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No. 66211-2-I

COURT OF APPEALS  
OF THE STATE OF WASHINGTON  
DIVISION ONE

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JUANITA COUNTRY CLUB CONDOMINIUM OWNERS  
ASSOCIATION,

Appellant/Defendant,

v.

LUCIENNE FIRTH,

Respondent/Plaintiff.

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APPELLANT JUANITA COUNTRY CLUB  
CONDOMINIUM OWNERS ASSOCIATION'S  
OPENING BRIEF

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## I INTRODUCTION

The plaintiff slipped and fell on property owned by the Juanita Country Club Condominium Owners Association (COA) and asserted personal injury damages based on negligence and other theories in a lawsuit filed in December 2009. The parties settled the claim on June 29, 2010, without the admission of liability. The terms of the settlement agreement were recorded in an email by the professional mediator who assisted the parties in reaching agreement:

This email confirms that **the parties have agreed to settle** this case for \$100,000 new money **conditional on:**

- Plaintiff executing a release and order of dismissal both with prejudice and without costs;
- A hold harmless regarding liens, subrogation interests, and unpaid bills;
- An arrangement **satisfactory to the defense** regarding any Medicare, liens, future set-asides, or other Medicare issues;
- Plaintiff's counsel holding sufficient funds to resolve any known liens, subrogation interests, and unpaid bills.

It is my working assumption that **settlement funds will be paid within 21 days of the execution of the above-listed documents.**

No party contradicted the mediator's email. The plaintiff has not executed a release document. While the lengthy process to receive confirmation from Medicare regarding payments and liens was pending (*i.e.*, the defendant was awaiting notice from Medicare, which typically takes 90 days), the plaintiff filed a motion to enforce the settlement agreement. The

plaintiff asked the Court to unilaterally change the settlement terms so that payment of the \$100,000 settlement amount was due on the day that settlement was reached; interest accrued daily even though the agreement contemplated payment after a release was signed; the defense was not permitted to wait for Medicare confirmation; and the plaintiff was no longer required to set aside funds for future Medicare payments. Over the COA's objections, the trial court entered the plaintiff's proposed order.

There are two Medicare issues of interest to the defense. *First*, the defense sought confirmation from Medicare that the plaintiff, who turned 65 during the pendency of litigation, had not yet received any Medicare benefits or payments related to injuries associated with the accident. *Second*, the defense negotiated with the plaintiff for a specific portion of the settlement amount to be "set aside" to reimburse Medicare for future medical care related to the accident. For both past and future Medicare payments, Medicare is entitled to pursue the COA, its insurer, or its attorneys directly for payments, even after a settlement is reached with the plaintiff. Thus, the defendant's ability to reach a "satisfactory" arrangement on the Medicare issues was essential to its decision to settle the claim.

While the defendant was waiting for confirmation of past payments by Medicare, the plaintiff repeatedly demanded payment, despite the express term of the agreement that the defendant had to be "satisfied" before

payment would issue. The plaintiff rejected the first version of the release agreement drafted by the defendants. On September 27, 2010, the defendant offered to pay the full settlement amount to the plaintiff, with a portion to be reserved in the plaintiff's counsel trust account pending confirmation from Medicare. The defendant also transmitted a revised settlement agreement. The plaintiff never responded directly to this draft. Instead, on the same day, the plaintiff filed her Motion to Enforce Settlement Agreement.

In its Motion to the trial court, the plaintiff asked the Court to (1) find that an enforceable settlement agreement existed that included "payment of \$100,000 and execution of a release with **an additional set-aside** to cover any potential interest by Medicare" and that "terms of the settlement are not in dispute;" (2) that the defendants "waived" the settlement requirement that the plaintiff set money aside for Medicare purposes; and (3) that the Court order interest of 12% on the settlement amount, starting the day the oral agreement was reached. The trial court entered the proposed order drafted by the plaintiff without any changes. The signed order includes findings that the defendants "did not tender a final release with accurate or appropriate terms to effectuate the settlement within three months of the settlement" and that "implying a due date for payment is indispensable to effectuate the intention of the parties."

The trial court's order changes the settlement terms agreed to by the parties and negates material terms required by the defendant. The order also adds new terms to which the parties did not agree. The defendant therefore requests that the Court of Appeals *reverse* the decision of the trial court and *require* that only the agreed terms of the settlement be enforced—namely, that the plaintiff sign a release of all claims; that the plaintiff agree to the Medicare set aside; and that no interest be awarded to the plaintiff. The amount of the settlement is not in dispute and has already been sent to the plaintiff's counsel trust account.

## II ASSIGNMENTS OF ERROR

The defendant assigns error to each of the following statements contained within the Order Enforcing Settlement (App. A) because they are not supported by the record and because they contradict the terms actually agreed upon by the parties:

1. "The terms of the settlement were payment of \$100,00 and execution of a release with an additional set-aside to cover any potential interest by Medicare." (Underlined portion only).
2. "The existence and terms of the settlement are not in dispute."
3. "At the time of the settlement, the defendant had sufficient information to verify that Ms. Firth had not received payments or benefits from Medicare."

4. “The defendants did not tender a final release with accurate or appropriate terms to effectuate the settlement within three months of the settlement.”
5. “The defendant had no just reason for the delay, and the defendants benefited from the delay.”
6. “Their delay was intentional and voluntary.”
7. “The defendants waived the term of the settlement that Ms. Firth set-aside money for the purposes of Medicare’s interests.”
8. “While Ms. Firth may owe this duty in law, she does not owe this duty to the defendants under the terms of the settlement.”
9. “The defendants did not tender payment within three months of the agreed settlement.”
10. “The defendants had no just reason for the delay and the defendants benefited from the delay.”
11. “Implying a due date for payment is indispensable to effectuate the intention of the parties.”
12. “This term is so clearly within the contemplation of the parties that they deemed it unnecessary to express it, so it is necessary to imply it in law.”
13. “This term is also so important that it would have been explicitly agreed to had attention been called to it.”

14. “The defendants owe interest at 12% compound interest per annum since June 29, 2010.”

### **III ISSUES PERTAINING TO ASSIGNMENTS OF ERROR**

1. The parties’ settlement agreement stated that payment should be made within 21 days of the plaintiff’s execution of a release. The plaintiff never signed a release and the defendant has not yet been “satisfied” that all Medicare issues have been addressed. Should the plaintiff be precluded from adding a unilateral term to the agreement requiring payment within three months? (Assignments of Error 4-6, 9-13)

2. The settlement requires the plaintiff to set aside a certain sum from the settlement amount for Medicare issues. Should the defendant be allowed to enforce this term and require the plaintiff to set aside a Medicare amount even though the plaintiff claims that the defendant was allegedly late in seeking Medicare confirmation? (Assignments of Error 1-8, 10)

3. Should the plaintiff’s request to add a term to the settlement agreement to require payment of interest from the day of the agreement be denied when the parties did not agree to the payment of interest and the only deadline expressly included in the agreement was not reached before payment was proffered? (Assignments of Error 1-14)

#### IV STATEMENT OF THE CASE

The plaintiff Lucienne Firth claims personal injuries from a fall on property owned by the COA.<sup>1</sup> She sued the COA and other parties for negligence and other theories on December 30, 2009.<sup>2</sup> The plaintiff sought both past and future medical expenses for her injuries; she turned 65 during the pendency of the lawsuit.<sup>3</sup>

The parties mediated the claims with professional mediator Thomas Harris of Washington Arbitration and Mediation Services.<sup>4</sup> On June 29, 2010, the parties reached an agreement by telephone with Mr. Harris.<sup>5</sup> Mr. Harris sent an email to both parties and summarized the terms of the agreement:

This email confirms that the parties have agreed to settle this case for \$100,000 new money **conditional on:**

- **Plaintiff executing a release** and order of dismissal both with prejudice and without costs;
- A hold harmless regarding liens, subrogation interests, and unpaid bills;
- An arrangement **satisfactory to the defense** regarding any Medicare, liens, future set-asides, or other Medicare issues;
- **Plaintiff's counsel holding sufficient funds to resolve any known liens, subrogation interests, and unpaid bills.**

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<sup>1</sup> CP 3-4.

<sup>2</sup> CP 1. Community Association Underwriters of America, Inc. (CAU) was dismissed separately and is not a party on appeal. CP 26-27. The appellants are Juanita Country Club Condominium Owners Association and The CWD Group, Inc., which is the property manager for the COA. Both appellants are referred to collectively as the COA.

<sup>3</sup> CP 92 at ¶4.

<sup>4</sup> CP 92.

<sup>5</sup> CP 92-93.

