Sedgwick LLP

CMS Continues the Deadline for Reporting Liability Settlements and Makes Other Changes That Could Affect Resolution of Product Liability Claims

Product Liability Advisory

December 2010

By: John Gherini

Introduction

Since Congress passed the Medicare, Medicaid and SCHIP Extension Act (MMSEA or the Act), litigants have scrambled to interpret the language and discern the likely ramifications of the Act on the resolution of liability claims. The sanctions for non-compliance imposed by Section 111 of the MMSEA, which includes double damages and fines of $1,000 per day of non-compliance, provide the necessary incentive for both the plaintiff and defense bars to actively engage the Centers for Medicare and Medicaid Services (CMS) on all manner of logistical issues associated with implementation of the Act. The result has been a continuing dialogue with CMS.

Despite these efforts, in February 2010, confusion surrounding application of the Act culminated in CMS moving the reporting start date to October 1, 2010 and the reporting deadline to January 1, 2011. However, as questions remained unanswered, CMS was again compelled to move these deadlines. On November 9, 2010, CMS issued an "alert" indicating the reporting start date for liability claims has been moved to October 1, 2011 and the reporting deadline has been extended to January 1, 2012. **The practical effect of this change is that any liability settlements completed before October 1, 2011 will not need to be reported.**

CMS also issued an alert that may impact settlements of certain product liability and other mass tort claims. Specifically, CMS clarified that if resolution of a claim involves multiple plaintiffs, but a particular settlement amount is not immediately identified for each individual plaintiff, the reporting obligations do not start until the plaintiff and amount are identified. It is that date that will trigger the reporting timeframes come January 2012. This could create logistical obstacles for these types of cases. If the settlement does not provide a process for determining how the funds will be allocated, the entire amount must be reported for each plaintiff and CMS will decide how

much of the entire settlement should be used to pay back conditional payments. All of this depends on the terms of the settlement, the ramifications of which must be considered.

It is clear that the MMSEA remains a moving target and there are several yet unanswered questions in the liability settlement area. This article is only intended to apprise the reader of the current reporting deadlines and offer some guidance for settlements entered in the near future. We will supplement this article as CMS continues to change the landscape surrounding liability settlements.

Changes to the Reporting Deadlines

CMS reporting deadlines are based in large part on the date the total payment obligation to claimant (TPOC) is established. TPOC refers to the dollar amount of a settlement, judgment, award or other payment and generally reflects a one-time payment to a claimant. CMS cautions that the TPOC date is not necessarily the date of payment but should be the date the payment obligation was created, which could be the date a settlement agreement was signed or the date an order is issued by a court approving the settlement (if necessary).

Prior to the November 9, 2010 alert, the most recent version of the CMS User Guide made it clear that "[responsible reporting entities (RREs)] are only required to report TPOCs with dates of October 1, 2010 and subsequent. ... Again, TPOCs with dates prior to 10/1/2010 do NOT have to be reported ... ." (Liability Insurance User Guide, Version 3.1, July 12, 2010 (hereafter user guide).) While claims with TPOC dates of October 1, 2010 and later had to be reported, the data associated with those claims did not have to be submitted until January 1, 2010.

According to the November 9, 2010 alert, "[t]he current rule requiring reporting of Non Group Health Plan TPOC Dates of 10/1/2010 has been changed to 10/1/2011 but only for liability insurance (including self insurance) TPOCs." (CMS November 9, 2010 Alert.) Although not relevant to this discussion, the alert did not change the reporting deadlines for other types of insurance coverage such as "no-fault insurance" and workers' compensation. The alert also indicates reporting of liability settlements will not be required until the first quarter of 2012.

The impact of this change is that settlements of claims concluded before October 1, 2011 (other than in the areas of no-fault insurance and workers compensation) do not need to be reported, even if the plaintiff is a Medicare beneficiary. CMS does, however, encourage voluntary reporting of these claims so that litigants can familiarize themselves with the process without the threat that a mistake will result in substantial penalties.

Recent Guidance From CMS Could Affect Product Liability and Mass Tort Settlements Involving Multiple Plaintiffs

We are aware that some RREs have started the process of voluntarily reporting claims involving Medicare beneficiaries. The initiation of the claims reporting process during this grace period before January 1, 2012 has its advantages. However, for those RREs that have not started reporting, we note CMS has indicated a new version of its user guide is forthcoming, which will likely alter currently existing reporting requirements and could clarify currently existing ambiguities.

One such ambiguity was recently addressed in an October 14, 2010 alert from CMS. CMS was concerned that lump-sum settlements would be reached in product liability cases involving one incident but multiple plaintiffs. Product liability pharmaceutical litigation was specifically cited by CMS as an example. (See p. 6 of the October 14, 2010 CMS Non-Group Health Plan teleconference transcript.) The alert explains that when a settlement is reached that provides for a lump-sum amount, with provisions as to how to determine allocation of the amount among several plaintiffs in the future, the actual TPOC date for each plaintiff is the date money from the settlement is actually allocated to the individual.

> Timeliness of MMSEA Section 111 reporting for a particular Medicare beneficiary will be based upon the date there is a determination both that payment will be made to or on behalf of that beneficiary and a determination of the amount of the settlement, judgment, award or other payment to or on behalf of that beneficiary.

(CMS October 14, 2010 Alert.) As the alert warns, a defendant settling such claims must track each plaintiff and work with Medicare to resolve each individual Medicare claim. For these reasons, it is not advisable for settlement

funds to be distributed to a plaintiff until the defendant is assured any Medicare claim is resolved. This could create logistical problems for the defendant, depending on (1) the number of plaintiffs, (2) the number of plaintiffs that are Medicare beneficiaries and (3) the provisions of the settlement that determine how the money should be allocated.

Lump-sum settlements are common in product liability cases because one event can give rise to multiple claims. Based on this alert, there are pitfalls associated with such a settlement, at least with respect to the Medicare implications. For example, if the settlement provisions allow for a claims process through which otherwise unknown claimants can come forward and make a claim, the fact they may be Medicare beneficiaries could impact the settlement value. If the settlement allocation to a Medicare beneficiary is less than the Medicare claim, then the plaintiff gets nothing. This could disrupt such a settlement if plaintiffs are not aware of the dynamics of the MMSEA.

Other pitfalls exist if the settlement agreement does not specify how the lump-sum payment is to be allocated among multiple plaintiffs. In this situation, then the entire settlement amount must be reported for each plaintiff and CMS will decide how much will be taken out to reimburse conditional payments made to all plaintiffs. (See p. 12 of the October 14, 2010 CMS NGHP telephone conference.) This could impact a settlement if CMS disproportionately takes funds from various plaintiffs to cover Medicare payments made. To avoid this scenario, a defendant could create separate settlement agreements for each plaintiff that includes the specific allocation for each. This would provide a framework for negotiating reimbursement of Medicare payments on a plaintiff by plaintiff basis. However, this may not be feasible depending on the number of plaintiffs involved.

This alert raises more questions than it answers. As CMS continues to evolve, it becomes evident that considerable care must be invested in order to resolve these cases. The same settlement strategies used before may not be as effective after the MMSEA is applied.

Conclusion

We think there is little doubt that even CMS would agree the process of implementing the provisions of the MMSEA, and specifically section 111, is complicated. CMS has also shown that it is an ever-changing process. At least for now, RREs can rest assured that penalties will not be imposed for another year. While this article did not address the multitude of issues surrounding the Act, it serves as an update of the obstacles and struggles confronting not only CMS, but all litigants.

Related Practices:

Healthcare

Insurance Practices

Products Liability

Specialty & Catastrophic Torts