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MSP News Brief Issue 38 ][ June 2012

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### What to Look Forward to:

**Putting the Medicare Cards On the Table**

***Court Rules That L-MSA Not Required Per the Parties' Mediation Settlement Agreement***

**By Mark Popolizio, Esquire**

In ***Bruton v. Carnival Corporation***, No. CV 11-21697-CIV., 2012 WL 1627729 (S.D. Florida May 2, 2012) the court ruled that a liability Medicare set-aside (L-MSA) was *not* required as part of the settlement based on the terms of the parties' mediation settlement agreement and other considerations.

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## Take Medicare Off That Check

***Court Rules That Medicare Not Required to be on Settlement Check***

**By Mark Popolizio, Esquire**

In ***Hearn v. Dollar Rent A Car, Inc., et. al.***, No. A11A2355, 2012 WL 987546 (Ga. Ct. App. March 26, 2012), the Georgia Court of Appeals was called upon to address whether the court could enforce a settlement agreement without Medicare being named as an additional payee on the settlement check.

The court ruled, in part, that public policy did *not* preclude the court's enforcement of a settlement agreement which omitted Medicare as a named payee on the settlement check in situations where, as in this case, a plaintiff expressly agreed to be responsible for any Medicare conditional payment claim, and agreed to indemnify the released parties in relation thereto.

### Summary

In the *Hearn* case, plaintiff and the third party administrator (TPA) reached a $20,000 settlement in connection with an auto accident claim. As part of this settlement, plaintiff agreed to satisfy any "liens" (including any potential Medicare claims), and agreed to indemnify the TPA in regard thereto. Plaintiff's counsel and the adjuster agreed that Medicare would not be named as a payee on the settlement check. However, a dispute subsequently developed on this point which derailed the settlement.

The crux of this dispute concerned the knowledge, existence and extent of a possible Medicare conditional payment claim. Specifically, pursuant to a subsequent file review, the TPA noted medical records reflecting that Medicare made payments related to plaintiff's alleged injuries. Thus, the TPA sent plaintiff's counsel a settlement check *with* Medicare named as an additional payee, despite the parties' initial agreement.

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Plaintiff's counsel objected and requested that the TPA re-issue the draft *without* Medicare named on the check. The TPA refused claiming that it had only initially agreed not to include Medicare on the check based on plaintiff counsel's representations that Medicare *"did not have an enforceable lien."* Plaintiff then filed suit for breach of the settlement agreement.

The trial court ruled in favor of the TPA, finding that the TPA's inclusion of Medicare as an additional payee on the check was reasonable and permissible based on the circumstances; and in accord with larger public policy considerations favoring conditional payment reimbursement. Plaintiff appealed to the Georgia Court of Appeals.

On appeal, the Georgia Court of Appeals *reversed* the trial court and held that public policy did *not* require that Medicare be included on the check since plaintiff had agreed to reimburse any Medicare conditional payment claim and to indemnify the TPA in connection therewith as part of the settlement agreement.

In this article, the author first breaks down the *Hearn* case and decision. This is followed by a review of important "practical considerations" raised by this case. The following analysis is hereby presented:

## Facts

On November 28, 2002, Minnie Hearn (plaintiff) was involved in a motor vehicle accident with another driver who was driving a rental car. Plaintiff filed a claim for alleged personal injuries which was handled by a TPA.

In October 2004, the claims adjuster extended a written settlement offer of $20,000 to plaintiff's counsel. On November 17, 2004, plaintiff's counsel accepted the settlement offer via letter. Of note, there was no mention of Medicare being named as an additional payee on the settlement check in either the adjuster's written settlement offer or plaintiff counsel's letter of acceptance.

Following these negotiations, the adjuster's supervisor conducted a file review through which it was discovered that medical records reflected that Medicare paid for some of plaintiff's accident related medical treatment. Upon noting this information, the TPA decided to include Medicare on the check.

During this process, the TPA sent plaintiff's counsel the settlement release for his client's execution. Plaintiff executed the release and returned it to the TPA five days before the statute of limitations expired. As part of this agreement, plaintiff agreed to release *"known and unknown liens including Medicare"* and agreed to indemnify the released parties against *"all further liability, loss, damage, claims of subrogation and expense."*[1]

After plaintiff's counsel returned the executed settlement agreement, the TPA sent counsel the settlement check which *included* Medicare as a named payee. Plaintiff's counsel objected and requested that the TPA re-issue the check removing Medicare from the draft.

