some insight into what it all means.

Case Law: Post-Longaberger

- ***T.A. Loving Co. v. Denton*, 723 F.Supp.2d 837 (E.D.N.C. 2010), applying the holding of *Great-West Life & Annuity Ins. Co. v. Bullock*, 202 F. Supp. 2d 461 (E.D.N.C. 2002)**

A self-funded ERISA plan brought a reimbursement action against the ERISA beneficiary, as well as the beneficiary's personal-injury attorney and the tortfeasor. The attorney kept a third of his fee and gave the client the remaining funds in accordance with the written agreement between him and his client, wherein the client agreed to take responsibility for any obligation he might owe to a private lienholder. While the ERISA plan secured a summary judgment against the client, it lost on its claims against the attorney and the tortfeasor. The ERISA plan sought to recover out of the attorney's contingency fee. In addressing the claim, the court applied the existing rule of the Fourth Circuit, which held that "an attorney may be liable under § 502(a)(3) *only where the attorney is a party to the plan, the attorney agrees to abide by plan provisions, or the attorney's wrongdoing or intentional effort enables the beneficiary to avoid plan provisions.*" *T.A. Loving*, 723 F. Supp. 2d at 840 (emphasis added). Because none of these circumstances were present, the attorney was not held liable. The court acknowledged *Longaberger*, but differentiated it, stating that while "*Longaberger* accepted at the outset the proposition derived from Sixth Circuit precedent that the plan could maintain an equitable claim under § 502(a)(3) against an attorney, this Court begins with the *contrary* proposition that the availability of an equitable claim against such an attorney under § 502(a)(3) is far more limited." *Id.* at 842 (emphasis added).

- ***AC Houston Lumber Co. Employee Health Plan v. Berg*, No. 10-15170, 2010 WL 5439786 (9th Cir. Dec. 29, 2010), applying the holding of *Hotel Employees & Rest. Employees Int'l Union Welfare Fund v. Gentner*, 50 F.3d 719 (9th Cir. 1995)**

A self-funded ERISA plan brought a successful action in which the district court held that a plan's equitable lien had priority over an attorney's contractual right to fees and that, consequently, an attorney who takes his fee from a plan participant's award against a third-party tortfeasor was responsible for paying a portion of the plan's lien. The district court's ruling was based on *Longaberger's* interpretation of *Sereboff v. Mid Atlantic Medical Services, Inc.*, 547 U.S. 356 (2006). The Ninth Circuit, through a divided three-judge panel, reversed the district court's entry of summary judgment for the plan and stated that "an ERISA plan's lien cannot be enforced against an attorney who did not sign the reimbursement agreement or expressly agree to honor the plan's lien." *AC Houston*, 2010 WL 5439786, at *1. It is worth noting that the one dissenting judge sided with the holdings from *Longaberger* and the district court, reasoning that the claim for restitution attached at the moment the settlement fund was identified.

¹ Employee Retirement Income Security Act, 29 U.S.C. § 1001, et seq. ("ERISA").



- ***CGI Tech. and Solutions, Inc. v. Rose*, No. C10-298RSM, 2011 WL 197772 (W.D. Wash. Jan. 19, 2011), also applying the holdings of *Gentner* and *AC Houston***

A self-funded ERISA plan brought an action under ERISA Section 502(a)(3) against a plan member and her personal-injury attorney for a third-party reimbursement claim. The plan language specifically stated that “no court costs or attorneys’ fees may be deducted from our recovery without our express written consent.” *CGI Tech.*, 2011 WL 197772, at *2. Despite this language, the district court held that *Sereboff* “falls short of making the broader pronouncement that a plan’s equitable lien may be enforced against an attorney who is not a signatory to the reimbursement agreement.” *Id.* at 3. The court went on to say that in the Ninth Circuit, an equitable lien may not be enforced against a plan member’s personal-injury attorney. It should not be ignored, however, that the plan was successful in asserting the full amount of its claim against the plan member, as the made-whole doctrine was abrogated by the language of the plan.

Summary

In summary, these three post-*Longaberger* cases have all held that a personal-injury attorney is not liable to an ERISA plan on a claim for equitable relief brought under ERISA Section 502(a)(3). The premise of all three decisions is that an attorney and his client can be viewed as two separate entities in their relation to an ERISA plan that has provided health benefits. The claimant/plaintiff is a plan member who is bound by the terms of the plan document and may be obligated to reimburse his employer-sponsored health plan. On the other hand, these three decisions instruct that the attorney has no obligation to the plan and is not bound by the terms of the plan document, as the attorney is not in privity of contract with the plan. Only if the attorney affirmatively agrees to be obligated to the ERISA plan will an equitable lien be enforced against his portion of a third-party settlement. These decisions are in complete opposition to the Sixth Circuit rule established in *Longaberger*.

Takeaways

- **But what about the claimant/plaintiff?**
 - o While attorneys in the Fourth and Ninth Circuits may be taking a collective sigh of relief, the fact remains that ERISA plans—especially self-funded plans with strong language — have a priority right to reimbursement over the attorneys’ clients, the plan members. Therefore, while the attorneys are off the hook, their clients are not. **If you represent a claimant/plaintiff and receive notice of a potential lien or become aware of an ERISA plan’s involvement, take heed and seriously address the matter with your client. Properly educate him and take all necessary steps to protect your his interests, including fully evaluating the strength of the ERISA claim, informing him of potential risks, and potentially consulting a lien-resolution expert to aid in resolving the matter.**
- **What can I expect from ERISA plans and their third party recovery agents in response to these cases?**
 - o Many groups have implemented *Longaberger’s* arguments into their standard responses and template letters, requesting maintenance of settlement funds regardless of what jurisdiction applies. **Remember that *Longaberger* is only a Sixth Circuit case. If you are outside of the Sixth Circuit, you should (1) become familiar with the above cases, and (2) recognize that the resolution of ERISA liens is often a fluid process, and that, arguably, legal answers to lien-resolution questions remain largely undecided in many jurisdictions. Nevertheless, a certain level of uncertainty and lack of court guidance can help promote an environment for a reasonable lien-resolution compromise.**



- **Also, be prepared for plans to take a more proactive approach.** This will likely include requests to enter into agreements whereby the attorneys agree to hold funds in trust and requests for information related to the receipt of settlement funds and how these funds are being held.

- **What accounts for the different opinions and apparent circuit split?**
 - In comparing the cases above with *Longaberger*, there is a clear split in the analysis of the issue. *Longaberger* and the dissent in *AC Houston* focus upon the creation of an equitable lien that comes into existence at the moment of settlement and attaches to all proceeds, including those which may be disbursed as attorney's fees. The issue of a duty or direct liability to the plan is largely irrelevant to this position, as the claim against fees is simply a byproduct of the larger, universal claim of an equitable lien. In adopting this position, *Longaberger* and the dissent in *AC Houston* apparently concluded that the means (an equitable lien) justified the result (the attorney's fees being subject to the plan's claim). On the other hand, the courts in *T.A. Loving*, *AC Houston*, and *CGI Technologies* were hesitant to take such a narrow view of an equitable lien. The courts in those cases were considerably more concerned with the end result and with sparing an attorney from an obligation that he did not bargain for.

 - **We fully expect that this same issue will be presented in other circuits, with lines being drawn between the two positions presented in this piece.** Eventually the stage may be set for the Supreme Court's review.

