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Insurers' New Reporting Obligations Under Medicare Medicaid SCHIP Extension Act
Complying with MMSEA Requirements for Plan Payers of General Liability and Personal Injury Claims

WEDNESDAY, DECEMBER 15, 2010
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Today’s faculty features:

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An Update on the Medicare, Medicaid, and SCHIP Extension Act: Preparing for the 2011 Reporting Deadlines

SPEAKERS:
Randy Bassett
Tara Kelly
OVERVIEW

- **MMSEA**: requires insurers and self-insured to report settlements involving Medicare beneficiaries where medical expenses are claimed or released
  
  • reporting required for settlements on or after October 1, 2010 after January 1, 2011 (look-back period)
  
  • what has been the practical experience with implementation?

- **MSP**: enhanced vigilance to ensure reimbursement
  
  • *US v. Stricker*: will we see more suits in the future?
  
  • what about MSAs for future medical expenses?

- **Best Practices**
Medicare Legislation
Medicare Secondary Payer (MSP)

- Medicare secondary payer (MSP) provisions enacted in 1980s
- Medicare generally will not pay for treatment if any another entity has an obligation to pay
  - The responsible entity is known as the “primary plan”
- Medicare authorized to recover payments from a primary plan even if the primary plan has already paid to settle the claim
MSP Basics

- A tort defendant’s responsibility is established through judgment, settlement, or other payment to Medicare beneficiary

- Scope of release and scope of medicals claimed is irrelevant to reporting obligation

- CMS may recover from beneficiaries and third parties who receive funds from primary plans

- If CMS is unable to recover from the recipients it may seek payment directly from the primary plan even if it has already paid to settle the claim
The Medicare Prescription Drug Improvement, and Modernization Act (MMA) and The Medicaid, Medicare, and SCHIP Extension Act (MMSEA)

- **MMA**: expanded the definition of “primary plan” to include “self-insured” entities that bear their own risk, e.g., self-insured tort defendants

- **MMSEA**: imposes an affirmative duty on entities including tort defendants to report the resolution of any claim or action brought by a beneficiary
Implementation of MMSEA Section 111

- CMS is responsible for implementing the very complicated provisions of the Medicare statute—how?
  - Alerts supersede User’s Guide
  - Regulations adopted through notice and comment rulemaking
Relationship Between MMSEA and MSP

- MMSEA establishes reporting requirements and fines for failing to report settlements
- MMSEA gives CMS additional information about payments to Medicare beneficiaries to ensure that Medicare only pays what it’s supposed to pay
- Based on the information received under MMSEA, Medicare can assert its rights under the MSP to recover conditional payments from other parties -- including tort defendants -- who are the primary plans
Relationship Between MMSEA and MSP

- RREs face potential liability to Medicare from multiple avenues:
  - failure to properly report under the MMSEA; and
  - failure to properly reimburse Medicare for conditional payments

- *United States v. Stricker* demonstrates that liability under the MSP can dwarf exposure under MMSEA
Updates to Reporting Requirements
1. Register with CMS

- **Responsible Reporting Entity (“RRE”):** any entity that is or may become liable to CMS as a “primary plan”

- **September 30, 2009:** RREs that expect to have something to report were required to begin registering

- **February 24, 2010 Alert:** RRE will be deemed compliant for registration if (1) it completes the registration process with COBC to begin working toward reporting the required data or (2) it notifies COBC of inability to register during its initial designated timeframe and subsequently registers during a later timeframe approved by COBC
2. Determine Plaintiff’s Status

- **What:** RREs must determine the status of all plaintiffs with whom claims are settled on or after October 1, 2010

- **Who:** RREs bear the sole responsibility for accurately determining a plaintiff’s status

- **How:** RREs must “implement a procedure” to determine plaintiff’s status

- **When:** RREs have ongoing duty to determine a plaintiff’s status
3. Reporting

- Electronic: all reporting must be done **electronically**
- January – March, 2011: deadline for RREs to submit first reports for **claims settled after October 1, 2010**
- Required Information:
  - Plaintiff’s name, DOB, SSN or HICN
  - CMS currently requires over **60 categories of information**, including identifying information, date of injury, cause of injury, and description of injury allegedly caused by RRE or its insured
  - CMS expected to expand to over 100 categories of information about the claim, including **ICD-9 codes** for cause of injury and injury allegedly caused by RRE or its insured
  - RREs must keep existing reports updated and correct
RRE Registration

- Registering RREs within a corporate structure
  - An entity *may not* register as a RRE for its sibling company
  - An entity may register as a RRE for a direct subsidiary
  - A captive is considered a subsidiary of its parent entity and a sibling of any other subsidiary of the parent

- Foreign Entities as RREs
  - must register between April 5 and January 1, 2011
  - should apply for Employer ID number (EIN) from IRS
  - User’s Guide says an alert is forthcoming
Effect of Indemnification