It is my working assumption that **settlement funds will be paid within 21 days of the execution** of the above-listed documents.<sup>6</sup>

No party contradicted this statement by Mr. Harris of the terms reached on June 29. The plaintiff has not executed a release document.<sup>7</sup>

Through the mediation process and subsequent communications regarding settlement documents, the COA explained that it needed further information on two issues before any settlement could be finalized:

1. The plaintiff had to agree to set aside a portion of the settlement (not an addition) for future care for her injuries. The plaintiff contemplated surgery, and Medicare would require the tortfeasor to contribute to the costs of this procedure. Thus, the COA, through its insurer, consulted a Medicare specialist who reviewed the plaintiff's medical records and set the amount of the set-aside for future costs at \$34,630.<sup>8</sup> This portion of the \$100,000 settlement amount would be placed by the plaintiff in an interest-bearing account to be used by her and Medicare to pay for the future care.<sup>9</sup>

2. In addition to future costs, the defendant sought to confirm that Medicare had not already paid for any care to the plaintiff related to the

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<sup>6</sup> CP 98-99 (emphasis added).

<sup>7</sup> CP 100-104.

<sup>8</sup> CP 44-46.

<sup>9</sup> CP 46; CP 102-103.

accident (known by Medicare as conditional payments).<sup>10</sup> Medicare typically takes 90 days to confirm whether any such payments have been made.<sup>11</sup> Although such payments were unlikely because the plaintiff did not become Medicare eligible until April 2010, the defendant is still directly liable to Medicare for reimbursement of such payments, plus penalties if the regulations are not followed. Thus, the defendants sought clarity on a real and tangible risk in settlements potentially involving Medicare.<sup>12</sup>

The COA's satisfaction that any settlement would protect it from additional claims from Medicare was essential to its decision to settle with the plaintiff for the agreed-upon amount. The issue was discussed throughout the settlement process.<sup>13</sup> Based on its counsel's prior experience, the COA knew that Medicare could take months to issue the proper confirmations, and thus the COA would not have agreed to a three month deadline to pay the settlement amount—or any similar length of time.<sup>14</sup> Thus, the defendant obtained the plaintiff's authorization and sought written confirmation from Medicare that no outstanding liens existed and no prior payments had been made on behalf of the plaintiff.<sup>15</sup>

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<sup>10</sup> CP 45.

<sup>11</sup> CP 94-96.

<sup>12</sup> CP 92.

<sup>13</sup> *Id.*

<sup>14</sup> CP 96.

<sup>15</sup> CP 93-94.

At the time that the plaintiff filed the Motion to Enforce Settlement, Medicare had not yet confirmed whether prior payments had been made for the plaintiff. Consequently, the settlement could not be finalized in accordance with the June 29 terms. Nevertheless, the defendant offered to pay the settlement amount to the plaintiff if the plaintiff agreed to reserve \$5,000 in the event that Medicare did assert a lien (in addition to the set aside for future expenses). Thus, the plaintiff would have been paid on September 28, but for her decision to file the motion and her refusal to accept the release language proposed by the defendant.<sup>16</sup>

The plaintiff first raised the issue of interest on the settlement amount on September 20, 2010:

As we are nearly three months since settlement, my lady is asking me whether we are going to get interest. **As it is tough to point to a breach of an express, written promise, I see how that issue is not clear cut in her favor;** however, she makes a good point. We would appreciate your raising it with the adjuster on her behalf.<sup>17</sup>

On September 23, 2010, the plaintiff requested final documents by September 27, 2010, or else she would seek relief from the Court.

I am leaning towards asking the court for relief unless we have some finality at the three month anniversary of the settlement. Unfortunately I am out of the office tomorrow. ... I will be in

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<sup>16</sup> CP 95-96.

<sup>17</sup> CP 75-76 (emphasis added).

the office Monday, September 27<sup>th</sup>, and I hope we have final documents then.<sup>18</sup>

As noted, the defendant provided a final release agreement on September 27. Despite the plaintiff's earlier assurance that it sought the document by the 27<sup>th</sup>, despite the plaintiff's agreement to wait until the defendant was "satisfied" before finalizing the agreement, and despite the plaintiff's recognition that it had no legal basis to seek interest, the plaintiff filed the Motion to Enforce rather than fulfill the terms of the agreement. After the trial court ruled in the plaintiff's favor, this appeal followed.

## V ARGUMENT

### A. The standard of review is *de novo*.

Summary judgment procedures are applied to determine whether there is a genuine dispute regarding the existence and material terms of a settlement agreement.<sup>19</sup> The moving party has the burden of proof.<sup>20</sup> Further, the meaning of a contract is an issue of law and therefore reviewed *de novo*.<sup>21</sup> Settlement agreements are a type of contract. When the central dispute relates to interpreting and applying a settlement agreement, therefore, the standard of review is *de novo*.

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<sup>18</sup> CP 77-78.

<sup>19</sup> *In re Patterson*, 93 Wn. App. 579, 969 P.2d 1106 (1999).

<sup>20</sup> *In re Marriage of Ferree*, 71 Wn. App. 35, 856 P.2d 706 (1993).

<sup>21</sup> *Chem. Bank v. Wash. Pub. Power Supply Sys.*, 102 Wn.2d 874, 894, 691 P.2d 524 (1984).

As part of the de novo review, a trial court's factual findings on summary judgment are entitled to no weight and the appellate court reviews the record de novo.<sup>22</sup> In contrast, the decision whether to compel enforcement of an agreement under CR 2A is reviewed on an abuse of discretion standard.<sup>23</sup> Here, though, the COA does not dispute that the parties reached an enforceable agreement on June 29, 2010. The only question for this Court is whether the plaintiff can add additional terms and change other terms because she is dissatisfied with the pace of obtaining Medicare authorization. The trial court's decisions on these issues are reviewed de novo.

**B. The plaintiff is not entitled to change the terms of the settlement agreement because she is disappointed with the pace of resolving the Medicare issues.**

Medicare is the federal health insurance program for people over age 65 or people with certain disabilities.<sup>24</sup> The Medicare Secondary Payer Act (MSPA) makes Medicare the secondary payer whenever another party,

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<sup>22</sup> *Chelan County Deputy Sheriffs' Ass'n v. Chelan County*, 109 Wn.2d 282, 745 P.2d 1 (1987).

<sup>23</sup> *Morris v. Maks*, 69 Wn. App. 865, 850 P.2d 1357 (1993); RCW 2.44.010.

<sup>24</sup> 42 U.S.C. §1395y(b); see Centers for Medicare and Medicaid Services, *Introduction to Section 111 Mandatory Medicare Secondary Payer Reporting*, February 23 2009, at 1, [www.cms.hhs.gov/MandatoryInsRep/Downloads/RevisedSection111022309.pdf](http://www.cms.hhs.gov/MandatoryInsRep/Downloads/RevisedSection111022309.pdf) (last accessed January 2, 2011); see generally Christopher Berdy and Steven Nichols, *The Medicare, Medicaid and SCHIP Extension Act of 2007: A Practitioner's Introduction to Resolving Personal Injury Liability claims by Medicare Beneficiaries*, *Defense Counsel Journal*, October 2009 (attached as App. B).

such as a tortfeasor, is required to pay for covered services. The Medicare, Medicaid and SChip Extension Act of 2007 (MMSEA), some of which went into effect in mid-2010, imposes strict reporting requirements and penalties when an insured tortfeasor pays on a claim by a Medicare beneficiary and does not provide for reimbursement to Medicare for past expenses or recognition of future costs that may fall within a Medicare covered expense. Medicare is automatically subrogated for its payments, past and future, when a tortfeasor may be liable.<sup>25</sup> It may assert claims directly, and it is entitled to recover double damages plus interest.<sup>26</sup> Even if the tortfeasor has already paid the Medicare beneficiary, it could be required to reimburse Medicare directly.<sup>27</sup> Under the new 2010 requirements, insurers, insureds, and their attorneys may all be liable under MMSEA.

The statute requires alleged tortfeasors to “reasonably consider” the interests of Medicare.<sup>28</sup> Medicare, however, has not yet promulgated regulations to define this term for personal injury lawsuits.<sup>29</sup> Thus, an insurer must make its own determination of what is “reasonable” when

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<sup>25</sup> 42 U.S.C. §1395y(b)(2)(B)(iv); 42 C.F.R. §411.26.

<sup>26</sup> 42 U.S.C. §1395y(b)(2)(B)(ii)-(iii); 42 C.F.R. §411.24(c)(2), (h)(m).

<sup>27</sup> 42 C.F.R. §411.24(i).

<sup>28</sup> 42 U.S.C. §1395y(b)(2)(A); 42 C.F.R. § 411.25(a).

