UK P&I CLUB

US Bodily Injury News

JULY 2010

Changing tides shifting sands

The UK Club's experience of some key changes for the US bodily injury claims scene are examined and explained along with an update in the Club's news....

IN THIS ISSUE

UK P&I CLUB IS MANAGED BY THOMAS MILLER

This summer's edition of the TMA BI Newsletter has captured some of the key changes which have recently occurred in the US bodily injury claims scene. These changes include new laws - the Cruise Vessel Security and Safety Act of 2010; new decisions – broadening of the rules of discovery; and new procedures - post accident arbitration agreements and addressing Medicare in personal injury settlements.

Members' Bodily Injury Team Workshop

The American Bodily Injury Team annual workshop on managing and understanding the complexities and costs of personal injury and illness claims will be held in the TMA New Jersey office in September this year. At last year's event Members participated in an energetic discussion of key bodily injury issues which centred on a mock mediation exercise involving a collision between a vessel and a commercial fishing boat. Past events have seen Members attending as representatives from both US and Canadian companies and local offices of other international companies. They represented a cross-section of ship operating sectors ranging from bulk, container and tanker operators to international cruise lines to tug and barge firms with varying levels of experience in claims handling.

Any Members based outside the Americas region who may wish to attend the seminar are invited to contact Louise Livingston (louise.livingston@thomasmiller.com +1 415 343 0121)

The Wright stuff

Finally, we recently welcomed a new member to our Bodily Injury Team, Linda Wright. Linda joined us last month bringing with her nearly thirty years experience as a P&I club correspondent in the US. In addition to her expertise in the field of bodily injury claims, we look forward to reading her contributions to this newsletter in future editions.

As always we welcome your feedback on the topics we cover in these newsletters. Suggestions for subjects for future coverage are also particularly welcome. Further information on these topics can be obtained directly from the the TMA Bodily Injury Team (see back cover for contact details).

Mike Jarrett
President & CEO
Thomas Miller (Americas) Inc.

The UK Club's Americas regional office is headquartered in New Jersey and is led by President and CEO Mike Jarrett. The Americas-based claims team is well equipped with global paperless claims files, IT systems, loss prevention support and claims and guarantee authority.

Claims Handling Procedures

We aim for efficient and responsive claims handling, with same day response to most enquiries. Teammail is the preferred and easiest means of reporting matters. All formal claims communication such as notifications of claims must be between the TMA office and Member. Both TMA offices are able to process payments and claims reimbursements.

Emergency Contact

If you need to call any of the UK Club's network of offices out of hours and at weekends an up to date list of the names of the Duty Executives and their mobile phone numbers is maintained on its website at www.ukpandi.com

Thomas Miller Americas maintains permanent emergency duty mobile numbers which are:

New Jersey +1 201 315 1755

San Francisco +1 415 860 9712

Post accident arbitration agreements

In an effort to avoid the risk associated with personal injury litigation in the U.S, a new path is being forged – the post accident arbitration agreement…. and it seems to be catching on. Dee O'Leary explains.

A post accident arbitration agreement is an agreement negotiated between a Jones Act employer and their seafarer employees after the seafarer has sustained an injury for which the employer might be found to have some liability. Jones Act seafarers are not part of the worker's compensation scheme in the U.S., but are entitled to maintenance and cure. Maintenance is essentially a subsistence allowance consisting of the cost of food and lodging, only for the seafarer, not for his family. Cure is the medical expenses which are paid until the injured seafarer reaches maximum medical improvement.

Maintenance payments are negotiated by seafarer unions and are typically very low (usually between $8.00 and $15.00 per day) and the post accident arbitration agreement seeks to provide the seafarer with all or a portion of his wages during the disability period in exchange for the seafarer agreeing to arbitrate his Jones Act claims against his employer. This serves the laudatory purposes of maintaining the seafarer (and their family) during disability and avoiding the risk and potential consequences to both sides which accompany a Jones Act jury trial.

Tried and tested

The arbitration agreements have been increasing in popularity and have been tested in several courts. Most plaintiffs have made similar arguments attempting to have the arbitration agreements invalidated, namely:

1. The Federal Employers' Liability Act (FELA), Section 5, voids the agreement which attempts to exempt a carrier from liability. FELA is incorporated into the Jones Act statute
2. The post injury arbitration agreement is invalid because it is part of the employment contract.
3. Post injury arbitration agreements are against public policy.
4. The claimaint has entered the post injury arbitration agreement under duress, coercion, or as a result or misrepresentation or fraud.

However, most post accident arbitration agreements have been upheld by several courts (the 5th Circuit, the Eastern and Southern Districts of New York, the New York Court of Appeals and the State Court of Appeals in Houston, Texas).

In *Terrebonne v. K-Sea Transportation Co.,* 2007 AMC 442 (5th Cir. 2007), the Fifth Circuit enforced an arbitration agreement that was reached between a seafarer and his employer, after the seafarer sustained a hernia on a tugboat, underwent hernia repair surgery, returned to work and settled his case with his employer. In the settlement, he reserved the right to seek recovery for reinjury that might develop after the date of the agreement relating to the original herniation but agreed to arbitrate any such future claims in New York.