## Plaintiff Files Suit

When the TPA failed to re-issue the settlement check, plaintiff, through new counsel, filed suit in Georgia trial court against the TPA, Dollar Rent A Car, Inc., and its franchisee, DTG Operations, Inc. alleging breach of the settlement agreement. All three defendants moved to dismiss this claim via summary judgment.

In addition, plaintiff sued defense counsel after learning that defense counsel put Medicare on notice of the claim shortly after plaintiff filed her lawsuit. By contacting Medicare, plaintiff's counsel alleged that defense counsel improperly became an *"active participant in the deeds of his clients."*[2]

Before the trial court, the parties advanced the following arguments:

## TPA's Position

The TPA argued that it had only initially agreed *not* to include Medicare as a payee on the check based on plaintiff counsel's representation to the adjuster that Medicare "*did not have an enforceable lien."*[3] However, after a supervisor's file review turned up medical records showing Medicare payments, a decision was made to include Medicare as a payee on the check.

According to the adjuster, she viewed the discovery of this subsequent information as being in *"direct contradiction to what [plaintiff counsel's] representations to me [sic], Medicare did have a right of reimbursement that would be enforceable not merely against [the plaintiff], but also against any third party payor who ignored that right of reimbursement.*[4]

Thus, the adjuster testified that Medicare was ultimately included on the check *"[i]n order to protect against any possibility that Medicare might accuse [the TPA], DTG, and/or [the rental car driver] of ignoring Medicare's claims, or being complicit in any alleged attempt by [plaintiff and/or her counsel] to defraud Medicare."*[5]

## Plaintiff's Position

Plaintiff's counsel argued that he and the adjuster knew "from day one" that plaintiff was on disability and that Medicare had paid for some of her accident related medical treatment. In support, he testified that he had provided the adjuster with medical records which clearly reflected Medicare payments approximately six months prior to the commencement of settlement discussions.

Further, counsel testified that it was his belief that he had no duty to notify Medicare of a settlement if Medicare had not notified anyone of its intention to seek reimbursement.[6] Along these lines, he testified that since neither he nor the adjuster was put on notice by Medicare of a possible lien, they both *"agreed that the … settlement draft would not have Medicare on it."*[7]

## Trial Court: *Medicare Can Stay on the Check*

The trial court ruled *against* plaintiff finding that the TPA had valid grounds to include Medicare as a payee on the settlement check.[8] Specifically, the court found the TPA's actions to be reasonable and a "good business practice" in light of what it termed as plaintiff counsel's "erroneous assurances" and "incorrect" representations.[9] The court also stated that by permitting Medicare to be omitted from the check this would improperly assist plaintiff *"evade her duty to reimburse*

*Medicare"* in contravention of the *"public policy in favor of reimbursement."*[10]

In addition, the court struck plaintiff's claim against defense counsel on procedural grounds, and awarded sanctions and attorney fees in favor of defense counsel.[11]

Accordingly, the trial court granted summary judgment in favor of the defendants. Plaintiff then appealed to the Georgia Appeals Court.

## Appeals Court Reverses: *Take Medicare Off that Check*

The Georgia Court of Appeals *reversed* the trial court's ruling in several respects, including ultimately ruling that public policy did *not* mandate that Medicare be named as an additional payee on the settlement check in this case.

The appeals court ruled that the trial court's granting of summary judgment was improper since there remained "issues of fact" regarding whether plaintiff's counsel made any misrepresentations to the adjuster, as well as the reasonableness of the adjuster's reliance on any purported misrepresentations.[12] On this latter point, the court commented that the TPA's decision to change the agreed-upon payees "*was made after a supervisor reviewed medical records that had been in possession of the claims adjuster for over six months."*[13]

Of particular note, the appeals court also took issue with the trial court's ruling that "public policy" supported the TPA's naming Medicare as a co-payee on the check.

In addressing this issue, the court started its analysis by noting that Medicare had the right to pursue multiple parties for conditional payment reimbursement under the Medicare Secondary Payer (MSP) statute, including the right to seek double damages against primary payers in certain circumstances.

