Dubious Claims

By Sharon C. Collier

The Medicare Medicaid and SCHIP Extension Act creates significant challenges for liability and self insurers. The new lien protection obligations are hindering settlements and complicating the efficient resolution of many claims. Liability insurers can, however, take steps to minimize the risks they face when settling Medicare beneficiary claims.

Medicare is a secondary insurance program that pays for medical services rendered to qualifying beneficiaries, which include people who are 65 and older, people under 65 who have certain disabilities and people of any age diagnosed with end-stage renal disease. In cases involving liability and self insurance, or "primary payers", Medicare typically pays for the medical services conditionally, subject to later recovery when there is a settlement, judgment or other payment. Medicare beneficiaries have an obligation to refund associated conditional payments to Medicare within 60 days of the settlement or judgment payment. The act's imposition of new reporting requirements and lien protection obligations on primary payers necessarily changes the way they handle third-party tort claims.

The act requires primary payers to identify all injured claimants who are or may be receiving Medicare benefits. Next year, primary payers will be required to report Medicare beneficiary injury claims so that Medicare can better identify when primary payer funds are potentially available. The primary payer has an affirmative duty to investigate whether a claimant is receiving Medicare benefits at any time during the life of the claim. The act requires the primary payer to report all injury claims made by Medicare beneficiaries, even if there is no determination or admission of liability. Failure to report Medicare beneficiary claims may result in a civil penalty against the primary payer of $1,000 for each day of noncompliance with respect to each claimant. The act provides no "safe harbor" provision for the primary payer if the claimant misrepresents his or her Medicare beneficiary status and/or it innocently fails to recognize that Medicare is making conditional payments.

Along with the obligation to investigate a claimant's Medicare beneficiary status comes a heightened duty to protect the Medicare lien. If the primary payer "is, or should be aware that Medicare has made a conditional primary payment," it is obligated to reimburse Medicare if the beneficiary does not, "even though it has already reimbursed the beneficiary or other party." 42 U.S.C. Sections 411.24(i)(1) and (2). Because the insurer is required to affirmatively investigate and identify which claimants are receiving Medicare benefits, the primary payer "should be aware" that Medicare is or may be making conditional payments in most instances. Thus, the insurer would be obligated to reimburse Medicare for unpaid liens, up to the amount of any settlement or judgment it paid, unless it can prove that the claimant misrepresented Medicare's involvement and that the insurer was otherwise deceived, despite its reasonable investigation. This new lien protection obligation also means the primary payer can no longer safely assume the Medicare beneficiary claimant will reimburse Medicare with the settlement or judgment proceeds.

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The primary payer who relies on the settling claimant and/or his or her attorney to repay the Medicare lien does so with potentially significant risk. In addition to suing any individual or entity who receives a primary payment, including an attorney, for reimbursement of the Medicare lien, the U.S. government has a right of action against the primary payer. The government may sue the primary payer for reimbursement of its Medicare lien up to the amount of the settlement or judgment paid by him or her, damages in the amount double that payment, and interest. The insurer who settles a Medicare beneficiary claim may, therefore, risk having to later pay three times the settlement amount if the claimant does not comply with his or her obligation to pay it.

If the government sues the primary payer for reimbursement of the Medicare payments, it will seek the full amount of the settlement payment, even though not all of the settlement proceeds were intended to cover the medical expenses incurred. The government has expressly warned primary payers that it will not consider liability or other allocations or motives behind any pre-trial settlement. It will not apportion medical expenses paid for any treatment originally alleged to have been caused and/or exacerbated by the accident. According to the Centers for Medicare and Medicaid Services, which administers Medicare, it is "not bound by any allocation made by the parties even where a court has approved such an allocation." The government has conceded that it will "normally" defer to an allocation made in a jury verdict or after a hearing on the merits. In all pre-trial settlements, however, the government will assume it is entitled to the entirety of the settlement proceeds to satisfy its Medicare lien.

The constitutionality of the government's stated refusal to recognize allocations and other considerations that take place in virtually all private settlements of third-party tort claims is questionable. Its failure to recognize the fault concepts inherent in liability claims creates particular challenges in catastrophic injury claims involving multiple tortfeasors. primary payers wanting to avoid the risk and expense of a lengthy trial cannot settle without fear that the government may later sue it for twice the entire amount it paid the claimant in settlement, if the claimant does not use the settlement funds to repay Medicare after the entire case is resolved. There are, however, claim resolution strategies that can minimize those risks.