The seafarer sustained a reinjury of the prior hernia but this time he instituted suit in New Orleans Federal Court. The court compelled arbitration, the arbitrators denied the seafarer's claims and the seafarer appealed. The seafarer attempted to invalidate the arbitration agreement by asserting that the incorporation of the FELA by the Jones Act invalidated the arbitration agreement.

Specifically, Section 5 of the FELA invalidates

> "any contract, rule, regulation or device whatsoever, the purpose or intent of which shall be to enable any common carrier to exempt itself from any liability created by this chapter."
> 45 U.S.C. Section 5 (2000).

The Supreme Court held that Section 5 invalidated a clause in an employment contract with the railroad which precluded the railroad worker from suing in Chicago, where the railroad was located. See, *Boyd v. Grand Trunk Western R.,* 338 U.S. 263 (1949 per curiam).

Because the forum selection provision in *Boyd* conflicted with the FELA's venue provisions permitting the suit in Chicago, the clause "exempt[ed] [the railroad] from ...liability created by this chapter." The *Terrebonne* Court rejected this argument and distinguished *Boyd* on the basis that the Jones Act had its own venue provision and therefore Section 5 of the FELA did not void an arbitration agreement that precluded any particular venue under the Jones Act.

The *Terrebonne* Court also held that the post-accident settlement agreement was not part of the seafarer's employment contract. Thus, it was not excluded by the Federal Arbitration Act provision which excludes enforcement of arbitration agreements in contracts of employment of seafarer. {9 U.S.C. Sect. 1} The seafarer argued that because the contract mentioned maintenance and cure, the agreement was part of the employment contract.

However, the Court rejected that argument, stating that the agreement {not to change anything regarding the maintenance and cure obligation or regarding his employment with the employer} was an agreement made after the employment agreement was made.

Finally, the Fifth Circuit summarily rejected the seafarer's argument that the clause in the arbitration agreement was against public policy, as he could not cite a viable public policy that would void the agreement.

Valid and enforceable

In *Barbieri v. K-Sea Transportation,* 2007 A.M.C. 339 (E.D.N.Y. 2006), the Court, though upholding the validity of the arbitration agreement generally, was sufficiently concerned about the circumstances of entering into the arbitration that a bench trial was ordered to determine whether the "claimed arbitration agreement" between the seafarer and his employer was valid and enforceable.

Specifically, the employer had agreed to pay Barbieri $70.00 per day, instead of the minimum $15.00 per day called for in the collective bargaining agreement, and the seafarer claimed that he felt that he had to sign it because he had a "gun to his head."

Further, Barbieri claimed he was never told that the filing fees for arbitration could exceed $750.00 and the filing fee could have gone as high as $10,000.00.

The Court also noted that the employer induced the seafarer to sign the arbitration agreement at a time in which he was not represented by counsel or even by a union official. This evidence was sufficient to create issues of material fact under the general contract law, fraud in the inducement, duress and unconscionability* that might render the arbitration agreement invalid.

The Court tried the issues raised by Barbieri and concluded that the agreement was enforceable and compelled arbitration on condition that defendant K-Sea bear any filing costs not waived by AAA.

The Court observed that there was no evidence at trial that Barbieri, who was college educated and who had business ventures in the past and one prior injury claim, was unable to properly evaluate and understand the agreement. Nor was there any evidence of misleading conduct, coercion, threats or intimidation by defendant K-Sea.

Burden of proof

In *Schreiber v. K-Sea Transportation,* 9 N.Y. 3d 331, 879 N.E. 733, 849 N.Y.S. 2d 194 (2007), the New York Court of Appeals upheld the validity of an arbitration agreement signed by a seafarer after his injury occurred. The seafarer's employer offered to pay the seafarer two-thirds of his regular wages as an advance against settlement of any claims based on his injury in consideration for agreement. However, the Court ordered a hearing to decide if this particular arbitration agreement was enforceable.

The Court placed the burden of proof on the party attempting to invalidate the arbitration agreement. The Court rejected the seafarer's argument that the arbitration agreement was part of a contract of employment and therefore excluded from the Federal Arbitration Act. The agreement was made after the seafarer was employed.

As in *Terrebonne,* the Court also rejected the argument that the arbitration clause was invalidated by Section 5 of the FELA which voided any contract by a common carrier which exempted itself from any liability "created by this chapter." The *Schreiber* Court reasoned that the federal policy favoring arbitration distinguished this situation from a forum preclusion clause which the Supreme Court had voiced in *Boyd v. Grand Trunk Western*, supra.

Finally, in *Schreiber* the Court rejected the "ward of the admiralty" argument which it found outdated and outweighed by the policy favoring arbitration. The court was similarly troubled by the filing fee correspondence, as was the Court in *Barbieri*. The employer agreed to be responsible for only $750.00 of the filing fee and the Court noted the possibility that this might have intentionally misled the employee to agree to arbitrate. Nonetheless, the seafarer would have the burden of proof to show that he was intentionally deceived.

