Practical Considerations

Mediating a Case Involving a Medicare Beneficiary

By David M. Melancon

You and your client need to make good-faith efforts to consider and protect Medicare's future interest in a settlement.

Most mediators and attorneys would agree that preparation is the key to mediation success. An integral part of mediation preparation is determining whether a plaintiff is a Medicare beneficiary, and if so, the issues presented by the Medicare Secondary Payer (MSP) statute and the Medicare, Medicaid and State Child Health Insurance Program (SCHIP) Extension Act (MMSEA). This article will provide a general overview of the Medicare Secondary Payer Program and offer some practical suggestions to ensure that you protect Medicare's interest in a mediated settlement.

Medicare and the Medicare Secondary Payer Statutes

Medicare is a federally administered health-insurance program that, generally speaking, covers medical expenses for (1) people age 65 or older; (2) disabled persons of any age who are otherwise qualified for Social Security; and (3) people with end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant). 42 C.F.R. §§408.10 *et seq.* (2006). In 1966 President Johnson signed the law establishing Medicare, and Medicare became the primary insurer of its beneficiaries for the first 14 years of its existence.

In 1980, in an effort to control the ever-increasing costs of the program, Congress enacted the Medicare Secondary Payer (MSP) statute. "Medicare secondary payer" is the term used to describe a third-party insurance plan, including self-insurance, that the government can reasonably expect to pay or has paid a Medicare beneficiary's medical expenses, deeming Medicare "secondary" to that other payer. 42 U.S.C. §1395y(b). Under this statutory scheme, Medicare makes "conditional" payments, and Medicare has a right of reimbursement if it determines that a third-party primary payer bore responsibility for those payments. 42 U.S.C. §1395y(b)(2)(B) (2006).

In 2003, Congress amended the MSP statute adding broad language expanding the number of entities and individuals from which Medicare could seek reimbursement. 42 U.S.C. §1395y(b)(2)(B). Specifically, the amendments imposed a duty on any entity responsible for making a primary payment to protect Medicare's interests. This includes an employer, an

■ David M. Melancon is a member of Irwin Fritchie Urquhart & Moore LLC in New Orleans. His general civil litigation practice concentrates on the defense of complex personal injury and property damage claims, products liability, and toxic torts. He is a founding contributor to the Firm's Louisiana Premises Liability Blog and he has developed an expertise in the area of Medicare compliance and lien resolution issues in the context of individual and global settlements.

insurance carrier, a plan or a program, and a third-party administrator. 42 U.S.C. §1395y(b)(2)(B); 42 C.F.R. §411.24(e).

Enacted in 2007, the Medicare, Medicaid, and State Child Health Insurance Program (SCHIP) Extension Act (MMSEA) further expanded the ability of the federal government to recover sums owed under the MSP statute by imposing strict reporting requirements and penalties for noncompliance. 42 U.S.C. §1395y(b)(7), (b)(8). Under MMSEA section 111, all insurers—liability, no fault, and workers' compensation—as well as self-insurers, collectively referred to as "responsible reporting entities," (RREs), must report information regarding payments made to Medicare beneficiaries and other data to ensure proper coordination of benefits with the Medicare program. 42 U.S.C. §1395y(b)(7)(A); 42 U.S.C. §1395y(b)(8)(A). The penalty for failing to report payments timely is steep: $1,000 per day per unreported claim. This is in addition to the double damages plus interest penalty that violators owe under the MSP statute when the government pursues litigation to enforce Medicare's reimbursement claims. 42 U.S.C. §1395y(b)(2); 42 C.F.R. §411.24.

Early in a case and definitely well before mediation, you need to determine the Medicare status of a plaintiff.

All the parties involved in a settlement with a Medicare beneficiary—a plaintiff, a plaintiff's attorney, an insurance carrier, or a self-insured—have a vested interest in protecting Medicare's lien interest. The balance of this article discusses practical strategies for protecting that interest.

