Hot Topics in Medicare Secondary Payer Compliance

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Catherine E. Goldhaber is a senior shareholder of Segal, McCambridge, Singer & Mahoney, Ltd., in Chicago, where she defends corporations directly in Illinois and Michigan and manages multi-state litigation as national coordinating and trial counsel. She is a senior shareholder with Segal McCambridge, licensed in Illinois, Michigan and several federal jurisdictions. Her litigation practice focuses on claims related to product liability, premises liability and exposure to toxic substances. From responsive pleadings, discovery strategy, pretrial motions through trial and appeal, Catherine has handled every aspect of a case. Along with her litigation practice, Catherine counsels clients in Medicare Secondary Payer (MSP) issues, particularly as the issues arise throughout discovery and in resolution. Catherine serves as Vice Chair of DRI's MSP Task Force. The MSP Task Force provides DRI members with updates and resources to understand the laws that affect litigation involving Medicare beneficiaries.

Charles Medlin is a leader on the complex settlement development team at Garretson Resolution Group, providing settlement advisory and consulting services. Charles received his B.A. in French and Political Science from Appalachian State University and his J.D. with honors from the Charlotte School of law where he clerked for Judge Sam J. Ervin on the North Carolina Court of Appeals. Charles has extensive experience in driving success in multiple operational and commercial business units of Garretson, including in-depth work and oversight of Asbestos exposure programs. Prior to getting involved in Environmental and Toxic exposure cases, Charles served as a Subject Matter Expert in Garretson's Private and ERISA lien resolution group.

Barrye Panepinto Miyagi is a partner with the Baton Rouge, Louisiana firm of Kean Miller LLP. She practices in the areas of litigation, toxic tort defense, alternative dispute resolution and Medicare compliance. She has significant experience in handling settlement and litigation issues related to the Medicare Secondary Payer Act ("MSP"). Barrye also assists clients with the MSP reporting requirements as well as reviewing and drafting procedures for compliance. Barrye earned her B.S. from Louisiana State University in 1989. She earned her J.D. from the LSU Law Center in 1992.

Hot Topics in Medicare Secondary Payer Compliance

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The 2007 implementation of mandatory reporting under the Medicare, Medicaid and SCHIP Extension Act ("MMSEA")(P.L. 110-173) gives many litigators and claims handlers pause when it comes to case resolution. Each year seems to bring additional challenges in regard to MMSEA reporting compliance. This article, an accompaniment to the November 10, 2016, panel presentation of authors Medlin, Miyagi and Goldhaber, focuses on three current considerations: 1) the impact of Medicare Advantage Plans; 2) considerations surrounding the end date of exposure as evidenced and alleged; 3) the possibility of Medicare Set Asides.

I. Medicare Advantage Plans: Another Super Lien?

Most practitioners are well aware of Medicare's super lien which, in effect, requires the parties to determine if a plaintiff is a Medicare beneficiary and, if so, to reimburse Medicare. If the parties do not reimburse Medicare, Medicare may assert claims against plaintiffs, plaintiff lawyers and defendants. Further, if Medicare has to file suit, the defendants in the suit may face double damages.

Typically, plaintiffs' counsel obtains a final demand from Medicare. The final demand is issued from the federal government through its Centers for Medicare & Medicaid Services ("CMS") and, once paid, the CMS usually issues a letter indicating that Medicare's interest in the settlement (or judgment) is resolved and that Medicare is closing its file (Appendix 1). Many practitioners believe that receipt of this closing letter completes the obligation to protect Medicare's interests. However, recent case law raises serious questions about entities referred to as Medicare Advantage Plans (also referred to as Medicare Advantage Organizations) and their interests in settlement (or judgment) proceeds. In fact, the latest decisions hold that Medicare Advantage Plans have the same super lien as the federal government.

A. What is a Medicare Advantage Plan?

Traditional Medicare includes Medicare Part A (such as hospital care, skilled nursing facility care, home heath care, hospice care) and Medicare Part B (doctor visits, lab tests, surgery). The CMS sometimes refers to these plans as Medicare Part A and Part B fee-for-service.

Medicare Part C, also known as the Medicare Advantage program, was enacted in 1997 and effective 1999. Under the Medicare Advantage program, private insurers contract with the federal government and provide at least the same benefits an insured would receive under traditional Medicare. When a private insurer contracts with the federal government to provide Medicare Part A and Part B services, the private insurer is considered a Medicare Advantage Plan. Some Medicare Advantage Plans also offer Medicare Part D (prescription coverage). Medicare Advantage Plans are sometimes referred to as private fee-for-service plans.

Individuals who are Medicare eligible must choose between traditional Medicare Part A and Part B fee-for-service and a private fee-for-service plan. There are a few exceptions to this, one being hospice care, as well as services provided by a qualified teaching institution. Thus, if a plaintiff has a private fee-for-service plan (Medicare Part C), it is possible that both traditional Medicare and a Medicare Advantage Plan paid the plaintiff's medical expenses.

When CMS issues a letter indicating that Medicare did not pay a plaintiff's medical expenses or that Medicare's final demand has been paid and Medicare's file will be closed, the letter does *not* address the potential interests of a Medical Advantage Plan. Where a Medicare-eligible plaintiff has incurred significant medical expenses and CMS issues a letter indicating it has not paid any of the plaintiff's medical expenses, this is a red flag that a Medicare Advantage Plan may have an interest in settlement or judgment proceeds.

One may ask: "How does a Medicare Advantage Plan learn of a payment to the plaintiff if the plaintiff does not disclose the payment?" There are numerous means by which a plaintiff's lawsuit may be discovered. Several practitioners also believe that the CMS may routinely exchange information with the Medicare Advantage Plans in order to assure that they are informed of settlements and have the information necessary to assert recovery claims.