Recently, in April 2010, the Court in *Harrington v. Atlantic Sounding Co.Inc. and Weeks Marine Inc. and the M/V Candace, her engines, equipment and tackle, in rem*, __ F. 3rd __ (2nd Cir. 2010), again upheld the validity of a post accident arbitration agreement.

The Plaintiff, an able bodied seafarer, suffered a back injury while working onboard a vessel. He left the vessel and began receiving maintenance checks of $20.00 per day from his employer, who also paid all medical expenses resulting from his injury. The plaintiff's doctors prescribed painkillers to help him cope with his injury, which the plaintiff testified interfered with his concentration and made him drowsy. The plaintiff also testified that during this time he was drinking over a half-gallon of vodka every 2 or 3 days and that he had a history of alcohol abuse. The plaintiff eventually was diagnosed with herniated discs that required surgery.

The plaintiff called his employer to request additional financial support for his injury and up-coming surgery. In response, the employer sent him an arbitration agreement which stated that in exchange for the plaintiff agreeing to arbitrate his claims, his employers would advance 60% of his gross wages as an advance against settlement for any claim he might bring. The plaintiff signed the agreement and had it notarized and began getting checks, which he cashed. The plaintiff testified that during this time, he was taking pain killers and drinking heavily.

After some time had passed, The plaintiff requested his employer to extend the payment of 60% of his wages and the employer agreed, sending him an Addendum Agreement which he again signed and had notarized and the payments continued. The plaintiff testified that during this period he was drinking 2 quarts of vodka and 6 beers every day. After the employer terminated the plaintiff's employment, the plaintiff filed suit seeking to invalidate the agreements.

**one-sided, oppressive or unfair contracts; absence of meaningful choice by one party with terms unreasonably favorable to the other party*

The plaintiff made similar arguments to the ones previously made and struck down, but also crafted additional arguments that failed as well. The plaintiff claimed the agreement was "unconscionable" and therefore unenforceable.

The Court recognized two types of unconscionability, procedural and sub-stantative. Procedural unconconscionability might occur in situations where the seafarer was found to be in a weaker bargaining position than the ship-owner, but did not necessarily render the agreement unenforceable.

Substantative unconscionability, on the other hand, the more harsh of the two, would occur only if the agreement, as a result of its operation, would shock the conscience of the Court. The Court reviewed that agreement and found that it did not impose any substantative obligations upon plaintiff nor did it deprive him of any rights and was thus enforceable.

The Plaintiff also argued that the agreement should be voided due to lack of mental capacity and intoxication, relying on the long standing rule that if a party lacks mental capacity to comprehend and understand then there is no capacity to enter a valid contract. The 2nd Circuit found that the District Court made no finding with respect to plaintiff's mental state and remanded the case to the District Court with the instruction that if the Court were to find plaintiff's defenses to have merit, it must also consider whether the plaintiff ratified the agreement by his conduct [in cashing the Defendant's checks every week]. The District Court has not yet ruled on the remanded matter.

Alternative dispute resolutions

It is clear that the courts are becoming much more comfortable with arbitrations as an alternate dispute resolution process and no longer view them with hostility. Thus, they are more inclined to hold that an arbitration agreement does not exempt an employer from any liability but merely regulates the forum. The U.S. Supreme Court in *Boyd v. Grand Trunk Western* found that for FELA purposes a forum preclusion clause was an exemption from liability and therefore void, but Congress may have elevated arbitration clauses to a different stature.

As the *Schreiber* Court noted, arbitration clauses are enforceable by federal statute, distinguishing them from forum selection clauses that the Supreme Court invalidated in *Boyd v. Grand Trunk Western*. Such clauses do not have the importance that federal courts give to arbitration clauses.

Another issue that has arisen within the context of enforcing a post injury arbitration agreement is whether a promise to re-employ the seafarer is considered an "employment contract." As this has not been clearly stated by a Court, the Club recommends that any arbitration agreement does not include a promise to re-employ the injured seafarer.

Dolores O'Leary

Dee joined TM(A) in December 2007 after 17 years of practicing law in New York City with a firm specializing in maritime matters. She handles all P&I claims.

Washington State: shifting discovery burdens

A new opinion issued by the Washington Supreme Court will require a party objecting to discovery requests to seek a protective order instead of the traditional method of waiting for the requesting party to bring a motion to compel. The Club's legal correspondents in Seattle explain the case of Magana v. Hyundai Motor Am., Case No. 80922-4 (Nov. 25, 2009)

The *Magana* case also reinforced that it is not sufficient for a company to produce documents solely from its legal or claims department; the company must make a good faith effort to produce all responsive materials from all relevant departments. A failure to make such a search could result in the severest of sanctions.

In *Magana v. Hyundai Motor America,* the Washington Supreme Court upheld the sanction of a default judgment against a car manufacturer defendant who did not timely provide full and complete answers to discovery seeking evidence of "other similar incidents." The defendant had objected to several requests for production on the basis that they were "overly broad and not reasonably calculated to lead to the discovery of admissible evidence." The defendant self-limited its production accordingly and produced only documents that were already on file with its legal department. The plaintiff did not move to compel and the defendant did not seek a protective order.