If you have any questions, please do not hesitate to contact Michael Russell, GRG's Lead Attorney in ERISA and Private Health Insurance matters, at mrussell@garretsonfirm.com or (704) 559-4300.



**Ultimate 2011 Update- Dealing with
Medicare Reimbursement Claims &
Set Asides**

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Mandatory Insurer Reporting where Medicare is a Secondary Payer: The Medicare, Medicaid and SCHIP Extension Act of 2007 and its current implications

By Matthew L. Garretson & Sylvius H. von Saucken¹
Updated December 15, 2010

Abstract: A current Medicare law could make it more difficult for parties to settle single event and mass tort personal injury claims on or after October 1, 2010². Now more than ever, practitioners must embrace new procedures on the front end of cases in order to minimize disruption on the back end.

On December 29, 2007, President Bush signed into law the "Medicare, Medicaid and SCHIP Extension Act of 2007"³ (the "MMSEA"), adding yet more teeth to the Medicare Secondary Payer (the "MSP") Statute.⁴ Section 111 of the MMSEA requires the providers of liability insurance (including self-insurance), no fault insurance and workers' compensation insurance (hereinafter "insurers") to determine the Medicare-enrollment status of all claimants and report certain information about those claims to the Secretary of Health and Human Services (the "Secretary").⁵ With the objective of assisting the Secretary to coordinate benefits and uncover potential reimbursement claims, this important legislation reinforces that the federal government is intent on ensuring Medicare always is treated as the payer of last resort. The penalty for non-compliance has teeth indeed - \$1,000 per day per beneficiary for each day the insurer is out of compliance. This penalty is in addition to the often-feared, rarely-levied "Double Damages Plus Interest" penalty that defendants (as primary payers) can be fined if Medicare's reimbursement claim is ignored in any settlement.⁶ The new

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² While the statute provides a July 1, 2009 starting date, CMS guidance has extended that date, as of November 9, 2010, to implement the statutory requirements. Reporting related to Ongoing Responsibility for Medicals ("ORM") must be reported if it occurs on or after January 1, 2010, but should be reported according to the revised time periods as listed later in this article. Certain liability settlements or judgments in excess of reporting threshold amounts (currently set at \$5,000 or less) occurring on or after October 1, 2011, must be reported by the "paying party" on or after January 1, 2012. The MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Worker's Compensation User Guide Version 3.1, published July 12, 2010, can be viewed at: http://www.cms.hhs.gov/MandatoryInsRep/03_Liability_Self_No_Fault_Insurance_and_Workers_Compensation.

³ Public Law No. 110-173.

⁴ MMSEA amended Section 1862(b) of the Social Security Act (42 U.S.C. §1395y(b)) by adding at the end these new requirements as paragraph 8.

⁵ Section 111 of the MMSEA also addresses new amendments to the Medicare Secondary Payer statute regarding reporting requirements for Group Health Plans. This article, however, only addresses the amendments related to providers of liability insurance (including self-insurance), no fault insurance and workers' compensation insurance.

⁶ Many things would need to go terribly wrong before a Medicare reimbursement claim gets to the point of a Defendant being liable for double damages plus interest. For instance, Medicare's final demand for reimbursement from the claimant after a settlement must be paid 60 days from the date the final demand was issued by the Medicare Secondary Payer ("MSP") department of the Centers for Medicaid and Medicare Services ("CMS"). The MSP department allows 180 days for payment. After these 180 days transpire, the department will send an "intent to refer" letter (i.e., refer to Treasury for collection) and provide an additional 60 days to respond. So, in effect, settling parties are allowed 240 days to address the final demand. (Certain exclusions apply to a referral involving a case pending on appeal). When a case ultimately is referred to Treasury, their first step is to send a letter to the beneficiary seeking collection of the debt. If unsuccessful, the second step is to seek the remedy available through the Tax Refund Offset Program ("TROP") whereby Treasury seeks satisfaction of the lien by being "constructively paid" through offsetting the claimant's government checks (benefits) and/or refunds (tax). The government will pursue this exhaustive solution to secure reimbursement from the beneficiary.



rules will apply to settlements on or after October 1, 2011⁷. The Centers for Medicare & Medicaid Services (“CMS”) is responsible for collecting various data elements from applicable reporting entities to implement the mandatory MSP reporting requirements of Section 111 of the MMSEA. This information will assist CMS in its “post-payment” debt recovery activities arising from medical expenses paid by Medicare on a conditional basis. Because Medicare is a secondary payer to liability insurance (including self-insurance), no-fault insurance and workers’ compensation, the MSP rules are intended to identify those situations in which Medicare does not have primary responsibility for paying for the medical expenses of a Medicare beneficiary.

The MMSEA signifies the next turbulent adjustment in the long continuum of change since President Bush signed the Medicare Prescription Drug, Improvement, and Modernization Act (“MMA”) into law in December 2003.⁸ The MMA further defined Medicare’s recovery rights, clarified its enforcement powers,⁹ and erased all doubt regarding the need for attorneys who represent Medicare beneficiaries in personal injury settlements or judgments to adopt a formalized process to verify, resolve and satisfy conditional Medicare payments made from the date of injury through the date of settlement.¹⁰ Whereas the teeth added to the MSP framework by the MMA in 2003 were targeted to clarify obligations of the Medicare beneficiary community, those added by the MMSEA are directed at insurers or other primary plans.¹¹ In this regard, the ongoing transformation of Medicare reimbursement policy and practice creates continual challenges for lawyers and their clients in personal injury and workers’ compensation cases. Simply put, the days of either treating Medicare as the proverbial sleeping dog or punting the issue until the end of the case are long gone.

Who Will Have to Report?

Business entities responsible for complying with the reporting requirements of Section 111 of the MMSEA are referred to by CMS as “Responsible Reporting Entities” (“RREs”). For liability and workers’ compensation settlements, the applicable plans, including the fiduciary or administrator of such law, plans or arrangements, and / or the insurers will have to comply with specific reporting requirements. For purposes of MMSEA compliance, this group of reporting entities is considered non-Group Health Plans, or “non-GHPs”.

To better understand these reporting concepts, it helps to be able to distinguish who reports for non-GHP purposes and who does not. Under the MSP, the term “Group Health Plans” means a plan (including a self-insured plan) of, or

Claimant’s counsel and the defendant/carrier typically is not a target for reimbursement until the second step of Treasury recovery is fully explored. But see *United States v. Henry L. Sosnowski, D.J. Weis, and Home Mutual Insurance Company, Defendants* (822 F.Supp. 570, 41 Soc.Sec.Rep.Serv. 312, [Feb. 5, 1993]). When payment was received, Sosnowski and his attorney neglected to reimburse Medicare from the settlement, as required under federal law (42 U.S.C. § 1395y(b)(2); 42 C.F.R. § 411.24). The federal government therefore commenced an action against both Sosnowski and his attorney, jointly and severally, for recovery of the amount due. Consistent with the MSP provisions, the court ruled that the government did have a cause of action for recovery against not only the Medicare recipient, but also his attorney for the entire reimbursement. See also *United States v. Stricker* (E.D. N.D. Ala. 2009) (No. CV-09-PT-2423-E) (U.S. brought an action against attorneys who represented Medicare beneficiaries, and against insurers who were a part of and paid into a mass tort settlement program involving PCB exposure to recover conditional payments plus double damages as part of a settlement program that appears to have not included a Medicare compliance program as part of its process. The attorney and corporate defendants challenged the Amended Complaint based on statute of limitations grounds. The 11th Circuit granted the Motion to Dismiss, and reserved its ruling on a tolling issue. The order further identified that for the corporate defendants a three year statute of limitations applies, measured from (at the latest) the date payment was made by those corporate defendants, and a six-year statute of limitations applies for the attorneys who represented the Medicare beneficiaries.