B. Why Parties Should Identify and Plan for Resolution of Potential Claims of Medicare Advantage Plans: The Evolving Case Law

The Medicare Part C program is a federal program – operated under federal regulations and funded by federal dollars. CMS takes the position that Medicare Advantage Plans have the same recovery rights as traditional Medicare under the Medicare Secondary Payer Act ("MSP') (Appendix 2). Several courts have addressed the issue and have reached the same conclusion. See, *e.g.*, *In re Avandia Mktg., Sales Practices & Products Liab. Litigation*, 685 F.3d 353 (3d Cir. 2012) ("*Avandia*"); *Humana Med. Plan, Inc. v. W. Heritage Ins. Co.*, 15-11436, 2016 WL 4169120 (11th Cir. Aug. 8, 2016) ("*Western Heritage*").

Many cases also hold that the federal right to reimbursement for Medicare Advantage plans preempts any state law limitations on such a right. *See, e.g.*, *Cupp v. Johns*, 2:14-CV-02016, 2014 WL 916489, at *1 (W.D. Ark. Mar. 10, 2014); *Potts v. Rawlings Co., LLC*, 897 F.Supp.2d 185 (S.D.N.Y. 2012); *Humana Med. Plan, Inc. v. W. Heritage Ins. Co.*, 15-11436, 2016 WL 4169120 (11th Cir. Aug. 8, 2016) ("*Western Heritage*"). When there is a claim by a Medicare Advantage Plan, practitioners may instinctively seek relief from a state court on the basis that the Medicare Advantage Plan's request for reimbursement appears contrary to state law and/or they seek state court adjudication on the amount of the Medicare Advantage Plan's reimbursement right. However, the growing case law suggests that the parties must exhaust the CMS administrative review and appeal process before a federal court may adjudicate the matter.

In *Western Heritage*, the Eleventh Circuit agreed with the Third Circuit's *Avandia* decision and held that the MSP private cause of action permits a Medicare Advantage Organization to sue a primary payer (defendant) that refused to reimburse the Medicare Advantage Organization. *Western Heritage* highlights the importance of reimbursing Medicare Advantage Plans and the underlying facts provide insight on how potential claims by Medicare Advantage Plans may be handled.

In *Western Heritage,* Humana operated as a Medicare Advantage Organization ("MAO") and provided Part C coverage to plaintiff who was injured at defendant's premises. Humana paid plaintiff's medical expenses. Plaintiff agreed to settle with defendant and its liability insurer, Western. While the settlement was pending, Humana issued an Organization Determination (or request for reimbursement) to plaintiff for the medical expenses it paid. Humana's request was based upon the MSP. An administrative appeal process was available, but no party appealed Humana's Organization Determination.

Shortly thereafter, in exchange for the payment of settlement funds, plaintiff released defendant. Plaintiff represented that no Medicare lien existed and agreed to indemnify defendant against any Medicare claims.

Humana sued plaintiff and plaintiff's counsel for reimbursement. However, the district court dismissed the case for lack of subject matter jurisdiction holding that a Medicare Advantage Plan does not have a private cause of action to recover reimbursement from a beneficiary under the MSP. Although the district court later vacated its order, Humana voluntarily dismissed its action. In response, defendant and Western attempted to make Humana a payee on the settlement check; however, plaintiff refused and sought sanctions against defendant for failing to comply with the settlement agreement. Thereafter, defendant agreed to a stipulated order under which Humana would not be a payee on the check, but plaintiff's counsel would hold the full amount of the Humana lien in trust pending resolution of the litigation.

Thereafter, plaintiff sued Humana in state court seeking a declaration as to the amount owed to Humana. Although a judgment was entered, it was reversed for lack of jurisdiction. The court discussed the parties' right to appeal a request for reimbursement through the CMS and for judicial review of that decision. In short, the court held that the Medicare Act expressly preempts state law. See, *Humana Med. Plan, Inc. v. Reale*, 180 So.3d 195, 199 (Fla. 3d DCA 2015).

Failing to secure prompt reimbursement from plaintiff, Humana then sued Western in federal court, seeking double damages under the MSP private cause of action, 42 U.S.C. §1395y(b)(3)(A) and declaratory relief under the Medicare statutory and regulatory scheme. The district court held that the MSP private cause of action is available to a Medicare Advantage Plan and that Humana was entitled to double damages. *Humana Med. Plan, Inc. v. W. Heritage Ins. Co*., 94 F.Supp 3d 1285 (S.D. Fla. 2015), *aff'd sub nom*. *Humana Med. Plan, Inc. v. W. Heritage Ins. Co.*, 15-11436, 2016 WL 4169120 (11th Cir. Aug. 8, 2016). Western appealed, and the Eleventh Circuit affirmed.

It should be noted that Western asserted that it did not fail to reimburse Humana because it had no constructive knowledge that Humana made a payment. However, the Court acknowledged the fact that Western attempted to make Humana a payee on the settlement check. The Court also addressed several discovery rules by which Western could have obtained information about Humana's interest. While the court's comments on Western's knowledge are dicta, it is clear that the court expected defendant/Western to identify Medicare Advantage Plans and assure that the plans were reimbursed. Also clear is the fact that an indemnity agreement between plaintiff and defendant is not sufficient to protect the defendant from a claim by a Medicare Advantage Plan.

C. Practical Solutions for Identifying and Resolving Potential Claims of Medicare and Medicare Advantage Plans

Litigants must remember that a "no lien letter" from CMS does not mean that there are no Medicare interests in the case. The parties should determine if a Medicare Advantage Plan has a potential interest in the settlement funds or judgment. If a Medicare Advantage Plan is not reimbursed, it may file suit against the settling defendant and obtain double damages, regardless of the fact that the defendant has funded the settlement.