- A party who is *fully indemnified* as part of a suit/settlement is *not* the RRE for MMSEA reporting purposes

- The party making the payment - the indemnifying party – is the RRE and must report

- Departure from prior CMS statements regarding indemnification
Insured and Self-Insured RREs

- Departure from prior guidance
- Generally the insurer is the RRE
- Entities with an insurance plan and deductible are no longer required to report
- Self-insured entities must report
- For umbrella insurance, key is whether payment is made to reimburse injured party or self-insured
Excluded Claims

- **Date of exposure before December 5, 1980**
  - No exposure on or after December 5, 1980 “alleged, established and/or released”
  - Specific to a claim/defendant

- **Unless claim involves continuing exposure beyond December 5, 1980**

- **Burden of documenting on RRE**

- **Subject of continuing discussion in Mass Torts Working Group**
Changes in Timeframe to Report Claims

- **TPOC Date:** date agreement obligating RRE to pay a claim is signed unless court approval is required

- **January – March, 2011:** period for submitting initial reports of claims after testing

- **Quarterly Reporting:** within the 7-day file submission timeframe assigned to RRE

- **45 day Grace Period:** if TPOC date occurs 45 days before file submission period then claim reported during the next quarter
MSP Liability: Past, Present and Future
Medicare Right to Reimbursement

- If CMS is unable to recover from Medicare beneficiaries, it may seek payment directly from the primary plan even if the primary plan has already paid to settle the claim.

- CMS may also recover from third parties who have received funds from primary plans (including defendants and plaintiff’s attorneys).

- CMS may recover *double* damages if legal action is required to secure payment.
United States v. Stricker: A Cautionary Tale

- Motion to dismiss granted because action was time barred
- On December 1, 2009, DOJ filed a civil action to recover conditional payments made to 907 Medicare beneficiaries involved in a $300,000,000 class action settlement
- Defendants included Plaintiffs’ Counsel, Travelers Indemnity Company, AIG, Monsanto Company, Pharmacia Corporation, and Solutia, Inc.
- The United States sought double damages (estimated at $67,156,770.01) and interest
Other Cases to Watch

[Bradley v. Sebelius, Docket No. 07-01690-CV-ORL-31GJK (11th Cir. Sept. 29, 2010)]

- Reversed district court’s decision that sided with HHS’s interpretation and implementation of MSP statute concluding that the district court had abused its discretion.
- Rejected extension of **Chevron** deference to MSP Manual. “The Secretary’s *ipse dixit* contained in the field manual does not control the law.”
- Found that strong public policy in favor of settlement was in conflict with HHS position. “The Secretary’s position would have a chilling effect on settlement.”

[Hadden v. U.S., 2009 U.S. Dist. LEXIS 69383 (WD KY Aug. 6, 2009), appeal pending, Docket No. 09-6072 (6th Cir.)]
H.R. 4796: Medicare Secondary Payer Enhancement Act of 2010

- Introduced on March 9, 2010 by Representatives Patrick Murphy (D-PA) and Tim Murphy (R-PA) to increase clarity and decrease burden on primary payers
- Allow primary payer to submit proposed conditional payment calculation to CMS before settlement to force CMS to accept or reject submission
- Create formal process to appeal CMS determinations on conditional payments
- Establish $5000 threshold to institute recovery actions
- Set statute of limitations for recovery actions of three years after submission of settlement information to CMS
- Establish safe harbors and grant CMS discretion in assessing fines and penalties for failing to report
Future Liability

- MSP statute addresses past and future liability -- prohibits Medicare payment for covered items or services where payment has already been made or “can reasonably be expected to be made”

- In liability context, CMS takes position that awarded funds can reasonably be expected to pay for future medical services

- MMSEA Section 111 did not change this requirement -- but makes it easier for CMS to identify payers
Medicare Set Aside Arrangements (MSAs)

- Under CMS guidance, MSA=administrative mechanism used to allocate a portion of a settlement, judgment or award for future medical and/or future prescription drug expenses
- May be in form of a Worker’s Compensation MSA, No-Fault Liability MSA, or Liability MSA
- MSA must be exhausted prior to any payment from Medicare
Medicare Set Aside Arrangements (MSAs)

- MSAs not required in any context

- Formal guidance in workers’ compensation arena:
  - CMS recommends MSAs
  - formal review process set up to review MSAs that meet certain thresholds
  - no safe harbor for instances where below threshold
Medicare Set Aside Arrangements (MSAs)

- No formal guidance in liability context
- MSAs not recommended in liability context as in worker’s compensation context
- CMS has repeatedly emphasized that while liability MSAs not required, need to take Medicare interests into account
Medicare Set Aside Arrangements (MSAs)

- CMS will review proposed liability MSAs depending on workload and amount at stake.