On remand from an appeal following a jury verdict, the plaintiff requested that the defendant supplement its answers to the prior discovery requests. The defendant provided further responses, but they were not complete. The plaintiff brought a successful motion to compel and defendants finally responded in full. By the time defendant responded, nearly five years had passed from when the plaintiff initially propounded the discovery and much of the information had gone stale.

The trial court entered a default judgment (striking its answer; as it it had never appeared in the case) against the defendant as a sanction after finding that its failure to timely and fully answer the discovery requests was a discovery violation. The Washington Supreme Court upheld the default. The Court stressed that if a party objects to a discovery request its **only option** is to seek a protective order from the court. The party cannot simply ignore the request, fail to respond, or give an evasive or misleading answer.

This is the opposite of how discovery disputes have traditionally played out, where the burden is on the party seeking the discovery to bring a motion to compel to overcome a responding party's objections. It is an important distinction and one that opposing counsel in state court cases could use strategically to set a party up for a sanctions motion on the eve of trial.

Moreover, the Court stressed that a company cannot simply rely upon the files of its legal department to answer discovery requests. It has an obligation to diligently respond to the requests, which includes seeking information from other relevant departments. While this is not new, it underscores the notion that the company claims manager cannot just try to answer requests off the top of their head. A more thorough search is required to avoid possibly disastrous consequences.

Keesal Young & Logan

Phil Lempriere
Philip, partner at Keesal Young & Logan, has a BS in nautical science & marine transportation from the US Merchant Marine Academy in 1984 and earned a J.D. degree in 1989. Philip litigates all types of traditional maritime claims and casualties as well as employers' employment disputes.
E-mail: Philip.Lempriere@ky.com

Molly Henry (associate)
Molly is a graduate of Smith College. She earned her J.D. degree in 2008 from the Ohio State University Moritz College of Law, where she graduated *summa cum laude* and was nominated to the Order of the Coif. Molly's practice focuses on maritime litigation.
E-mail: molly.henry@kyl.com

US Coast Guard medical evacuations

With limited medical capabilities on most seagoing vessels, it is not uncommon for vessel masters to request medical assistance from coastal governmental agencies. Karen Hildebrandt shares her recent experience.

Members are sometimes faced with crewmembers or passengers being injured or becoming ill at sea. Club cover includes the Member's liability to pay hospital, medical and other necessary expenses incurred in relation to a seafarer's or passenger's illness or injury including the cost of repatriating the crewmember to his/her home and sending a substitute to the vessel. The Club also covers the expense of diverting the vessel for the purpose of securing treatment for an ill or injured party onboard.

In certain cases where the crewmember or passenger is thought to urgently need medical treatment it is possible to request assistance from the U.S. Coast Guard ("Coast Guard") if the vessel is operating in or near U.S. waters, to evacuate the ill or injured parties to a shore side hospital. As more fully discussed below, medical evacuations (Medevacs) are carried out only if certain guidelines are met.

Coast Guard Medevac policy and procedures for merchant vessels is set forth in U.S. Coast Guard Addendum to the National Search & Rescue Supplement (CGADD). Typically, requests for medical assistance are initially received by the nearest Search and Rescue ("SAR") Coordinator.

The SAR Coordinator is charged with completing a Medevac checklist in order to rapidly develop an accurate description of the patient's condition. Masters and crew should be immediately prepared to relay the following information:

- Patient's name, age, gender and nationality;
- Patients' respiration, pulse rate, temperature and blood pressure;
- Location of pain and/or nature of illness or injury (including cause);
- Symptoms and medication given (including type, time and amounts)
- Time of last consumption and ability to eat/drink and walk;
- Contents of the vessel's medical chest;

- Whether a suitable clear area is available for helicopter landing/hoisting
- Name, address and phone number of vessel's agent; and
- Last port of call, next port of call and ETA of next port of call.

When deciding whether a case is sufficiently urgent to justify the risks involved with a Medevac, Coast Guard personnel will confer with medical personnel, preferably Coast Guard flight surgeons who are trained to evaluate on five points:

1. What symptoms does the patient have?
2. What specific treatment do they need enroute and at destination?
3. When do they need it (how soon)?
4. Where can they get it (destination)?
5. Can the Coast Guard safely meet the window of opportunity?

There are many situations where a helicopter or boat evacuation creates greater risk to the patient than simply monitoring the case. In all Medevac operations, the Coast Guard considers the risks of the mission against the risk to the patient and the responding Coast Guard resource. Factors routinely considered by the Coast Guard include the following:

- The patient's clinical status;
- The patients probable clinical course if a Medevac is not performed;
- Medical capabilities of responding Coast Guard personnel and equipment;
- Aircraft endurance;
- Daylight or night operations;
- Prevailing weather, sea and other environmental conditions; and
- Contractual arrangements between vessels & hospitals or commercial medical advisory systems

Medevacs can be extremely hazardous to both patient and responders because of severe environmental conditions frequently encountered at sea, and from dangers inherent in transferring a patient from vessel to vessel or from a vessel to a helicopter. When deemed required, the Coast Guard does not seek to recover the costs associated with Medevacs from the recipients of those emergency services. However, 14 United States Code § 88 (c) makes it a federal felony for anyone to knowingly and willfully cause the Coast Guard to attempt to save lives and property when no help is needed. Given the significant costs associated with Coast Guard Medevacs, penalties include up to 6 years in prison and a maximum fine of $250,000, and the liability for all resulting costs incurred by the Coast Guard.