As part of this review, the court made specific reference to 42 C.F.R. § 411.24(h) and (i). This regulation provides that if Medicare requests reimbursement from a plaintiff and he/she does not reimburse Medicare within 60 days from receipt of a settlement, the primary payer must then *"reimburse Medicare even though it has already reimbursed the beneficiary or other party."* Accordingly, the court acknowledged that the TPA in this action *"faced potential liability for both the amount of any Medicare lien and double this amount if [plaintiff] failed to satisfy any such lien within 60 days of receiving the settlement check."*[14]

From there, the court zeroed in on the public policy question, framing the issue as whether "*public policy precludes enforcement of an agreement to omit Medicare as a payee on a settlement check, when both parties have knowledge that Medicare has a right to seek reimbursement?"*[15]

Finding no Georgia decisions on point, the court turned to cases from other jurisdictions. In doing so, the court found a mixed bag of rulings, rendered in relation to varying fact patterns.

On the one hand, the appeals court noted cases where courts had enforced settlement agreements providing that Medicare would *not* be a named payee on the settlement check.[16] The court also noted authority holding that federal law did *not* require Medicare to be included on a settlement draft.[17]

At the other end of the spectrum, the court found decisions *"in the limited context of bad faith failure-to-pay claims"* holding that it was reasonable for a primary payer, in the absence of an explicit agreement, to name Medicare as a payee on a settlement check.[18]

From this review, the Georgia Court of Appeals ultimately concluded that public policy did ***not*** preclude enforcing a settlement agreement, without Medicare being on the check, in certain situations. Specifically, in reversing the trial court's ruling on this point, the Georgia Court of Appeals, stated:

> After reviewing and considering the Medicare reimbursement statutes and regulations relevant to the specific facts of this case, we conclude that public policy does *not* preclude a court from enforcing an agreement to omit Medicare as a co-payee on a settlement check *where, as here, the plaintiff signed a release that acknowledged her responsibility to pay any Medicare claim and agreed to indemnify the released parties*. We express *no opinion* as to whether public policy would be violated in the absence of an express acknowledgment of liability and/or an indemnity agreement." (Emphasis Added).[19]

## Practical Considerations

The *Hearn* case highlights important considerations (and potential problems) with respect to the practice of "putting Medicare on the check."

On a global level, *Hearn* calls into focus the legitimate concerns primary payers have with respect to ensuring that Medicare's conditional payment claim will be properly reimbursed as part of the settlement process in light of certain challenges posed by current CMS practices and existing MSP provisions.

In this regard, the inability (in most cases) to obtain Medicare's final conditional payment figure *prior* to settlement (or the failure to at least obtain Medicare's most current conditional payment number prior to settlement) can create uncertainty and concern leading the primary payer to decide to simply include Medicare on the check by default, upon the thinking that this will best protect their interests. This idea may become particularly appealing in the primary payer's eyes given that Medicare has a direct and independent right of action against the primary payer, Medicare retains the right to still pursue the primary payer if the plaintiff fails to reimburse Medicare (see, 42 C.F.R. § 411.24(h) and (i)), and Medicare can pursue "double damages" against the primary payer in certain circumstances.

Against this backdrop, the issue for consideration becomes whether including Medicare on the settlement check can be achieved practically or legally, or even represents the best method to address the issue.

From a practical perspective, absent an agreement to the contrary, naming Medicare as a payee on the settlement check will likely meet with resistance from plaintiff's counsel since this will very likely create an additional (and perhaps considerable) delay in disbursing the settlement funds to the plaintiff, as securing Medicare's endorsement could take time. In this sense, it is doubtful that many plaintiff practitioners will view this as an

acceptable or reasonable manner to address the issue.

From a legal perspective, consideration must be given to existing case law on the issue, especially any controlling authority that may exist in the applicable jurisdiction governing the particular claim. On that count, as *Hearn* illustrates, the courts have expressed different opinions and rendered different rulings with respect to the propriety of naming Medicare as a payee on the settlement draft. As part of this mix, we find the Georgia Court of Appeals in *Hearn* ruling that public policy does *not* preclude enforcing a settlement agreement (without Medicare being a named payee on the check) in situations where a plaintiff agrees to reimburse Medicare and agrees to indemnify the released parties with respect to that obligation.

When the dust settles, primary payers are left to wrestle with how best to ensure that Medicare's conditional payment claim will be properly satisfied as part of claim settlement to minimize their potential liability under the MSP. A full examination of these potential options is outside the scope this analysis. However, in the context of the issue as presented in *Hearn*, primary payers need to determine whether including Medicare on the check is a viable, practical, or efficient way to address the issue. This assessment should be premised on a complete and proper understanding of Medicare's rights under the MSP, current CMS practices in this area, and a review of all relevant case law and other applicable authority.

On another level, *Hearn* brings to light *other* practical points for consideration in relation to dealing with Medicare conditional payment claims, and for that matter, MSP matters in general.