⁷ See footnote #2.

⁸ Medicare Modernization Act, Pub. L. No. 108-173, 117 Stat. 2066 (2003) (codified as amended in scattered sections of 42 U.S.C. §1395). Section 301 further clarifies the government’s right to reimbursement that it had been seeking in *Thompson v. Goetzmann*, 337 F.3d 489 (5th Cir. 2003) and *Baxter*, 345 F.3d 866. See also *Brown v. Thompson*, 374 F.3d 253 (4th Cir. 2004) (further clarifying congressional intent to modify the MSP statutes using §301).

⁹ CMS has a right to seek recovery “against any entity, including a beneficiary, provider, supplier, physician, attorney, state agency, or private insurer that has received any portion of a third party payment directly or indirectly” if those third-party funds—rather than Medicare—should have covered injury-related medical expenses. The right of reimbursement exists regardless of whether the settlement acknowledges liability and how the settlement agreement stipulates disbursement should be made. This includes situations in which the settlement does not expressly include damages for medical expenses. The Medicare beneficiary, attorney and even the defendant can be held responsible for twice the amount owed to the agency. See 42 U.S.C. §1395y(b)(2)(B)(iii) (2000 & Supp. 2004); 42 C.F.R. § 411.24(g) – (i). Until the 2003 amendments, there was little statutory support for this position, but 42 U.S.C. §1395y(b)(2)(B)(ii) now mandates recovery from an entity that receives payment from a primary insurer, including attorneys and their Medicare beneficiary clients.

¹⁰ As a result, no matter how a particular settlement agreement is worded and no matter whether the tortfeasor is covered by a commercial insurance insurer or a self-insured insurer, or is just paying the claim out of its general assets, any payments Medicare makes from date of injury to date of settlement are considered conditional, and are fixed as such once the parties settle, thereby creating an entity who accepted responsibility, if not liability.

¹¹ One could argue, however, that another target of the MMSEA are the settling parties or those parties involved in judgments with Medicare beneficiaries, since the MMSEA would be superfluous if the federal government felt its interests were being protected after the MMA.



contributed to by, an employer (including a self-employed person) or employee organization to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families.¹² For example, any employer-sponsored plan which provides health insurance coverage, such as Blue Cross/Blue Shield, or a self-insured plan such as Wal-Mart Associate's Health & Welfare Plan, would have a reporting obligation that started January 1, 2009. Non-GHPs, then, are everyone else who has an obligation or assumes the responsibility for medical payments for Medicare entitled beneficiaries. For the non-GHPs the reporting timelines are being pushed back to account for the coordination necessary for CMS to receive a crush of electronic data starting in 2012.

The applicable statutory language,¹³ the definitions provided by the MMSEA's Paperwork Reduction Act Supporting Statement and the Alert for Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Workers' Compensation: Who Must Report, published May 26, clarifies which business entities need to report.¹⁴

Can Agents Report on Behalf of RREs?

Yes, agents may register with CMS on behalf of RREs during the initial data file set up process. CMS recognizes that business entities use third party administrators and other agents to handle the large volume of claims and administration processes. Agents are not, however, RREs for purposes of Section 111 of the MMSEA. RREs may contract with agents to handle reporting, however, the RREs remain solely responsible and accountable for complying with CMS instructions for implementing Section 111 and for the accuracy of data submitted.

What Triggers a Reporting Obligation for Non-GHPs?

Reporting for non-GHPs is event-specific (as opposed to ongoing coverage provided by GHPs). The triggering events are the dates when a business entity accepts responsibility for medical payments or when an entity settles or concludes a dispute such that there is an award, judgment, settlement or other payment involving an injured person currently entitled to Medicare. Pending settlements should not be reported and attempting to report such pending settlements does not constitute compliance with respect to Section 111 reporting obligations.

RREs are to report to CMS only with respect to Medicare beneficiaries (including a deceased individual who was a Medicare beneficiary at the time of settlement, award, judgment or other payment). If a reported individual is not a Medicare beneficiary or CMS is unable to validate a particular Social Security Number ("SSN") or Health Care Identification Number ("HICN") based on the submitted information, CMS will reject the record for that individual. This does not mean, necessarily, that the reported individual is not a Medicare beneficiary, but rather that CMS was unable to identify the individual based on the information provided. The RRE would need to further investigate the identification numbers for the next quarterly submission. Equally important is an RRE's monitoring responsibilities. If, for example, an individual was not a Medicare beneficiary at the time an RRE assumed responsibility for ongoing medical payments, the RRE must continue to monitor the entitlement status of that individual and report to CMS when that individual does become so entitled (to Medicare coverage), unless the responsibility for ongoing medicals ends before the individual qualifies for Medicare.

Understanding triggering events is simplified when taken in context of the MSP. The sole purpose of Section 111 of the MMSEA is to ensure that settling parties fully comply with the MSP requirement – that is, **conditional payments** must be verified and resolved in all liability, workers compensation and no-fault settlements. In this regard, if the Medicare beneficiary's attorneys are already verifying and resolving Medicare's reimbursement claim in all their settlements, these new reporting rules should result in business as usual for those attorneys and their clients. And, according to the Supporting Statement of the MMSEA,¹⁵ for most non-GHPs, gathering the data required may not create a huge burden for those entities that have traditionally coordinated proper claim payments with Medicare to ensure proper order of payment. Non-GHP entities not currently reporting to CMS, on the other hand, will need to adopt the CMS reporting methodology set forth in the most recent version of the User Guide.

¹² 42 U.S.C. §1395y(b)(1)(A)(iv), *citing* the income tax definition of group health plans under 26 U.S.C. §5000(b)(1).

¹³ 42 U.S.C. §1395y(b)(8)(F).

¹⁴ 42 U.S.C. §1395y(b)(8) (CMS-10265)(Aug. 1, 2008); *see also* http://www.cms.hhs.gov/MandatoryInsRep/09_Alerts (last visited June 7, 2010).

¹⁵ See footnote 12.



The history of the MSP statute provides further insight into the true meaning of Section 111 of the MMSEA. On December 5, 1980, the MSP statute as we know it today was modified to include liability settlements, judgments or other payments as being subject to Medicare's conditional payment recovery rights. It was not until twenty-three years later, under Section 301 of the MMA, when additional enforcement provisions were added to the MSP statute, focusing compliance on reimbursement obligations for settling parties, including attorneys and their Medicare-enrolled clients. Now, Congress has closed the loop with Section 111 of the MMSEA by placing a reporting obligation on self-insured defendants and/or insurance carriers. The User Guide emphasizes the fact that Section 111 of the MMSEA did not change or remove any existing MSP rules regarding recovery, but adds a reporting obligation to existing MSP requirements. As a result, for claimants and their attorneys, the obligation is still to "verify and resolve" Medicare's conditional payments, but for defendants, the sole obligation (through the MMSEA) is to verify Medicare entitlement and report to CMS when appropriate (presuming Medicare reimbursement will occur as part of the process such that double damages are not in issue).

What are the Reporting Rules?