Club cover for such fines and penalties would be discretionary. Each case will be decided by our Club Board of Directors on its merits, considering the circumstances of the case, and the Directors would need to satisfy themselves that the member had taken reasonable steps to prevent the event giving rise to the fine. Accordingly, crewmembers should be reminded not to embellish or misrepresent a patient's medical condition when communicating with SAR Coordinators.

Medevacs continue to be invaluable resource to Members dealing with medical emergencies at sea. However, Medevacs pose unique risks to patients, responders and vessels and will only be authorized by the USCG after the potential benefits are weighed against the inherent dangers of such operations.

Freehill Hogan & Mahar LLP

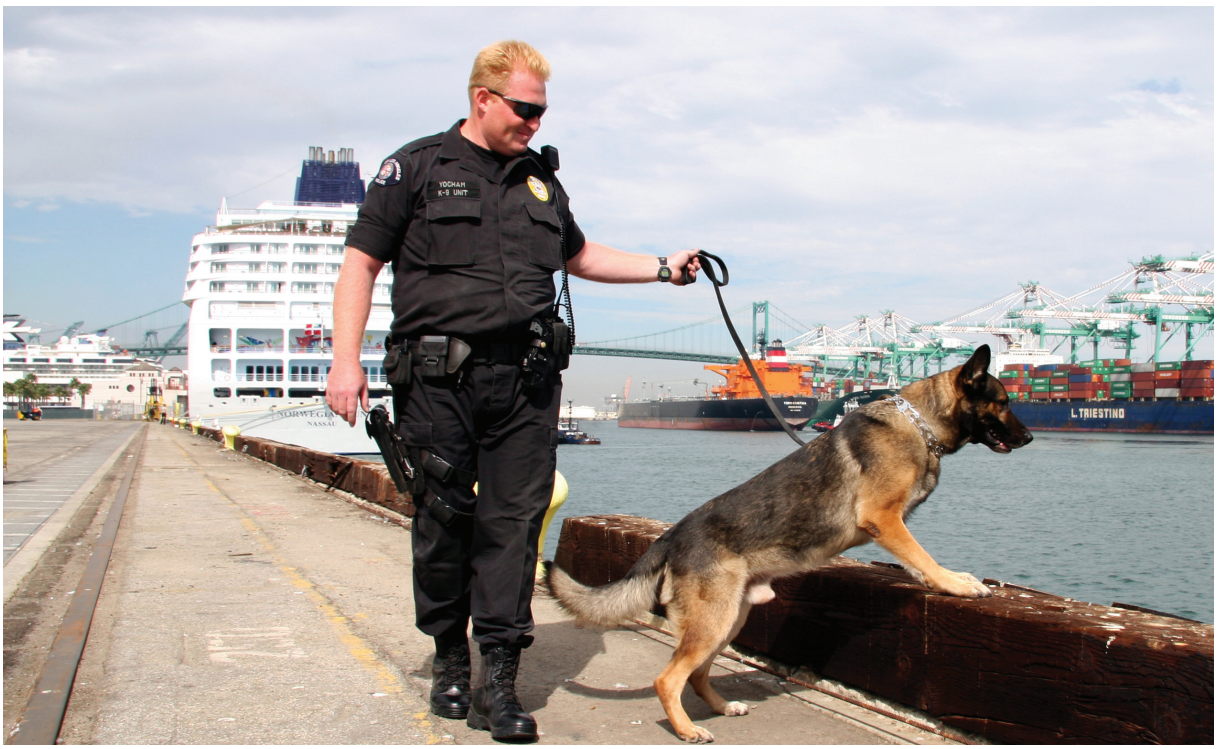
Daniel J Fitzgerald
Dan assists ship owners in the full range of maritime cases including Jones Act and LHWCA personal injury claims. A Lieutenant Commander in the U.S. Coast Guard Reserve, he serves on the USCG Navigation Safety Advisory Council and is a member of the Maritime Law Association's Marine Torts & Casualties Committee.
E-Mail: fitzgerald@freehill.com

Karen Hildebrandt

Karen was a partner at a leading maritime law firm before joining TM(A) in May 1998. She specializes in bodily injury claims.

Cruise ship crime reporting

Larry Kaye and André M. Picciurro summarise the impending Cruise Vessel Safety and Security Act and the requirements it places upon ships carrying more than 250 passengers calling at US ports.



The proposed Cruise Vessel Security and Safety Act of 2010 ("the Act") is expected to become U.S. law in the very near future. The Act imposes various requirements on cruise ships carrying over 250 passengers on international voyages which embark or disembark passengers in any U.S. port ("cruise ships").

