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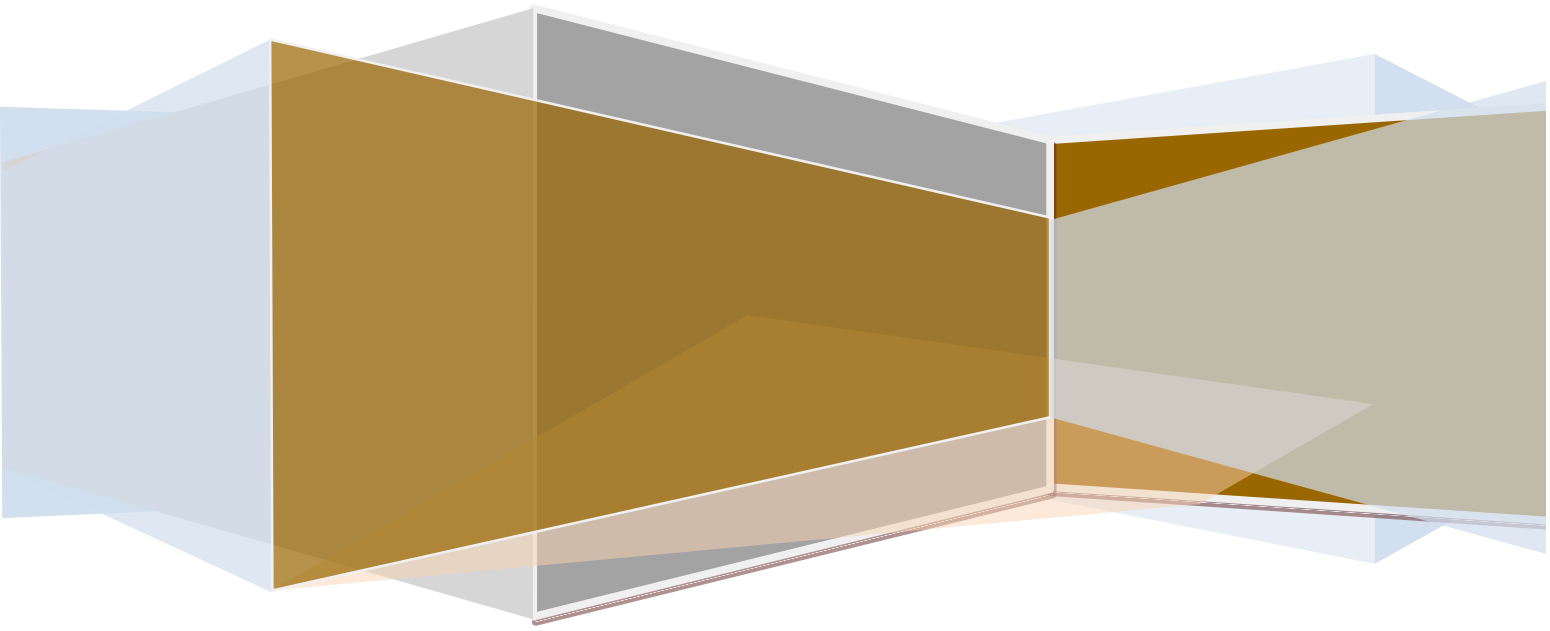
The Medicare Secondary Payer Act And Mandatory Reporting Requirements:

Driving Through the Fog



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Driving Through the Fog

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Table of Contents

I. Introduction

The Medicare laws have undergone significant changes. With the relatively new reporting regulations and the focus on compliance, litigators must implement new procedures in their practice. Many companies are establishing guidelines to obtain information needed to comply with the Medicare Secondary Payer Act ("MSP") and the Medicare, Medicaid and SCHIP Extension Act of 2007 ("MMSEA").

The Centers for Medicare & Medicaid Services ("CMS") is responsible for oversight of the Medicare program. While the CMS has published information to guide the parties, there is room for interpretation of many of the guidelines and, in some instances, there are no guidelines to assist the parties.

This manuscript is designed to provide parties involved in toxic tort liability suits with knowledge of the key provisions of the MSP and the MMSEA. The manuscript focuses on the practical aspects of obtaining information needed for compliance, common misconceptions and risk avoidance. The manuscript also discusses the significance of cases involving incidents that pre-date the December 5, 1980 MSP, practical aspects of determining when the December 5, 1980 policy may be applied and recent guidance from the CMS on that issue.