Discovering the existence of and the identity of a Medicare Advantage Plan requires effort and cooperation on the part of the parties. The following action items may pave the way to discovery of and resolution of the interests of such plans.

1. Asbestos-related cases: Private fee-for-service reimbursement
    a) Determine if plaintiff is a member of the "Master Agreement Governing the Asbestos Private Lien Resolution Program" dated May 18, 2015 (sometimes referred to as "Rawlings Agreement" and the "PLRP"). The PLRP is an agreement for asbestos-related cases in which participating insurers' interests in payments to Medicare-beneficiaries are resolved through a defined procedure. Be forewarned, however, that not all insurance companies participate in the PLRP. In addition, it is important to obtain the paperwork needed to document the fact that a plaintiff is a current participant and that his private insurer is a current participant.
    b) Consider following the steps set forth below for non-asbestos related cases.
2. Non-Asbestos Related Cases
    a) Propound discovery to plaintiff and obtain the identity of all insurers. Ask for copies of insurance cards.

b) Propound discovery to plaintiff to determine if any insurers have issued inquiries about the pending lawsuit, requests for reimbursement and/or Organization Determination (as referred to in *Western Heritage*).

c) Search medical records and medical bills for potential secondary payers.

d) With the proper authorizations, propound discovery to any insurers who are identified by plaintiff to determine the amount of their potential interest in the case.

e) Obtain an authorization to log on to Medicare.gov and/or to speak directly with Medicare about plaintiff's Medicare coverage. In some cases, Medicare will identify the current Medicare Advantage Plan. Beware that there may be gaps in the information that CMS provides on a plaintiff's coverage. Please note that this option is only available for living claimants as MyMedicare.gov will not grant access to information where a claimant is deceased.

f) Demand that the claims of insurers, especially Medicare Advantage Plans, be reimbursed before the settlement or judgment is funded. The Settlement Agreement may include language requiring that any and all lienholder interests (or Medicare Advantage Plan interests) be identified and negotiated before plaintiff is paid. Defendant may want to send a separate payment to the Medicare Advantage Plan in order to obtain an acknowledgment that payment has been made in full.

g) In light of the facts in *Western Heritage,* if there is a demand for payment by the Medicare Advantage Plan, then it may behoove the Defendant to negotiate resolution such that the agreed procedure is for the Defendant to issue payment directly to the Medicare Advantage Plan. If plaintiff disputes the reimbursement amount, then he or she must utilize the administrative review and appeal process. Defendants have no such process nor are they in privy of contract with the Medicare Advantage Plan.

In sum, litigants must be mindful that a "no lien letter" from Medicare may be a red flag and not a shield. Upon receipt of such a letter in a case with a known Medicare beneficiary, the parties should investigate whether the plaintiff had coverage through a Medicare Advantage Plan and confirm that the Medicare Advantage Plan's interests have been reimbursed and/or set forth a procedure whereby those interests will be reimbursed. Absent these protections, a defendant may receive a claim from a Medicare Advantage Plan long after its file has been closed and the settlement funds have been distributed.

II. The December 5, 1980, Policy

Asbestos matters fall within those that involve exposure, ingestion and/or inhalation, and thus, CMS advised that it will not pursue reimbursement, nor is reporting necessary, in these resolutions when the exposure ends before December 5, 1980, and there are no allegations to the contrary. For asbestos litigation, this December 5, 1980, date continues to trip-up resolutions as parties do not always agree on when exposure occurred, nor are pleadings necessarily clear in this regard. As December 5, 1980, is the date of enactment of the Medicare Secondary Payer Act, it is presumed that, like CMS, Medicare Advantage Plans will not seek reimbursement when exposure was evidenced *and* alleged to have ended before December 5, 1980.

To clarify reporting requirements in exposure, ingestion and implantation matters, CMS issued an alert on August 19, 2014 ("Alert") that remains available on-line at https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Non-Group-Health-Plans/Downloads/Liability-Insurance-including-Self-Insurance-Exposure-Ingestion-and-Implantation-Issues-and-December-5-1980.pdf . (Appendix 3)

From the Alert and in various Town Hall Teleconferences, CMS instructs that no reporting is necessary when:

- All exposure or ingestion ended, or the implant was removed before12/5/1980; **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 after12/5/1980; 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.

Should just one of these three determinations not hold true, then reporting is necessary.

Commonly the disagreement between parties as to reporting arises from vague pleadings. A plaintiff's complaint will generally provide a span of exposures with no specification as to particular defendants, or a complaint may contain no exposure dates. CMS addressed the latter in Town Hall Teleconferences, including on October 19, 2011 (Appendix 4). If a complaint is silent as to exposure dates, then exposure dates are considered to include exposure on or after 12/5/80. Thus, reporting is necessary and Medicare has a right to seek reimbursement. From the CMS Alert, this is true even if the facts establish that exposure ended before 12/5/80 as the allegations put exposure occurring after 12/5/80 at issue. Further, if a complaint alleges that exposure ended before 12/5/80, but the facts demonstrate that exposure continued after that date to a particular defendant, then reporting is necessary and Medicare may seek reimbursement.

The December 5, 1980, policy applies to liability claims. It does not pertain to workers' compensation claims. Medicare has been a secondary payer in workers' compensation claims since its inception in the 1965 amendments to the Social Security Act.