<sup>29</sup> In contrast, regulations exist for claims involving workers compensation benefits. These regulations require a set aside for future medical costs.

settling a claim, knowing that it faces stiff penalties for violating MMSEA.<sup>30</sup>

In this context, the COA (who was insured for the claim asserted by the plaintiff) would only agree to a settlement with the plaintiff if the Medicare considerations were addressed in the agreement. Given the lack of direction from Medicare itself, the COA did not agree that the plaintiff could decide or share in the decision of what particular method to take to ensure Medicare confirmation. Rather, the settlement was contingent on the COA's "satisfaction" with the Medicare provisions before a settlement could be finalized and before payment was actually owed to the plaintiff.

The plaintiff argued that her short time of eligibility was proof that Medicare did not pay any past bills for this December 2007 accident. Nevertheless, the COA was entitled to wait for direct confirmation from Medicare—entitled by the terms of the agreement to which Ms. Firth voluntarily agreed through mediation. Ms. Firth could have proposed any number of additional terms to the settlement agreement on June 29—for example, that submissions to Medicare be completed by a certain date, that all or part of the settlement amount be delivered by a date certain, or that a limited amount of the settlement be reserved for possible past Medicare payments. Instead, she agreed that payment of the settlement

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<sup>30</sup> See generally Berdy, *supra*, at 6-8.

amount was contingent on the defendant's satisfaction regarding any Medicare issue and she did not request a deadline.

The COA has not withheld its approval for Medicare issues arbitrarily. It simply stated that it could not release the settlement amount until Medicare confirmed that no prior payments had been made. Further, the COA offered in September to pay the plaintiff the settlement amount and only withhold \$5,000 for payment of any potential liens (even though Medicare could have claimed a higher amount). In other words, the defendant voluntarily accepted additional risk to resolve this case with the plaintiff.<sup>31</sup> The COA has fulfilled its obligations under the settlement agreement and has acted in good faith to negotiate the final terms with the plaintiff. The plaintiff, however, announced on September 20 that she also wanted interest, and thus now seeks to change the terms of the agreement.

**C. The plaintiff cannot now add terms to the agreement that she wished she had included.**

Here, the parties reached an agreement on the following terms: that the COA would pay the plaintiff \$100,000 **contingent** on a full release of

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<sup>31</sup> The second issue is the set aside for future Medicare payments. The parties agreed on an amount to set aside (\$29,630) and the defendant proposed language that the plaintiff found agreeable. CP 100-104. The only dispute remaining when the Motion to Enforce was filed was timing and waiting for Medicare's confirmation regarding past payments.

claims and **an arrangement satisfactory to the defense regarding any Medicare, liens, future set-asides, or other Medicare issues.** The plaintiff further agreed that payment could occur 21 days after the release was signed—and the plaintiff has still not signed a release of any kind. The agreement did not provide that any interest would accrue while waiting for a Medicare arrangement (here, a Medicare confirmation letter) that was satisfactory to the defendant. The agreement did not provide that payment would occur by a certain date.

The trial court has the authority to enforce a settlement agreement.<sup>32</sup> The purpose of CR 2A and RCW 2.44.010 is to give certainty and finality to settlements and compromises, if they are made. A settlement agreement is an enforceable contract, even if a later, more formal release or agreement is contemplated.<sup>33</sup> The interpretation and application of the agreement is governed by contract law.<sup>34</sup>

Washington follows the objective theory of contracts—the existence and terms of a contract depends on the outward manifestations of intent by each party.<sup>35</sup> A contract requires mutual assent based on “an objective manifestation of ... intent on the essential terms of the promise,”

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<sup>32</sup> CR 2A; RCW 2.44.010.

<sup>33</sup> *Morris v. Maks*, 69 Wn. App. 865, 872, 850 P.2d 1357 (1993).

<sup>34</sup> *Id.*

<sup>35</sup> *Ford v. Trendwest Resorts, Inc.*, 146 Wn.2d 146, 43 P.3d 1223 (2002).

and not on the unilateral or subjective intent of an individual party.<sup>36</sup> Thus, if one party demonstrates the existence of a contract and its opponent's objective manifestation of intent to be bound by the contract, the opponent's unexpressed subjective intent is irrelevant.<sup>37</sup> In simpler terms, if party A and B agree to settlement terms, party A's subjective intent that certain terms should have additional limitations (such as time), or A's subjective desires to supplement or change terms at a later date, are irrelevant.

Every contract contains an implied duty of good faith and fair dealing, but only as to terms agreed on by the parties.<sup>38</sup> A party is not required to accept a material change in the terms of the contract, and there is no breach in merely requiring performance of a contract according to its terms.<sup>39</sup>

When interpreting a contract, the courts examine the terms actually written, and not "what was intended to be written."<sup>40</sup> While extrinsic evidence may be used to explain a term, it may not be used to vary or

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<sup>36</sup> *Wetherbee v. Gary*, 62 Wn. 2d 123, 381 P.2d 237 (1963); *Barnes v. Treece*, 15 Wn. App. 437, 549 P.2d 1152 (1976).

<sup>37</sup> *Saluteen-Maschersky v. Countrywide Funding Corp.*, 105 Wn. App. 846, 22 P.3d 804 (2001); *Retail Clerks Health & Welfare Trust Funds v. Shopland Supermarkets, Inc.*, 96 Wn.2d 939, 640 P.2d 1051 (1982).

<sup>38</sup> *Badgett v. Security State Bank*, 116 Wn.2d 563, 807 P.2d 356 (1991) (duty of good faith did not require bank to renegotiate contract on more favorable terms).

<sup>39</sup> *Haire v. Patterson*, 63 Wn. 2d 282, 386 P.2d 953 (1963).

<sup>40</sup> *Hearst Communications v. Seattle Times*, 154 Wn. 2d 493, 501, 115 P.3d 262 (2005).

modify what was actually included in the agreement.<sup>41</sup> Further, extrinsic evidence may rarely be used to imply additional terms or covenants.<sup>42</sup> Implied covenants are not favored in the law and will not be implied unless five requirements are met: (1) the implication must arise from the language used or be indispensable to effectuate the intent of the parties; (2) it must be clearly contemplated by the parties such that it was unnecessary to express it; (3) it must be a legal necessity; (4) it must be a promise that would have been included if attention had been called to it; (5) and the subject is not otherwise covered by the contract.<sup>43</sup> Here, the plaintiff seeks to impose three terms onto the parties' agreement: that settlement payments be made within three months of June 29; that the agreement term to make a Medicare set aside be waived after three months; and that interest accrue from the date of settlement. The plaintiff's only authority for allowing the court to add, vary, and modify the agreement terms is *Oliver v. Flow*.<sup>44</sup> In *Oliver*, the plaintiff sought to prove that the defendant had an implied duty to manufacture and sell a product that the plaintiff had sold to the defendant. The court refused to imply any obligations on the defendant to market or sell the product

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<sup>41</sup> *Id.*

<sup>42</sup> *Oliver v. Flow International Corp.*, 137 Wn. App. 655, 660-61, 155 P.3d 140 (2006), cited with favor by the plaintiff in her Motion to Enforce.

<sup>43</sup> *Id.*; *Brown v. Safeway Stores*, 94 Wn.2d 359, 370, 617 P.2d 704 (1980).

<sup>44</sup> 137 Wn. App. 655, 660-61, 155 P.3d 140 (2006).

because such terms were not a legal necessity. “Typically, a term is implied in order to supply consideration, without which there would not be a valid contract. Here, the contract was supported by [] consideration ...” Thus, the court refused to imply any additional terms.<sup>45</sup>

The same reasoning applies here. The parties agreed that the settlement was contingent on the defendant’s satisfaction as to Medicare terms. The defendant has defined what information it needs for “satisfaction” and has communicated with Medicare to obtain this information. The term is being fully and fairly met. The plaintiff has not, and cannot, point to any legal requirement that the settlement be finalized within three months. The plaintiff cannot point to any agreement by the parties that payment would be made, with interest, by a date certain. To the contrary, the agreement states expressly that payment is not due until after the contingent terms have been met. The plaintiff’s subjective desire for money is not a legal necessity, was not contemplated by the parties, and should not be added to the agreement by the court. Indeed, the COA would not have agreed to any settlement that imposed time limits or the payment of interest because it is dependent on waiting for confirmation from Medicare, and the COA cannot control how long it will take Medicare to respond.

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<sup>45</sup> *Id.*

The plaintiff has provided no authority to support its argument that the court should be able to add terms to the parties' agreement. The court's role is not to write the agreement that the plaintiff should have or could have made, but to enforce the agreement that actually exists. Here, this means that the plaintiff shall release the defendants; shall set aside a portion of the settlement in a separate account to pay for future medical expenses; and is not entitled to interest. The trial court's order should be reversed, and the court ordered to enforce the actual settlement agreement.