One such item relates to general knowledge of MSP obligations. In *Hearn*, the case decision reflects that at least plaintiff's counsel (if not the adjuster also) proceeded from the erroneous conclusion that Medicare has no right of recovery if CMS has not placed the parties on notice of any potential claim or its intent to seek reimbursement. Further, the case indicates that the adjuster, at least to some extent, was relying on (or at least deferred to) plaintiff counsel's understanding of what the parties' MSP obligations were in determining how to best to proceed.

In fairness to the parties in this case, the underlying events in *Hearn* transpired in 2004 when the claims industry was not as knowledgeable, skilled or savvy about MSP issues as it is today; and when Medicare itself was still sharpening and coordinating its MSP recovery efforts. Nevertheless, fast forwarding to the current MSP reality, primary payers need to develop specific protocols and MSP best practices to ensure that conditional payments are being properly addressed as part of everyday claims handling and settlement practices.

In general, some factors to consider on this front include: **(a)** starting the process to obtain conditional payment information early and during the course of the claim, as opposed to waiting until the claim settles; **(b)** reviewing Medicare's conditional payment claim and requesting the removal of inappropriate items to obtain an accurate exposure assessment; **(c)** clearly delineating who will be responsible for reimbursing Medicare's conditional payment claim and how this will be done as part of the settlement negotiations and settlement agreement; **(d)** including all necessary settlement provisions and language, and **(e)** employing the most effective and practical safeguards to ensure that sufficient funds are available once Medicare's "final" conditional payment figure is received post-settlement.

In addition, it must be recognized that a degree of cooperation between the parties is necessary when it comes to addressing MSP issues. For example, in order for a primary payer in a liability claim to obtain conditional payment information from Medicare, it will need the plaintiff to execute a "consent to release" form. Efforts to challenge and reduce Medicare's claim may very likely require the exchange of certain records and/or require a coordinated approach in other regards with respect to dealing with Medicare.

In an ironic twist, when it comes to MSP compliance, no matter how acrimonious the claim may be, and despite the fact that the parties may be light years apart on the underlying issues, in most instances the parties will ultimately find themselves standing side by side, front and center, in Medicare's bull's eye. Understanding this reality is an important first step toward developing the necessary practices to optimize claim settlement, avoid disputes and litigation (such as occurred in *Hearn*), and minimize potential liability with respect to MSP matters.

## About the Author

Mark Popolizio, Esquire is Section 111 Senior Legal Counsel for Crowe Paradis Services Corporation. Mark is a nationally recognized authority in MSP compliance. He has authored numerous articles on MSP issues including MMSEA Section 111, MSAs and conditional payments. Mark is a regularly featured presenter at national seminars and other industry events. Prior to dedicating his practice to MSP compliance in 2006, Mark practiced workers' compensation and liability insurance defense for ten years representing carriers, employers, third party administrators and self insureds. Mark is based out of Miami, Florida and can be reached at mpopolizio@cpscmsa.com or (786) 459-9117.

## Endnotes

[1] *Hearn v. Dollar Rent A Car, Inc., et. al.*, No. A11A2355, 2012 WL 987546, at *2 (Ga. Ct. App. March 26, 2012).

[2] *Id*. at *3.

[3] *Id.* at *1.

[4] *Id*. at *8 ,n 1.

[5] *Id*.

[6] *Id*. at *2.

[7] *Id*.

[8] In addition, to this ruling, the trial court ruled that Dollar was entitled to summary judgment on grounds that it did not have "any involvement in this case." The trial court found that DTG was entitled to summary judgment on grounds that the TPA settled the claim as an independent contractor and, therefore, could not be held liable. The trial court also ruled that all three defendants were entitled to attorney fees. *Id*. at *3.

[9] *Id*. at *3.

[10] *Id.* It is noted that the appeals court, in ultimately reversing the trial court's ruling, found "no evidence" of any kind suggesting that plaintiff or her counsel were attempting to improperly circumvent Medicare's reimbursement rights. *Id.* at *8, n. 4.

[11] The trial court struck plaintiff's amended complaint on grounds that plaintiff's counsel failed to obtain the necessary leave of court to amend the pleading per applicable rules of civil procedure. In a subsequent court proceeding, defense counsel was awarded $1,775 in attorney fees. On appeal, the appeals court ultimately vacated this award of attorney fees on grounds that the trial court's order did not include the necessary findings in support under Georgia law. The appeals court remanded the matter back to the trial court with instructions to make the "appropriate" findings of fact and to enter a new judgment accordingly.