When possible, settlements should be conditioned upon resolution of the Medicare lien. The primary payer should seek the claimant's agreement to either include Medicare as a payee on the settlement check or delay payment of the settlement until receipt of the final demand letter. Medicare will not issue a final demand letter until a settlement is reached. It may take many months to get the final demand letter, significantly delaying and/or frustrating settlement. The delay of withholding payment until receipt of the final demand letter from Medicare may also create a conflict with California's fair claims handling practices. If the insurer is unable to condition settlement upon satisfaction of the Medicare lien, protective language should be included in the settlement release.

At a minimum, the settlement release should include provisions of indemnification and waiver. The claimant should agree to indemnify the liability insurer for any claims of Medicare payment reimbursement. In practice, the claimant who does not repay Medicare would undoubtedly not repay or indemnify the insurer. An indemnification provision does, however, theoretically offer protection and may help encourage claimants to repay the Medicare lien. A settlement release should also require that the claimant waive his or her right to assert a private cause of action against the insurer and its insured for further recovery should the government sue him or her for reimbursement of the Medicare payments.

In some settlements, it may be appropriate to characterize the nature of the settlement proceeds. The release that includes the amount of Medicare payments, allocations of fault and apportionments of non-medical expense damages could help limit the amount Medicare would be entitled to recover. Although the Centers for Medicare and Medicaid Services has expressly stated its position that it is not bound by the parties' allocations, some courts have upheld them. See, e.g., *Estate of Foster v. Shalala*, 926 F.Supp. 850 (D. Iowa 1996), where the court concluded Medicare was not entitled to reimbursement for claims paid in the settlement of decedent's children's loss of consortium claim because Medicare proffered no evidence that the settlement compensated for the beneficiary's medical expenses; and *Smith v. Travelers Indemnity Co.*, 763 F.Supp. 554 (D. Fla. 1989), which permitted the government recovery for only the portion of settlement proceeds that had been identified as being for medical expenses of a Medicare beneficiary.

In larger settlements involving significant Medicare liens, the liability insurer may desire greater protection than a release can provide. A motion for court determination of the settlement allocations or judicial arbitration should provide persuasive evidence of the settlement portion Medicare is entitled to recover. Medicare should be served with notice of the motion or arbitration proceeding in advance of the hearing so that it has an opportunity to invoke its right to intervene and object to the allocations. The government's failure to object would provide further support for the validity and enforceability of the allocations confirmed by the judge or arbitrator.

The primary payer may also minimize its risks by creating a Medicare set-aside. A set-aside is a fund created from settlement proceeds to cover the anticipated lien amount. Unlike workers' compensation cases, Medicare set-asides are not required in liability cases. They may, however, provide a desirable solution in some settlements. Insurers and settlement structure brokers are creating new products, like set-asides, to cover the risks the Medicare Medicaid and SCHIP Extension Act creates for primary payers desiring to settle Medicare beneficiary claims.

Some practitioners have also considered actions in interpleader to resolve lien satisfaction. An interpleader action, however, would likely require plaintiff's counsel's consent, which may be difficult to obtain. It would also require the insurer to deposit into the court an estimated amount of Medicare's recovery entitlement. If the estimate is too high, the insurer would not be entitled to recover the overpayment. Jurisdiction may also present a problem. The federal government might remove a state interpleader action to federal court. Some federal courts have dismissed actions seeking resolution of the Medicare lien for failure to exhaust administrative remedies, even though it is unclear what administrative remedies exist to exhaust. See, e.g., *Walters v. Leavitt*, 376 F.Supp.2d 746 (E.D. Mich. 2005), in which a declaratory relief action seeking a final Medicare reimbursement demand was dismissed for the plaintiff's failure to exhaust his administrative remedies. Nonetheless, an action in interpleader may be worthwhile in the right case.

The Medicare Medicaid and SCHIP Extension Act is an evolving area of new law. There has not yet been any published court decisions indicating how it will be interpreted or applied in the context of third-party liability claims. The Centers for Medicare and Medicaid Services continues to hold bi-monthly teleconferences to address the questions and concerns of the act's practical application and issue written "alerts" to guide primary payers on these complicated issues. Either revision of the act or litigation of its intent may ultimately change the practical challenges created by the government's current failure to recognize the fault concept of liability insurance claims that distinguish them from no-fault programs like group health plans and workers' compensation. In the meantime, liability insurers must endeavor to identify Medicare beneficiary claimants, comply with the reporting requirements, and seek creative resolutions of their claims that at least minimize their risks.

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