II. What is Medicare, and Who is Entitled to Medicare?

Medicare is the nation's health insurance program for individuals who are age 65 or older and individuals with certain disabilities. Individuals of any age with end-stage renal disease ("ESRD") (permanent kidney failure requiring dialysis or a kidney transport) may qualify for Medicare. In addition, persons who have received Social Security or Railroad Retirement Board Disability benefits for 24 months may receive Medicare benefits. If an individual has Lou Gehrig's disease, Medicare benefits begin the first month he received disability benefits. *The Official Website of the Social Security Administration;* What is Medicare?; SSA Publication No. 05-10043, ICN 460000, June 2011; December 7, 2011; (http://www.socialsecurity.gov/pubs/10043.html)

Medicare provides coverage for 47.5 million people. Medicare is paid for from two trust fund accounts held by the U.S. Treasury (collectively "Medicare Trust Funds"). Medicare is funded by the taxpayers, interest earned on the trust fund investments and premiums paid by those who are not eligible for premium-free benefits. Department of Health & Human Services,; Centers for Medicare & Medicaid Services; How is Medicare Funded?; CMS Product No. 11396; Revised May 2011; December 7, 2011;
(http://www.medicare.gov/Publications/Pubs/pdf/11396.pdf)

III. The Medicare Time Line

In evaluating Medicare's rights and the parties' responsibilities, it is necessary to understand at least some history of the Medicare provisions. The following summary is an abbreviated time line designed to assist litigators in determining whether Medicare has an interest in the case, and/or whether there is an exception to either protecting Medicare's interests

or reporting a payment to a Medicare beneficiary in the form of a settlement, judgment, award or other payment (hereinafter "settlement or judgment").

A. The 1965 Social Security Act

Medicare was first enacted on July 30, 1965 as a part of the Social Security Act ("the Act"). *The United States Social Security Administration*; SSA History; History of SSA During the Johnson Administration 1963-1968; December 7, 2011; (http://www.ssa.gov/history/ssa/lbjmedicare1.html). Under the original system, Medicare was, in almost all instances, the primary payer – that is, it paid health claims first. In workers' compensation claims, however, the worker's compensation plan was deemed the primary payer, and Medicare acted as only a secondary payer. As one would expect, the costs of Medicare soared.

B. The Medicare Secondary Payer Act ("MSP")

In 1980, Congress amended the Social Security Act to include the MSP, which became effective on December 5, 1980. 42 U.S.C. § 1395y(b)(2) (Regulations are promulgated under 42 C.F.R. 411.20, *et seq)*. The MSP sets forth Medicare's status as a secondary, rather than primary payer, providing that Medicare will not make a payment in the event a payment has been made, or reasonably could be expected to be made under a workers' compensation law or plan, an automobile or liability insurance policy or plan (including a self insurance plan) or no fault insurance. The underlying rationale of the MSP is that because Medicare uses tax dollars to pay beneficiaries' medical expenses, the public interest is best served by requiring that employers and tortfeasors be deemed primary payers and reimburse Medicare for costs related to such claims. "Medicare Secondary Payer" is the term used when the Medicare program does not have primary payment responsibility (that is, another entity has the responsibility for paying before Medicare). The MSP has significantly broadened Medicare's reach, with the clear intent of shifting primary responsibility for payment of a beneficiary's medical expenses from the Government to the responsible entities.

Under the MSP, if Medicare makes payments on an injured party's behalf when the treatment should have been covered by the worker's compensation carrier or the tortfeasor, then the Medicare payment is deemed "conditional," and Medicare is entitled to reimbursement pursuant to 42 U.S.C. § 1395y(b)(2). Litigators refer to this reimbursement right as a "lien". In Medicare terms, the reimbursement obligation is known as a "conditional payment obligation." As to any conditional payments it has made, Medicare may seek reimbursement from any of the following: a Medicare beneficiary, a provider, a supplier, or attorney who has received a primary payment.

It is important to note that the conditional payment obligation is statutory. There is no need for an "intervention" or even notice to the parties. The parties' knowledge of Medicare's reimbursement rights is presumed under the statute. 42 C.F.R. § 411.24.

As a practical matter, defendants must be aware that tortfeasors are looked upon as potential primary payers, and the CMS has a right of reimbursement if the claim is settled or if there is an adverse judgment.

C. Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 ("MMSEA")

The MMSEA ("Section 111"), effective January 1, 2009, requires all liability insurers (which includes self-insurers, no fault insurers and workers' compensation insurers) to determine whether the plaintiff is Medicare eligible. In addition, these entities must report every case in which there is a payment to a Medicare beneficiary in the form of a settlement or judgment. Entities responsible for complying with Section 111 are referred to as Responsible Reporting Entities ("RREs"). Failure to follow the reporting requirements contained within Section 111 may lead to significant penalties and fines. 42 U.S.C. § 1395y(b)(7)&(8).

IV. Medicare Pre-Settlement Procedural Overview

As stated, the CMS is responsible for oversight of the Medicare program. The Coordination of Benefits Contractor ("COBC") identifies other health benefits/plans available to a Medicare beneficiary for the purpose of preventing the mistaken payment of Medicare benefits. The Medicare Secondary Payer Recovery Contractor ("MSPRC") protects the Medicare Trust Funds by recovering payments Medicare has made when another entity in fact had primary payment responsibility.

When an injured party has a pending liability, no fault, or worker's compensation claim, he is required to report information about his claim to the COBC. A defendant may also report a pending claim. However, a report of a pending case does not satisfy the requirement that an RRE report a settlement or judgment under the MMSEA. Once the case is established with the COBC, the MSPRC issues a "rights and responsibilities letter" to the party. Within 65 days of issuance of the rights and responsibilities letter, the MSPRC should issue a conditional payment letter, which sets forth "identified" medical services (and associated costs) believed to be related to the pending claim. The MSPRC makes clear that the conditional payment letter cannot be relied upon as the "final amount" due Medicare. Rather, the conditional payment calculation is merely an "interim" amount of conditional payment obligations and is not a request for payment, for the simple reason that Medicare has not yet completed its investigation. As discussed below, once the investigation is completed, Medicare's final calculation of the amount it is owed could be greater or less than the amount set forth in the conditional payment letter.