- In CMS’s view, the fact that the language of a particular settlement, judgment or award does not specify that it accounts for future medical expenses does not protect a primary payer from a contrary determination by Medicare.

- CMS has suggested that it will look at whether the case involves a catastrophic injury and whether there is a life plan or similar document.
Medicare Set Aside Arrangements (MSAs)

- Take action to ensure Medicare’s future interests are accounted for
- Plaintiff’s attorneys and defendants may have mutual interest at time of settlement
- CMS guidance -- not the product of notice and comment rulemaking
Best Practices

Now:

- Determine and communicate assigned 7-day reporting period
- Communicate expectations and procedures with outside counsel, so concerns can be identified and discussed
- Gather information on existing cases to identify those implicating MMSEA/MSP
- Coordinate with co-defendants and industry trade groups
- Revise standard releases for additional language addressing MMSEA requirements and MSP liability
- Gather information on reporting settlements on or after October 1 for early reporting or after January 1
Best Practices

During Litigation:

- Obtain discovery on Medicare status and pre-1980 exposure if applicable
- Query CMS database and continuously document results
- Use CMS “safe harbor” documentation if claimant refuses to provide necessary information
- Communicate early and often with plaintiff’s counsel, so they understand RRE’s obligations and can assist in the process
- Seek Statement of Conditional Payments for plaintiff, if Medicare beneficiary
Best Practices

Settlement:

- Assess completeness of information needed for reporting when settlement discussions appear imminent
- Structure settlement terms to require plaintiff to provide information needed for reporting as material terms
- Incorporate liquidated damages clause into settlement agreement as consequence for inaccurate or incomplete information
- Incorporate indemnity language and hold-back provisions into settlement agreement to address MSP liability
- Retain discovery and other documents that support decision NOT to report (e.g., discovery showing no pre-1980 exposure)
Best Practices

Settlement (If Medicare Beneficiary):

- Obtain statement of conditional payments from plaintiff or Medicare at beginning of case and least 60 days before potential settlement

- Consider whether MSA (“Medical Set-Aside”) is needed where future medicals are reasonably expected
  - Are the injuries/damages claimed and released catastrophic and continuing?
  - Is there a life-care plan addressing future medical expenses?

- Minimize exposure for MSP liability
  - write two settlement checks: one to CMS and one to plaintiff’s counsel
  - establish escrow to hold amount equal to conditional payments to be released only upon proof that Medicare has been satisfied
  - obtain letter of satisfaction and indemnity/hold harmless from plaintiff
Considerations For Terms of Settlement

Potential Exposure
High

Low

Hold Back Provision
CMS Acknowledgement
Establish MSA

Statement of Conditional Payments
Indemnity/Hold Harmless
Declaration of Plaintiff’s Status

Time to Resolution
Fast

Slow
CMS Resources

- General link to CMS website regarding MMSEA:
  http://www.cms.hhs.gov/MandatoryInsRep/

- Statutory Language:

- CMS Town Hall Transcripts on MMSEA:
  http://www.cms.hhs.gov/MandatoryInsRep/07_NG_HP_Transcripts.asp#TopOfPage
CMS Resources

- CMS comment mailbox on MMSEA issues:

PL110-173SEC111-comments@cms.hhs.gov
Randy Bassett is a partner with King & Spalding’s Product Liability Practice where he has over 15 years experience representing foreign and domestic manufacturers in high exposure product liability cases.

He has represented product manufacturers such as Brown-Forman Corporation, General Motors, Purdue Pharma, Reynolds American Inc., and Sofamor Danek in the federal and state courts throughout the Southeast and Southwest. He has argued cases in the federal circuit court of appeals for the Fourth, Sixth, and Eleventh Circuits, and has appeared in the appellate courts of Alabama, Florida, Georgia, North Carolina, and Tennessee. Mr. Bassett has been recognized by Chambers USA and Legal 500 for his work in the area of products liability and was named a Georgia Super Lawyer for 2010.

He is a graduate of The Citadel and the University of Georgia School of Law and is a member of the Georgia and Florida bars.
Speaker Biography

Tara Kelly is counsel in the Houston office of King & Spalding and a member of its Litigation Practice Group. Her practice is concentrated on environmental and toxic tort litigation. She has also defended pharmaceutical and tobacco companies in product liability litigation. Ms. Kelly graduated from Stockton State College in New Jersey, obtained a M.A. in literature from the American University, and her J.D. from New York University School of Law. She is a member of the Texas and New Jersey bars. Her article on the MMSEA recently appeared in the ABA Mass Torts newsletter and is available at the King & Spalding website at: [http://www.kslaw.com/bio/Tara_Kelly/Publications](http://www.kslaw.com/bio/Tara_Kelly/Publications).