Determining a Plaintiff's Medicare Status

Early in a case and definitely well before mediation, you need to determine the Medicare status of a plaintiff. Because of the shared interest among all the parties, you can often confirm the Medicare status of a plaintiff through informally exchanged information. Other avenues for learning a plaintiff's Medicare status include using formal discovery and using Medicare's query process. Your client should have a process in place for querying Medicare as long as it has basic information about a plaintiff, namely, his or her first and last name, date of birth, Social Security number, and gender. Your client should complete this query at the earliest possible litigation stage. And even when a client initially confirms that a plaintiff is not a Medicare beneficiary, the client should regularly complete queries or, at a minimum, as the mediation date approaches, undertake a query to make sure the plaintiff's status hasn't changed. Importantly, the relevant inquiry under the Medicare statutes is whether a person is a Medicare beneficiary at the time of a settlement, not necessarily when that person initiates a claim or litigation.

Determining the Amount of Medicare's Interest

Once your client confirms the Medicare status of a plaintiff, the next step is to determine whether Medicare has made any "conditional payments" and, if so, the amounts. Although Medicare is deemed a secondary payer for medical expenses covered by insurance policies or self-insured entities by law, Medicare often makes conditional payments for covered expenses to accommodate its beneficiaries. When Medicare makes a conditional payment, it has a right to recover the amount from a third-party payer, which in the case of litigation, is an insurer or a self-insured entity. This right of recovery, while technically a claim for reimbursement, is often referred to as a "super lien." Resolving this claim or "super lien" is a necessary part of a mediated settlement, so you should determine the amount of a claim, or at least the approximate amount, which Medicare refers to as the "conditional payment amount," before mediating.

The next step in protecting Medicare's interest is deciding which party will have the ultimate responsibility for the determining the amount of Medicare's interest, the beneficiary or the insurer or the self-insured entity, typically through their attorneys. While in some limited circumstances a defendant would have an interest in taking a more active role in the Medicare recovery process, historically the plaintiff's attorney has taken responsibility for determining the lien amount, whether Medicare or otherwise, and he or she should retain that responsibility. Further, a plaintiff has a strong incentive to resolve Medicare's claim since he or she must reimburse Medicare within 60 days of receipt of payment by a primary payer. 42 C.F.R. §411.24(h). This reimbursement obligation applies equally to a plaintiff's attorney. For example, in *United States of America v. Paul Harris*, 2009 WL 891931 (N.D.W. Va. 2009), the court found that the plaintiff's attorney who failed to pay Medicare's claim within the statutorily required 60-day time period was individually liable to Medicare for the amount of the Medicare claim plus interest. In that case, the plaintiff's attorney ignored the 60-day notice letter, disbursed the settlement funds, and failed to file an appeal contesting the amount of the conditional payments that Medicare sought to recover.

Irrespective of which party takes responsibility for handling the Medicare recovery process, the general procedure for determining the amount owed to Medicare remains the same. The first step is to contact the Medicare Coordination of Benefits Contractor (COBC) to initiate opening an MSP potential recovery case. The COBC will need a plaintiff's full name, Medicare Health Insurance Claim Number (HICN), gender, date of birth, address, and phone number, as well as the date of the injury or onset of the illness, a description of the alleged injury or illness, and the type of third-party insurance that would cover the claim—liability insurance, or no-fault insurance, for example. When a beneficiary has representation by counsel, the COBC requires the name of the plaintiff's attorney and the law firm, if any, the address and the phone number, and proof of representation. The COBC then transmits the information to a system used by the Centers for Medicare & Medicaid Service (CMS) Medicare Secondary Recovery Contractor (MSPRC) to establish a potential recovery case.

Once a case is established with the Medicare recovery contractor, it will send a "rights and responsibilities" letter to a plaintiff's attorney, which, as the name indicates, describes the rights and responsibilities of the Medicare beneficiary dur-

ing the Medicare recovery process. Within 65 days of the date of the rights and responsibilities letter, Medicare will issue a "conditional payment" letter and a payment summary form that lists all payments that Medicare has made and that it believes are related to the involved injury or illness. At this time, a beneficiary will have an opportunity to review the itemized payments and challenge payments that are not related to the injury or illness at issue. Updated conditional payment amounts will then become available on the Medicare website at https://www.mymedicare.gov/. A beneficiary also can request that Medicare send updated conditional payment letters.

After completing negotiations with the Medicare recovery contractor regarding the "relatedness" of Medicare's payments, a plaintiff's attorney will have a realistic idea of the maximum amount that a beneficiary might owe to Medicare as part of a settlement. While the negotiations with the Medicare recovery contractor won't finalize the demand that Medicare will make, a plaintiff's counsel should be able to proceed to negotiate a settlement knowing that he or she likely can negotiate a lower final payment to Medicare based on other factors such as attorney's fees and other procurement expenses.