The process of reporting pending liability claims to Medicare and obtaining the amount actually owed to Medicare is described on the MSPRC website. *Medicare Secondary Payer Recovery Contractor;* Liability Insurance, No-Fault Insurance, and Workers' Compensation Recovery Tool Kits; December 7, 2011; (http://www.msprc.info/index.cfm?content=Toolkits). The entire process (from initially contacting the COBC) to issuance by the MSPRC of the final demand letter, which takes place after a settlement) ordinarily takes approximately eight (8) weeks, although the COBC is experiencing significant delays at this time.

V. Tools for the Litigator

One of the first steps the parties should take in litigation is to determine if the plaintiff is Medicare eligible. If the plaintiff is not Medicare eligible, the parties should determine if he/she

could become eligible during the pendency of the suit or within the thirty (30) months of a settlement or judgment. There are several tools to assist in making this determination.

1. Written Discovery

Written discovery to the plaintiff should be aimed at determining Medicare eligibility and the possibility of future eligibility. Many of the items listed in the CMS User Guide Claim Input File Layout should be requested. (CMS User Guide, Chapter V, p. 10). *Centers for Medicare & Medicaid Service;* MMSEA Section 111 Medicare Secondary Payer Mandatory Reporting; Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Workers' Compensation USER GUIDE (July 3, 2012) ("CMS User Guide");
(http://www.cms.gov/Medicare/Coordination-of-Benefits/MandatoryInsRep/NGHP_User_Guides.html)

The defendant's discovery should include authorizations, which allow the defendant to contact Medicare and investigate the conditional payment obligation. If the defendant is met with objections, reference should be made to 42 U.S.C.1395y(b)(8)(A)(i), as well as the CMS User Guide, which mandates that a defendant obtain and report certain information.

2. Case Management Orders and/or Scheduling Orders

A more efficient mechanism for obtaining the necessary Medicare related information is to request that the court issue a Management Order and/or a Scheduling Order. Some courts already have such orders in place.

3. Query Process

If there is an immediate need to determine the Medicare status of an injured party, the Beneficiary Lookup feature on Section 111 of the Coordination of Benefits Secure Website ("COBSW") allows an online query. (CMS User Guide, Chapter I, p. 12 and Chapter IV, p.8). The information provided by the query is limited to whether the injured party is a beneficiary. No additional details are provided. There are limitations to the number of plaintiffs that may be queried per month. In addition, there are two methods of reporting settlements. RRE's who plan to report by the Direct Data Entry reporting option will not have access to the query system.

4. Self-Service Information Feature

The MSPRC has announced it is adding a Self-Service Information feature to its Customer Service Line. This new feature gives callers the ability to obtain the most up-to-date "conditional payment" and "final demand" letters, as well as the dates those letters were issued, without having to speak with a Customer Service Representative. CMS indicates this feature will be available 24 hours a day, 7 days a week, with no wait time. Callers will need the following information to utilize the feature:

- Case identification number (found on all MSPRC correspondence)
- Beneficiary's date of birth
- First five letters of the beneficiary's last name as it appears on his/her Medicare card

- Last four digits of the beneficiary's Social Security number (or full Medicare number)

Medicare Secondary Payer Recovery Contractor; MSRPC E-News Bulletin: New Self Service Information Feature 03-30-11; December 7, 2011;
(http://www.msprc.info/newsletter/view_message.cfm?mid=35)

VI. Defendants/RREs Have Two Separate and Distinct Duties

If the plaintiff is or may become a Medicare beneficiary (during the pendency of the suit or within thirty (30) months), the Medicare regulations impose two separate and distinct duties: (A) determine if Medicare has a potential interest in the case and, if so, protect that interest; (B) report the settlement or judgment.

A. The Parties Must Protect Medicare's Reimbursement Interests

A common misconception among plaintiffs, defendants, and attorneys is the scope of the settling defendant or RRE's duties. Some litigators are under the impression that an RRE's duty under the MSP is limited to reporting. Both the MSP and recent case law make clear that an RRE also has a duty to reimburse Medicare for payments made to an injured party. In addition, a recent letter issued by the CMS provides that the parties must also consider Medicare's potential future payments.

1. Reimbursing Medicare for its Conditional Payments

Pursuant to 42 C.F.R.§ 411.22, a primary payer must reimburse Medicare "if it is demonstrated that the primary payer has or had a responsibility to make a payment." The quoted language seems to infer that, absent liability (or responsibility), there is no reimbursement obligation. However, the regulation quickly dispels that notion by providing that a primary payer's responsibility may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver or release (whether or not there is a determination or admission of liability), or by other means, including but not limited to a settlement. The regulation even delineates the agency to whom the payment should be made.