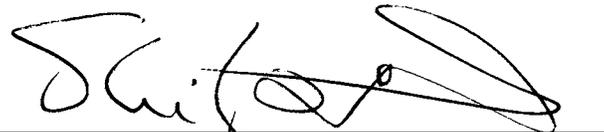
## VI CONCLUSION

The parties reached a settlement agreement on June 29, 2010 based on express terms to which the plaintiff agreed. Any other terms that the plaintiff might now contemplate are not part of the agreement. This court should **reverse** the trial court's order on the Motion to Enforce and **require** the parties to fulfill the original agreement.

Respectfully submitted this 19<sup>th</sup> day of January, 2011.

WILSON SMITH COCHRAN DICKERSON

By



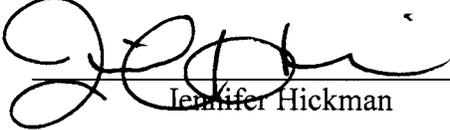
Shilpa Bhatia, WSBA no. 28012  
Attorneys for Appellant Juanita Country Club  
Condominium Owners Association

**CERTIFICATE OF SERVICE**

The undersigned certifies that under penalty of perjury under the laws of the State of Washington that on the below date I caused to be served the foregoing document by ABC Legal Messenger:

Aaron V. Roche  
ROCKE LAW GROUP, PLLC  
1424 Fourth Avenue, Suite 505  
Seattle, WA 98101

SIGNED this 19<sup>th</sup> day of January, 2011 at Seattle, Washington.

  
Jennifer Hickman

# Appendix A

The Honorable Julie Spector  
Hearing Date: October 5, 2010  
Trial Date: June 13, 2011

Received

OCT 12 2010

Wilson Smith  
Cocoflat Person

IN THE SUPERIOR COURT OF THE STATE OF WASHINGTON  
IN AND FOR THE COUNTY OF KING

9	LUCIENNE FIRTH, an individual,	)	No.:09-2-46863-0 SEA
		)	
10	Plaintiff,	)	<del>PROPOSED</del> ORDER ENFORCING
	v.	)	SETTLEMENT
11		)	
12	JUANITA COUNTRY CLUB	)	
	CONDOMINIUM OWNERS	)	
13	ASSOCIATION, a Washington corporation,	)	
	THE CWD GROUP, INC., a Washington	)	
14	corporation, and COMMUNITY	)	
	ASSOCIATION UNDERWRITERS OF	)	
15	AMERICA, INC., a Washington corporation,	)	
	Defendants.	)	

THIS MATTER having come on regularly for hearing before Hon. Julie Spector of the King County Superior Court, upon Plaintiff Firth's Motion to Clarify and Enforce Settlement, and the Court having reviewed the pleadings, including the complaint, answer, motion, supporting declaration, and any opposition and reply papers;

**Settlement**

The court hereby FINDS the parties reached a settlement agreement by phone through the assistance of mediator Tom Harris of Washington Arbitration and Mediation Service. The settlement was reached on June 29, 2010. The terms of the settlement were payment of \$100,000 and execution of a release with an additional set-aside to cover any potential interest by

ORIGINAL

1 Medicare. Writings exist that corroborate the existence and terms of the settlement. The  
2 existence and terms of the settlement are not in dispute.

3 **Medicare Set-Aside**

4 The court further FINDS: At the time of the settlement, the defendants had sufficient  
5 information to verify that Ms. Firth had not received payments or benefits from Medicare.  
6 Ms. Firth cooperated with defendants and negotiated in good faith. The defendants did not  
7 tender a final release with accurate or appropriate terms to effectuate the settlement within three  
8 months of the settlement. The defendants had no just reason for the delay, and the defendants  
9 benefited from the delay. Their delay was intentional and voluntary. The defendants waived the  
10 term of the settlement that Ms. Firth set-aside money for the purposes of Medicare's interests.  
11 While Ms. Firth may owe this duty in law, she does not owe this duty to the defendants under the  
12 terms of the settlement.

13 **Interest**

14 The court further FINDS: The defendants did not tender payment within three months of  
15 the agreed settlement. The defendants had no just reason for the delay, and the defendants  
16 benefited from the delay. Imposing a due date for payment is indispensable to effectuate the  
17 intention of the parties. This term is so clearly within the contemplation of the parties that they  
18 deemed unnecessary to express it, so it is necessary to imply it in law. This term is also so  
19 important that it would have been explicitly agreed to had attention been called to it. Lastly, the  
20 existing agreement does not completely cover it. The defendants owe interest at 12% compound  
21 interest per annum since June 29, 2010.

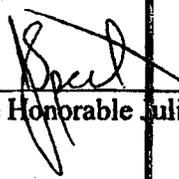
22 The court further FINDS: \_\_\_\_\_  
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IT IS HEREBY ORDERED that

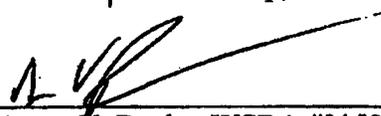
Plaintiff may reduce the terms of the settlement agreement and this order to judgment.

DATED this 6 day of October, 2010.

  
\_\_\_\_\_  
The Honorable Julie Spector

Presented by:

ROCKE | LAW Group, PLLC

  
\_\_\_\_\_  
Aaron V. Roche, WSBA #31525  
Attorney for plaintiff

# Appendix B

Westlaw.

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76 Def. Couns. J. 393

Page 1

C

Defense Counsel Journal  
October, 2009

Feature Article

**\*393 THE MEDICARE, MEDICAID AND SCHIP EXTENSION ACT OF 2007: A PRACTITIONER'S INTRODUCTION TO RESOLVING PERSONAL INJURY LIABILITY CLAIMS BY MEDICARE BENEFICIARIES**

Christopher S. Berdy [FN1]

W. Steven Nichols [FN2]

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WITH EVER-RISING health care costs and growing federal budget deficits, expansion of government powers to recoup government-provided health care expenditures should come as no surprise. Effective on July 1, 2009, the Medicare, Medicaid and SCHIP Extension Act of 2007 [FN1] (“MMSEA”) substantially expands the federal government's ability to seek reimbursement for past and future Medicare payments. By imposing stringent reporting requirements and stiff penalties on Group Health Plans (“GHPs”) and non-Group Health Plans (“non-GHPs”) (including self-insurance, no-fault insurance, and workers' compensation insurance plans) involved in an estimated 2.7 million personal injury liability claims annually, the MMSEA provides Medicare additional tools with which to seek reimbursement for Medicare claims. [FN2] In essence, the MMSEA will require practitioners handling personal injury liability claims brought by Medicare beneficiaries to give serious, ongoing, and proactive consideration to past and future medical expenses covered by Medicare.

For those practitioners heretofore unfamiliar with the Medicare Secondary Payer Act, this article provides an introduction to the Secondary Payer Act and the MMSEA, focusing exclusively on Medicare reimbursement obligations for non-GHPs. In particular, the article explains the MMSEA's implications in the context of personal injury liability claims and provides practitioners with strategies to not only ensure statutory compliance, but also to reduce the risk of increased exposure in \*394 such cases. Because the MMSEA is grafted onto existing legislation (the Secondary Payer Act), this article first addresses the Secondary Payer Act and its obligations and potential penalties. In light of the expanded reach of Medicare into the realm of personal injury litigation through the MMSEA, as well as the attendant risks of failing to comply, practitioners cannot overestimate the importance of familiarizing themselves with these statutes.

**I. Medicare and the Secondary Payer Act****A. Introduction to Medicare**

Medicare is the federal health insurance program for individuals over the age of sixty-five, as well as for in-

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dividuals under age sixty-five with permanent disabilities and permanent kidney failure. [FN3] The Centers for Medicare & Medicaid Services ("CMS"), a bureau of the Department of Health and Human Services, oversees the Medicare program and is responsible for implementation of the MMSEA. [FN4]

## **B. The Medicare Secondary Payer Act**

By statute, Medicare has become generally a payer of "last resort." The Medicare Secondary Payer Act ("MSPA") mandates in all situations where another entity is required to pay for covered services that the other entity pay before Medicare does, and such entity must do so without regard to a patient's Medicare entitlement. [FN5] The MMSEA is the most recent addition in a series of expansions to the Secondary Payer Act to expand the areas in which Medicare is a "secondary" payer.