[12] *Hearn v. Dollar Rent A Car, Inc., et. al.*, 2012 WL 987546, at *5. The appeals court reversal in this regard related specifically to DTG and the TPA.

[13] *Id.*

[14] *Id.* at * 6.

[15] *Id.* at *7.

[16] *Citing*, *Wright v. Liberty Medical Supply*, C.A. No. 7:09-cv-02490-JMC, 2011 WL 3235762 (D. South Carolina July 25, 2011) and *Riccardi v. Strunk*, CV 085008671, 2010 WL 744934 (Conn. Super., January 21, 2010). By way of example, the court in *Riccardi* entered a default judgment against the primary payer where the primary payer issued a separate settlement check, with Medicare as a co-payee, to cover the known Medicare conditional payment amount. In ruling against the primary payer, the court cited the fact that the plaintiff had executed an indemnity and hold harmless agreement in favor of the defendant and further found that *"[n]othing in the agreement indicate[d] that plaintiff is obligated to accept a check comprising a portion of the settlement made out to payees other than the plaintiff and his attorney."*

[17] *Citing*, *Tomlinson v. Landers*, No. 3:07-cv-1180-J-TEM, 2009 WL 1117399 (M.D. Fla. April 24, 2009) and *Wisinski v. American Commerce Group*, No. 07-346 Erie, 2011 WL 13744 (W.D. PA January 4, 2011). In addition, the author notes that the court's decision in *Zaleppa v. Seiwell*, 9 A.3d 632 (Pa. Super. Ct. Nov. 17, 2010) could also be cited for this principle.

[18] *Citing*, *Porter v. Farmers Ins. Co.*, 2012 WL 256014 (N.D. Okla. 2012); *Wilson v. State Farm Ins. Co.*, 795 F. Supp. 2d 604 (W.D. Ky. 2011); and *Lewis v. Allstate Ins. Co.*, No. 09-05-225 CV, 2006 WL 665790 (Tex.Ct.App.2006).

[19] *Id.* at *8. In addition, the appeals court reversed the trial court's grant of summary judgment in favor of DTG finding that issues of fact remained in regard to the nature and extent of their principle-agent relationship. However, the appeals court upheld the trial court's summary judgment ruling in favor of Dollar find that the evidence showed that the rental car in question was owned by DTG, and not Dollar, and that the TPA was not acting on behalf of Dollar when it settled this case.

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# Putting the Medicare Cards On the Table

## *Court Rules That L-MSA Not Required Per the Parties' Mediation Settlement Agreement*

### By Mark Popolizio, Esquire

In ***Bruton v. Carnival Corporation***, No. CV 11-21697-CIV., 2012 WL 1627729 (S.D. Florida May 2, 2012) the court ruled that a liability Medicare set-aside (L-MSA) was *not* required as part of the settlement based on the terms of the parties' mediation settlement agreement and other considerations.

The ***Bruton*** case, and the important practical considerations it raises, can be broken down as follows:

### Facts

Berneva Bruton (plaintiff) filed a claim against Carnival Corporation (defendant) for injuries allegedly sustained in a slip and fall accident aboard a Carnival ship.

In December 2011, the parties reached a settlement at a mediation conference. In relation thereto, the parties executed a Mediation Settlement Agreement (Mediation Agreement) which, in pertinent part, required plaintiff to execute a *"general release with approved confidentiality provisions and Medicare provisions."*[1]

Following the mediation, defendant sent plaintiff the settlement agreement[2] which contained provisions related to Medicare. Plaintiff was agreeable to certain provisions contained therein, but objected to specific provisions requiring her to establish an L-MSA.

In this regard, plaintiff was agreeable to the following provisions:

> Based on the grounds that the Plaintiff has reached Maximum Medical Improvement (MMI) as relating to the incident, no part of the monetary settlement is intended to provide compensation for future medical expenses incurred by MEDICARE. Additionally, as of the time of settlement, the parties were unable to obtain from MEDICARE the amount of past medical expenses, if any, incurred by MEDICA[R]E as a result of the alleged incident aboard the VESSEL. However, [Plaintiff] agree[s to] satisfy any MEDICARE lien amount out of the monetary settlement amount herein.[3]

However, plaintiff objected to, *and actually crossed out*, the following language:

> [Plaintiff] further agrees to retain a portion of the amount in a trust account administered by their undersigned attorneys for three (3) years from the date settlement funds are received or until MEDICARE provides [Plaintiff] with written notice that any claim for reimbursement, as authorized by the Medicare Secondary Payer statute … has been waived or resolved, whichever occurs first.[4]

After deleting the MSA language, plaintiff returned the modified release to defendant. However, defendant refused to tender payment based on plaintiff's deletion of the MSA provisions.