Plaintiffs who receive payment from a primary payer have the same obligation under 42 C.F.R. § 411.22. In fact, a plaintiff is obligated to reimburse Medicare within 60 days of receipt of payment. This requirement could present problems, especially in cases involving multiple defendants.

a. *United States v. James Stricker*

The complaint filed in *United States v. James Stricker* outlines the reimbursement obligations of the parties. *United States v. James Stricker at* (ftp://173.226.159.173). The suit included several defendants, including plaintiffs' counsel, the defendants in the underlying case, and their insurers. Although *Stricker* was ultimately dismissed on the basis of prescription, the court's discussion of the reimbursement obligations is helpful. *United States v. James Stricker*, 2010 WL 6599489 (N.D.Ala).

In light of *Stricker* and regulations which require both a plaintiff and defendant to reimburse Medicare, the following question is often posed: If the regulations allow either party to reimburse Medicare, should a defendant fund a settlement and rely upon plaintiff to reimburse Medicare? It is critical that defendants be aware that payment of the settlement funds to anyone other than the CMS (or one of its designated agencies) is contrary to 42 C.F.R. § 411.22 and poses significant risks. Unless the CMS is a party to a settlement agreement, the CMS is not bound by a contractual agreement between plaintiff and defendant. Funding a settlement and relying upon a plaintiff to pay Medicare carries the risk of a subsequent claim by Medicare. Thus, a defendant who has paid the plaintiff risks having to pay the settlement funds, again, to CMS. If the CMS does take legal action to recover from the primary payer, CMS may recover double damages and interest. 42 C.F.R. § 411.24. See *Harrelson v. Arcadia (68 So.3d 663, 2010-1647 (La.App. 1 Cir. 6/10/11))* and *Wilson v. State Farm Mutual Automobile Insurance Company (2011 WL 2378190 (W.D.Ky.))* which held that the defendants were reasonable in withholding settlement funds in order to assure that Medicare's interests were protected. Note, however, that in *Zaleppa v. Seiwell (9 A.3d 632)*, the Pennsylvania Superior Court held that in order for a defendant to withhold settlement funds to protect Medicare, the defendant should ensure that Medicare's interests are contemplated during (or before) negotiations (or trial) and that methods used to protect Medicare should be agreed upon (to the extent possible) by the parties.

CMS has a right of action to recover payments from any entity that has received a primary payment. As evidenced in *Stricker*, CMS clearly intends to enforce its reimbursement rights.

b. Is Medicare Entitled to 100% Reimbursement When Plaintiff Settles with a Defendant Who is Only Partially at Fault?

The United States Court of Appeals recently addressed the issue of reducing Medicare's interest in a settlement based upon the defendants' degree of fault in *Hadden v. U.S.A.*, 661 F.3d 298 (6th Cir. 2011). Hadden, a Medicare beneficiary, was hit by an 18-wheeler truck which swerved to avoid hitting a vehicle that made an illegal turn and then fled the scene. Hadden brought a claim against the trucking company under the laws of West Virginia, a comparative law state. He made a claim against the defendant for full damages, even though it was clear that the "empty chair" defendant was partially, if not 100% at fault. Plaintiff settled the claim against the defendant for $125,000.00.

Following the settlement Medicare requested all of its conditional payments totaling $82,036.17 (less recovery cost due Hadden's attorney per 42 C.F.R. 411.37), despite the fact that plaintiff's settlement included non-medical items. Hadden paid the amount demanded and administratively appealed the decision. The appellate court, in a 2-to-1 decision, upheld the trial court citing the following rationale:

> **And thus a beneficiary cannot tell a third party that it is responsible for all of his medical expenses, on the one hand, and later tell Medicare that the same party was responsible for only 10% of them on the other.**

That is precisely what Hadden attempts to do here. In his claim against Pennyrile (the defendant), he did not demand that it pay for only 10% of the medical expenses that he incurred as a result of his accident; he demanded that it pay for *all* of them. That choice has consequences - one of which is that Hadden must reimburse Medicare for those same expenses…

In *Zinman v. Schalala*, 67 F 3rd 841 (9th Cir. 1995), the Ninth Circuit issued a similar opinion. *Zinman* holds that Medicare has a right to full reimbursement of its conditional payment even when a beneficiary receives a discounted settlement from a third party.

2. Protecting the Medicare Trust Funds When the Injured Party Could Incur Future Medicals

The CMS has been actively involved in protecting the Medicare Trust Funds in workers' compensation settlements, and in fact has issued numerous guidelines to assure that the Medicare Trust Funds are protected from payment of future medicals. However, it is only recently that Medicare has addressed future medicals in a liability setting.