Medicare Set Aside

In addition to considering Medicare's interest in past conditional payments, you must consider Medicare's interest in future related payments. How best to protect Medicare's interest in future payments remains mired in uncertainty and debate. Although analyzing the debate is beyond the scope of this article, it often revolves around whether a Medicare set aside (MSA) is required. Basically, an MSA "sets aside" funds to compensate Medicare for future medical expenses related to the injuries at issue in a case. Once the MSA fund becomes exhausted, Medicare resumes paying medical expenses as the beneficiary's primary payer. Although attorneys use MSAs as a matter of course in workers' compensation settlements, the CMS has not directed them to do it routinely in liability cases. The only guidance from the CMS to date on using liability Medicare set-aside arrangements is in a CMS Alert dated September 9, 2011, which states that when

> the beneficiary's treating physician certifies in writing that treatment for the alleged injury related to the liability insurance (including self-insurance) 'settlement' has been completed as of the date of '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.

Nor does Medicare have a policy or procedure in place for reviewing or providing an opinion regarding the sufficiency of a set-aside amount. And, although some courts have agreed to rule on motions to determine whether the proposed amount of a Medicare set aside properly considered and protected Medicare's interests in future payments, whether obtaining court approval is necessary or even practical remain open questions. For example, in *Big R Towing v. Benoit*, Civ.A.10-538, 2011 WL 43219 (W.D. La. Jan. 5, 2011), the parties filed a joint motion "to determine future medical expenses for purposes of allocating the settlement proceeds taking Medicare's interests into account." *Id.* at *1. The court ordered reimbursement of its conditional amounts to Medicare and that the plaintiff set aside a portion of the settlement proceeds to pay for future medical benefits arising from the alleged injuries. *Id.* at *3. In doing so, the court found that a proposed set aside of $52,400 from a gross settlement amount of $150,000 was reasonable. *See also Schexnayder v. Scottsdale Insurance Co.*, Civ.A.6:09-cv-1390, 2011 WL 3273547 (W.D. La. July 29, 2011) (granting a jointly filed motion by the parties for a declaratory judgment seeking approval of the settlement and a declaration that the interests of Medicare were adequately protected by setting aside a sum of money for future medical expenses after the parties could not obtain approval from Medicare of the proposed Medicare Set Aside Arrangement in a liability case); *Frank v. Gateway Ins. Co.*, Civ. A. 6:11-0121, 2011 WL 868872 (W.D. La. March 13, 2012) (ordering the plaintiff to deposit in a separate account a portion of the settlement proceeds to pay for future medical expenses in response to the parties' Motion for Determination of Need for, and the Amount of Medicare Set Aside).

Ultimately, whether a settlement requires an MSA will vary depending on the particular facts and circumstances of a case. However, irrespective of whether a settlement needs to include an MSA, the parties carefully should consider Medicare's interest in future payments and document their efforts. Afterward, if the parties remain uncertain whether they need an MSA, they should consider retaining a third-party vendor that specializes in MSP compliance to evaluate the need for an MSA and, if necessary, assess the amount of the MSA. If a third-party vendor specializing in MSP compliance does not recommend an MSA after evaluating a case, the third party's opinion letter will serve as additional proof that the parties reasonably considered Medicare's future interests at the time of the settlement.

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Medicare Settlement Policy

To ensure that a Medicare claim does not derail settlement negotiations during a mediation, you must help your client clearly articulate the conditions for settling a claim with a Medicare beneficiary before mediating. This raises three important questions that you need to address early in a case; namely, what is your client's Medicare settlement policy, and how and when should you communicate this to the opposing counsel? In light of the MMSEA reporting requirements and the increased likelihood that Medicare will seek to recover conditional payments that it has made, although in the past companies contentedly have included strong indemnity language in settlement agreements and relied on the plaintiffs' counsel

to reimburse Medicare, most clients have stopped trusting the plaintiffs' counsel to satisfy Medicare's interests. It is therefore critical that you understand your client's Medicare settlement policy so that you can communicate that policy effectively to an opposing counsel before you mediate.