Cruise lines and cruise ship operators should be aware of these requirements which are soon to become law, especially as non-compliance can result in denial of entry into U.S. ports, civil penalties of up to $50,000 per violation, and criminal penalties of up to $250,000 and/or 1-year imprisonment for willful violations.

Design and Construction Standards

The Act requires all cruise ships to meet the following design and construction standards within 18 months of its enactment:

1) ship rails must be 42 inches above the cabin deck;
2) passenger and crew cabin doors must have a "means of visual identification," such as peephole";
3) cruise ships must be equipped with technology, if available, to detect persons who have fallen overboard;
4) cruise ships must be equipped with a video surveillance system to document crimes; and
5) cruise ships traveling in certain high risk areas must have acoustic hailing and warning devices.

Immediately upon the Act becoming law, all new-build cruise ships must provide latches and time-sensitive key technology on all passenger and crew cabin doors.

Information Available to Persons Aboard Ship

The Act also requires cruise ships to provide passengers and crew a list of all U.S. embassies and consulates for the countries in which it will travel. Congress has not yet agreed on a provision which would require cruise ships to provide a guide to all passengers listing each ship's medical and security personnel and the law enforcement agencies of the jurisdictions in which such cruise ships will travel.

Sexual Assaults

For the purpose of treating and examining persons alleging sexual assault, the Act requires cruise ships to maintain onboard:

1) medications to prevent sexually transmitted diseases (e.g., anti-retroviral medications);
2) equipment and materials for performing a post-assault medical examination; and
3) credentialed medical staff (doctors and/or registered nurses with appropriate experience/certification in emergency medicine).

Cruise lines are also required to make available to the patient:

1) an examination report[2];
2) contact information for various law enforcement agencies (including the FBI), U.S. embassies and consulates, and a third party victim advocacy hotline; and
3) private telephone and computer access to contact law enforcement, an attorney, or support services.

Log Book and Crime Reporting

The Act requires cruise ships to keep a log book (electronic or otherwise) detailing complaints of homicide, suspicious death, a missing U.S. national, kidnapping, assault with serious bodily injury, sexual assault, setting fire to or tampering with the vessel, and theft of property in excess of $1,000.

Cruise ships are also required to notify the nearest FBI office (by telephone) and electronically send a report to the Secretary of Transportation ("Secretary") of all such crimes (except for theft of property less than $10,000) if:

1) any owner of the vessel (regardless of flag) is a U.S. person;
2) the incident occurs within U.S. territorial waters;
3) the incident occurs on the high seas and involves a U.S. national (as either the victim or perpetrator); or
4) the incident (regardless of where it occurred) involved a U.S. national on a voyage that embarks or disembarks passengers in the U.S.

The Secretary will maintain a publicly-available website keeping track of all such reported crimes for each cruise line. All cruise line websites must provide a link to the Secretary's website.

Crime Scene Preservation

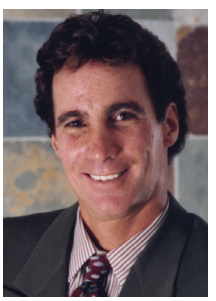
Finally, the Act requires the Secretary to develop training standards and curricula for certification of passenger vessel security personnel "on the appropriate methods for prevention, detection, evidence preservation, and reporting of criminal activities in the international maritime environment" within one year from enactment.

Two years after such standards and curricula are established, cruise ships may only enter U.S. ports if they have at least one certified crewmember onboard.

[1] *The Act also requires cruise ships to implement regulations as to which crew members have access to passenger staterooms and when such access is permitted.*

[2] *The examination report is confidential; absent patient consent, the cruise ship is only entitled to such findings in the report which will assist the cruise ship master or representative in complying with safety and reporting laws.*

Kaye Rose & Partners LLP, San Diego, California



Larry Kaye

Larry has been involved in advising/defending cruise lines for over 25 years. He is maritime counsel to CLIA the cruise line industry association and has been intimately involved in advocating the cruise industry's position on crime reporting and other issues before the U.S. Congress.
E-mail: lkaye@kayerose.com

André M. Picciurro

André is licensed to practice law in Florida and California and has spent the past decade defending cruise lines and insurers through trial and appeal. He was also directly involved in advocating the cruise industry's position on the Cruise Vessel Security and Safety Act.
E-mail: apicciurro@kayerose.com

Are Medicare set-asides required in liability cases?

Jana Byron explains the significance of the new reporting requirements in the second of a two part series on addressing Medicare issues in personal injury settlements in the US. In part 1, we covered the new reporting requirements enacted under Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 ("MMSEA").

Medicare is a federally funded public health plan that is administered by the Center for Medicare and Medicaid Services ("CMS"). Under the Medicare Secondary Payer Act ("MSP Act" or "the Act"), Medicare is prohibited from providing coverage for medical treatment where insurance such as auto, liability, no-fault and self-insurance is legally or contractually obligated to provide coverage.