There are numerous distinctions between workers' compensation and liability cases. Arguably, the policies issued in order to protect the Medicare Trust Funds and the penalties for failure to protect Medicare's interests in a workers' compensation case should not equally apply in a liability case. However, in a recent handout, CMS took the position that the Medicare Trust Funds must be protected from payment for future services in both workers' compensation and liability cases. *Stalcup, Sally; Department of Health & Human Services, Centers for Medicare & Medicaid Services, Division of Financial Management and Fee for Service Operations; Region VI* May 25, 2011 handout; ("Region VI May 25, 2011 handout"). (ftp://173.226.159.173). In light of this statement and until additional guidance is issued from the CMS or the judicial system, a review of the procedures in workers' compensation settings is instructive.

a. Workers' Compensation Setting

In the workers' compensation arena, the CMS discusses the requirements for setting aside funds to pay for future medical expenses in a series of memoranda. The first of these memoranda is dated July 23, 2001, and is often referred to as the "Patel Memorandum". *Centers for Medicare & Medicaid Services; Workers Compensation Agency Services*; Overview; December 7, 2011; (https://www.cms.gov/WorkersCompAgencyServices/)

Medicare will review a proposed Medicare Set Aside ("MSA") for Medicare beneficiaries in a workers' compensation case if the settlement exceeds $25,000. In cases in which the injured party is not yet eligible, the CMS will review a proposed set aside if the settlement exceeds $250,000 and there is a "reasonable expectation" of Medicare enrollment in 30 months or less after the settlement. CMS's April 22, 2003 memorandum defines a "reasonable expectation" of Medicare enrollment as follows:

1. The individual has applied for Social Security Disability Benefits;
2. The individual has been denied Social Security Disability Benefits but anticipates appealing that decision;
3. The individual is in the process of appealing and/or re-filing for Social Security Disability Benefits;
4. The individual is 62 years and 6 months old (i.e., may be eligible for Medicare based upon his/her age within 30 months); or
5. The individual has an End Stage Renal Disease (ESRD) condition but does not yet qualify for Medicare.

CMS will not review a worker's compensation case below the thresholds. However, the CMS memoranda indicate it expects the parties to protect its future interests.

In a worker's compensation case where an injured party receives a settlement in which there are remaining funds, even after payment of the conditional payment obligation, there are risks for failure to establish a set aside or some other fund to pay for future medicals. If Medicare pays medical bills it believes should have been paid by the injured party's MSA, it may, among other actions:

1. Deny the claimant future medical care.
2. Refuse to recognize the settlement.
3. Assert a claim or file suit against the beneficiary, primary payer and/or an attorney.

42 C.F.R.§ 411.46; 42 C.F.R.§ 411.24

b. Liability Setting

Until recently, the parties had no guidance on whether a set aside, or some similar mechanism, is required in a liability setting. After much scholarly debate on whether MSAs were required, the CMS issued the Region VI May 25, 2011 handout. (ftp://173.226.159.173). The applicability of the handout is limited to the states covered by the Region VI office, which are Oklahoma, Texas, New Mexico, Louisiana and Arkansas.

According to the Region VI May 25, 2011 handout (which expressly states is not intended to take the place of written law or regulations), the law does not require a "set-aside". Rather, the law requires that the Medicare Trust Funds be protected from payment for future services in both workers' compensation and liability cases. CMS states that there is no distinction in the law. A "set-aside" is the CMS's method of choice, and the CMS believes it provides the best protection for the program and the Medicare beneficiary.

CMS assumes that whenever a settlement or judgment provides funds for future medical services, it can be reasonably expected that those funds are available to pay for future services related to what was claimed and/or released in the settlement or judgment. For that reason, Medicare should not be billed for future services until those funds are exhausted by payments to providers for services that would otherwise be paid by Medicare. CMS also takes the position

that Medicare's payment for those same past services is recoverable and payment for those future services is precluded by Section 1862(d)(2)(A)(ii) of the Social Security Act.

The Region VI May 25, 2011 handout also addresses the obligations of the plaintiff and defense attorneys. The following quote is instructive:

> Each attorney is going to have to decide, based on the specific facts of each of their cases, whether or not there is funding for future medicals and, if so, a need to protect the Trust Funds. If the answer for plaintiff's counsel is yes, they should see to it that those funds are used to pay for otherwise Medicare covered services related to what is claimed/released in the settlement, judgment or award. If the answer for the defense counsel or the insurer is yes, they should make sure their records contain documentation of their notification to plaintiff's counsel and the Medicare beneficiary that the settlement does fund future medicals which obligates them to protect the Medicare Trust Funds.

The Region VI May 25, 2011 handout certainly answers the question as to the parties' obligations to protect the Medicare Trust Funds. However, the mechanisms for protecting the Medicare Trust Funds and numerous other questions remain unanswered.

1. May the Parties Allocate the Settlement Funds to Categories Other than Future Medicals?

In most personal injury cases, a plaintiff usually asserts a claim for general damages, such as pain and suffering, as well as special damages, such as past and future medicals. Medicare has no interest in settlement funds that compensate a plaintiff for pain and suffering. If the parties allocate the settlement to pain and suffering, does this obviate the need to protect the Medicare Trust Funds? The CMS recently addressed this issue and stated as follows:

> The fact that a settlement/judgment/award does not specify payment for future medical services does not mean that they are not funded. The fact that the agreement designates the entire amount for pain and suffering does not mean that future medicals are not funded. The only situation in which Medicare recognizes allocations of liability payments to nonmedical losses is when payment is based on a court of competent jurisdiction's order after their review of the merits of the case. A review of the merits of the case should involve a review of the facts to determine whether there are future medicals – not to determine the proper allocation of funds. If the court of competent jurisdiction has reviewed the facts of the case and determined that there are no future medical services Medicare will accept the court's designation.