At its inception, Medicare was not exclusively a secondary payer. When Medicare was first established, it was the "secondary" payer only for medical services covered by workers' compensation, and the "primary" payer for all other eligible medical services provided to eligible participants. [FN6] In direct response to increasing financial burdens on Medicare and to shift costs from the Medicare program to private payment sources, in 1980 Congress enacted the first of a series of provisions that collectively made Medicare the secondary payer when additional insurance was available to assume primary responsibility for medical payments. [FN7] As a result of these expansions, Medicare is rarely the primary payer for medical services if a private payer is available. [FN8]

In general, Medicare is "secondary" in two situations. First, Medicare is a secondary payer to GHPs for Medicare beneficiaries who are eligible Medicare beneficiaries (e.g. age sixty-five and older or under than age sixty five, have a disability, or have end state renal disease) and who have GHP coverage on the basis of their own or their spouse's current employment with an employer that has least twenty employees for beneficiaries aged sixty-five or older, or at least 100 employees for the disabled, or have end stage Renal Disease and who have GHP coverage on any basis. [FN9] Second, Medicare is a secondary payer when certain types of non-GHP insurance coverage, including liability (including self-insurance), no-fault, \*395 and workers' compensation insurance are responsible for a Medicare-eligible individual's health care expenses. [FN10]

## **C. Reimbursement Of Medicare "Conditional" Payments**

### **1. Medicare Conditional Payments Defined**

Although Medicare is a secondary payer, it often makes the first payment to providers for health care services. These Medicare past payments are considered "conditional," and as a secondary payer, Medicare can and will seek reimbursement from GHPs and non-GHPs ("primary payers") for conditional payments made if it determines that those payments were the responsibility of a primary payer. [FN11] Thus, as a secondary payer, Medicare conditionally pays for beneficiaries' treatment with the expectation of reimbursement for all or part of the payments it makes.

Conditional payments can also arise when (1) a claim is denied or disputed by the primary payer; (2) the primary payer fails to make prompt payment; (3) Medicare makes payment without knowledge of the primary payer's existence; (4) the claimant fails to document the primary payer's existence; (5) Medicare is mistakenly billed instead of the primary payer; and, (6) the beneficiary fails to file a proper claim due to mental or physical incapacity. [FN12]

## 2. Timing of Reimbursement To Medicare

A Medicare beneficiary who receives payments from a primary payer must reimburse Medicare within sixty (60) days of receiving payment. [FN13] To that end, CMS's right to seek recovery accrues when a primary payer pays for a Medicare conditional payment by settlement, judgment, or "other means." [FN14] However, CMS cannot demand reimbursement until a beneficiary's claim is settled. [FN15]

## 3. Amount Owed To Medicare

Medicare has a right to reimbursement for health care services that a primary plan has or had a "responsibility" to pay. [FN16] Because this right to recover conditional payments does not accrue until after a settlement has been reached, a conditional payment can be difficult to compromise and to reduce below its actual amount. [FN17] Moreover, Medicare is entitled to reimbursement regardless of whether or not there has been a finding or admission of liability. [FN18] As a result, settlements may result in reimbursement to Medicare of all or a substantial portion of the settlement value.

Nevertheless, the beneficiary may reduce the reimbursement amount owed by any "procurement costs" -- the costs the beneficiary paid to an attorney in pursuing her claim. [FN19] Moreover, the Medicare Secondary Payer Manual suggests that by involving CMS prior to reaching a settlement, the parties also may be able to compromise the amount owed to Medicare. [FN20] This compromise would result from negotiations with CMS and the parties, potentially complicating any settlement discussions.

### \*396 D. Protecting Medicare's Interests in Future Medical Expenses

In the context of workers' compensation claims, CMS has developed and issued guidelines on how claimants are to consider and protect Medicare's financial interests regarding future medical expense payments. In contrast and as discussed below, CMS has yet to provide any clear guidance on how to consider Medicare's interests in personal injury liability claims.

#### 1. Medicare Set Aside Arrangements

For workers' compensation claims, a CMS-recommended method of protecting Medicare's future financial interests is a Medicare Set Aside ("MSA"), which carves out a portion of any settlement proceeds for future medical expenses. [FN21] A set aside arrangement should be utilized and may be submitted for CMS review under either of the following two scenarios:

(1) The claimant is currently a Medicare beneficiary and the total settlement amount is greater than \$25,000; OR,

(2) The claimant has a "reasonable expectation" of Medicare enrollment within thirty (30) months of the settlement date and the anticipated total settlement amount for future medical expenses and disability/lost wages over the life or duration of the settlement agreement is expected to be greater than \$250,000. [FN22]

A claimant may have a "reasonable expectation" of Medicare enrollment when the individual (1) has applied for Social Security Disability Benefits; (2) has been denied Social Security Disability Benefits but anticipates appealing that decision; (3) is in the process of appealing and/or refiling for Social Security Disability Benefits;

(4) is 62 and six months old; or, (5) has an End Stage Renal Disease condition but does not yet qualify for Medicare. [FN23]

Not all circumstances require a set aside arrangement. For example, CMS currently does not require initiation or approval of set aside arrangements for liability-based claims. Additionally, if future medical expenses of a workers' compensation claim remain "open," then a set aside arrangement is unnecessary because the primary payer (*i.e.*, the workers' compensation insurer) continues to cover the ongoing medical expenses and Medicare remains a secondary payer. [FN24] Finally, CMS has stated that an MSA is not necessary if all of the following apply:

- (1) The facts of the case demonstrate that the injured individual is only being compensated for past medical expenses (*i.e.*, for services furnished prior to settlement);
- (2) There is no evidence that the individual is attempting to maximize the other aspects of the settlement (*e.g.*, the lost wages and \*397 disability portions of the settlement) to Medicare's detriment; and,
- (3) The individual's treating physicians conclude (in writing) that to a reasonable degree of medical certainty the individual will no longer require any Medicare-covered treatments related to the [workers' compensation] injury. [FN25]

## 2. How Much to Allocate in a Medicare Set-Aside

Generally, the primary payer has responsibility for only those expenses that Medicare would have that are related to the claimant's injury. [FN26] Thus, the settlement should allocate an amount approximating the expected future medical expenses that would otherwise be covered by Medicare over the claimant's life expectancy. [FN27]

While difficult to determine, the computation of this amount should include, but is not limited to, all future medical expenses (including prescription drugs), repayment of any Medicare conditional payments, previously settled portions of a workers' compensation claim, life expectancy, inflation, administrative fees, wages, and attorney fees. [FN28] Careful consideration should be given to inclusion of the set-aside calculation formula in related settlement documents.

## 3. Exhaustion of Set Aside Funds And Subsequent Medicare Benefits

Once the CMS-approved set aside amount has been exhausted and accurately accounted for to CMS, Medicare will assume "primary" payment responsibilities for future Medicare-covered expenses related to the workers' compensation injury. [FN29]

## 4. Administration of a Set Aside Arrangement

The Medicare beneficiary may "self-administer" the set-aside arrangement, if permissible under state law. [FN30] A set aside arrangement may also be professionally administered. [FN31] In either case, these funds must only be spent for future injury-related treatment.

## E. Enforcement of Medicare's Right to Reimbursement

The Secondary Payer Act (and as set forth below, the MMSEA) creates potentially significant exposure for practitioners and their clients. Because a large part of the Secondary Payer Act's purpose was to shift costs from the Medicare program to private sources, the Secondary Payer Act and MMSEA contain significant tools available for CMS to implement those cost-shifting goals.

The Secondary Payer Act gives Medicare automatic subrogation rights for its conditional payments. [FN32] Therefore, if Medicare makes secondary payments for medical services, Medicare has a direct right of action to obtain reimbursement from the primary payer and from the entity or individual that receives payment from the primary plan at the time the primary plan pays the claim. [FN33]

\*398 To enforce its subrogation rights, CMS has the right to initiate recovery efforts for conditional payments as soon as it learns that payment has been made or could be made by any of the plans responsible for primary payment. [FN34] To that end, CMS can bring an action against "any or all entities that are or were required or responsible" for primary payments and that fail to reimburse Medicare for them. [FN35] Notably, one federal district court recently held that a plaintiff's attorney was liable for reimbursing Medicare's conditional payments. [FN36]

In addition, Medicare's potential remedies are severe. If CMS is forced to bring suit against a primary payer, Medicare is entitled to recover double damages plus interest. [FN37] If CMS takes no legal action to recover its conditional payments, CMS may recover the lesser of the conditional payment or the full payment that the primary payer is obligated to pay. [FN38] Even if Medicare is not timely reimbursed, a primary payer is still required to reimburse Medicare two times the reimbursement amount, even if the primary payer has already paid the Medicare beneficiary. [FN39] Finally, CMS has the right to reject any settlement and to refuse payment of future benefits. [FN40]

The Secondary Payer Act also provides for a private cause of action. Like Medicare's right to initiate suit, a Medicare beneficiary can sue a primary payer that fails to reimburse Medicare or otherwise make primary payment. [FN41] Moreover, a private litigant's claim against a primary payer "shall be in an amount double the amount otherwise provided." [FN42]

## II. MMSEA and its Expansion of the Secondary Payer Act's Reach into Personal Injury Liability Claims

### A. Overview of the MMSEA

Effective on July 1, 2009, the MMSEA significantly expands the reach of the Secondary Payer Act, including all personal injury liability claims by imposing strict reporting requirements and potentially stiff penalties for non-compliance upon non-GHPs, including self-insurers, liability insurance, no-fault insurance, and workers' compensation insurance providers. [FN43]

Under the MMSEA, Responsible Reporting Entities ("RREs") are required to report to CMS specified information regarding the GHP arrangements and non-GHP arrangements of Medicare beneficiaries to ensure proper coordination of benefits with the Medicare program. [FN44] In general, the MMSEA requires an RRE to determine whether a "claimant" [FN45] who has brought a claim against an RRE or an entity insured by an RRE is eligible for Medicare benefits. [FN46] Should a claimant be Medicare-eligible, the RRE must report specific information to CMS until the claim is resolved by settlement, judgment, or other payment. [FN47] Failure to

comply with the MMSEA and existing provisions of the \*399 Secondary Payer Act can result in liability to not only claimants and defendants alike, but also to insurers, their insureds and their attorneys.