These entities are the Primary Payers under the Act. If Medicare pays medical expenses for which it is the Secondary Payor under the Act, Medicare is entitled to recover those payments either from the Primary Payer, or where a claim has been settled among the parties and the settlement contemplated injury-related future medical expenses, from the claimant himself and/or his attorney. Although Medicare has been entitled to enforce the Secondary Payer status for quite some time, CMS encountered problems enforcing its rights because it had no way to monitor when an injured party enters into a settlement with a Primary Payer.

The new reporting requirements were adopted to enable the CMS to monitor certain liability and workers compensation settlements - namely those settlements involving claimants who are Medicare-eligible - to ensure that Medicare is not making payments for care that is the responsibility of a known Primary Payer. What is important for the purposes of this article is that MMSEA was completely silent with respect to determining whether a Medicare set-aside, which allocates a portion of a personal injury settlement for future medical expenses, is required in reported (and unreported) liability settlements.

If our Members are confused about set-asides in liability cases, they are in good company. Even the American Association for Justice, formerly the Association of Trial Lawyers of America, has weighed in on the issue and advised its membership – incorrectly, we think - that the CMS does not require liability set-asides. In our view, this advice, while technically correct, is ill-conceived and short-sighted because it all but completely ignores the mandate of the MSP Act, namely that the settling defendant

and/or his insurer, as the Primary Payer, is legally obligated to cover a plaintiff's future injury-related medical expenses if the settlement included compensation for those expenses, thereby protecting and maintaining Medicare's Secondary Payer status.

Despite all the confusion and debate, what is clear is that CMS has stated, repeatedly and unequivocally, that in liability cases, Medicare considers itself to be the Secondary Payer and, as such, the participants in a liability case (including the plaintiff, his or her attorney, the defendant, the defendant's insurer and the defendant's attorney) must consider and, where warranted, protect Medicare's Secondary Payor status.

Additional evidence of the CMS' position recently came to light when the United States filed suit in Alabama federal court against various defendants including attorneys, product manufacturers and the manufacturers' insurers who had entered into a $300 million personal injury settlement in 2003. The 2009 Complaint alleged that the settling defendants, their insurers and the attorneys failed to protect Medicare's interests under the MSP Act when they entered into the 2003 settlement.
The United States also alleged that it is entitled to collect **double damages** for any payments made by Medicare that should have been covered in the 2003 settlement agreement.

Now that the new reporting requirements have been enacted, the question that many ship owners, underwriters and indemnity insurers and employers have been asking is: Are set-asides required in both liability and workers compensation cases? We think they are because the MSP Act does not distinguish between liability and workers compensation when it mandates that Medicare's interests must be protected in cases where there is a Primary Payor in the picture.

Accordingly, we believe that it is in the Club's and our Members' best interest to ensure that Medicare's interests are consider and, where warranted, protected in liability settlements involving US claimants. We hope that this article provides some insight into how to review and analyze this issue; however, the information contained herein is not a substitute for legal advice and we strongly recommend that our Members consult with counsel and the Club before entering into a personal injury settlement in the US.

Medicare's Secondary Payer Status is Always a Consideration

As a starting point, regardless of the age or Medicare eligibility status of a claimant or the dollar value of a settlement, we recommend that whenever a settlement contemplates (or should contemplate) compensation for future injury-related medical expenses, the language in the settlement agreement should demonstrates that that the parties have considered and, if warranted, taken steps to protect Medicare's Secondary Payer status. Currently, in every workers compensation settlement where

- the claimant is already a Medicare beneficiary and the total value of the settlement exceeds $10,000; or
- the claimant is reasonably expected to become eligible for Medicare within 30 months of the settlement and the total value of the settlement is more than $250,000, the CMS requires that the proposed MSA arrangement be submitted to the CMS for approval.

However, we caution against using these guidelines to determine whether Medicare has an interest in the settlement of a claim in the first place because the guidelines are self-limiting and by their own language only apply to the CMS' review and approval of certain set-asides.

That is not to say that every settlement requires some form of a set-aside. In cases where it is clear that a claimant will not require additional injury-related medical care, the settlement documents should make clear that he has been released from medical care by his doctors and requires no further medical care in the future related directly or indirectly to the injuries contemplated in the settlement.

There are also cases where it is clear that Medicare is not likely to cover future injury-related medical expenses. In those cases, we recommend the settlement agreement include language in which the claimant acknowledges that he is responsible to pay for future medical care related to the injury and that the claimant agrees to defend and indemnify the Primary Payer from any further liability for medical expenses, including any claim brought by or on behalf of Medicare.

Options for Analyzing Set-Asides in Liability Settlements

When faced with a settlement that contemplates compensation for future injury-related medical expenses and Medicare's Secondary Payer status comes into play, the parties have three basic options:

1. Do nothing and wait until the CMS clarifies what they expect in liability cases;
2. Determine future medical costs and include language in settlement documents that seeks to protect Medicare's interest if the same is warranted; or
3. Follow the guidelines for workers compensation settlements in liability cases and prepare formal and comprehensive set-asides for all liability claims and submit them to the CMS for approval.