Region VI May 25, 2011 handout*;* (ftp://173.226.159.173)

2. Medicare Has Issued a Safe Harbor Where the Treating Physician Certifies that Future Treatment is Not Required.

CMS has issued a policy memorandum addressing liability set asides in cases where future treatment is not required. The memorandum provides that if the treating physician certifies in writing that no future medical treatment is required, Medicare will consider its interest satisfied. *Department of Health & Human Services, Centers for Medicare & Medicaid Services*, September 30, 2011 Memorandum; Medicare Secondary Payer – Liability Insurance (Including Self-Insurance) Settlements, Judgments, Awards, or Other Payments and Future Medicals – INFORMATION;
(https://www.cms.gov/COBGeneralInformation/Downloads/FutureMedicals.pdf)

3. With No Formal Procedure for Approving Set Asides in a Liability Setting, How Do the parties Resolve a Case Where Future Medicals are Reasonably Expected to be Incurred?

In cases where a plaintiff will incur future medicals, plaintiff's counsel may wish to approach the court for an order approving a proposed plan. There are a number of cases, some involving liability settlements, which support this procedure. *Smith v. Marine Terminals of Arkansas*, 2011 WL 3489806 (E. D. Ark., August 9, 2011); *Big R. Towing, Inc. v. Benoit*, 2011 WL 43219 (W.D. La., June 5, 2011) and *Neil v. Ditter, Inc.*, 2009 WL 3815388 (Minn. Dist. Ct., July 29, 2009).

B. The RRE Must Report Settlement, Judgments, Awards and Other Payments

Section 111 of the MMSEA establishes mandatory reporting requirements. 42 U.S.C. 1395y(b)(7) & (b)(8). The Section 111 requirements are an addition to existing MSP law and regulations. They do not change or eliminate any existing MSP requirements. (CMS User Guide, Chapter I, p. 7).

The purpose of Section 111 is to help the Medicare program determine primary versus secondary payment responsibility. Section 111 assists the CMS in determining if there is a recovery claim. Reporting is required regardless of whether there is an admission or determination of liability.

While Section 111 has received substantial attention, it should be noted that 42 C.F.R.§ 411.25 has required primary payers to notify the CMS of settlements or judgments since the inception of the MSP in 1980. In fact, the complaint filed in *United States v. James Stricker* is based, in part, on the parties' failure to report pursuant to 42 C.F.R.§ 411.25.

Section 111 reporting involves much more detail than a report pursuant to 42 C.F.R.§ 411.25. In addition, in an effort to assure full compliance, the CMS imposes a penalty of $1000, per day, per plaintiff, for failure to report under Section 111. 42 U.S.C. § 1395y(b)(7) & (b)(8).

1. Who is Required to Report?

All RRE's are required to report. If a defendant pays a settlement or judgment, and that settlement or judgment does not fall within a policy exception to Section 111 or is not below a certain threshold, the RRE must report.

What rules apply if numerous defendants enter into separate settlements with the plaintiffs - a common scenario in many toxic tort cases? The CMS User Guide indicates if there are separate settlements with the same plaintiff, then each RRE reports that separate settlement amount. However, for a settlement or judgment with joint or several liability, each RRE must report the total settlement or judgment – not just its assigned or proportionate share. (CMS User Guide, Chapter III, p. 19). In addition, notice to the CMS by an entity other than the applicable RRE does not satisfy an RRE's reporting obligations under Section 111. In other words, a report by one RRE does not satisfy the reporting obligations of another RRE, even if they report on the same plaintiff in the same case. (CMS User Guide, Chapter III, p. 19).

2. Should the Entire Settlement or Judgment be Reported, or Only the Amount Paid to Compensate the Plaintiff for Medical Expenses?

The Total Payment Obligation to the Claimant ("TPOC") must be reported, regardless of any allocation by the parties or the court. The TPOC is the dollar amount of a settlement or judgment. A TPOC is usually a "one-time" or "lump sum" payment intended to resolve/partially resolve a claim. (CMS User Guide, Chapter III, p. 7). In most settlements of liability cases, there is no Ongoing Responsibility for Medicals ("ORM"). The parties almost always resolve all past, present and future claims, including future medicals. If the defendant will pay ongoing medicals, the User Guide provides that TPOC does not include amounts paid for ORM. Different reporting rules apply to TPOCs and ORMs.

3. When Is a Liability Settlement Reportable?

The RRE is required to report settlements and judgments when there is a TPOC. The TPOC date is the date the obligation is signed if there is a written agreement, unless court approval is required. If court approval is required, it is the later of the date the obligation is signed or the date of court approval. If there is no written agreement, it is the date of payment (or first payment if there will be multiple payments). The CMS User Guide explains that the TPOC date is not necessarily the payment date or check issue date. Rather, the TPOC date is the date the payment obligation was established.

Determining the date of the TPOC, as defined and discussed by the CMS, certainly seems to be subject to interpretation. For example, if the parties resolve a case and sign a short letter agreement that merely sets forth the amount of the settlement, but states that a Settlement Agreement, with more complete terms, will be drafted and signed, is there a TPOC? A litigator would certainly argue (and most courts would likely agree) that a settlement is not consummated or final until the parties have reached agreement as to price and terms. However, the CMS User Guide at least infers that a letter may be sufficient to create a TPOC. For those who are risk averse, it may be prudent to consider the TPOC date as the date of a letter agreement.