### Plaintiff Files Suit

Plaintiff then filed a *Motion to Compel Settlement Pursuant to Terms of Mediation*

*Settlement Agreement* in United States District Court for the Southern District of Florida.

Plaintiff argued that the Mediation Agreement did not require her to establish an L-MSA, and that one was not required by law. Further, plaintiff claimed defendant was adequately protected since as part of the settlement agreement she agreed to satisfy any Medicare liens or claims, and agreed to fully release defendant from any future obligations that may arise in relation to the underlying accident.

Defendant countered that the *"overriding need of the Defendant to consider [Medicare's interests]"* dictated that the settlement include an L-MSA. While defendant acknowledged the "unsettled state" of the law in regard to whether MSAs were mandated in liability claims, it argued that consideration of *"Medicare future's interests in the context of the need for any future medical expenditure on"* plaintiff's part should serve as the "guide post" for the parties. Thus, defendant argued that the *"most appropriate course of action"* was for plaintiff to establish an L-MSA.

## How Did the Court Rule?

The court framed the question before it as follows: *The sole issue here is whether the [Mediation Agreement] requires the creation of a Medicare set-aside trust account.*[5]

In addressing this issue, the court began by first explaining that under Florida law it is the party seeking to enforce the agreement who has the burden of showing *"assent by the opposing party and [establishing] that there was a meeting of the minds or mutual or reciprocal assent to certain definite propositions."*[6] The court further noted that to have an enforceable settlement the agreement must be *"sufficiently specific and mutually agreeable on every essential agreement"*[7] and that *"a contract results if the acceptance of an offer is absolute and unconditional, and identical with the terms of the offer.*[8]

From there, the court then measured the facts of this case with these principles. In doing so, the court concluded that the Mediation Agreement did *not* require plaintiff to establish an L-MSA, essentially finding that there was "no meeting of the minds" on this particular issue. The court ruled:

> We find that the [Mediation] Agreement does not require the creation of a Medicare set-aside trust account. The Agreement specified only that Plaintiff was to execute a general release with 'Medicare provisions' without specifying what those provisions would be. *The Agreement makes no mention whatsoever of a Medicare set-aside account. Moreover, Defendant has not claimed that the parties discussed this particular issue during settlement negotiations or that settlement was conditioned upon the creation of such an account*. (Emphasis Added).[9]

In addition, the court noted that plaintiff agreed to be responsible *"for any claims or liens by Medicare"* and was required to indemnify and hold harmless defendant *"from any liens, suits, or actions arising under the Medicare Secondary Payer statute"* as part of the settlement agreement. In light thereof, the court found that the settlement agreement (without the MSA language) adequately *"addresse[d] Defendant's concerns about Medicare's interests and its own liability for Medicare liens."*[10] The court also commented that there was *"no legal requirement that the settlement in this personal injury lawsuit include a Medicare set-aside trust account, a point Defendant has implicitly conceded."*[11]

Accordingly, the court found that plaintiff fulfilled her obligations under the Mediation Agreement; and ruled that defendant, by failing to tender timely payment, breached said agreement.

## Practical Considerations

From the author's view, one of the main takeaways from the *Bruton* case relates to the importance of making sure that all Medicare Secondary Payer (MSP) issues are clearly raised, specifically identified, and ultimately agreed upon as part of the settlement negotiations.[12] Unfortunately, the failure of the parties to clearly address MSP compliance issues continue to complicate, frustrate, and in some cases, torpedo, settlements in far too many instances.

To avoid these potential quagmires, the key is to **(a)** understand what the Medicare cards are (or could be) and **(b)** make sure that these cards are on table as part of the settlement negotiations.

With respect to point **(a)**, this involves having a solid understanding of one's compliance obligations under the Medicare Secondary Payer (MSP) statute and CMS' policies. This also includes recognizing the various MSP issues which remain uncertain or unclear to ensure that all relevant MSP matters are properly considered.

For defense counsel, knowledge of any specific client requirements concerning MSP compliance is absolutely critical, not only with respect to properly representing and protecting client interests, but also in regard to appropriately addressing the Medicare issues as part of defense handling. Toward this end, counsel should inquire about, and become familiar with, any applicable client MSP protocols or best practices early on, and assure that his/her defense handling proceeds in accordance therewith.