For all triggering events occurring on or after October 1, 2011, RREs must engage in a two-step process:

Step 1: Determine whether a claimant (including an individual whose claim is unresolved) is **entitled** to Medicare benefits.
Step 2: If the claimant is determined to be entitled, electronically submit data about the claimant, the injury, and other, more specific **information** concerning the settlement to the Secretary of Health and Human Services through the Coordination of Benefits Secure Website ("COBSW").

While seemingly straightforward, when the MMSEA first became law, practitioners needed clarification regarding the intended scope of the words entitled and information. Since then, practitioners have been given guidance in the form of multiple "town hall" teleconferences with CMS representatives to ensure this process is understood and compliance is effective as of the beginning dates. On February 22, 2010, CMS published Version 3.0 of the User Guide, followed by Version 3.1 of a User Guide, dated July 12, 2010, with updated information to assist responsible reporting entities to comply with federal law. The Guides provide copious information about Section 111 compliant reporting.

Through these open forums, interim record layouts and the User Guide, now at Version 3.1, the following points can be gleaned:

- RREs must report where there has been a settlement, judgment, award, or other payment; and when a case has not settled, but an initial payment for medical expenses has been made based on an RRE accepting such responsibility.
- One-time payments for settlements, judgments or awards are reportable.
- If an RRE has accepted an ongoing responsibility for medical payments ("ORM") (e.g. workers' compensation settlements), only two events must be reported: (1) an initial record to reflect the acceptance of such responsibility; and (2) a second (and final) report reflecting the termination of that responsibility. An example of such reporting would be the case where an insurer starts making medical payments based on an injury (initial date of payment obligation), and then stops when the case settles and that obligation ends (date of settlement). The RRE need not report every occasion a payment is made.
- RREs must report settlements, judgments, awards or other payments **regardless of an admission or denial of, or determination of liability.**
- The RRE, for reporting purposes, only needs to report the total obligation, and does not have to allocate damages between indemnity and medical payments.¹⁶
- There is no reporting requirement for "property damage only" claims.
- There is, however, a reporting requirement for settlements, awards or judgments or other payments in which medicals are claimed and/or released, regardless of allocation by the parties or a determination of "no medicals" by a court. This does not affect an RRE's reporting obligation, although it may impact whether or not CMS has a recovery claim with respect to that settlement, judgment, award or other payment.
- There is no age threshold for reporting purposes.
- If there is no settlement, judgment, award or other payment and the file is ready to be closed, there is no reporting obligation.

¹⁶ This is an important point when defusing the misinformation claiming that the MMSEA now requires liability Medicare Set Asides. Whereas in the context of considering Medicare's interests for future costs of care in settlements, allocation is a key tool to determining the propriety of a set aside, allocation plays no role in reporting for MMSEA compliance purposes. MMSEA addresses Medicare's past interest (date of injury to date of settlement). Medicare Set Asides address Medicare's future interest. The obligations are separate and distinct. MMSEA does not change any previously existing Medicare Set Aside obligation. Practitioners should handle any Medicare Set Aside questions in the same manner they have been addressing such issues prior to the enactment of the MMSEA.



- However, if a file is closed due to a “return to work,” but a payment responsibility is subject to reopening or otherwise subject to an additional payment request, the RRE must add this claimant to the reporting list.
- For liability insurance cases (including self-insurance), each new payment obligation must be reported as a separate settlement, judgment, award or other payment. But, where such payment is made through structured settlement, or annuity purchase, there is only a single report required with respect to the total amount of the obligation.
- CMS is considering appropriate modifications to reporting rules for mass tort or Multi-District Litigations.

Importantly, CMS provided interim reporting thresholds in its User Guide, Version 3.1. Those interim reporting thresholds are as follows:

- For no-fault insurance, there is no de minimus dollar threshold for reporting the assumption/establishment of ORM or for reporting the total payment obligation to the claimant (“TPOC”) (i.e., a lump-sum settlement amount);
- For liability insurance, there is no de minimus dollar threshold for reporting the assumption/establishment of ORM;
- For workers’ compensation ORM, claims meeting all of the following criteria are excluded from reporting for file submissions due through December 31, 2011:
 - “Medicals only”; and
 - “The associated “lost time” for the worker is no more than the number of days permitted by the applicable workers’ compensation law for a “medicals only” claim (or 7 calendar days if the applicable law has no such limit); and
 - All payment(s) has/have been made directly to the medical provider; and
 - Total payment does not exceed \$750.00;
- For liability insurance and workers’ compensation TPOCs, the following dollar thresholds apply:
 - For TPOCs, where the last (most recent) TPOC Date is **prior to January 1, 2013** with TPOC amounts totaling, \$0.00 - \$5,000.00 are exempt from reporting except as specified below.*
 - For TPOCs, dates of January 1, 2013, through December 31, 2013, amounts of \$0.00 – \$2,000.00 are exempt from reporting except as specified below.*
 - For TPOCs, dates of January 1, 2014 through December 31, 2014, amounts of \$0.00 – \$600.00 are exempt from reporting except as specified below.*
 - *Where there are multiple TPOCs associated with the same claim record, the combined, cumulative TPOC amounts must be considered in determining whether or not the reporting threshold is met; however, multiple TPOCs must be reported in separate TPOC fields. For TPOCs involving a deductible, where the RRE is responsible for reporting both any deductible and any amount above the deductible, the threshold applies to the total of these two figures.

The User Guide also informs us that these thresholds are solely for purposes of Section 111 reporting, and have no applicability to any other obligations or responsibility with respect to any other MSP provisions. CMS representatives made this very clear during its “town hall” conference calls with industry representatives to ensure a better understanding of the mandatory insurer reporting rules. CMS officials also stressed on the conference calls that these are INTERIM thresholds and may be changed by CMS at any time.

General Reporting Requirements.

The RRE will submit Section 111 information electronically through the COBSW. Each RRE will be assigned a separate identification number (“RRE ID”) unique onto itself. Files will be submitted on a **quarterly** basis, within an assigned seven day submission period during each quarter.

Input Claim Files will contain at least forty nine data points, organized by: i) injured party/Medicare beneficiary information; ii) injury/incident/illness information; iii) self insurance information; iv) plan information; v) injured party’s attorney or other representative information; vi) settlement, judgment, award or other payment information; and vii) additional claimant information (if applicable). Further data point details are available at www.garrettsongroup.com.

The RRE will also submit a Tax Identification Number (“TIN”) Reference File. The TIN may also be known as the RRE’s federal employee identification number (“FEIN”). For those who are self-insured, their TIN may be an Employer Identification Number (“EIN”) or SSN depending on their particular situation. The TIN Reference File is submitted with the Claim Input File so that RRE name and address information associated with each TIN used does not have to be repeated on every Claim Input Record.



A REPORTING TIMELINE.

Because CMS is still completing its Coordinator of Benefits Secure Website, RREs will have to adhere to a specific timeline. While the original statutory interpretation of Section 111 of the MMSEA suggested to settling parties that reporting would have to occur starting on July 1, 2009, the practical application of this new Medicare law clarifies that **registration should have been complete by September 30, 2009**. As a result, RREs should implement the following timeline (for non-GHP matters):

- RRE Registration: 9/30/2009 (ongoing if not yet registered)
- Test/production Query input files accepted: 07/01/09
- Trigger date for ORM 01/01/10
- Claim input file testing begins: 01/01/10
- Production claim input files accepted: 01/01/10
- Trigger date for TPOC 10/1/11
- Initial production claim input files due: 1st Quarter, 2012

The User Guide details the recent changes to the implementation timeline. While RREs are permitted to test until December 31, 2011, once testing has been completed successfully, RREs are required to submit their first live production files during its designated seven day window during the 1st Quarter, 2012.