On its face, the MMSEA imposes reporting requirements and attendant fines for failure to report on non-GHPs in the personal injury context. However, in its application, the MMSEA will require that non-GHPs, claimants, defendants, and their respective counsel all “reasonably consider” Medicare's interests in handling personal injury liability claims involving Medicare beneficiaries or face staggering penalties.

#### **B. Responsible Reporting Entities Defined**

A non-GHP Responsible Reporting Entity is an employer or defendant's insurance carrier (*i.e.*, workers' compensation insurer, general liability insurer, or no-fault insurer). [FN48] If an employer or defendant is self-insured for workers' compensation or liability insurance, the employer may be an RRE. [FN49] If an employer or defendant is self-insured for any deductible, the insurer constitutes the RRE. [FN50]

#### **C. How Reporting Entities Determine Medicare Eligibility**

An RRE can determine a claimant's Medicare status in a variety of ways. An RRE can request that the claimant provide his or her Health Insurance Claim Number (“HICN”), which is the number on the claimant's Medicare card. [FN51] RREs may also obtain a benefits statement from the Social Security Administration by searching the CMS-developed “Query System”, or by using the claimant's first and last names, Social Security Number, and Social Security Consent Form signed by the claimant. [FN52]

#### **D. Information Reporting Entities Must Report When Medicare Eligibility is Determined**

Once an RRE has determined that a claimant is a Medicare beneficiary, it must report the claimant's identity and other information necessary to make an appropriate determination concerning coordination of benefits, including any applicable recovery claim. [FN53] Specific requirements for the reporting data are set forth in GHP and non-GHP User's Guides promulgated by CMS, [FN54] and generally include: the claimant's name, address, date of birth, Social Security Number or HICN; the RREs name, address, policy type, Tax Identification Number, and policy number; the insured's name; the date, nature, and cause of injury or incident; and the settlement date and amount. [FN55]

#### **E. Timing for Reporting Entities to Report**

The MMSEA requires that reportable information shall be submitted “after the claim is resolved through a settlement, judgment, award, or other payment.” [FN56] Information must be submitted regardless of \*400 whether or not there is a determination or admission of liability. [FN57]

#### **F. Penalties for Reporting Entities' Failure to Report**

In addition to existing penalties under the Secondary Payer Act, an RRE's failure to comply with the MMSEA's requirements may result in penalties of up to \$1,000 per day per claimant. [FN58]

### G. Forthcoming Implementation of the MMSEA

Although by law MMSEA had an effective date July 1, 2009, implementation of the reporting requirements of the MMSEA has been delayed. [FN59] RRE registration will remain open until September 30, 2009, and training and testing will run from January 1 to March 30, 2010. Actual reporting by RREs will not begin until April 1, 2010. [FN60]

Despite the delay in implementing MMSEA reporting, all existing Secondary Payer Act requirements (and penalties) remain otherwise in full force and effect for Responsible Reporting Entities, meaning that RREs will have to report the settlements they have made retroactive to January 1, 2010. Therefore, in the context of personal injury liability claims, a non-GHP has an express obligation to report to Medicare if it knows that Medicare made a primary payment for services that the primary payer has made or should have made. [FN61]

### III. Protecting Medicare's Interests in Personal Injury Claims

#### A. Lacking Additional CMS Guidance, Parties to a Liability Claim Must Reasonably Consider Medicare's Interests in Resolving Those Claims

Enactment of the MMSEA has alleviated previous uncertainty about the Secondary Payer Act's application to personal injury liability cases and clarified Medicare's role as a secondary payer in this context. [FN62] Guidelines for compliance with the Secondary Payer Act's expanded requirements when settling personal injury liability claims have not been promulgated yet. However, the Secondary Payer Act requires that the parties give "reasonable consideration" to Medicare's interests, including its (1) past payments (*i.e.*, its conditional Medicare payments) and (2) future Medicare-covered expenses. For past payments, Medicare reimbursements in liability cases will likely prove to be handled in a manner similar those of workers' compensation claims. However, the methodology to protect Medicare's interests for future medical costs is anything but clear.

In particular, CMS has yet to provide any clear guidance on what actions will constitute "reasonably consider[ing]" Medicare's interests in liability claims. In light of the imposing penalties authorized by the MMSEA and Secondary Payer Act, \*401 this lack of guidance and uncertainty is particularly troubling in the context of personal injury claims, especially with respect to future Medicare-covered costs and expenses. Absent CMS guidance specifically for personal injury liability claims, practitioners should consider the workers' compensation guidelines discussed above, while adhering to two general principles set forth in the MMSEA: (1) RREs must "reasonably consider" Medicare's interests in settling personal injury liability claims, and (2) RREs must notify CMS of such claims. [FN63]

#### 1. Use of Set Aside Arrangements in Personal Injury Liability Cases

Commentators have proposed a host of different strategies for practitioners to "reasonably consider" Medicare's interests, including (1) interpleading an estimated amount of Medicare's recovery entitlement; (2) characterizing the nature of the settlement proceeds as compensating non-economic losses; (3) seeking compromise with CMS; (4) waiting for an initial CMS demand letter; (5) specifying the party responsible for satisfying the Medicare reimbursement; (6) seeking declaratory relief; and (7) endorsing Medicare and the beneficiary as payees on the settlement proceeds. [FN64] However, each potential solution carries its own set of problems. [FN65]

While a Medicare Set Aside is not currently required in personal injury liability claims, commentators uniformly agree that set aside arrangements provide the most prudent approach to protect Medicare's interests for future expenses in liability cases. [FN66] CMS has not developed or promulgated procedures to require and/or review set aside arrangements in personal injury cases, but to the extent a liability settlement meets the appropriate criteria previously developed in the workers' compensation context (*i.e.*, the settlement is greater than \$250,000 and the claimant has a "reasonable expectation" of Medicare enrollment within thirty months of the settlement date), then a set aside arrangement may be an appropriate vehicle for reasonably considering Medicare's interests in liability claims. [FN67]

## 2. Communication with CMS

While the MMSEA requires RRE notification of a claim, the reporting entity does not need claimant approval to do so. [FN68] To protect their interests, RREs and practitioners should involve CMS in the settlement process as early as possible. [FN69] Doing so may allow for negotiation of a favorable set aside amount with CMS. [FN70] Of course, the negotiated amount must be sufficient to demonstrate a reasonable consideration of Medicare's interests. [FN71] What is more, only CMS -- not a third-party contractor -- may compromise a Medicare claim. [FN72]

### \*402 IV. Unintended Consequences of the MMSEA and Options to Face These Challenges

#### A. More Difficulties in Handling Personal Injury Liability Claims Involving Medicare Beneficiaries

The MMSEA adds another device in CMS' cost-shifting arsenal, leaving claimants, RREs, and practitioners alike to face a host of new challenges in resolving liability claims involving Medicare beneficiaries. Above all else, the MMSEA will prove to be a "roadblock" to settling liability cases. [FN73]

MMSEA compliance will undoubtedly increase the cost (and potentially reduce the likelihood) of settlement. [FN74] Parties to liability claims will have to demonstrate that they have reasonably considered Medicare's interests to avoid the Secondary Payer Act's penalties -- increasing the proportion of settlement proceeds reserved for Medicare and reducing the proportion of proceeds available for claimants. CMS, especially if involved late or post-settlement, may have little or no ability or incentive to compromise the conditional payments and future expenses allocated to Medicare. Thus, what might otherwise have proven to be a significantly compromised medical specials lien may now become an extraordinary settlement impediment that must be overcome before a plaintiff will realistically consider settlement.