Key inquiry areas on this front include, but are not limited to: Does the client have specific WC-MSA protocols? What is the client's position regarding the question of Medicare's "future interests" in liability settlements and/or the L-MSA issue? If a MSA is applicable, does the client have any protocols regarding MSA administration? How is the issue of Medicare conditional payments to be handled? Are there specific settlement provisions and language the client would like included in the settlement agreement? Do the unique circumstances of a particular claim warrant additional considerations and approaches?

If the client does not have set practices or protocols, counsel should coordinate with the client to develop a Medicare game plan. One way or another, counsel and the client need to be on the same page with respect to what the MSP issues are, and how they will be handled, *prior* to entering into settlement discussions.

With respect to point **(b)**, once equipped with this precursor knowledge and understanding, it is then imperative that all relevant MSP issues are clearly raised, identified and discussed as part of settlement negotiations

(and, in some instances, perhaps even before entering into settlement discussions).

Here is where it all too often falls apart. This is can be so for a myriad of reasons, such as incomplete knowledge of MSP issues, discovery of subsequent facts that raise MSP concerns, or perhaps defense counsel learning about client protocols *after* negotiating the settlement. Also, the use of general phrases often leads to confusion as parties may interpret same differently based on their particular understanding of MSP compliance obligations, past practices, or their own private interests. To a large extent, these latter issues surfaced in *Bruton* as the crux of the dispute in that case concerned exactly what was meant and intended by plaintiff agreeing to execute a *"general release with approved … Medicare provisions."* Accordingly, spelling out the exact MSP issues and addressing them with specificity is critical as part of the settlement process.

In terms of preemptively addressing MSP issues, it may be prudent, or even necessary, to get the Medicare cards out on the table in *advance* of the actual settlement discussions themselves as these issues could directly impact the negotiations. Take, for example, the MSA. If an MSA is deemed appropriate by the primary payer, then alerting plaintiff's counsel of this fact and obtaining the MSA figure *prior* to starting the settlement discussions may make sense as this could have a direct impact on plaintiff expectations, case value, and corresponding "demand" and "offer" positions. In the author's experience, settling the claim and *then* advising the plaintiff that an MSA will be necessary and/or obtaining the MSA figure post settlement often creates significant complications which could ultimately doom the settlement for a number of reasons. Also, if a party has an objection to including an MSA, then this issue is identified early and the parties can work to address how best to resolve the matter.

On many levels, the *Bruton* case illustrates the importance of getting the Medicare cards out on the table as part of the settlement negotiations. In arriving at this point, it is important to understand that there are many different facets to MSP compliance. Accordingly, all relevant MSP compliance components (i.e. MSAs, conditional payments, etc.) as may pertain to a particular case should be specifically identified during the settlement negotiations, and the intended obligations and requirements pertaining to each should clearly spelled out.

## About the Author

Mark Popolizio, Esquire is Section 111 Senior Legal Counsel for Crowe Paradis Services Corporation. Mark is a nationally recognized authority in MSP compliance. He has authored numerous articles on MSP issues including MMSEA Section 111, MSAs and conditional payments. Mark is a regularly featured presenter at national seminars and other industry events. Prior to dedicating his practice to MSP compliance in 2006, Mark practiced workers' compensation and liability insurance defense for ten years representing carriers, employers, third party administrators and self insureds. Mark is based out of Miami, Florida and can be reached at mpopolizio@cpscmsa.com or (786) 459-9117.

## Endnotes

[1] *Bruton v. Carnival Corporation*, No. CV 11-21697-CIV., 2012 WL 1627729 , at *1 (S.D. Florida May 2, 2012).

[2] This agreement was officially titled as *"Release and Hold Harmless."*

[3] *Bruton v. Carnival Corporation*, 2012 WL 1627729, at *1.

[4] *Order on Plaintiff's Motion to Compel Settlement* (Torres, J.) May 2, 2012 (United States District Court, Southern District of Florida, Case 1:11-cv-21697-UU, Pacer Document No. 36, p. 2).

[5] *Bruton v. Carnival Corporation*, 2012 WL 1627729 , at *2.

[6] *Citing, Ribich v. Evergreen Sales & Serv., Inc.*, 784 So.2d 1201, 1202 (Fla. 2d DCA 2001); *see also Vital Pharms, Inc. v. S.A.N. Nutrition Corp.*, 2007 WL 1655421, at *6 (S.D. Fla. June 6, 2007).