File Submission Steps & Timing Issues.

Once insurers and other RREs identify a reporting obligation, steps need to be taken to both register and implement a claims procedure in which the additional information is gathered for reporting purposes. The key element in any claims procedure will be determining whether an injured party is a Medicare beneficiary. RREs will have to submit (to CMS) either the SSN or the HICN for the injured party on all Input Claim File detail records. RREs will have to report on all claims whether the injured party is/was a Medicare beneficiary, that are resolved or partially resolved through a settlement, judgment, award or other payment on or after October 1, 2011, regardless of the assigned date for a particular RREs first submission. Any ongoing responsible medical payment that is completed before January 1, 2010 will not require reporting. But any such payment that starts before January 1, 2010 and continues past that date will be required to be listed on the RRE's first live submission starting after January 2011. Despite the fact that settlements prior to October 1, 2011 will not need to be reported, any ongoing payment responsibility assumed by the RRE on or after October 1, 2010 will still require reporting according to CMS' most recent guidance.

The Need for SSNs and HICNs in the Section 111 Reporting Process.

CMS recognizes the critical importance of RREs being able to obtain SSNs and/or HICNs. This is because the SSN is the basis for the HICN. The Medicare program uses the HICN to identify Medicare beneficiaries receiving health care services and to otherwise meet its administrative responsibilities to pay for health care and to operate the Medicare program. CMS also uses the HICN to ensure the Medicare program makes payment in the proper order and/or takes the proper recovery actions. Without this cornerstone, CMS could not systematically link the reported data to a particular beneficiary.

Any discussion of providing SSNs cannot be reviewed without referring to the federal privacy rules under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). HIPAA created regulations which strictly regulate data transfer issues such as when an SSN is to be used for personal health information, how that information is to be managed and used, who can collect it, and how it can be shared. Understandably, in light of today's "information age" and legitimate concerns surrounding identify theft, claimants may be hesitant about providing their SSNs to insurers and other RREs. However, the collection of SSNs and similar protected health identification information for the purposes of coordinating benefits with CMS is a required, legitimate and necessary use of the SSN under federal law.¹⁷

Despite the legitimate function of an RRE collecting this protected health information, Section 111 does not provide "implied consent" allowing RREs to request Medicare entitlement information. Section 111 of the MMSEA also does not require a claimant to authorize an RRE to obtain entitlement information from the Social Security Administration. CMS

¹⁷ See footnotes 12, 13 and the Supporting Statement for the MSP Mandatory Insurer Reporting Requirements of Section 111 of the MMSEA, which notes that while collecting SSNs is a legitimate federal function, MSP and HIPAA laws also preempt any state statutes which might otherwise attempt to limit this information.



has also clarified in its many “town hall” teleconferences and in its guidance on MMSEA reporting that RREs remain responsible for creating procedures to determine a claimant’s Medicare status. Finally, settling parties are also obtaining some measure of guidance through court action with respect to the propriety of requesting and using SSNs for purposes of coordinating benefits with Medicare.¹⁸

To attempt to address this seeming dichotomy, CMS has developed a QUERY ACCESS System to be added to its Section 111 MMSEA website for RREs. RREs can use this system to determine a claimant’s Medicare entitlement status, provided the RREs submit the appropriate identifying health information. To match an individual to determine if he or she is a Medicare beneficiary, the COBC uses: i) HICN or SSN; ii) first initial of the first name; iii) first six characters of the last name; iv) date of birth; and v) gender. First, the COBC must find an exact match in its database on the HICN or SSN. Then, at least three out of the four final remaining criteria must be matched exactly. If a match is found, the RRE will always be returned the correct HICN.

How will Medicare use this Information?

As MMSEA implementation begins, a moment should be spent contemplating how Medicare will apply this information. The statutory language of Section 111 of the MMSEA provides that the Secretary shall specify the information that insurers must submit that will enable the Secretary to make “an appropriate determination concerning coordination of benefits, including any applicable recovery claim.”¹⁹

The phrases “coordination of benefits” and “applicable recovery claim” address two separate, but inter-related issues. The former refers to MSP’s two activities: “pre-payment activities” and “post-payment activities”. Pre-payment activities are generally designed to stop mistaken payments from occurring when Medicare should be secondary payer. Post-payment activities are designed to recover mistaken or conditional payments made by Medicare where there is a contested liability insurance (including self-insurance), no-fault insurance, or workers’ compensation case which has resulted in a settlement, judgment, award or other payment. The latter phrase speaks solely to who should have paid those expenses.

More specifically, in the personal injury and workers’ compensation context, coordination of benefits is Medicare-speak for ensuring that if there is another source of coverage that is available for someone’s injury-related care, he or she should use it. If no other source of coverage is available (and the person is eligible for Medicare), Medicare will begin paying for injury-related care. Further, in the same context, recovery claim refers to situations where some other source of funding is later found that should have been paying all along. In that instance, Medicare gets reimbursed for past injury-related expenses.

MMSEA Does Not Equal Liability MSAs.

The point of this article is to spark dialogue and provide an MMSEA roadmap for those impacted entities, not anxiety in meeting Medicare compliance obligations. In recent years, the timeframe that is subject to Medicare’s interest in personal injury matters has been the subject of tremendous scholarly as well as practical debate. Specifically, the focus of the debate is whether Medicare’s interest is only related to the past (i.e., for injury-related care from the date of injury through the date of settlement) or, whether Medicare has an interest in settlement proceeds related to the future cost of care. In previous articles,²⁰ our firm explored the issue of whether Medicare requires parties who settle liability claims to calculate a “set aside” amount that the injured claimant must spend on injury-related care before Medicare picks up the tab again. The roots of the set aside obligation are similar to the coordination of benefits concept, which, in effect, stands for the proposition that *if another source of coverage (i.e., settlement dollars earmarked as payment for medicals) exists for a claimant, he or she should use it first.*

¹⁸ See *Seeger v. Tank Connection, LLC*, U.S. Dist. Ct. D. Neb., Docket No. 8:08CV75, 2010 WL 1665253 (Plaintiff refused to provide information requested by Defendant; Court averred no harm in providing information for Medicare compliance purposes); *Hackley v. Garofano, et. al*, 2010 WL 3025597, 2010 Conn. Super. LEXIS 1669 (in a personal injury settlement, Court held that insurance carrier could condition its disbursement of settlement funds upon receipt of SSN, and that the insurer had a right to verify all Plaintiffs information to determine which ones were Medicare enrolled, but since the parties did not reach a meeting of the minds on as to the settlement terms, specifically disclosure of confidential information, consequently, the Court refused to require the settlement to proceed).

¹⁹ 42 U.S.C. §1395y(b)(8)(B)(ii).

²⁰ “Making Sense of Medicare Set Asides,” *Trial*, May 2006. See also “The Use and Propriety of Medicare Set Asides in Liability Settlements” available in the library at www.garretsonfirm.com, which contains further analysis and articles regarding set aside issues in the liability settlement context.