Defendants and Responsible Reporting Entities will be forced to either pay more to settle a case or resort to trial when a plaintiff will not accept an amount that will both satisfy Medicare's full interest and compensate him or her for the alleged injuries. [FN75] Under either scenario, the costs of resolving such disputes -- to the detriment of the parties -- will increase.

As a result of these changes, plaintiffs (and their attorneys) will recover a lower amount than pre-MMSEA. [FN76] By forcing plaintiffs to reimburse almost the full amount of their medical expenses -- rather than a compromised amount -- plaintiffs can expect to recover less. [FN77]

Consideration of Medicare's interests will likely slow the settlement process. With another entity involved --

one that is not even a party to the suit or claim -- the parties' ability to quickly reach a timely settlement will inevitably decline. If Medicare is involved before the settlement, communication with and feedback from CMS will no doubt introduce additional time and considerations into the negotiations. Moreover, if CMS is not involved until after the settlement, the parties may not have certainty that Medicare will timely consider the settlement in a fashion that allows for quick closure of that process.

The MMSEA removes certainty from the settlement process. With CMS' current lack of guidance regarding involvement in and approval of beneficiary settlements and/or set aside arrangements in liability cases, the parties, their attorneys, and their insurers are faced with entering into settlements that lack certainty due to exposure from failure to timely reimburse Medicare or for failure to reasonably consider Medicare's interests. [FN78]

In addition to impeding settlement, the MMSEA also may reduce claimants' access to representation. If plaintiffs' attorneys accustomed to working on a contingency fee basis are faced with the possibility of earning reduced fees by virtue of the plaintiffs' obligation to reimburse Medicare in full, some may give serious consideration to declining representation of Medicare \*403 beneficiaries. [FN79] Moreover, in cases of highly disputed liability and/or cases in states where the plaintiff's contributory negligence or assumption of the risk is a complete bar to any recovery, this unintended consequence may prove to be amplified. [FN80]

#### **B. Overcoming Problems Created by the MMSEA**

Although the MMSEA has complicated the landscape of personal injury significantly, a thoughtful practitioner can proactively take steps to reduce the risk of post-settlement or post-judgment exposure to MMSEA and Secondary Payer Act penalties and fines.

Practitioners must first consider the threshold question of whether the Secondary Payer Act is even implicated. As with any personal injury case, an appropriate release for medical information, narrowly-tailored interrogatories, document requests, and subpoenas regarding the plaintiff's injuries, social security number, HICN, medical costs and expenses, identification of the Medicare secondary payer recovery contractor, and health care provider records will prove invaluable in determining whether and the extent to which Medicare's interests must be reasonably considered.

Early and ongoing proactive involvement of CMS in any claim or suit may also result in reducing the reimbursement costs to Medicare. [FN81] While CMS may have little room to compromise its demand for reimbursement and set aside amounts after a settlement is reached, pre-settlement involvement and discussions with CMS may allow for significant reductions in the Medicare subrogation and/or set aside amounts. [FN82]

Practitioners should also advise their clients in writing that the plaintiff is, or is reasonably likely to become, a Medicare beneficiary, especially if the client is insured. Reporting entities' failure to comply with reporting requirements can unnecessarily expose it to MMSEA's onerous new penalties. [FN83]

At or before any mediation or settlement conference, practitioners should advise the mediator or neutral of the fact that the plaintiff is, or has applied to become, a Medicare beneficiary to allow the mediator to ensure that Medicare's interests are considered. Moreover, practitioners should also give serious consideration to discussing this issue among counsel before the mediation or settlement conference so as to ensure reasonable consideration of Medicare's interests. [FN84] Again, early consideration of Medicare's interests can only help facil-

[FN25]. 4/22/03 CMS Memorandum, at Q20; *see also* MCWSA, at 4.

[FN26]. 42 U.S.C. § 1395y(b)(2)(B)(ii); 42 C.F.R. § 411.24(c)(1).

[FN27]. 42 C.F.R. § 411.46(d)(2).

[FN28]. *See* WCMSA, at 2.

[FN29]. 42 C.F.R. § 411.46(d)(2).

[FN30]. 4/22/03 CMS Memorandum, at Q8.

[FN31]. Robert C. Black, *Here it Comes ... The Medicare Secondary Payer Statute and Its Effect on Bodily Injury Cases: Considerations for the Transportation Litigator*, at \*12-13 (unpublished manuscript on file with authors) (hereinafter "Black").

[FN32]. 42 U.S.C. § 1395y(b)(2)(B)(iv); 42 C.F.R. § 411.26.

[FN33]. 42 U.S.C. § 1395y(b)(2)(B)(ii); 42 C.F.R. § 411.24(b),(e).

[FN34]. 42 U.S.C. § 1395y(b)(2)(B)(iii); 42 C.F.R. § 411.24(b).

[FN35]. 42 U.S.C. § 1395y(b)(2)(B)(iii); 42 C.F.R. § 411.24(g)

[FN36]. *See* *United States v. Harris*, No. 5:08CV102, 2009 WL 891931 at \*3 (N.D. W. Va. March 26, 2009) (*citing* 42 C.F.R. § 411.24(g) and holding that plaintiff's attorney in personal injury case was individually liable for reimbursing Medicare because it can recover "from any entity that has received payment from a primary plan," including an attorney).

[FN37]. 42 U.S.C. § 1395y(b)(2)(B)(ii)-(iii); 42 C.F.R. § 411.24(c)(2), (h), (m).

[FN38]. 42 C.F.R. § 411.24(c)(1).

[FN39]. 42 C.F.R. § 411.24(i).

[FN40]. 42 C.F.R. § 411.46(a).

[FN41]. 42 U.S.C. § 1395y(b)(3)(A).

[FN42]. 42 U.S.C. § 1395y(b)(3)(A).

[FN43]. *See* 42 U.S.C. § 1395y(b)(7), (b)(8).

[FN44]. 42 U.S.C. § 1395y(b)(7)(A); 42 U.S.C. § 1395y(b)(8)(A).

[FN45]. A "claimant" is an individual filing a claim directly against the applicable non-GHP, or an individual filing a claim against an individual or entity insured or covered by the applicable plant. *See* 42 U.S.C. § 1395y(b)(8)(D)(i)-(ii).

[FN46]. 42 U.S.C. § 1395y(b)(8)(A)(i).

itate a more certain and favorable settlement at the mediation or settlement conference.

Finally, if a set aside arrangement is included as part of a settlement agreement, several provisions should be incorporated into the written settlement agreement. [FN85] At a minimum and when appropriate, the agreement should specifically reference the existence of a set aside arrangement, the amount of the arrangement, and the calculation for arriving at the set aside amount. [FN86] Doing so will serve to demonstrate that the parties reasonably considered Medicare's interests in resolving the plaintiff's claims, thereby protecting the claimants' right to future Medicare payments and protecting the parties from exposure to the Secondary Payer Act's onerous penalties.

#### \*404 V. Conclusion

With enactment of the MMSEA, practitioners involved in representing parties in personal injury liability claims must now take significant, proactive but as of yet undefined steps to reasonably consider Medicare's interests in resolving personal injury liability disputes involving Medicare beneficiaries. Moreover, insurers must now follow tedious reporting requirements in such cases. To enforce these new requirements, CMS now has vastly expanded powers to ensure claimants, insurers, parties, and practitioners alike comply. For personal injury liability practitioners previously unfamiliar with this statutory scheme, understanding how to comply with the Secondary Payer Act and MMSEA will protect their clients' (and their own) interests.

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[FN1]. Pub. L. No. 110-173 (2007) (codified in scattered sections of 42 U.S.C.).

[FN2]. 42 U.S.C. § 1395y(b)(7), (b)(8) (2008); *see also* Roy A. Franco, Jeffrey J. Signor & Thomas S. Thornton III., *Mission Impossible: Resolution of a Case with a Medicare Claimant?* FOR THE DEFENSE, May 2009 at 8, 11 (hereinafter "Franco"). Additional information regarding the MMSEA and its requirements is available at [www.cms.hhs.gov/MandatoryInsRep/](http://www.cms.hhs.gov/MandatoryInsRep/).

[FN3]. *See* Ctrs. for Medicare and Medicaid Serv., *Introduction to Section 111 Mandatory Medicare Secondary Payer Reporting*, February 23, 2009, at 1, <http://www.cms.hhs.gov/MandatoryInsRep/Downloads/RevisedSection111022309.pdf> (hereinafter "2/23/09 CMS Memorandum").

[FN4]. *Id.*

[FN5]. *Id.*

[FN6]. *See generally* Ctrs. for Medicare and Medicaid Serv., *Medicare Secondary Payer Manual*, Pub. No. 100-05, Ch. 1, § 10 (65th rev. ed. 2009), <http://www.cms.hhs.gov/Manuals/IOM/itemdetail.asp?filterType=none&filterByDID=99&sortByDID=1&sortOrder=ascending&itemID=CMS019017&intNumPerPage=10> (hereinafter “MSP Manual”).

[FN7]. *Id.*

[FN8]. 2/23/09 CMS Memorandum, at 2.

[FN9]. *Id.*

[FN10]. 42 U.S.C. § 1395y(b)(2)(A)(ii) (2008); 2/23/09 CMS Memorandum, at 2.

[FN11]. 42 U.S.C. § 1395y(b)(2)(B)(ii) (2008); 42 C.F.R. § 411.24(b), (e).

[FN12]. *See* 42 C.F.R. § 411.45(a)(2), 411.53(2).

[FN13]. 42 U.S.C. § 1395y(b)(2)(B)(ii) (2008); 42 C.F.R. § 411.24(h).

[FN14]. 42 U.S.C. § 1395y(b)(2)(B)(ii) (2008); 42 C.F.R. § 411.24(b).

[FN15]. *See* MSP Manual, Ch. 7, § 50.4.1.

[FN16]. 42 U.S.C. § 1395y(b)(2)(B)(ii); 42 C.F.R. § 411.24(c).

[FN17]. *See* Franco, *supra* note 2, at 11.

[FN18]. *See* 42 U.S.C. § 1395y(b)(2)(B)(ii); 42 C.F.R. § 411.24; MSP Manual, Ch. 7, §50.5.4.4.

[FN19]. 42 C.F.R. § 411.37(a).

[FN20]. MSP Manual, Ch. 7, § 50.4.2.

[FN21]. *See* Ctrs. for Medicare and Medicaid Serv., *Workers Compensation Medicare Set-aside Arrangements*, [www.cms.hhs.gov/WorkersCompAgencyServices/04\\_wcsetaside.asp#TopOfPage](http://www.cms.hhs.gov/WorkersCompAgencyServices/04_wcsetaside.asp#TopOfPage), at 1 (hereinafter “WCMSA”). Without such a setaside, Medicare may withhold payment for future medical claims until claims equal the entire amount of the settlement payment. *See* 42 C.F.R. § 411.46(a).

[FN22]. WCMSA, at 1, 3 (emphasis omitted).

[FN23]. *See* Ctrs. for Medicare and Medicaid Serv., *Medicare Secondary Payer - Workers' Compensation (WC) Frequently Asked Questions*, April 22, 2003, at Q2, <http://www.cms.hhs.gov/WorkersCompAgencyServices/Downloads/42203Memo.pdf> (hereinafter “4/22/03 CMS Memorandum”).

[FN24]. *Id.* at Q19.

[FN47]. 42 U.S.C. § 1395y(b)(8)(A)(ii).

[FN48]. 42 U.S.C. § 1395y(b)(8)(F)(i)-(iii).

[FN49]. John J. Campbell, *Mandatory Insurance Reporting Under The MMSEA*, THE MEDICARE SET ASIDE BULLETIN, No. 54, May 18, 2009 at 2, <http://www.jjcelderlaw.com/MMSEA2MSABull.htm> (hereinafter "CAMPBELL - MMSEA").

[FN50]. *Id.* at 2.

[FN51]. *Id.* at 3.

[FN52]. *Id.* at 3.

[FN53]. 42 U.S.C. § 1395y(b)(8)(B)(i)-(ii).

[FN54]. *See* Ctrs. for Medicare and Medicaid Serv., *MMSEA Section 111 MSP Mandatory Reporting: GHP User Guide*, (v.2.3 2009), [http://www.cms.hhs.gov/MandatoryInsRep/02\\_GHP.asp#TopOfPage](http://www.cms.hhs.gov/MandatoryInsRep/02_GHP.asp#TopOfPage); Ctrs. for Medicare and Medicaid Serv., *MMSEA 111 Medicare Secondary Payer Mandatory Reporting: Liability Insurance (Including Self Insurance), No-Fault Insurance, and Workers Compensation*, (v.2 2009), <http://www.cms.hhs.gov/MandatoryInsRep/Downloads/NGHPUserGuideV2.0.pdf>.

[FN55]. CAMPBELL - MMSEA, at 5.

[FN56]. 42 U.S.C. § 1395y(b)(8)(C).

[FN57]. *Id.*

[FN58]. 42 U.S.C. § 1395y(b)(8)(E)(i).

[FN59]. *See* Ctrs. For Medicare and Medicaid Serv., *ALERT for Liability Insurance (Including Self-Insurance), No-Fault Insurance and Workers' Compensation Responsible Reporting Entities*, May 11, 2009, at 1, <http://www.cms.hhs.gov/MandatoryInsRep/Downloads/NGHPV10UserGuide051109.pdf> (hereinafter "5/11/09 CMS Memorandum").

[FN60]. *Id.* at 1.

[FN61]. 42 C.F.R § 411.25(a), (c); *see* United States v. Baxter Intern., 345 F. 3d 866, 901 (11th Cir. 2003) (requiring primary payer to inquire whether claimant was Medicare-eligible and that failure to inquire would result in primary payer having constructive knowledge, thereby triggering reporting obligations under 42 C.F.R § 411.25).

[FN62]. 42 U.S.C. § 1395y(b)(2)(A); 42 C.F.R § 411.25(a); *see also* Franco, *supra* note 2, at 10; Renee Y. Little, *The Check's Almost in the Mail: Legal and Practical Handling of Medicare Liens and Other Medicare Roadblocks to Settlement*, DEFENSE RESEARCH INSTITUTE ANNUAL MEETING COURSE MATERIALS, October 2008, at 590 (manuscript on file with authors)(hereinafter "Little").

[FN63]. One must consider whether, for example, (i) the claimant is currently a Medicare recipient, or (ii) the settlement is greater than \$250,000 and the claimant has a "reasonable expectation" of Medicare enrollment

within thirty (30) months of the settlement date. *See* Little, *supra* note 62, at 593; Black, *supra* note 31, at \*11-13; MCWSA, at 4; Heather Kelly, Jonathan Allan Klein, Annmarie M. Liermann & James M. Meseck, *Medicare Reimbursement Problems*, FOR THE DEFENSE, February 2008 at 9, 53 (hereinafter “Kelly et al”).

[FN64]. *See, for example*, Kelly et al, *supra* note 63, at 12, 53.

[FN65]. *Id.*

[FN66]. *See* Little, *supra* note 62, at 593; Black, *supra* note 31, at \*11-13; MCWSA, at 4; Kelly et al, *supra* note 63, at 53.

[FN67]. *See, for example*, WCMSA, at 3.

[FN68]. 42 C.F.R § 411.25(a); 42 U.S.C. § 1395y(b)(8)(A)-(B).

[FN69]. MSP Manual, Ch. 7, § 50.4.2; *see also* John J. Campbell, *A Step-By-Step Guide For Medicare Set Aside Attorneys*, THE MEDICARE SET ASIDE BULLETIN, No. 20, Sept. 5, 2005, at 1 (hereinafter “CAMPBELL - GUIDE”).

[FN70]. MSP Manual, Ch. 7, § 50.4.2; CAMPBELL - GUIDE, *supra* note 69, at 1.

[FN71]. MSP Manual, Ch. 7, § 50.4.2; CAMPBELL - GUIDE, *supra* note 69, at 1.

[FN72]. MSP Manual Ch 7, § 50.4.2.

[FN73]. Black, *supra* note 31, at \*13; Kelly et al, *supra* note 63, at 10-11; Little, *supra* note 62, at 590.

[FN74]. Kelly et al, *supra* note 63, at 10-11; Rick Swedloff, *Can't Settle, Can't Sue: How Congress Stole Tort Remedies From Medicare Beneficiaries*, 41 AKRON L. REV. 557, 600 (2008).

[FN75]. Swedloff, *supra* note 74, at 600.

[FN76]. *See id.* at 580-592.

[FN77]. *Id.*

[FN78]. *See* Kelly et al, *supra* note 63, at 11.

[FN79]. Swedloff, *supra* note 74, at 601; Black, *supra* note 31, at \*13-14.

[FN80]. Swedloff, *supra* note 74, at 601; Black, *supra* note 31, at \*13-14.

[FN81]. *See* Franco, *supra* note 2, at 10-11.

[FN82]. MSP Manual, Ch. 7, § 50.4.2.

[FN83]. 42 U.S.C. § 1395y(b)(8)(E)(i); 42 C.F.R § 411.25(a).

[FN84]. *See* Little, *supra* note 62, at 593.

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[FN85]. *Id.*

[FN86]. *Id.*; *see also* Black, *supra* note 31, at \*12.  
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