[7] *Citing, Vital Pharms.*, 2007 WL 1655421, at *6 (internal citation omitted).

[8] *Citing, Ribich*, 784 So.2d at 1202; *Giovo v. McDonald*, 791 So.2d 38, 40 (Fla. 2d DCA 2001) (what is an "essential term" of a contract differs according to the circumstances, but it must include the terms specified in an offer in order to make a contract).

[9] *Bruton v. Carnival Corporation*, 2012 WL 1627729 , at *2.

[10] *Id.* at *2.

[11] *Id.* at *3.

[12] With respect to the main import of the *Bruton* case, the author recognizes that some may focus on the court's statement that there was *"no legal requirement that the settlement in this personal injury lawsuit include a Medicare set-aside trust account, a point Defendant has implicitly conceded." Id*. at *3. In essence, these observers will view the primary significance of this case from the vantage point of the issue of MSAs in liability cases.

While certainly noting the court's statement, in the "practical considerations" section of this article the author focuses on certain practical aspects of MSP compliance in relation to the issue as specifically defined by the court in this case: *The sole issue here is whether the [Mediation Agreement] requires the creation of a Medicare set-aside trust account*. From this vantage point, the author concentrates on the specific claims handling implications and concepts raised by *Bruton* from this perspective.

Thus, a complete examination into the complex, convoluted and polarizing topic of "liability MSAs," and how this decision may apply to that question, is beyond the scope of this analysis. On that note, in the author's view, that issue would entail review of additional and different information and considerations than that presented and evaluated by the court in this case. In addition, from the author's perspective, a proper examination into this question would require a much broader analysis than considered in *Bruton*. In that regard, in *Bruton*, the parties and the court approached the issue in terms of whether an MSA was "required" in the context of a liability settlement. From that perspective, the parties and court essentially concluded that there was no such "requirement;" which is essentially in accord with CMS' statements that an MSA is not technically "required" per se – in either workers' compensation *or* liability claims. *See e.g., CMS Town Hall Transcript*, March 24, 2009 at p. 61*; CMS Town Hall Transcript*, September 30, 2009 at p.25-26*; CMS Town Hall Transcript*, October 22, 2009 at p. 64-65*;* and *Written Statement of Sally Stalcup, CMS MSP Regional Coordinator (Dallas Regional Office)*, May 25, 2011.

However, from the author's review of CMS' statements (both oral and written) on the issue, the question may not necessarily be *"is an L-MSA required?"* That answer is seemingly "no"--- even from CMS' perspective. *Id*. Rather, the "issue" may more appropriately be: *"Is there an obligation to protect Medicare's 'future interests' as part of a liability settlement?"* or, from a more practical position, "*Does CMS believe there is an obligation to protect Medicare's 'future interests' as part of a liability settlement?" See id*; and Charlotte Benson, *CMS Memorandum: Medicare Secondary Payer: Liability (Including Self Insurance) Settlements, Judgments, Awards, or Other Payments and Future Medicals*, September 30, 2011. As part of this, consideration should also be given to the fact that

recent versions of the MSP manual have included references to both L-MSAs and no fault Medicare Set-Asides. Also, at the time of this article's publication, CMS has advised that it is in the process of developing regulations surrounding Medicare Secondary Payer compliance regarding future medicals. See pending rule; "Medicare Secondary Payer and 'Future Medicals' (CMS-6047-ANPRM)," May 3, 2012. Thus, while CMS may acknowledge that L-MSAs, are not "required," this other evidence would seem to suggest that on some level, to some extent, and in some manner, the agency believes there is some obligation to consider Medicare's interests with respect to certain liability settlements, with the "MSA" being just one vehicle or option available toward that end. Assuming that this in fact CMS' position, the question would then become; *"are they correct legally?"*

So there is no misunderstanding, the author wants to be clear here: The author is *not* opining on the issue of L-MSAs, or what obligations may exist, if any, with respect to Medicare's "future interests" in liability settlements as part of this analysis. Rather, he is merely suggesting that, from a purely academic standpoint, the *Bruton* case probably should not be looked upon as some seminal judicial opinion regarding the $64 million question regarding L-MSAs or the nature and extent of any potential rights Medicare may have regarding its "future interests" in liability cases based on the nature of this case, the exact issue before the court *as actually framed by the court*, the information and resources considered, and, the limited phraseology of the "future interests" question as discussed by the parties and the court.

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