VENABLE LLP

product liability update

www.Venable.com
JULY 2009

For questions or comments, please contact:

Bruce R. Parker
brparker@Venable.com
410.244.7534

DS Gray
dsgray@Venable.com
410.244.7682

Christine C. Carey, a summer associate at Venable LLP, helped research and draft this Newsletter.

The Myths and Realities of Self-Insured Entities' Responsibilities in Light of Recent Changes to the Medicare Secondary Payer Act and Recent CMS Guidance

Introduction

These are uncertain times for self-insured entities trying to comply with the Medicare Secondary Payer Act ("MSP") and accompanying federal regulations. In some ways, the responsibilities of self-insured entities involved in personal injury litigation have not changed: they still have to coordinate the payment of claims and settlements involving Medicare recipients with those recipients, their attorneys, and the Centers for Medicare and Medicaid Services ("CMS"). In other ways, self-insured entities should see the significant change just over the horizon: section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 ("Section 111") requires, among other things, self-insured entities to electronically report certain information to CMS. The manner by which self-insured entities defending mass tort litigation comply with those reporting obligations is one of several issues that we have had to address in helping clients remain in compliance with the MSP and its amendments. To clarify this still-evolving area of the law, this Newsletter addresses the more common questions that self-insured entities have asked in navigating the MSP's reporting obligations and includes a concise chart reflecting the various reporting obligation updates.

Background

Statutorily deemed a secondary payer, Medicare has the right to be reimbursed for any payments made on behalf of personal injury plaintiffs. Medicare beneficiaries therefore must exhaust all coverage from private health plans before receiving payment from Medicare. An individual's private insurance—as a "primary payer"—has primary responsibility for the individual's medical bills, and Medicare—as a "secondary payer"—has responsibility only for those amounts not covered by the primary payer or under the primary plan.

As a settling tortfeasor, self-insured entities are "primary payers." If a self-insured entity fails to ensure that Medicare is reimbursed, Medicare can sue the self-insured entity, even if the entity already paid the plaintiff. Section 111's reporting obligations are intended to alert CMS to these payments.

Questions That Self-insured Entities Have Asked (*or Should Ask*) About Remaining in Compliance with the MSP and the Accompanying Reporting Requirements

Q: Can Medicare come after us before seeking reimbursement from the plaintiff?

A: Yes. Medicare can seek money from either the plaintiff or the settling defendants, even when the defendants already have paid the plaintiff. If Medicare must take legal action to recover from the "primary payer," Medicare has the authority to recover twice the amount of the Medicare primary payment. Additionally, if a self-insured entity fails to comply with the reporting obligations, which exist independently of Medicare's reimbursement right, it could incur a $1,000 per day fine.

Q: What portions of the MSP and Section 111 have been stayed?

A: None. CMS is implementing the reporting process with group health insurance plans. The reporting process for non-group health insurance plans, such as self-insured entities, has simply been delayed several months. While the reporting obligations (and the $1,000 per day failure to report fine) for self-insured entities have been delayed, Medicare's right to seek reimbursement from either the plaintiff or settling defendant has not.

Q: What are our reporting obligations?

A: It depends on the type of payment made. Two types of payments exist: (1) Total Payment Obligations to Claimants ("TPOCs") and (2) Ongoing Responsibility for Medicals ("ORMs"). ORM involves an agreement to pay, on an ongoing basis, a Medicare beneficiary's medicals associated with a claim. TPOC is the dollar amount of a settlement, judgment, award, or other payment in addition to or apart from ORM. Entities must report TPOC payments made on or after January 1, 2010, and ORM payments made on or after July 1, 2009.

CMS has set interim threshold amounts that must be reached before a self-insured entity must report a TPOC payment. At this time, those thresholds—which do not apply to ORMs—are:

TPOC dates	Reporting Threshold
January 1, 2010 – December 31, 2010	$5,000.01
January 1, 2011 – December 31, 2011	$2,000.01
January 1, 2012 – December 31, 2012	$600.01

Note that CMS has reserved the right to change these interim thresholds.

Entities must report all TPOC amounts where the combined TPOC amounts dated on or after January 1, 2010, satisfy the reporting threshold. When calculating whether the TPOC reporting threshold has been met, an entity must add all associated TPOC amounts dated on or after January 1, 2010.

These thresholds are not "safe harbors." If an entity does not report a claim where the total TPOC amount satisfies the reporting threshold, the entity could be liable for the entire claim plus the imposed failure to report fine, not the entire claim less the threshold amount.