In the workers' compensation arena, this question has been squarely, yet controversially, answered. If a workers' compensation carrier is settling its future obligation to pay for injury-related care, the settlement must properly recognize the shift of this future burden to Medicare by allocating a portion of the settlement proceeds to cover those costs of care.²¹ Medicare does not pay for care -- before or after a settlement -- until the beneficiary has exhausted his or her remedies under workers' compensation.²² This includes spending the portion of any settlement earmarked for future medical expenses.²³

For liability settlements, this set aside question has never been addressed to the satisfaction of most personal injury practitioners. Certainly, the fundamental statutory principle requiring settling parties to protect Medicare's interests in workers' compensation settlements already exists and appears to apply to liability settlements as well.²⁴ Yet, while perhaps no new laws or regulations need be promulgated before Medicare could extend the reach of set asides to the liability context, obstacles currently exist which have made it, in our opinion, very difficult to fairly, efficiently and uniformly apply the set aside arrangement to liability settlements.

Specifically, unlike workers' compensation, liability insurance policies generally have caps, and the doctrines of comparative fault and contributory negligence inherent in personal injury cases work to offset the damages to an amount less than full value. Currently, CMS' "set aside" calculation methodologies are geared toward the full-value, "no fault" nature of workers' compensation statutes. The types of damages in workers' compensation cases, such as "indemnity" and "medical" payments, are readily delineated, but in personal injury settlements, an array of damages can be categorized as "general" and "special." Absent a court finding on the merits of the case, presently there is not an efficient mechanism to determine what the intention of the parties was in making payment to the claimant (i.e., allocation between medical and non-medical damages).

"MSA" has become a buzzword in the settlement community due to various memoranda from CMS. As a part of the "Patel Memorandum" issued in 2001, CMS expressed its preference for practitioners to use MSAs as the suggested means for considering Medicare's interest in workers' compensation settlements. Subsequent memoranda further elaborated on the proper application of MSAs in workers' compensation settlements. However, CMS has yet to address the use of MSAs in liability settlements in a similar manner. This lack of guidance has created uncertainty among practitioners involved in liability settlements.

When the MMSEA was announced, some opined that Medicare would now begin requiring liability settlements to include MSAs starting July 1, 2009 (original timeline) and/or that such guidance is expected shortly from CMS. Such an interpretation of the MMSEA misses the mark as the MMSEA does not reach the issue of considering/protecting Medicare's future interests. CMS has not offered any formal guidance on the issue of liability MSAs and we believe such guidance will not be coming in the near future.²⁵ Moreover, CMS has repeated in its "town hall" teleconferences that the MMSEA's settlement reporting requirements are not intended to replace or change CMS recovery practices, including MSA guidance. The User Guide emphasizes the fact that Section 111 did not change or remove any existing MSP rules, but adds to existing MSP requirements. Quite simply, the MMSEA is not designed to be a "Trojan horse" for liability MSAs.²⁶

²¹ 42 C.F.R. §411.46 (2005).

²² 42 C.F.R. §411.45 (2005) specifies two exceptions.

²³ 42 C.F.R. §411.46 (2005).

²⁴ The MSP provisions say Medicare is always secondary to workers' comp and other insurance, including no-fault and liability insurance. Under the Social Security Act, payment "may not be made under Medicare for covered items or services to the extent that payment has been made, or can reasonably be expected to be made promptly, under a liability insurance policy or plan." 42 U.S.C. §1395y(b)(1), *amended by* Pub. L. No. 109-171, 120 Stat. 4 (2006). Also, Medicare's authority to review liability settlements arises under the same statute as its authority to review workers' comp settlements does. Social Security Act §1862, *as amended*, 42 U.S.C. §§1395y(b)(2), 1395y(b)(5)(d), 1395y(b)(6), *amended by* Pub. L. No. 109-171, 120 Stat. 4 (2006).

²⁵ The only statement the authors envision Medicare making on the issue will be designed to clarify any misinformation about whether or not MMSEA is intended to lead to formal protocols/procedures for addressing the liability set aside issue. For more information about the factors involved in conducting a good-faith, case-by-case analysis of whether steps must be taken to protect Medicare's future interest in liability settlements see page 15 of the article entitled, "Medicare's Reimbursement Claim - The Only Constant is Change" available at <http://www.garretsonfirm.com/library.php>].

²⁶ When CMS announced the "review and approval" protocols for Workers' Compensation MSAs, it did so with a series of memoranda. See for instance, Memorandum from Parashar B. Patel, Deputy Director, CMS Purchasing Policy Group, Center for Medicare Management, to All Associate Regional Administrators, "Workers' Compensation: Commutation of Future Benefits" (July 23, 2001), *available at*



A rational interpretation of Section 111 of the MMSEA is that the new requirement for defendants to report information about resolved or unresolved claims is a sign that CMS is not yet content with the entire regulatory framework utilized to enforce its secondary payer status. The MSP is a work in progress so to speak.²⁷

Changing Habits

From the start of every new case, claimant's counsel is familiar with worrying about possible third party recovery rights against client claims. These concerns, however, are in large part relatively new for defendants and insurers. Accordingly, insurers will need to institute internal procedures for compliance with the MMSEA. Such procedures will follow guidance provided in the User Guide. While the User Guide continues to be tweaked, with the latest version 3.1 released in July 2010, here are some practical considerations:

- *Consent to Release Information* - Since insurers will need to determine the Medicare eligibility status of every claimant, regardless of whether the claim has been resolved, they may need to require each claimant to sign a Social Security Form SSA-3288 (Consent to Release Information). This form can be submitted to the Social Security office closest to the claimant's residence with a request for complete benefit eligibility information. Ideally, this should be done at the time the claim is opened and again at the time the claim is resolved through judgment, settlement or award. A claimant who is not eligible for Medicare at the time the claim is initiated may have become eligible by the time the claim is finally resolved. The consent to release information should include the claimant's counsel so he or she is included on any resulting correspondence.
- *Data Collection and Storage* - Further, insurers must take the required steps to ensure they are set up to collect, manage and transmit (in a HIPAA-compliant manner) such data as the claimant's SSN or Medicare HICN and the additional required data points as set forth in the User Guide. In other contexts, like resolving Medicare reimbursement claims after settlement or seeking the approval of Medicare set asides, the data transmitted includes: a copy of the judgment or settlement; medical records; applicable ICD-9 codes; life care plans or cost projections; life expectancy information; the insurer's payment history on the claim; and any other documentation that Medicare deems helpful in determining whether its interests were reasonably considered.

One also may question whether the new requirements ultimately will lead to a change in the process by which claims are paid by defendants. In recent years, many claimants' attorneys have seen insurers place both the claimant's name and Medicare on a settlement check, leaving the attorney and claimant with the obligation of getting Medicare to endorse the check. The assumption by the carrier is that this process, while a terrific burden on the claimant and his or her attorney, ensures that any obligation to Medicare is addressed since the check cannot be cashed by the claimant unless Medicare first signs off.²⁸ Those insurers who like to wear a "belt with suspenders" are going even farther and agreeing on settlement in principle, but requiring some written verification by Medicare (provided by claimant or his/her attorney) demonstrating that no reimbursement obligation exists, or that it has been satisfied. However, recently attorneys have started challenging this position by pointing out that the manner of payment is a material condition of settlement, which if not agreed upon, can lead to further litigation to modify settlement agreements or specifically enforce those provisions absent the Medicare check endorsement.²⁹ Further, courts have started to look into the fundamental premise about the propriety a Medicare check endorsement. In one case, a Pennsylvania Superior Court considered the question and

<http://www.cms.hhs.gov/WorkersCompAgencyServices/Downloads/72301Memo.pdf> (last visited Mar. 27, 2009). At this point, there is no objective evidence that such policy memoranda could be coming soon addressing set asides in liability settlements.