Alternatively, any letter agreement confirming a dollar amount of a settlement should set forth conditions, absent which there is no obligation to fund the settlement.

The CMS has routinely extended the deadlines for reporting certain liability settlements and judgments. The CMS website and alerts should be routinely reviewed, as thresholds are subject to change. The most recent Alert provides the following minimum thresholds and TPOC dates for reporting in liability insurance (including self-insurance) cases: *Centers for Medicare & Medicaid Services; Office of Financial Management/Financial Services Group*; June 20, 2012 Alert. Mandatory Total Payment Obligation to the Claimant (TPOC) Dollar Thresholds for Certain Liability Insurance (Including Self Insurance); October 3, 2012[1] http://www.cms.gov/Medicare/Coordination-of-Benefits/MandatoryInsRep/Downloads/NGHP_ALERT_TPOC_ThresholdsForLiabilityInsurance06202012.pdf

TPOC Amount	TPOC Date On or After	Section 111 Reporting Required in the Quarter Beginning
TPOCs over $100,000	October 1, 2011	January 1, 2012
TPOCs over $50,000	April 1, 2012	July 1, 2012
TPOCs over $25,000	July 1, 2012	October 1, 2012
TPOCs over $5,000	October 1, 2012	January 1, 2013
TPOCs over $2,000	October 1, 2013	January 1, 2014
TPOCs over $300	October 1, 2014	January 1, 2015

An RRE is not required to report settlements or judgments less than the existing thresholds. However, if the RRE does report, keep in mind that settlements and judgments with a TPOC less than a certain amount are currently exempt from reporting, and any attempts to report these settlements will be rejected. For example, if the TPOC date is on or after October 1, 2012 (in a liability settlement/judgment) and the TPOC amount is less than or equal to $300, the report will be rejected. (CMS User Guide, Chapter III, pp. 30-31).

These thresholds are solely for reporting and do not limit other obligations (such as reimbursement obligations) under the MSP. Based upon prior Alerts, the minimum thresholds for reporting will continue to decrease. It is anticipated that by January 1, 2015, all settlements, regardless of the amount, will be reported.

As previously mentioned, ORM is treated differently than a TPOC. RREs must report ORM if the ORM was assumed on or after January 1, 2010. In addition, there is no minimum threshold related to ORM. All ORMs must be reported, regardless of the amount, with the exception of workers' compensation ORM that meet all criteria in Table 11 of Section 6.8.2 of the July 2012 User Guide Version 3.4. (CMS User Guide, Chapter IV, p. 84).

[1] The mandatory TPOC thresholds for reporting workers compensation settlements are summarized in the CMS User Guide, Chapter III, pp. 31-33.

VII. The December 5, 1980 Policy

A. The Significance of Cases in Which Exposures or Ingestion Pre-date December 5, 1980

December 5, 1980, the effective date of the MSP, is important in evaluating the parties' responsibilities. CMS has determined, as a matter of policy, that it will not recover under the MSP provisions with respect to liability insurance (including self-insurance) or no-fault insurance settlements or judgments where the date of the incident ("DOI"), as defined by CMS, was prior to December 5, 1980, unless the claim involves exposure continuing on or after December 5, 1980.

The date of the incident does not affect the RRE's obligations or reporting responsibilities for workers' compensation because workers' compensation plans have been primary payers since 1965. (CMS User Guide, Chapter III, p. 37). As a practical matter, the December 5, 1980 issue only arises in certain types of cases, such as exposure, ingestion or implantation cases.

B. What Circumstances Warrant Reliance on the December 5, 1980 Policy?

The December 5, 1980 issue has been the subject of CMS teleconferences and Alerts. The most recent Alert provides as follows:

CMS indicates it will assert a recovery claim and Section 111 MSP reporting is required in the following situations:

- Exposure, ingestion, or the alleged effects of an implant on or after 12/5/1980 is claimed, released, or effectively released.

- A specified length of exposure or ingestion is required in order for the claimant to obtain the settlement or judgment, and the claimant's date of first exposure plus the specified length of time in the settlement or judgment equals a date on or after 12/5/1980. This also applies to implanted medical devices.

- A requirement of the settlement or judgment is that the claimant was exposed to, or ingested, a substance on or after 12/5/1980. This rule also applies if the settlement or judgment depends on an implant that was never removed or was removed on or after 12/5/1980.

When ALL of the following criteria are met, Medicare will not assert a recovery claim against a liability insurance (including self-insurance) settlement or judgment, and Section 111 MSP reporting is not required.

- All exposure or ingestion ended, or the implant was removed before 12/5/1980; and

- Exposure, ingestion, or an implant on or after 12/5/1980 has not been claimed and/or specifically released; and,

- There is either no release for the exposure, ingestion, or an implant on or after 12/5/1980; or where there is such a release, it is a broad general release (rather than a specific release), which effectively releases exposure or ingestion on or after 12/5/1980. The rule also applies if the broad general release involves an implant.

