Medicare Endgame:

Applying Predictive Settlement Strategies to Mitigate MSP Exposure (Part 1)

"**Maryland Law Firm Meyers, Rodbell & Rosenbaum, P.A., Agrees to Pay the United States $250,000 to Settle Claims that It Did Not Reimburse Medicare for Payments Made on Behalf of a Firm Client**." https://www.justice.gov/usao-md/pr/maryland-law-firm-meyers-rodbell-rosenbaum-pa-agrees-pay-united-states-250000-settle (last visited June 4, 2019).

"**Insurers May Be Liable for Double Damages for Failure to Reimburse Other Insurers Acting as "Medicare Advantage Organizations**." https://www.11thcircuitbusinessblog.com/2016/08/insurers-may-be-liable-for-double-damages-for-failure-to-reimburse-other-insurers-acting-as-medicare-advantage-organizations/ (last visited June 4, 2019).

"**Philadelphia Personal Injury Law Firm Agrees to Start Compliance Program and Reimburse the United States for Clients' Medicare Debts**." https://www.justice.gov/usao-edpa/pr/philadelphia-personal-injury-law-firm-agrees-start-compliance-program-and-reimburse (last visited June 4, 2019).

Right now, you cannot ignore the headlines involving recovery under the Medicare Secondary Payer (MSP) Act. *42 U.S.C. § 1395y(b)(2).* Settling a case involving a Medicare beneficiary challenges all sides. Everyone shares a desire to obtain a permanently closed file. What accompanies a closed file is the knowledge that Medicare cannot collect any additional proceeds above and beyond the amount it was paid before the file was closed. Historically, getting to that point was a labored and arduous path, taking months not days. One might think that Medicare's full recovery, without regard to the amount of any settlement, is inevitable. It's not.

While hope may seem lost, there are strategies that will lead to that permanently closed file and a fair and just result. There is an alternative; the application of predictive settlement strategies. Predictive settlement strategies minimize conditional payment and Medicare Set-Aside (MSA) obligations in a way that traditional MSP compliance processes cannot replicate. By applying a predictive settlement strategy before agreeing to a settlement, you can close the file permanently, giving Medicare no chance to recover additional proceeds.

Setting the Scene: MSP Issues Today.

The Medicare conditional payment reimbursement process confounds the notion of a speedy resolution of a case. Identifying and negotiating, or disputing, conditional payments owed to Medicare or Medicare Advantage carriers (or liens held by Medicaid, hospitals, healthcare providers and health carriers for that matter) delays the settlement process. The potential that liens may go unpaid (or worse, that Medicare's final demand figure may be greater than anticipated) gives most practitioners nightmares.

According to Medicare officials at the Centers for Medicare & Medicaid Services (CMS), a settlement must also "protect Medicare's interest" in the future in some way. The MSP Act provides that Medicare will not pay for medical expenses where payment has been made under a workers' compensation plan, automobile plan, liability insurance plan (including self-insurance), or a no-fault plan. *42 U.S.C. § 1395y(b)(2)(A)(ii).* Complying with the future medical provisions of the MSP Act is easier said than done. In fact, it's so complicated that many practitioners in

2019 have chosen to ignore those provisions, betting that Medicare will not enforce them. In fact, Medicare can and does deny benefits to beneficiaries who fail to properly and adequately "protect Medicare's interest" in the future. *https://ametros.com/blog/medicare-issuing-denials/* (last visited June 6, 2019).

Rarely does the Medicare beneficiary receive full compensation for injuries sustained when settling a workers' compensation (WC) or liability insurance case. Most cases settle for less than judgment value. Sometimes, they settle for substantially less than what a finder of fact might award. Said another way, cases settle based on a compromise between the parties as opposed to a full commutation of benefits. The result leaves the Medicare beneficiary with potentially less than required to satisfy medical liens and demands which Medicare may make on the funds or reasonably compensate the Medicare beneficiary for non-pecuniary damages.