Irrespective of the particulars of your client's Medicare settlement policy, you should make clear to a plaintiff's counsel that satisfying any interest that Medicare may have in the case is a precondition to funding a settlement. While one particular fixed formula will not ensure satisfaction of Medicare's interest, some practical suggestions include the following: (1) include Medicare as a payee on the settlement check; (2) withhold funding the settlement until a plaintiff's counsel provides a final demand letter to you from Medicare, and after you receive it, have your client issue two separate checks, one directly to Medicare in the amount of its claim, and a second check to the plaintiff and his or her attorney for the balance of the settlement proceeds; and (3) hold back a portion of the settlement funds based on the conditional amount of Medicare's claim and fund the balance of the settlement immediately; then release the amount that a client held back after the plaintiff's attorney sends Medicare's final demand letter to you. Again, whatever Medicare settlement policy your client has adopted, the key takeaway is that you must communicate the policy effectively to the opposing counsel well before you mediate.

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Mediation

In addition to reiterating your client's requirements for satisfying Medicare's reimbursement claim, you should document in writing the mechanism for funding a settlement and paying Medicare's claim before concluding a mediation. At the end of a long mediation, an attorney typically has a tremendous amount of pressure to put something in writing and will leave the details of the settlement for the final release. Frequently a lawyer will think that as long as a mediation agreement includes the essential terms of the settlement, a client can avoid requirements that could derail the agreement. The attorney will think of Medicare's interest as an ancillary matter that he or she can address in detail later. The reality is that an attorney should view the particulars of reimbursing Medicare as an essential *term* of a settlement partly because failing to reach an agreement on those particulars could render the settlement unenforceable. In fact, at least one reported case has reached this exact conclusion. *See Tomlinson v. Landers*, 2009 WL 1117399 (M.D. Fla. 2009) (holding that no settlement was reached between the parties because there was no meeting of the minds over whether Medicare should have been listed as a payee on the settlement check, which was an essential term of the agreement). At a minimum, a mediation agreement should contain language obligating a plaintiff to satisfy Medicare's claim, and it should state the mechanism for paying Medicare.

A final settlement agreement should reiterate the conditions for funding the settlement and include indemnify and hold-harmless language, a waiver of the plaintiff's private cause of action under 42 U.S.C. §1395y(b)(3)(A), language expressly acknowledging the potential impact of the settlement on the plaintiff's right to future Medicare benefits and related release language, and a cooperation clause regarding future Medicare issues and reporting requirements.

Once a client settles a case, the plaintiff's counsel will need to report the amount of the settlement to Medicare's recovery contractor, along with the procurement costs, meaning attorney fees and other costs. On receiving this information, Medicare will perform a search of its claim history and issue a final demand letter stating Medicare's final claim amount. This letter serves as formal notice that the 60-day clock for paying the claim has begun. If the plaintiff and his or her attorney do not pay Medicare within 60 days, interest begins to accrue on the amount owed. 42 U.S.C.A. §1395y(b)(2). At the same time, your client will need to report the settlement to Medicare to comply with MMSEA section 111. To do so, you will need to provide your client with the following information about the Medicare beneficiary: (1) full name; (2) Social Security number; (3) state of venue; (4) date of the incident; (5) alleged cause of the injury or illness (ICD-9 "E" or event code required); (6) the date of total payment; and (7) the date of the payment amount. Once a plaintiff's counsel has received Medicare's final demand letter and forwarded it to you, your client can fund the settlement adhering to the arrangement to which the parties previously agreed.

Conclusion

Preparing for a mediation involving a Medicare beneficiary begins at the earliest stages of litigation. Once you or your client determine that a plaintiff is a Medicare beneficiary, you need to consider Medicare's reimbursement rights for past and future expenses. The amount of past expenses or conditional payments can be obtained directly from Medicare. The conditional payment figure will provide the parties with a good idea of the amount of Medicare's reimbursement claim although Medicare won't make that clear absolutely until it issues a final demand letter. You and your client need to make good-faith efforts to consider and protect Medicare's future interest in a settlement. These efforts should include evaluating medical expenses, if any, that a plaintiff may incur from the date of settlement forward and whether a Medicare set aside (MSA) is required. Although ultimately the parties involved will need to decide whether a settlement warrants an MSA on a case-by-case basis, in every instance you will need to analyze in good faith its appropriateness and document the analysis.

In the end, all parties participating in a mediation involving a Medicare beneficiary have a vested interest in protecting Medicare's interest. Addressing Medicare's claim early in a case will best serve mediating parties so that the Medicare claim does not impede settlement negotiations during mediation. FD