Centers for Medicare & Medicaid Services; Office of Financial Management/Financial Services Group; Liability Insurance (including Self-Insurance): Exposure, Ingestion and Implantation Issues and December 5, 1980 (12/5/1980); December 7, 2011;
(https://www.cms.gov/COBGeneralInformation/Downloads/NGHPExpIngImplant.pdf)

The CMS will look to the last date of exposure or ingestion when determining whether it will assert a claim and if reporting is required pursuant to Section 111. As indicated, the CMS not only looks to the facts established in a case, they also consider the facts that are "claimed, released or effectively released." The parties should proceed with caution when relying upon this exception as a basis for determining that there is no duty to protect Medicare's interests and no duty to report. The following examples should be considered when evaluating whether the parties fall within the December 5, 1980 policy.

> Example 1: Petition and written discovery indicate plaintiff worked at a defendant's premises from 1970 through 1982. Plaintiff testifies in deposition that he worked at defendant's premises through 1982, but his counsel stipulates that there was no exposure beyond 1979. Will the CMS defer to the stipulation? In light of statements by CMS that it will not defer to the parties' allocations on the types damages at issue in a settlement, it is unlikely it will defer to stipulations of the parties.
>
> Example 2: Petition alleges exposure post December 4, 1980. Plaintiff cannot recall any post December 4, 1980 work at defendant's premises or for defendant (his direct employer). Plaintiff recalls that he worked for a specific employer at a specific site. Plaintiff's Itemized Statement of Earnings from the Social Security Administration indicates he worked for that specific employer until 1982. The CMS could claim it has a reimbursement right. A risk adverse RRE who prefers not to litigate this issue should err on the side of caution and classify the case as a post December 4, 1980 case.
>
> Example 3: Plaintiff worked at Defendant X's premises from 1960 to 1970. He then worked at Defendant Y's premises from 1971 through 1985. Defendant X and Y enter into separate settlements with plaintiff. The CMS User Guide and the October 11, 2011 Alert indicate that the application of the December 5, 1980 issue is specific to a particular defendant. Thus, Defendant X would not report. Defendant Y would report and would assure that Medicare's interest in the settlement has been protected.

In discussions that pre-date the October 11, 2011 Alert, the CMS took the position that RREs should have "incontrovertible evidence" that exposure on or after December 5, 1980 did not exist. While the "incontrovertible evidence" language is not included in the October 11,

1011 Alert, it may be prudent for an RRE to rely upon the December 5, 1980 policy only where the pleadings and discovery provide no evidence of post December 5, 1980 exposures.

The October 11, 2011 Alert and the CMS User Guide provide examples of how the policy related to December 5, 1980 should be applied. These examples are instructive, but do not address all possible scenarios.

C. Potential Pitfalls of Relying Upon the December 5, 1980 Policy

The parties must recognize that the December 5, 1980 policy applies to liability insurance (including self-insurance) or no-fault insurance settlement and judgments. The date of the incident does not affect the RRE's obligations under the MSP or its reporting obligations under Section 111 for workers' compensation. (CMS User Guide, Chapter III, p. 37). When determining whether the December 5, 1980 policy applies, an RRE should carefully review the type of case at issue as well as what is claimed and/or released in the settlement.

VIII. Conclusion

The MSP and related regulations are complex provisions that are often subject to interpretation. While the CMS has provided guidelines to assist parties in interpretation and compliance, many questions remain unanswered. Hopefully, as the CMS obtains additional insight into the procedural problems with some of the regulations and the need for clarification, it will address and attempt to resolve those specific issues.

In the meantime, it is anticipated that CMS will continue to update its User Guides and issue Alerts, and may very well alter the thresholds amounts and dates for reporting. Defendants and potential RRE's should routinely refer to the CMS website for modifications to and/or guidance on its policies.

As in any area of the law, where an agency does not have the means to move quickly enough to resolve unanswered questions, the parties will look to the courts for interpretation of the regulations and rulemaking on areas that appear to remain unaddressed. Although formerly a rare topic for parties and litigators involved in liability cases, Medicare related issues are rapidly moving to the forefront and are becoming an indispensable consideration in these cases. As a result, we can expect that more courts will be addressing Medicare related issues, which should provide additional clarity as we search for a clearing in the Medicare fog.

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References with an (*) are password protected: Login is drimedicare. Password is password. Instructions: Select FTP directory. Select FTP again. Select DRIMEDICARE. Click on the link you wish to access.

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42 C.F.R.§ 411.24

42 C.F.R. § 411.25

42 C.F.R. 411.37

42 C.F.R. § 411.46

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Acronyms:

CMS - Centers for Medicare and Medicaid Services
COBC - Coordination of Benefits Contractor
COBSW - Coordination of Benefits Secure Website
DOI - Date of the Incident
ESRD - End-Stage Renal Disease
MMSEA - Medicare, Medicaid and SCHIP Extension Act of 2007
MSA - Medicare Set Aside
MSP - Medicare Secondary Payer Act
MSPRC - Medicare Secondary Payer Recovery Contractor
ORM - Ongoing Responsibility for Medicals
RRE - Responsible Reporting Entities
TPOC – Total Payment Obligation to the Claimant