This is the problem with the status quo of MSP compliance efforts. Since cases are settled for less than judgment value, Medicare beneficiaries suffer a disproportional reduction in their net proceeds when Medicare exercises the full scope of its statutory recovery rights under the MSP Act. Medicare frequently demands reimbursement in full of its final demand. The MSP Act allows Medicare to recoup the total amount of the settlement proceeds, less procurement costs under 42 C.F.R. § 411.37, to obtain full satisfaction. See *Hadden v. United States*, 661 F.3d 298 (6th Cir. 2011). While Medicare waivers are possible, they are unpredictable and time consuming.

In the authors' experience, Medicare Advantage plans tend to be more flexible and amenable to negotiation than traditional Medicare, as are some state Medicaid offices. Still, they do not provide a predictable final net award to the Medicare beneficiary. And, of course, when cases cannot be settled, payers cannot permanently close their files, increasing the costs of defense and claims resolution. The MSP compliance status quo fails to provide the certainty all parties desire.

Predictive Settlement Strategies Provide Certainty Where None Exists Today.

Of the many solutions that may exist in the MSP compliance universe, very few offer the certainty and predictability parties crave. Very few allow the insurance carrier/self-insured to calculate its MSP exposure with absolute certainty. Very few allow the Medicare beneficiary to calculate a potential net award with absolute certainty. Very few allow the file of each respective side to stay closed permanently. Those very few predictive settlement strategies which accomplish these goals include: 1) obtaining a judicial allocation on the merits via an arbitration; 2) establishing a Qualified Settlement Fund (QSF); and 3) ensuring that a Medicare beneficiary's medical treatment is provided on a lien basis as opposed to medical providers submitting bills to Medicare for reimbursement. This article explores the first strategy. Later articles will address the others.

Judicial Allocations on the Merits.

When the judiciary speaks, everyone must listen. That includes Medicare. When a court issues an order on the merits after hearing evidence from both sides, Medicare must abide by the order of the court. While Medicare does not have to respect an allocation of proceeds made by settling parties themselves, it must respect a judicial allocation on the merits. If you can obtain a judicial allocation on the merits that limits that portion of a settlement payable for medical expenses (past and future medicals), you can effectively cap what portion goes to Medicare.

Complicating matters is the fact that Medicare's right of recovery ripens under the MSP Act when there is a settlement, judgment, or award, but not sooner. *42 U.S.C. § 1395y(b)(2)(B)(ii)*. In order for this predictive settlement strategy to work, parties must not agree to a settlement figure before approaching a judge for sign-off on their allocation.

That's unusual, of course. Most parties resolving cases with Medicare payment issues participate in pre-trial mediation to reach a settlement before submitting to the expense and uncertainty of trial. That approach, while generally effective meeting the goals of settling the case, fails to mitigate the Medicare payment issues entirely. A judicial allocation made post-settlement will not effectively prevent Medicare from breaching the allocations intended and desired by the parties.

To ensure that any allocation is effective at limiting Medicare's recovery rights the trick is that it must be made "on the merits." A mere rubber stamp from a judge of the settling parties' self-serving allocation after a settlement will not suffice. There must be evidence presented by both sides. The trier-of-fact must then weigh that evidence and determine an equitable allocation, based on their experience and the relevant law. As noted below, judicial determination on the merits must be made before a settlement is reached. Typically, this can force the parties to participate in an expensive and uncertain trial on the merits. But a slight process change accomplishes all goals: a permanently closed file with minimal MSP exposure. Instead of mediation and settlement, or submitting to a trial, parties seeking to mitigate MSP exposure should participate in arbitration instead.