In evaluating how to comply with CMS requirements, DRI's Defense Practitioner's Guide to Medicare Secondary Payer Issues (2015), included the following steps:

1. Determine if the claimant is Medicare eligible. If the claimant is not a Medicare beneficiary, then the resolution need not be reported.
2. If the claimant is Medicare eligible, even a loss of consortium claimant, review the complaint to determine whether there are any claims of exposure occurring on or after December 5, 1980 either specifically against the resolving defendant or generally as to all defendants. If there are any such claims – or the complaint is silent – and the resolution amount meets the threshold, reporting and reimbursement are at issue. The case should be reported regardless of evidenced exposure dates.
3. If the claim states that exposure ended before 12/5/80, then determine if there was evidence of exposure to the resolving defendant's product or premises on or after December 5, 1980. This includes a scenario where a claimant was on premises containing the product both before and after 12/5/80. If there is evidence of exposure occurring on and/or after December 5, 1980 and the resolution amount meets the reporting threshold, then the settlement should be reported. If there is no evidence contracting the allegations in the petition, then the case need not be reported and Medicare will not seek reimbursement.
4. If there is no exposure claimed, evidenced and/or specifically released as occurring on or after December 5, 1980, then there may be no reporting as to any claimant. Depending on whether a loss of consortium claim is a derivative claim in a jurisdiction, there may need to be reporting as to that claim in pre December 5, 1980 exposure cases. If the non-exposed claimant is an estate

administrator who both raises and releases no personal claims – and is not claiming loss of consortium- then reporting may not be necessary.

5. Where the settlement, judgment, award or other payment meets the reporting threshold and exposure occurs on or after December 5, 1980, obtain the reporting data, including as to the loss of consortium claimant.
6. When reporting, report the total settlement amount paid in the case as if paid to each claimant. Meaning, if Mr. and Mrs. Jones are Medicare beneficiaries and Mr. Jones was exposed, with Mrs. Jones claiming loss of consortium and they settle the case for a total of $100,000, then report settlement of $100,000 with Mr. Jones and a $100,000 settlement with Mrs. Jones.
7. For the loss of consortium claimant, use the ICD code "NOINJ" where that claimant has **neither claimed nor evidenced** physical or mental injury. If the loss of consortium claimant refuses to provide such an attestation or cannot provide one, consider requiring the escrow of funds pending confirmation from CMS of resolution of potential reimbursement issues.

III. Will Medicare Implement a Set-Aside Review Process for Liability Cases?

With a posting to its "What's New" page on https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Whats-New/Whats-New.html CMS announced in June of 2016 that it is considering expanding its voluntary Medicare Set-Aside Arrangements (MSA) amount review process to include the review of proposed liability insurance (including self-insurance) and no-fault insurance MSA amounts. CMS stated that it "plans to work closely with the stakeholder community to identify how best to implement this potential expansion." CMS stated that future announcements of the proposal and for town hall meetings will occur later this year. At the time of this writing, Septempber 20, 2016, no such announcements had occurred.

CMS previously issued a draft Notice of Proposed Rulemaking for handling future medical costs in liability cases. CMS, *Medicare Program; Medicare Secondary Payer and "Future Medicals,"* 77 Fed. Reg. 35917 (June 15, 2012). Comments were submitted by the public, but the CMS withdrew the notice without discussion. We continue to await further guidance as to how this may affect cases going forward and whether or not this type of review may be necessary for Medicare Advantage plans.

In conclusion, the law and policies surrounding MSP reporting and reimbursement continue to develop. From Medicare Advantage Plan and 1980 date considerations through monitoring the potential requirement of Medicare Set-Asides, MSP factors into almost every personal injury liability case.

IV. Appendix 1: Sample Medicare Closing Letters

MSPRC

Learn about your letter at www.msprc.info

CMS CENTERS for MEDICARE & MEDICAID SERVICES

August 22, 2012

Beneficiary Name:
Medicare Number:
Case Identification Number:
Date of Incident:

Dear :

We received communication dated , which included the date of settlement, judgment, or award for the above referenced case.

A review of Medicare's records indicates Medicare did not pay any claims related to this case and accordingly we have closed our file.

Although the file is closed, please understand that Medicare has no responsibility to pay for any claims related to the above referenced case that were incurred from the date of incident until the day after the case was finalized (settled). Medicare has no responsibility for these claims as they should be paid out of any settlement, judgment, or award proceeds.

If you have any questions concerning this matter, please call the Medicare Secondary Payer Recovery Contractor (MSPRC) at 1-866-677-7220 (TTY/TDD: 1-866-677-7294 for the hearing and speech impaired) or you may contact us in writing at the address below. When sending any correspondence please provide the Beneficiary Name, Medicare Health Insurance Claim Number (the number on the Medicare card), and Case Identification Number (if known). This will allow us to associate the correspondence to the appropriate records.

MSPRC LIABILITY
PO BOX 138832
OKLAHOMA CITY, OK 73113

SGLA34NGHP
Page 1 of 2

Sincerely,

MSPRC

MSPRC

Learn about your letter at www.msprc.info

CMS CENTERS for MEDICARE & MEDICAID SERVICES

August 23, 2012

COPY

For Information Only

August 23, 2012

8K20122300005870O

Medicare Number:
Beneficiary's Name:
Date of Incident:
Case Identification Number:

Dear Estate of ,

We have received check number in the amount of . This amount has been applied to the outstanding debt due Medicare. The principal amount of the debt and interest (if applicable) has been reduced to zero and our file is being closed.

If a refund is due it will be processed and forwarded to the appropriate party under separate cover. If the original check submitted to Medicare had multiple payees it will be the attorney and/or beneficiary's responsibility to disburse the funds to all other payees.

If you have any questions concerning this matter, please call the Medicare Secondary Payer Recovery Contractor (MSPRC) at 1-866-677-7220 (TTY/TDD: 1-866-677-7294 for the hearing and speech impaired) or you may contact us in writing at the address below. When sending any correspondence please provide the Beneficiary Name, Medicare Health Insurance Claim Number (the number on the Medicare card), and Case Identification Number (if known). This will allow us to associate the correspondence to the appropriate records.

