Set Asides and Set Backs

By Leonard S. Levy

The mediation has been a difficult one, with liability and damages being contested. After many hours of hard work by all involved in the process, it is now going well. The parties move toward settlement of a personal injury suit involving an elderly woman who fell and fractured her hip. The plaintiff is in need of the settlement proceeds, since she has been unable to work at her part time job since the injury. Future surgery is contemplated.

After the mediator presents an offer, the plaintiff's attorney explains the calculation of the net amount available to the plaintiff after the defendant's insurer pays. The plaintiff accepts, and a settlement agreement is drafted. During the drafting process, counsel for the defense announces that, in order to ensure that Medicare's interests are protected, the company must set aside the full amount of the medical bills paid by Medicare, and for the future surgery.

Plaintiff's counsel is shocked. After all, he just explained to his client that historically, Medicare rarely enforced its lien. Besides, he has already explained to his client that there was no statutory or regulatory requirement that he notify Medicare that suit has been filed or settled. While he had every intention to contact Medicare to ascertain the extent of their claim, he had no idea that the insurance company would feel compelled to set aside sums to protect Medicare's interest in future medical bills. Until January 1, 2010 he would be correct.

Effective January 1, 2010, the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA), Pub.L. 110-173 (110th Congress), any and all parties who settle a personal injury claim with a Medicare recipient will be required to report the information to Medicare, and also ensure that Medicare's interests are protected through the date of settlement, judgment or other payment. To be sure, the law does not require set asides. However, it has been opined that the requirement to protect Medicare's interest is, in essence a "strict liability" requirement. That is, the burden will be on the defendant to ensure that Medicare's interests are protected up to 100% of its subrogation right as it exists as of the date of settlement, judgment or payment, regardless of the facts or defenses which are available.

Medicare now wants full reimbursement, regardless of comparative negligence issues. This is because Medicare does not recognize state law which apportions liability among plaintiffs and others who also are at fault.

The law was enacted in an attempt to ensure that the federal government saves money in cases where Medicare is supposed to be a secondary payer for its beneficiaries, after, among others liability carriers and self-insured employers pay their primary share of claims. The reporting requirements (which require a

defendant to answer numerous questions, including a claimant's social security and/or Medicare identification number), are designed to enable Medicare to review all liability and workers compensation settlements, judgments and awards owed to Medicare beneficiaries.

The question being asked by defense lawyers is, "how can I be sure that my client has complied with the requirement of protecting Medicare's interests without setting aside the full amount paid by Medicare?" Of course, this creates great difficulties for plaintiffs and defendants alike. For example, if all the money which would be paid by a carrier must be paid to Medicare instead, Plaintiff's incentive to settle is diminished. Matters that would otherwise resolve must move toward trial. Defense costs increase.

There is also a significant penalty for failure to report: $1,000 per day, per claim. This will certainly provide virtual certainty that the settlement will, indeed be reported.

In response to the proposed implementation of the new law, an organization, the Medicare Advocacy Recovery Coalition (MARC) was formed. Information on MARC's web site (www.marccoalition.com) states that the coalition is comprised of many different sectors including attorneys, brokers, insured, insurers, insurance and trade associations, self-insureds and third party administrators. Among MARC's stated purposes is to "develop and implement legislative and regulatory strategy to enhance Medicare reimbursement and ensure that the secondary payer program works effectively, efficiently and economically." To that end, meetings are being held with the Centers for Medicare & Medicaid Services, an entity of the Department of Health and Human Services (DHHS), until 2001. According to Roy Franco, Director for Risk Management Strategies for Safeway, Inc., and steering committee co-chair for MARC, the government has focused more on smoothing the reporting mandate's implementation than on penalizing payers. But, if the process is proving complex for sophisticated players, the beneficiaries are even more likely to be caught in the middle.

At the present time, the "rules of the road" under the MMSEA have yet to be clearly defined. Until they are, both the defense and plaintiff bar must make their clients aware of the potentially significant impact of the enactment of the statute's provisions on resolution of personal injury and workers' compensation actions. A significant amount of work must be done to clarify precisely how MMSEA will be implemented.

Certainly, under the rules that presently exist, it is not at all prudent for plaintiff's counsel to ignore a Medicare lien simply because there is no specific requirement that he or she report a settlement to Medicare. Medicare does have the right, under applicable regulations, to seek reimbursement from the beneficiary's attorney to the extent the beneficiary received payments from tortfeasors or insurers. A beneficiary "or other party" that receives a "third party payment" is required to

reimburse Medicare within 60 days. (See 42 USC §1395y(b)(2)(B); 42 CFR §411.24(g), (h), (f)).

The major change brought about by the MMSEA is the requirement that Medicare's interests be protected. In effect, Medicare has acquired a level of insurance. The insurers are the third party's carrier, as well as the beneficiary's attorney. The unanswered question existing at this time is how to fulfill those duties, while at the same time bringing lawsuits to a close.

In the absence of clear guidance on how Medicare will consider those duties to have been fulfilled, it is necessary, that the plaintiff bar and defense bar discuss means by which this issue is approached in the context of case resolution. If such dialogues provide some general approach which takes into account the concerns each has, it will be of benefit to all concerned. Certainly, the first discussion of this topic should not be in the context of drafting a settlement agreement after hours of mediation. Although one possible solution is to create set asides, it is not necessarily the only solution.

Leonard S. Levy is a full-time mediator and arbitrator at ADR Services, specializing in insurance, real estate, commercial contract and general business, personal injury, and construction matters. He can be reached at lslevy@adrservices.org.