²⁷ Further analysis focusing on the debate concerning Medicare Set Asides in liability settlements can be found in the author's Aug. 19, 2009 White Paper entitled "The Use and Propriety of Medicare Set Asides in Liability Settlements", at <http://www.garretsonfirm.com/garretson/news/?newsID=92>.

²⁸ If the insurer makes the check out to more than one party including Medicare, Medicare's policy is as follows: All parties must endorse the check. The check is then sent to Medicare for deposit. Medicare will issue a separate check for the award amount less Medicare's claim amount to the attorney after a five-day waiting period. Alternatively, if Medicare is sent separate a check for Medicare's claim amount, Medicare will deposit the check made out to Medicare and endorse the multi-party check. The multi-party check will be immediately returned to the attorney.

²⁹ *Tomlinson v. Landers*, 2009 WL 1117399 (U.S. D.Ct., M.D. Fla. 2009) (where insurance company placed Medicare's name on a settlement check and plaintiff's attorney rejected settlement, suing to enforce the settlement without the check endorsement over to the Medicare, the U.S. District Court held Federal law does not mandate that a primary payer or insurer make payment directly to Medicare, and the insurance company would not have violated Federal law if it omitted Medicare from the settlement check, despite fact an insurer may be liable to Medicare if the beneficiary/payee does not reimburse Medicare for any amounts owed to Medicare within 60 days.



determined that the paying party to a personal injury settlement did not have what amounts to a private Attorney General action to ensure Medicare is properly reimbursed by putting Medicare's name on a check or by escrowing funds.³⁰

Indeed, on this point, Medicare's intent is clear – Medicare wants its interest satisfied in any settlement prior to distribution to the claimant or attorney. Medicare states that no disbursement of settlement should be made until Medicare's interest is satisfied in full.³¹ The authors believe that the cautionary steps of requiring Medicare's name on the check and/or asking for proof that Medicare's interests have been satisfied can be avoided if the claimants' firms have in place a formalized process to identify, verify and resolve Medicare claims early in their firm's case management procedures. Doing so would allow those firms: i) to demonstrate to RREs that they reported the case timely to the COBC; and ii) to provide the RREs with a) the data that was already reported to the COBC (to ensure it comports with the RRE's data reporting); as well as b) the most current conditional payment summary (such that the only remaining step is to get the final demand issued by presenting MSPRC with the settlement details). Integrating an RRE's procedures with those of claimants' counsel will only serve to protect the RRE from the penalties associated with Section 111 reporting. If connected properly, this procedure can yield greater efficiencies and protection throughout the settlement process, without resorting to adding Medicare to a settlement check, which does not satisfy those reporting obligations in the first place.

Issues for Claimants' Counsel

Medicare's role in settlements is undeniably evolving. As most claimants' attorneys already understand, formal procedures must be implemented in their practice, and they cannot wait to receive a notice of a potential claim from CMS before taking action. The agency is not required to give notice, so lawyers must proactively identify, verify, and satisfy Medicare's interests before distributing any settlement proceeds.³²

For those practitioners who have not yet created solid internal protocols, this new law places greater importance on making sure that an appropriate Medicare verification and resolution strategy is fully integrated into their practice. The tenets to such a successful strategy would include protocols for getting started early, enhanced client intake information, client education modules³³ and, for complex cases, perhaps changes in retainer agreements that allow the attorney to seek outside assistance to handle lien verification and resolution.

For those practitioners representing insurers (and other RREs), the claimant's obligations to "verify and resolve" would be complemented by this new obligation to "verify", provided the claimants have representation. In the case of the unrepresented claimant, the necessity to verify **and** resolve becomes more readily apparent. In those cases, insurers should implement a protocol in which assistance is sought to ensure proper compliance with the MSP rules, including satisfaction of conditional payments. Simply put, given the impact of Section 111 of the MMSEA, a RRE's mandatory duty to verify (Medicare entitlement) through reporting on the CMS website may not be enough to properly address Medicare's interests where conditional payments have been made. In that case, outsourcing to a qualified lien resolution firm may be an insurer's best response to ensure absolute Medicare compliance.

Neutral Assistance for the Parties

This notion of seeking outside assistance for lien resolution is a relatively new development, yet it is not without good purpose. Claimants' attorneys are keenly aware that they struggle to keep up with the changing healthcare regulations, protocols and contractors associated with the liens competing for a "share" of their client's recovery. Many believe their clients' interests are best served if the attorney's time and efforts are spent on addressing damages and liability.³⁴ With the MMSEA, defense attorneys now share these same concerns.

³⁰ *Zaleppa v. Seiwel*, 2010 PA Super 208, Pennsylvania Superior Court (Case No. 2019 MDA 2009). While this decision carries weight in only one jurisdiction, however, if viewed in conjunction with *Tomlinson v. Landers* (2009 WL 1117399 (M.D. Fla 2009) (holding that Medicare is not required to be a payee on the check after judgment), *Zaleppa* provides some helpful interpretations by the court regarding applying the Medicare Secondary Payer statute to liability cases.

³¹ §50.4.1 Medicare Secondary Payer Manual, "Existence of Overpayment", stating that settlement proceeds should not be disbursed until Medicare's claim has been satisfied.

³² Medicare's right to reimbursement is superior to almost all other claims, including those of the injured individual. 42 C.F.R. §411.26, amended by 71 Fed. Reg. 9466-01 (Feb. 24, 2006). See also footnote 5 for discussion of *United States of America v. Henry L. Sosnowski*.

³³ Visit www.garretsonfirm.com for copies of client education materials.

³⁴ Certainly seeking the assistance of experienced and knowledgeable resources is the accepted practice in personal injury matters when the case requires attention related to probate, bankruptcy, the calculation of Medicare Set Aside accounts and disability planning (e.g., special needs trusts).



Conclusion

As discussed above, the MMSEA impacts insurers. The new reporting requirements are designed to close the MSP reporting loop, ensuring that claimant and their counsel alike have satisfied their obligations to verify and resolve Medicare's (conditional payment reimbursement claim) interests. At the same time, the new reporting requirements have sharp teeth, with a \$1,000 per day per beneficiary penalty for non-compliance. And, the MMSEA also allocates \$35 million towards assisting CMS in its compliance activities, which CMS has been utilizing through its regular town hall teleconferences, its updated websites and increased communications concerning Medicare compliance.

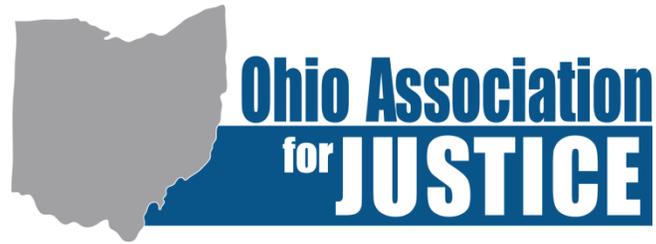
Undeniably, lien resolution is no longer an administrative function that can be addressed by the attorneys on the back end of cases. Nor is it any longer a subject that parties can address simply with an indemnification clause. Rather, lien resolution has evolved over the last several years into one of the most demanding conditions precedent in any settlement agreement, often requiring counsel to affirmatively notify the governmental healthcare agencies (i.e., Medicare and Medicaid) of claimants who are settling their cases, and then proactively satisfying those agencies' interests prior to disbursement of settlement proceeds to those claimants.