Sincerely,

MSPRC

V. Appendix 2: 12-5-2011 CMS Memo

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
7500 Security Boulevard, Mail Stop C4-21-26
Baltimore, Maryland 21244-1850

CENTER FOR MEDICARE

DATE: December 5, 2011

TO: Medicare Advantage Organizations and Prescription Drug Plan Sponsors

FROM: Danielle R. Moon, J.D., M.P.A.
Director, Medicare Drug & Health Plan Contract Administration Group

Cynthia Tudor, Ph.D.
Director, Medicare Drug Benefit and C&D Data Group

SUBJECT: Medicare Secondary Payment Subrogation Rights

The purpose of this memorandum is to summarize and convey our support for our regulations giving Medicare Advantage organizations (MAOs) and Prescription Drug Plan (PDP) sponsors the right, under existing Federal law, to collect for services for which Medicare is not the primary payer. In recent decisions, several courts have challenged Federal regulations governing these collections. Specifically, several MAOs have not been able to take private action to collect for Medicare Secondary Payer (MSP) services under Federal law because they have been limited to seeking remedy in State court.

CMS regulations at 42 CFR § 422.108 describes MSP procedures for MAOs to follow when billing for covered Medicare services for which Medicare is not the primary payer. These regulations also assign the right (and responsibility) to collect for these services to MAOs. Specifically, §422.108(f) stipulates that MAOs will exercise the same rights of recovery that the Secretary exercises under the Original Medicare MSP regulations in subparts B through D of part 411 of 42 CFR and that the rules established in this section supersede any State laws. Additionally, the MSP regulations at 42 CFR §422.108 are extended to Prescription Drug Plan (PDP) sponsors at 42 CFR §423.462. Accordingly, PDP sponsors have the same MSP rights and responsibilities as MAOs.

Notwithstanding these recent court decisions, CMS maintains that the existing MSP regulations are legally valid and an integral part of the Medicare Part C and D programs.

VI. Appendix 3: Alert 1980 Date Amended Complaints Control 2014.8.19

Department of Health & Human Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Financial Services Group

August 19, 2014

Note: This document revises the October 11, 2011 document issued on this subject. The revised language is highlighted below.

Liability Insurance (Including Self-Insurance): Exposure, Ingestion, and Implantation Issues and December 5, 1980

The Centers for Medicare & Medicaid Services (CMS) has consistently applied the Medicare Secondary Payer (MSP) provision for liability insurance (including self-insurance) effective December 5, 1980. As a matter of policy, Medicare does not assert an MSP liability insurance-based recovery claim against settlements, judgments, awards, or other payments where the date of incident (DOI) occurred before December 5, 1980.

When a case involves continued exposure to an environmental hazard or continued ingestion of a particular substance, Medicare focuses on the date of last exposure or ingestion for purposes of determining whether the exposure or ingestion occurred on or after December 5, 1980. Similarly, in cases involving ruptured implants that allegedly led to a toxic exposure, the exposure guidance or date of last exposure is used. For
non-ruptured implanted medical devices, Medicare focuses on the date the implant was removed. (**Note:** The term “exposure” refers to the claimant’s actual physical exposure to the alleged environmental toxin, not the defendant’s legal exposure to liability.)

In the following situations, Medicare will assert a recovery claim against settlements, judgments, awards, or other payments, and the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) Section 111 MSP mandatory reporting rules must be followed:

- Exposure, ingestion, or the alleged effects of an implant on or after December 5, 1980, is claimed, released, or effectively released in the most recently amended operative complaint or comparable supplemental pleading;

- A specified length of exposure or ingestion is required for the claimant to obtain the settlement, judgment, award, or other payment, and the claimant’s date of first exposure plus the specified length of time in the

settlement, judgment, award or other payment equals a date on or after December 5, 1980. This also applies to implanted medical devices; and

- A requirement of the settlement, judgment, award, or other payment is that the claimant was exposed to, or ingested, a substance on or after December 5, 1980. This rule also applies if the settlement, judgment, award, or other payment depends on an implant that was never removed or was removed on or after December 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, judgment, award, or other payment; and MMSEA Section 111 MSP reporting is not required. (**Note:** Where multiple defendants are involved, the claimant must meet all of these criteria for each individual defendant for a settlement, judgment, award, or other payment from that defendant to be exempt from a potential MSP recovery claim and MMSEA Section 111 reporting):

- All exposure or ingestion ended or the implant was removed before December 5,1980;

- Exposure, ingestion, or an implant on or after December 5, 1980, has not been claimed in the most recently amended operative complaint (or comparable supplemental pleading) and/or specifically released; and

- There is either no release for the exposure, ingestion, or an implant on or after December 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 December 5, 1980. The rule also applies if the broad general release involves an implant.

Any operative amended complaint (or comparable supplemental pleading) must occur prior to the date of settlement, judgment, award, or other payment and must not have the effect of improperly shifting the burden to Medicare by amending the prior complaint(s) to remove any claim for medical damages, care, items and/or services, etc.

Where a complaint is amended by Court Order and that Order limits Medicare's recovery claim based on the criteria contained in this alert, CMS will defer to the Order. CMS will not defer to Orders that contradict governing MSP policy, law, or regulation.

EXAMPLES:

Below are some illustrative examples of how the policy related to December 5, 1980, should be applied to situations involving exposure, ingestion, and implantation. These examples are illustrative, as each situation must be evaluated individually on its merits. (**Note:** It is the parties' responsibility to make a determination regarding this policy).

Situation	Application of December 5, 1980, Policy
The claimant was exposed to a toxic substance in his house. He moved on December 4, 1980. The claimant did not return to the house.	Exposure ended before December 5, 1980.
The claimant was exposed to a toxic substance in his house. He moved on December 4, 1980. The claimant makes monthly visits to the house because his mother continues to live in the house.	Exposure did not end before December 5, 1980.
The claimant was exposed to a toxic substance while he worked in Building A. He was transferred to Building B on December 4, 1980, and did not return to Building A.	Exposure ended before December 5, 1980.
The claimant was exposed to a toxic substance while he worked in Building A. He was transferred to Building B on December 4, 1980, but routinely goes to Building A for meetings.	Exposure did not end before December 5, 1980.
The claimant had a defective implant removed on December 4, 1980. The implant had not ruptured.	Exposure ended before December 5, 1980.
The claimant had a defective implant that was never removed.	Exposure did not end before December 5, 1980.

REPORTING REMINDER:

Information related to the MMSEA Section 111 MSP reporting requirements can be found in the NGHP User Guide found on the CMS website. When reporting a potential settlement, judgment, award, or other payment related to exposure, ingestion, or implantation, **the date of first exposure/date of first ingestion/date of implantation is the date that MUST be reported as the DOI**. This is true for purposes of individual self-identification of a pending claim to CMS' Coordination of Benefits Contractor, as well as for MMSEA Section 111 reporting.

VII. Appendix 4: Transcript Town Hall 10 19 2011NGHP Sect. on 1980

TRANSCRIPT
TOWN HALL TELECONFERENCE

SECTION 111 OF THE MEDICARE, MEDICAID & SCHIP EXTENSION ACT OF 2007
42 U.S.C. 1395y(b) (8)

DATE OF CALL: October 19, 2011

SUGGESTED AUDIENCE: Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Workers' Compensation Responsible Reporting Entities- Question and Answer Session.

CAVEAT: THIS TRANSCRIPT IS BEING PLACED AS A DOWNLOAD ON CMS' DEDICATED WEB PAGE FOR SECTION 111 FOR EASE OF REFERENCE. IF IT APPEARS THAT A STATEMENT DURING THE TELECONFERENCE CONTRADICTS INFORMATION IN THE INSTRUCTIONS AVAILABLE ON OR THROUGH THE DEDICATED WEB PAGE, THE WRITTEN INSTRUCTIONS CONTROL.

Bill Ford: When you send to Bill -- note just if you could give a specific example we can finally (inaudible). Thanks Crystal?

Operator: Your next question comes from the line of (Jerry Harial) with Louisiana Insurance. Your line is open.

(Jerry Harial): Thank you. My question concerns the 12/05/1980 date. If we have a plaintiff who worked for multiple contract or let's say he was a union for bore one maker pipe cutter. And he is clearly working in a place where over the years where he has multiple exposures to asbestos, chemical plants things of that nature. The petition does not allege that he has exposure post 12/05/1980. However, when we kept the social security print out, he continues to work through the same three, four, five different contractors. If we take a general release noting that there is no exposure alleged day after 12/04/1980, is this reportable loss or settlement because we don't know what the exposure are after 12/05/1980.

Barbara Wright: It seemed to me, if you look at the alert one of the three boards is that the exposure in just didn't impact and before 12/05/80 and at least on the facts that you just presented your information if anything look likes the exposure continue. You said you have information that he was exposed to various employers and stuff and he continued to work on that. So, unless you have information that is foxed, why would you assume.

(Jerry Harial): OK. I don't have because I don't know, I know the contractors he worked for, but I don't know who or where he worked subsequent to 12/05/1980.

Barbara Wright: Well, you have a obligation to determine the facts and, you know, that's really all we can say. If you look we were attempting to carve out an exception where the exposure did not in fact continued, and it had been specifically released, we wanted to you know, give some people some certainly that if all that was being based on was a general release then we weren't going to pursue a recovery claim. But, we are not going to sit here and say that we are the evidence you have most likely indicates exposure continued that's somehow we don't have a recovery claim.

(Jerry Harial): Even if they won't release that information then we are to assume when I say they don't release it, plaintiff counsel does not release that information, we are too assume that there was continuing exposure.

Barbara Wright: It's in Plaintiff's counsel's interest to work with you on those because they are the one that don't want us that recovery claims, against their client or against their client settlement.

(Jerry Harial): No, unfortunately plaintiff counsel is not always as cooperative as you think they maybe?

Barbara Wright: Well, I'm just saying in this particular case. If they are going to leave you with information, and that leads you to think there was exposure it isn't. If they don't want a recovery claim by Medicare then it's in their best interest to particularly be speaking to you about this issue and resolving it with you. So, if it was a problem before on this particular issue with this alert. Hopefully, it will the problem will take on different tone or different center, because it's clearly in their interest to, you know, work with you on this particular issue.

(Jerry Harial): Thank you.

Operator: Your next question comes from the line of Romeo (inaudible). Your line is open.

Female: Hi, good afternoon. So, client ask this question recently, if a claim has been -- a roster has been filed against the number of defendant, and one of the defendants by either law or contract or we should rephrase that another party that is not named to the lawsuit or even if they are named to the lawsuit, assume the defense of let's say of my clients either through law or contract in the events of a settlement or judgment. If my client who did not pay to the plaintiff because someone else is responsible for that payment. But their name is part of the caption and their name is included in the release, would they be obligated to report that settlement or judgment.

Barbara Wright: Are they self-insured, I mean if they are self-insured and they are the ones that are settling something then yes, they have reporting obligation if there is an insurer involved, you need to go through the RRE examples that are in the

Stacey Baker: Correct, I am saying if you are past that two years, your statuette of limitation is up, can we use that as an ORM termination?

Barbara Wright: If that is a legal basis in your state to terminate your responsibility then yes it is the reason to terminate ORM.