Although we again strongly recommend that each settlement be discussed with counsel and the Club, we think that choice number two is the most sensible and economical route to take until the CMS issues some more concrete guidance.

'Do Nothing'

First, let's consider why option one - the 'do-nothing' option - is more often than not a bad idea. While this option has the benefit of a speedy settlement conclusion, it completely ignores the letter and spirit of the MSP Act. As noted above, the MSP Act and related regulations require that Medicare retain its Secondary Payer status. Electing to do nothing can result in the Primary Payer – that is, the ship owner or charterer – being held liable for reimbursement of costs (plus interest and penalties) to Medicare in the future.

When the value of a settlement takes future medical expenses into account, doing nothing and waiting for guidance from the CMS could mean that a ship owner (or his insurer) could effectively have to pay for future medical expenses twice: once to the claimant in the settlement and then again to Medicare if Medicare pays for treatment contemplated in the settlement.

'Do Everything'

We also consider option three, complying with the regulations promulgated for workers compensation set-asides, to be less than ideal because, in most liability cases, it is probably unnecessarily burdensome. While creating a set-aside and having it reviewed by the CMS might be the safest route to take, it can be more costly and can cause serious delay in settling a claim.

In addition, the Club is aware of instances where liability set-asides have been submitted to the CMS for review and approval and the CMS has refused to act. This means that the CMS can simply sit on a request for assistance in regard of a proposed liability set-aside and, if the settlement eventually goes forward anyway, a ship owner or charterer may still not completely insulated from an indemnity claim from Medicare down the road.

The balanced approach

Given the draw-backs and benefits of the various options, we think that option two is, in most cases, usually the most sensible route until the CMS addresses the issue. Under option 2, the parties should obtain a cost projection of future medicals (whether from a Life Care Plan or Medical Cost Projection in more serious cases, or the estimates of a treating physician in less drastic matters; in any event, past and future medical care, prescription expenses, current condition and the life-expectancy of the plaintiff should be considered) and make that projection part of the settlement agreement. The settlement agreement should also contain specific provisions that

(i) designate a specific amount for future medicals relating to injury complained of by the plaintiff;

(ii) clearly indicate that the parties to the settlement have given due consideration to Medicare's interest in arriving at the estimated future medical expense projection;

(iii) indicate how the funds ear-marked for future medical expenses will be administered (self-administration by the plaintiff versus a custodial account); and

(iv) address issues of responsibility and liability in the event that the plaintiff fails to utilize the funds as designated. This route provides evidence to the CMS that the parties took proactive steps to consider and account for Medicare's interests.

Although the CMS might still have a right of recovery against the Primary Payer if the plaintiff squanders the funds ear-marked for future medical care (because ultimately the CMS does not care who makes them whole only that they are made whole by someone), option two at least provides some level of comfort to settling defendants and their insurers that a solid foundation has been laid upon which they can argue to the CMS that their recourse lies with the fund-squandering plaintiff and not the Primary Payers.

Jana Byron

Jana joined TM(A) in November 2005 after seven years of practice as an attorney specializing in maritime matters. She handles both Defence and P&I claims.

The Team

More than half of the Club's personal injury claims over $100,000 are brought in the American courts.

The TMA Bodily Injury Team are a specialist group of executives from both the New Jersey and San Francisco offices empowered with a significant settlement authority to deal with these demanding cases on our Members' behalf. Under the leadership of Louise Livingston they apply collective team expertise and experience to a variety of bodily injury matters. Louise, Karen Hildebrandt, Jana Byron and Dee O'Leary are all former practising attorneys in both Federal and State Court. Linda Wright has 30 years experiece handling bodily inury claims. The team review and determine strategy in all major injury cases and attend all settlement conferences and mediation with, and sometimes on behalf of, our Members.

Louise S. Livingston

Direct line:
+1 415 343 0121

Louise is an attorney specializing in bodily injury claims. Before joining Thomas Miller (Americas) in March 2002, Louise was a partner in a San Francisco maritime law firm. She leads TM(A)'s Bodily Injury Team.

Jana Byron

Direct line:
+1 201 557 7433

Jana joined Thomas Miller (Americas) in November 2005 after seven years of practice as an attorney specializing in maritime matters. She handles both Defense and P&I claims. She is also a member of TM(A)'s Bodily Injury Team.

Karen C. Hildebrandt

Direct line:
+1 201 557 7425

Karen was a partner at a leading maritime law firm before joining TM(A) in May 1998. She specialises in personal injury claims and is a member of TM(A)'s Bodily Injury team.

Dolores O'Leary

Direct line:
+1 201 557 7402

Dee joined TM(A) in December 2007 after 17 years practicing law in New York City with a firm specializing in maritime matters. She handles all P&I claims and is also a member of TM(A)'s Bodily Injury Team.

Linda Wright

Direct Line:
+1 415 343 0122

Linda joined Thomas Miller (Americas) in May 2010. Previously she was a P&I Club correspondent on the Pacific West Coast for 29 years. She handles personal injury cases and is a member of the Bodily Injury Team.