Furthermore, although entities do not have to submit their first report until the second quarter of 2010 (from April 1, 2010 to June 30, 2010), the first report must contain all ORMs since July 1, 2009 and all TPOCs since January 1, 2010; self-insured entities therefore should begin gathering this information now.

Q: Is there a reporting exception for mass tort cases involving asbestos, toxic torts, or pharmaceuticals?

A: In a very limited sense and for some limited cases, yes. According to the latest version of the User Manual issued by CMS: "CMS has determined as a matter of policy that it will not recover under the MSP provisions with respect to liability insurance (including-self insurance) or no-fault insurance settlements, judgments, awards or other payments where the Date of Incident (DOI) as defined by CMS was prior to December 5, 1980." CMS has defined the DOI as follows:

> For an automobile wreck or other accident, the date of incident is the date of the accident. For claims involving exposure (including, for example, occupational disease and any associated cumulative injury) the DOI is the date of first exposure. For claims involving ingestion (for example, a recalled drug), it is the date of first ingestion. For claims involving implants, it is the date of the implant (or date of the first implant if there are multiple implants).

CMS basically adopted a reporting exception for payments where the DOI was prior to December 5, 1980, because CMS apparently does not intend to pursue Medicare's reimbursement on those claims. The December 5, 1980 cut off date does not appear in the MSP, amendments to the MSP, or any federal regulations and, therefore, remains subject to change by CMS.

Claims involving any exposure alleged, established, and or released on or after December 5, 1980, however, must be reported. For example, if the date of the initial exposure occurred before December 5, 1980, but the plaintiff's complaint alleges that the exposure continued to, on, or after December 5, 1980, then Medicare has a potential recovery claim and the entity must report it for Section 111 purposes. Claims involving voluntary ingestion also must be reported only if the date of first ingestion alleged, established, and or released was on or after December 5, 1980.

CMS set this exception simply as a matter of policy. Although 30 years seems significant, this date likely will not affect the reporting obligations for even many asbestos and toxic tort defendants under present practices. Plaintiffs tend to allege exposure over longer time frames, thereby raising the specter of exposure after December 5, 1980. Settling defendants also seek resolution of plaintiffs' entire claims, no matter when that exposure occurred, and often do not specify when exposure may have stopped.

Furthermore, in mass tort cases where an injured party sues multiple defendants, the December 5, 1980 cutoff applies to each defendant and for each particular claim. For example, if an injured party pursues a claim against A, B, and C, all self-insured entities, for asbestos exposure, and exposure for A ended prior to December 5, 1980, but exposure for B and C did not, a settlement, judgment, or other payment made by A need not be reported to CMS, but payments made by B and/or C must be reported.

Q: How can we realistically manage the reporting process?

A: CMS offers two ideas, but does not necessarily endorse either one: agents or self-insurance pools. Although entities may hire agents to submit information on an entity's behalf and one agent may submit claims for more than one entity, that agent may not accept reporting responsibility for that self-insured entity by contract or otherwise. In other words, if a claim should be reported, but is not due to some oversight by the agent, the self-insured entity is still on the hook. If an agent is used, the agent should indemnify the entity if the agent fails to report a claim where the injured party is a Medicare beneficiary.

Alternatively, if otherwise permitted by law, similarly situated entities also can join together in a self-insurance pool. If the self-insurance pool (1) is a separate entity; (2) has full responsibility to resolve and pay claims using pool funds; and (3) is without involvement of the participating entity, then the self-insurance pool is the responsible reporting entity.

Q: To comply with Section 111, what should we do now?

A: Start planning for implementation. Companies need to determine now who will manage their reporting obligations within the electronic reporting system. Whether it be an outside agent or a company's own information technology department, the entity itself and not an agent must first register online at the Coordination of Benefits Contractor Secure Web site.

Registration must be completed by an officer with the requisite authority between now and September 30, 2009. Although CMS has not announced any penalty for failing to register, entities must register by this date to ensure that they pass the requisite testing phase before the first files are due in the second quarter of 2010.

Lastly, those who will implement the reporting obligations should familiarize themselves with CMS's 180-page, detailed User Guide, and check its website frequently for updates. Readers also can obtain the latest information regarding the implementation of Section 111 here.

Click here to review a chart that summarizes the most recent guidance on complying with the MSP's reporting requirements.

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