Stacey Baker: OK, great thank you very much for taking my question.

Operator: OK, your next question comes from line of (inaudible) Sidley Austin LLP, your line is open.

Female: Hi, good afternoon my name is (Ronnie) my question is in regards to the 12/5/80 alert and I just wanted to know with regard to the first bullet discussing when Medicare would assert a recovery claim in reporting another with a certain one when exposure on or after 12/5/1980 was effectively released and then on the second page in the exception it says you know, that the exception would be carved out if a broad general effectively releases exposure. What I understood was that earlier today was basically that that CMS would assert a recovery claim or reporting if there is a claim and it is effectively released, but the exception would be effective if there is no claim and there is a broad general release, is that correct?

Barbara Wright: It is effective only if you meet all three requirements, all three bullets. If you look at the exception there is the conjunction between each one when you look at the first page of that alert, the items that are listed, there is no conjunction between those. But to get the exception you have to meet all three of those.

Female: I guess by meeting all three are you saying that it can't be claimed and you can have a broad general release whereas in the first the way to relay is, I mean if you are effectively releasing exposure then recovery and reporting is required., you know, recovery -

Barbara Wright: That is the general rule and then we say if you meet all three of those things in conjunction then we won't exercise our right with respect to the broad general release, effective release.

Female: OK, so you are saying that exposure ended before 12/5/1980 and there wasn't a claim and there was a broad general release. Is that the correct way of reading it?

Barbara Wright: You are paraphrasing it but yes.

Female: OK, great, thank you so much.

Operator: Your next question comes from line of Robin Kindall with (inaudible), your line is open.

Robin Kindall: Hi, we are wondering if you could give us some clarification on what you want entered when you are adding in estate as additional claimant, there is a field for the address and telephone number and we are not real clear what you are looking for there, are you looking for the address of the attorney, if so, are you wanting the estate attorney, if that is different than the claimant's attorney. Are you wanting a personal representative, what are you looking for in those fields?

Barbara Wright: We are looking for the address where we should officially send any mail that needs to be addressed to the estate.

Robin Kindall: So, if we just pose that question to claimant's counsel and then basically whatever they provide is what we would use.

Barbara Wright: That's fine as long as they are clear that that is where you know, mail for the estate needs to go.

Robin Kindall: OK, thank you.

Barbara Wright: I mean if the estate has a separate representative then you have got the representative field for that claimant anyway. So, often there will be own address, or maybe a relative or anything that is -- particularly if the relative is the executer or there could be both an attorney and an attorney for the liability case as well as an executer for the estate. So, it will just be fact specific, but it is basically where official mail for the estate needs to go.

Robin Kindall: OK, thank you.

Operator: Your next question comes from the line of Emily Green, with (inaudible), your line is open.

Emily Green: Hi, I just wanted to get some clarification on the alert on the reporting exception for exposures ending before December 5th, 1980. When do you view exposures ending in cases where the physical contact with the product ends before 12/5/80, but the toxin remains in the body and any disease ultimately develops after 12/5/80. One example that comes to mind is tobacco, you know, in those cases the person might have stopped smoking before 12/5/80, but the lung cancer for example developed after 12/5/80 will that be viewed as the case involving exposure after 12/5/80.

Barbara Wright: We have said for something like tobacco or asbestos that it is when they stop being exposed to the toxin in terms of smoking or in terms of working in that environment etcetera. Implants are the ones that cause the most trouble for people in that if those are not removed then obviously exposure continues. If it is an implant that is filled with something like let's say breast implants.

If that implant was removed before 12/5/80 and it did not rupture, we consider that exposure ended, but it if ruptured since the allegation has to do with what filled the breast implant, not the sac itself or the capsule then in that case we consider that continues, but for most of the exposure ones you will be dealing with, you are usually talking about an outside source, something that is not in the body and we re-look to when that exposure stopped.

Emily Green: OK, so for the tobacco example if you for example stopped smoking you know, on January 1, 1980, you develop a disease five years later and you receive Medicare benefits post 12/5/80, that case would not be reportable?

Barbara Wright: No, as long as your exposure is based on your smoking, if you are claiming second hand smoke then I think you are in a whole different ballgame.

Emily Green: Right, of course, OK, thank you very much.

Operator: Your next question comes from the line of Johnny Bolton with SVMIC, your line is open.

Barbara Wright: Those liabilities cases we are looking at liability insurance only. This is generally outside the scope of this call. As I said at the beginning of the call when this alert went up in order to get the information up speedily we took alert that was prepared for broader purposes, but you know, that is not really part of this call, the information about that option will be on the MSPRC website as soon as it is available.

Female: OK, but you don't think its going to include worker's comp?

Bill Ford: Right, it is focused on liability insurance.

Female: OK, thank you.

Operator: And again to ask a question press star one on your telephone keypad. Your next question comes from the line of Catherine Goldhaber with Segal McCambridge, line is open.

Catherine Goldhaber: Hi in regard to the 1980 date issue, when you were discussing it Barbara you talked about specifically claims. In a situation where a plaintiff alleges exposure from a work history and it is from 1960 to 1985 and there is no claim against any particular defendant then as the discovery shapes up, Acne boilers, all of the evidence of the Acne Boilers in 1975, would Acne Boiler still need to report?

Barbara Wright: We have said that let us claim the release. If you want to have this exception then the industry is going to have to form their claims somewhat to allow them to get those exception. We have not said that you can simply go ahead and claim you know, exposure for everybody and then change your mind later. We have heard both sides from the industry. We have heard one just say well we just always claim everything. But we are trying to give you an exception that means that you have to comport with our rules.

We have also heard from other ones that we always get the information before we file the claims. We don't make it too broad well particularly and doing this or we have changed the process and we are trying to be more focused now. We understand what you are doing trying to give us this exception so

now under us you can't simply claim release where you claim that you had exposure from all these defendants and then change your mind.

Catherine Goldhaber: And using that same scenario, in that case would you expect that that claimant if he claimed exposure throughout his work history to 1985, but then all the evidence showed the exposure ended in 1975 that's for all defendant, would you still be expecting that plaintiff to be contacting Medicare and advising Medicare of losses?

Barbara Wright: I would because they claimed it. I mean you, plaintiffs or defendants all routinely self-report if they have done that consistently close to 100 percent then we might not have had the mandatory insurer reporting. I mean part of the concept for mandatory insurer reporting was that there was at least evidence or an indication that everything was not being reported ahead of time or afterward and we needed a way to ensure that we were getting a more consistent and fuller representation of what was going on.

Catherine Goldhaber: And one more question on the loss of conversion reporting where all the exposure excuse me, if there is some exposure post 1980 and then John Smith is the injured party, but he is not Medicare eligible and his wife has a loss of conversion claim and she is Medicare eligible, would you still expect reporting from the wife?

Bill Ford: If there are medical claim then they are released to the wife, yes.

Catherine Goldhaber: All right thank you.

Operator: Your next question comes from line of Mike Balm with Nationwide Insurance, your line is open.

Mike Balm: Good afternoon, this is regarding ORM reporting and let me give you a scenario to explain my question, we have a worker's comp claim and say the guy is 30 years old and injures his back and we pay a couple of months medicals and he has done treating, however, we cannot get anything from the doctor saying that his treatment that he is never going to incur anymore treatment which is more common than not. Our understanding is that you

about is you know, if they haven't had treatment for a certain time or with a certain type of injury, something like that to limit those cases for us.

Barbara Wright: Yes, certain period of time one of things we are definitely concerned about is where there has been joint replacement everything because they may go longtime in between that, but evidence shows that they typically do have to joint replacement after a certain number of years. So anything if you can think of ways to help us categorize we would be interested in hearing that, but it needs to take into account situation that would routinely have a long gap in treatment as well.

Mike Balm: OK. Thank you.

Operator: Your next question comes from the line of Marjorie Wilcox with (inaudible) your line is open.

Marjorie Wilcox: Barbara, I wanted to follow-up on the question that asked a little while ago just to make sure I'm understanding on the pre 12/5/80 guidance. If often get the asbestos law suits where there is you know, dozens if not you know, a 100 of defendants that are actually named in the initial complaint and those complaints will have broad exposure allegation that address the entire body of defendants.

There maybe some defendants that only have early timeframes of physical exposure and there maybe some that have post 12/5/80 exposure. If you have a defendant that exclusively the evidence throughout the discovery process is consistent that the physical exposure was only pre 12/5/80, ended in the 1970s. For that defendant, are you wanting to hear from those parties and if the plaintiffs oppose to report to CMS those particular claims because you are going to get a lot of claims reported in that situation for which there is a recovery.

Barbara Wright: You are saying there is no recovery and what we are saying is legally there is a recovery. Our touchstone is what is claimed to release are effectively released. We are granting, giving whatever you want to call it an exception where the only basis for our potential recovery is a broad general release. We

have not come up with any type of exception that we believe can be applied when exposure has actually been claimed.

Marjorie Wilcox: So even though exposure has not been specifically claimed with regard to a certain defendant?

Barbara Wright: Well, it is then claimed by virtue of the complaint.

Marjorie Wilcox: The broad originally file complaint.

Barbara Wright: And that's what I was saying a few minutes ago, we've heard from various attorneys that they are being more careful in terms of how they file complaints and we've heard from many that have said they don't file the complaint until they determine, which ones there is or is not exposure.

Marjorie Wilcox: And if they actually then understanding the historic approach for some folks has been a much more kind of broad inclusive, allegation in the original complaint, what if the plaintiff amends their complaint? And only can include relevant dates prior to 12/5/80. That then takes the place of the originally filed complaint that was less precise.

Barbara Wright: Could you send that question into the mailbox because we haven't specifically addressed, amended complaints.

Marjorie Wilcox: OK. And my understanding then is whenever they have those broad originally filed complaints the plaintiff should be notifying CMS.

Barbara Wright: The plaintiff may or may not do a free settlement notification, but you do have the reporting obligation if it meets the threshold etcetera.

Marjorie Wilcox: OK. One of the other issues that has arisen with regard to the flowchart that's available online, the MSPRC flowchart, it talks about the steps and it does note in that flowchart that after receipt of medical services the beneficiary or the representative is supposed to notify COBC of the accident, illness, or incident?

Barbara Wright: That's how we get notification and that's how we are going to get it prior to settlement with a longer and what we say is the longer anyone delays in

notifying us then the longer it is going to be till we can make any determination or pull claims to give you know, a potential conditional payment amount.

Marjorie Wilcox: OK. So what is the time when they should notify and if for some reason they fail to take that step you would get the notification at time of settlement.

Barbara Wright: Right.

Marjorie Wilcox: OK. All right, thank you. That's helpful.

Barbara Wright: OK.

John Albert: Operator it's now 3 o'clock and we have to end the call because we have other meetings to get to. So this is John Albert again I wanted to thank everyone for their participation. Please stay tuned to the website for any future alerts and to get a reminder about the upcoming call, November 16, 2011, it is a technical call. On December 14th will be a policy and technical call that alert was dated October 14th that has the -- it is the same phone number and pass code as for this call.

Barbara Wright: And that is available also as a downloadable document on the liabilities of worker's compensation tab on the website.

John Albert: And we kind of thank you everyone for participating. And if operator, you could stay on the line up to you let the go.

Operator: This does conclude today's conference call. You may now disconnect.

END