Arbitration is a long-standing American tradition in dispute resolution. Under the Federal Arbitration Act (FAA), the parties to a dispute may agree to refer a case to arbitration. *9 U.S.C. § 1*. This can be done by contract, extrajudicial agreement, or by a consent order. *Id.* The parties may agree to follow the arbitration rules established by law or by associations such as the American Arbitration Association (AAA). *Id.* The parties may agree to arbitrate before a panel of arbitrators or a single arbitrator. *Id.* The parties are at liberty to negotiate which party will pay the arbitrator's fees/costs or can agree to share the costs. *Id.* The parties may choose which issues are arbitrable. *Id.* They can set limits, by agreement and stipulation, of the scope of the arbitration award. *Id.* This includes, of course, the stipulation that the total award may be capped and that the elements of damages awarded may be proportionally reduced within that cap. *Id.* The arbitration laws of most states (which are almost uniformly based on the FAA) follow the FAA. *See*, for example, *La. R.S. 9:4201-4217*.

Here is how it works:

Federal law conditions a "Primary Plan's" responsibility to reimburse Medicare on a settlement, judgment, or award. *42 U.S.C. § 1395y(b)(2)(B)(ii)*. Medicare's right to reimbursement can be no greater than that provided in the settlement, judgment, or award. *Id.* Medicare's own policy on this issue is clear: "Medicare does not seek recovery from portions of court awards that are designated as payment for losses other than non-medical services." *Medicare Secondary Payer Recovery Manual*, Chapter 7, § 50.4.4. Several judicial decisions support Medicare's policy position. *Zinman* v. *Shalala*, 835 F. Supp. 1163, 1167 (N.D. Cal. 1993), *aff'd* 67 F.3d 841 (9th Cir. 1995) and *Denekas* v. *Shalala,* 943 F. Supp. 1073 (S.D. Iowa 1996). Simply stated, CMS must recognize allocations for medical services and non-medical losses in award by a court *or*

other adjudicator (*emphasis added*). *Medicare Secondary Payer Recovery Manual*, Chapter 7, § 50.4.4.

When a case settles (via mediation or otherwise), CMS has a statutory right to collect up to the full amount of the settlement. However, when an adjudicator allocates the award between medical and non-medical losses, CMS must defer to the specific limitations of the award. It has no discretion to deviate from the adjudicator's allocation. It must limit its final demand to the amount of the medical expenses and costs awarded by the adjudicator.

Also clear (based on the MSP Recovery Manual and other CMS authored documents) is the fact that CMS understands that some cases would not be decided on the merits by judges/juries. Instead, they would be decided on the merits by "adjudicators" of other kinds including arbitrators. Let's contemplate a hypothetical where arbitration could be used to mitigate MSP exposure.

Assume a Medicare beneficiary suffered a serious spinal injury in an automobile accident in 2016. The plaintiff's pain, suffering and mental anguish was, is, and will remain severe. Past medical expenses are high, and Medicare's initial conditional payment letter reveals Medicare has paid $100,000 in conditional payments on behalf of its beneficiary to date. The plaintiff was also enrolled in a Medicare Advantage plan during some of the period of medical treatment. That plan says it has paid $45,000 on behalf of the plaintiff. Future medical care is anticipated and an un-apportioned medically based MSA report suggests $50,000 as the total set aside for future medicals. The judgment value of the case exceeds $800,000, but there appears to be only $400,000 in coverage available. To complicate matters, a potential dispute exists relating to coverage and limits. The insured tortfeasor has no assets and little income.

Each side has incentive for the case to settle. The carrier will pay the limit of $400,000 if the insured is dismissed and any claims for extra-contractual coverage are waived. How can this case be settled and provide fair compensation to the plaintiff for his pain and suffering while ensuring that the insured tortfeasor is released and the payer's file is permanently closed?

This is a perfect case for arbitration:

- Instead of mediation, the parties should agree to refer the case to an arbitrator(s).
- The parties should choose an arbitrator(s) with extensive experience in personal injury litigation, valuing personal injury cases and assessing medical expenses, coupled with a deep understanding of the Medicare Secondary Payer Act and its regulations. The same can be said if the matter involves a WC claim instead of a general liability claim.
- The parties should discuss and agree to the scope of the arbitration, including but not limited to: the maximum/minimum amount of the potential arbitration award; the issues to be considered by the arbitrator(s); the amount to be allocated to medical expenses versus non-medical expenses; and (if possible) the amount(s) for past medicals (to satisfy Medicare conditional payment demands and other potential liens) and future medicals (to address potential MSA issues). The arbitrator(s) can and should facilitate this discussion, assisting in the process in a similar manner as a mediator.
- The parties should discuss costs and should agree in advance about the funding of the arbitration. Of course, using a single arbitrator reduces the total cost of the arbitration. Typically, the parties will share the cost of the arbitration.

- The agreements of the parties will be reduced to a "Pre-Arbitration Agreement" which will become the constitution of the arbitration. Its terms will govern the scope of the arbitration and the arbitrator's authority. The "Pre-Arbitration Agreement" thereby ensures that the parties have control over the predicted outcome even after the matter is submitted to the arbitrator.
- The parties should then file a Motion or Joint Petition to Arbitrate and Stay the Proceedings with the Court. This pleading should formalize the agreements between the parties by seeking an order appointing the arbitrator(s) and payment agreements.
- Once the Order is signed and sent to the arbitrator(s), the arbitrator(s) will set a telephone status conference and the parties will establish a schedule for submission to the arbitrator(s). A hearing will not usually be needed but may be scheduled.
- The parties will deliver evidence to the arbitrator(s) that they wish to be considered to support their individual positions. The arbitrator(s) will analyze the merits of the case, assess the total judgment value, study the evidence presented (including but not limited to medical bills, expenses, MSA reports, and future medical needs of the Medicare beneficiary). The arbitrator(s) may also consider other issues such as coverage, limits or disputes deemed arbitrable by the parties within the scope of the stipulations set out in the "Pre-Arbitration Agreement".
- The arbitrator(s) will issue a written Arbitration Award, detailing the total amount of the award. The Arbitration Award will include specific amounts for past medical expenses, future medical expenses, pecuniary damages and non-pecuniary damages, including pain, suffering and mental anguish. The arbitrator(s) may also make specific awards to Medicare, a Medicare Advantage plan or a lienholder. In most instances, the total award will be less than judgment value. Thus, all of the other awards, including specific awards for past medical expenses and future medical care, will be reduced proportionally.
- If the parties agree to the Arbitration Award, they will file a Joint Petition with the Court to make the Arbitration Award binding. The Court will review the award. With the agreement of the parties, it will likely make the award an Order of the Court. This Order will then establish the maximum amounts owed to Medicare as well as other claimants and lienholders. Once the judgment is paid, liens and demands (including Medicare's) may be satisfied. At that point, the matter is concluded and files may be permanently closed.

The result is one that satisfies all litigants. The final award payable to the Medicare beneficiary is within a range that had been agreed to by the parties prior to arbitration. The arbitrator reaches the award based on evidence submitted independently by each side. The arbitrator's awards and allocations for medical costs and non-pecuniary damages are based not only on that same independently submitted evidence, but also the relevant law and experience of the arbitrator: It is a determination made on the merits of the case. Each side thus obtains that elusive permanently closed file. Judicial allocations on the merits based on arbitration is one of the only solutions available which ensures that the parties maintain control of the outcome and the file stays closed permanently, all in an efficient and cost effective manner.

Conclusion.

Arbitration is not new. In fact, it's almost 100 years old. Arbitration is not some cutting edge version of alternative dispute resolution. What might be new is its application to the MSP context.

This new application, though, does not dilute the effectiveness of its results. Arbitration awards are as binding as any jury verdict, bench verdict, or settlement agreement when made an order of a court. The benefit of arbitration over those other dispute resolution techniques is that you can predict the outcome with certainty. It's the one (1) outcome out of the many possible Medicare payment outcomes which mitigates MSP exposure while satisfying all parties' interest in obtaining a permanently closed file.

Medicare can wreak havoc with a potential settlement. By snapping its fingers, it can collect up to the full amount of the net proceeds payable to a Medicare beneficiary. A judicial allocation on the merits based on arbitration represents one of the only solutions which can permanently protect parties against that snap. Arbitration, not mediation, represents the best chance to mitigate MSP exposure and obtain a permanently closed file.