In light of the MMSEA, claimants, defendants and insurers must communicate and cooperate to make sure the MMSEA does not add yet another disruptive layer to the already complex, dense and time-consuming settlement process. With all settlement-related Medicare issues, a proactive rather than reactive approach yields a better result. Integrating claims procedures to verify entitlement with claimants' attorneys (if any) with existing procedures to verify and resolve those subrogation issues will insulate the settling parties from the potentially harsh realities of today's MSP program.

It is equally important to not fall into the hysterical trap of believing that the MMSEA does more than add a reporting requirement to insurers and other RREs. The statutory history and recent CMS guidance does not bear out the premature and incorrect missives that the new reporting obligations means Medicare Set Asides are required under the law. Instead, if the parties focus on compliance through collaboration on the reporting end, and analyzing every case to identify and quantify Medicare's interests under the law through formalized processes, including implementing standard operating procedures based on CMS guidance, you can settle your cases with confidence that Medicare's interests are being properly addressed such that double damages will not attach and penalties will not accrue.

However, given the lead time needed to gather the required information, the parties need to start earlier in the settlement process. That is the true meaning of the MMSEA. Simply put, if you know you are going to have to deal with it in the end, why not start addressing it in the beginning?

To learn how the Garretson Resolution Group, Inc. is taking proactive measures to implement MMSEA requirements into its lien resolution practice for settling parties, please contact the authors at (513) 794-0400.



Are You Committing Malpractice Doing Your Own Lien Resolutions

**Mark Kitrick, Esq. & Linda Hinkle
*Kitrick, Lewis & Harris, Co., LPA
Columbus, Ohio***



Medicare: Need I Say More?

Why outsourcing lien resolution
is the smart decision

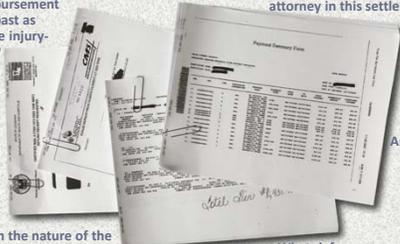
Presented to the Ohio Association for Justice
Friday, May 13, 2011

Mark Kitrick
The Law Offices of Kitrick, Lewis & Harris
Columbus, OH

Ensuring total compliance in each case

Does the health plan
have a reimbursement
interest for past as
well as future injury-
related care?

What are my obligations as an
attorney in this settlement?



Am I liable?

Given the nature of the
client's recovery, is full
reimbursement appropriate?

What defenses,
compromises, waivers or
offsets are available?

Ensuring total compliance in each case

What you have to consider:

Medicare Compliance = 2 Obligations

✓ REPORTING OBLIGATION [NEW]

➢ Accountable Party is the Defendant

✓ RESOLUTION OBLIGATION [OLD]

➢ Accountable Party is the Plaintiff & Plaintiff Counsel

Ensuring total compliance in each case

When is a MSA Required?

A MSA is required in a workers' comp case if the case **meets all 3** of the following criteria:

- Claimant is Medicare entitled at time of settlement or possesses "reasonable expectation" of Medicare entitlement within thirty (30) months of settlement;
- Settlement closes future meds, creating permanent burden shift ("PBS") of obligation to pay future injury-related care to Medicare; and
- Claimant will require future injury-related care ("FCC") that would otherwise be covered by Medicare.

How do you go from this...



- ✓ What defenses, compromises, waivers, or offsets are available?
- ✓ What are my obligations?
- ✓ Does the health plan have a reimbursement interest for past as well as future injury-related care?
- ✓ Are we compliant with our affirmative duties with MMSEA?

... to this?



Outsourcing.

Objectives for today:

- Show why you should outsource healthcare compliance and resolution
- Give you guidance on choosing the best partner
- Help develop your next steps

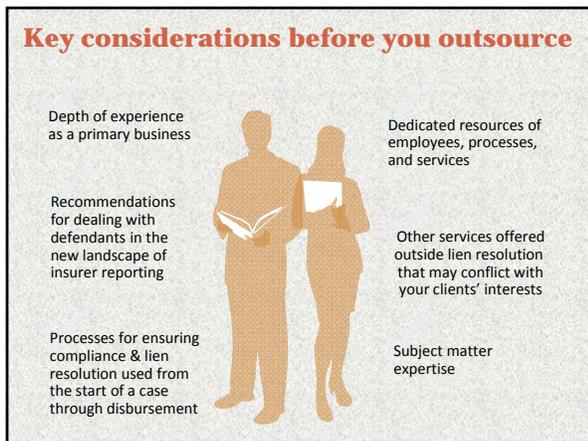
Agenda

- 1 Why so many firms outsource healthcare compliance and resolution
- 2 Important considerations before outsourcing
- 3 Evaluating a healthcare compliance partner
- 4 Benefits of outsourcing to your client, staff, and the firm
- 5 What makes a successful outsourcing partnership/alignment
- 6 Examples of outsourcing success
- 7 The ethics of outsourcing

Most common reasons firms outsource



Key considerations before you outsource



Evaluating a lien resolution company

Examples of Some Key Questions to Ask:

- How long has your company been resolving liens as a primary business?
- Is all of the work done in-house or do you outsource? How many employees do you have dedicated to lien resolution?
- What are your recommendations for dealing with defendants in the new landscape of insurer reporting?
- What types of systems and processes do you have? Do you have online tools that can make the process more efficient?
- What other services does your firm offer outside of lien resolution? Do any of those conflict with my clients' interests?
- Tell me exactly what your process is from the moment you get a case for lien resolution through satisfaction and discharge of the obligation.

Evaluating a lien resolution company, *continued...*

- A competent firm should be able to demonstrate their collaborative relationships with key agencies.



Benefits to key stakeholders

Benefits to Attorneys, Plaintiff, and Staff

Attorneys

- Strengthen cash flow (quicker settlement closing)
- Ensure compliance with federal and state laws
- Improve client satisfaction with disbursement
- Cost effective solution (vs. in-house)
- Your team's focus stays on revenue-generating activities
- Outsourced costs deductible from claimant proceeds
- Leverage legal and operational expertise in case screening

Benefits to key stakeholders

Benefits to Attorneys, Plaintiff, and Staff

Plaintiffs

- Quicker access to net proceeds
- Higher disbursements from negotiated lien resolution
- Satisfies contractual and/or statutory obligation
- Provides plaintiff choices w/ MSA admin
- Maintain healthcare coverage
- Reduce risk of future lien actions

Benefits to key stakeholders

Benefits to Attorneys, Plaintiff, and Staff

Staff

- Able to stay on track
- Stay focused on revenue-generating activities
- Less training demands, don't have to keep up with changing rules and regulations
- Stay focused on your clients' cases, not wasting time on the phone trying to get through to agencies

Before you outsource...

➤ Define the scope of service:

- Will you outsource certain lien types by default?
- Or will you make the determination to outsource on a case by case basis?

Lien types:

- Medicare
- Medicaid
- ERISA/Private Health Plans
- Workers' Comp Liens
- Military Plans
- Medicare Set Asides (when/where appropriate)

In summary...

This brings us to your decision point:

Administer healthcare compliance on your own?

OR

Engage the vast resources of a third party expert to: