

Welcome back to Your Best Defense, Wayman, Irvin & McAuley's quarterly newsletter.

This edition has as its focus two new sets of regulations, very recently put into place, which will have profound impact on our real estate and insurance clients. Initially, Gregory Knight takes a look at the Home Valuation Code of Conduct, which just became effective on May 1, 2009. These new regulations seek to gain more control over the appraisal process in real estate transactions. In short, rather than the typical process whereby the mortgage broker or perhaps the real estate agent points a buyer toward an appraiser, the new requirements seek to take these entities out of the process and replace them with the lender directly or with appraisal management companies. While Mr. Knight's article addresses the finer points of the Code in more detail, the idea is that the new procedures will preserve impartiality and integrity in the appraisal process, the shortcomings of which have played such a major role in the mortgage and real estate crisis. As the article discusses, however, many in the industry are concerned that the Code will create additional costs and have a chilling effect on the portability of legitimate appraisals and even promote partiality in some instances. Knight looks at all of these aspects of the HVCC.

Jon Gesk in this edition takes a look at the Medicare Secondary Payer Act and the huge burden it places on insurers moving forward. While the Act itself has been on



the books for some time, the new SCHIP Extension Act enacted in December 2007 and set to go into effect on July 1, 2009, details new heightened reporting requirements for primary payers. In short, the Act applies to all settlements where an injured party has foreseeable future medicals that will arise when he is Medicare eligible. Thus, whether a claimant is a Medicare beneficiary at the time of

settlement is not determinative of whether a Medicare Set Aside (MSA) is required. A Medicare Set Aside is essentially a separate trust account that is intended solely to cover future medical costs that would otherwise be covered by Medicare. The issue is whether it is reasonably likely that the subject-injuries will necessitate future medical treatment at a time when the party is Medicare eligible. Failure to comply could subject payers/insurers of fines up to \$1000 per day per claimant.

Obviously, the impact of the noted provisions will have profound impact, creating standards that will be very tough to meet even under the best circumstances. Those individuals and entities affected should take steps now to familiarize themselves with the new requirements so as to avoid substantial penalties or problems in the event of non-compliance.

If you know of anyone else who might be interested in receiving an e-mail of this newsletter, please let me know at dforsythe@waymanlaw.com.



HOME VALUATION CODE OF CONDUCT - *New Standards for Real Estate Professionals*

By: Gregory S. Knight, Esq.

On March 3, 2008, Freddie Mac announced an agreement with the FHFA and the New York Attorney General for adoption of the Home Valuation Code of Conduct (Code). Between March 14, 2008 and January 7, 2009, an industry comment period began for discussion of the Code provisions, and on May 1, 2009, the Code became effective.

As a result of the passage of the Code, it is imperative that all professionals involved in real estate transactions make themselves fully aware of the requirements and restrictions provided in the Code. Below is a summary of some of the key provisions of the Code (or HVCC).

Now, all sellers who want to deal with Freddie Mac and Fannie Mae must have adopted the Code by that date. There is an exception – a “small bank” with no more than \$250 million in assets and who might suffer a hardship, as determined by Freddie Mac and Fannie Mae, will be exempt from adopting the Code. Also, several types of mortgages

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are excluded from this Home Valuation Code of Conduct, including FHA/VA mortgages, Section 184 Native American Mortgages and Section 502 Guaranteed Rural Housing Mortgages. It is important to note that this applies only to mortgages to single family homes; multi-unit dwellings are not included or covered by this Code of Conduct.

Probably the most important goal of the code is ensuring appraiser independence. The appraiser must be licensed or certified by the state in which the property is located. There can be no influence or attempt to influence the development, reporting, result, or review of an appraisal. However, the lender may request an appraiser to provide additional information or explanation about the basis for the evaluation or correct objective factual errors in the report. The Code also does not restrict managing appraisal lists for bonified administrative reasons based on written policies approved by management of the lender. Also, a lender can provide a Sales Contract on a purchase transaction to the appraiser prior to performance of the appraisal. Ordering a second appraisal if it is part of the lender's written pre-established policies and procedures can also be done. However, the lender must use the most reliable appraisal rather than the appraisal with the highest value.

Another important aspect of the Code requires that the lender must provide a copy of the appraisal report to the borrower promptly upon completion and no less than three days prior to the closing of the loan, unless the borrower specifically waives this requirement. Three days means three business days. Promptly upon completion means when the lender has satisfied all its internal requirements as to the appraisal, which may mean after obtaining a second appraisal. The borrower can waive this three day requirement if it is in writing and in a form provided for in the policies and procedures of the lender.

One of the key elements of the Code is its attempts to take the mortgage broker and the real estate agent completely out of the appraisal process, again in the name of impartiality. The Code requires that the Lender or an authorized third party is responsible for selecting, retaining and providing the appraiser with payment and all compensation. Third parties include appraisal companies, appraisal management companies and correspondent lenders, but third parties do not include mortgage brokers or real estate agents. Note that an appraisal prepared for another lender is acceptable if written assurances are provided that the other lender complied with the Code for the appraisal and the appraisal otherwise conforms to the lender's requirements and is otherwise acceptable.

Lenders are also made responsible for quality control testing. Lenders must quality control test a randomly selected 10 percent (or other bona fide statistically

significant percentage) of appraisals or valuations. Any adverse, negative, or irregular findings from testing and any findings indicating non-compliance with the Code must be reported to Freddie Mac and Fannie Mae. Lenders shall certify, warrant, and represent that the appraisal report was obtained in a manner in compliance with this Code. Freddie Mac will enforce all applicable rights and remedies, including suspension or termination of the lender's eligibility to sell loans to Freddie Mac if the lender fails to remediate.

Moreover, under the Code, the Lenders are expected to help police the industry. Lenders, with a reasonable basis to believe an appraiser or appraisal management company is violating applicable laws or otherwise engaging in unethical conduct, must promptly refer the matter to the applicable State appraiser certifying and licensing agency, or other relevant regulatory bodies

Reaction from real estate professionals has been generally negative to the HVCC, as enacted. The National Association of Mortgage Brokers estimates that the HVCC is costing consumers \$2.8 billion a year in extra fees created by long delays (extended lock-in fees) and higher appraisal costs. It is argued that unregulated appraisal management companies (AMCs), who have been the subject of several misconduct investigations, are the center piece of the HVCC. AMCs are claimed to be driving honest appraisers and mortgage brokers out of business, eliminating competition, increasing costs to consumers, and reducing state revenues. Lack of portability is another complaint. Consumers are trapped with a specific lender. If another lender becomes available at a better rate, the consumer will be forced to pay for another appraisal. Under the HVCC, any lender using a professional appraiser incurs substantial regulatory risks and additional costs, where AMCs and other evaluation alternatives are expressly exempt from the same regulations and liabilities. Note that lenders can own up to 20 percent of an AMC or other related entity, and so it is asserted that this provision allows the conflict the HVCC expressly intends to resolve.

This Code is new, so no case law has yet established it as the standard of care for real estate professionals, dealing with appraisals, in law suits. However, this is likely to be used by plaintiffs' lawyers and courts in the future. This is definitely something for all professionals to watch very closely moving forward.

If you would like to discuss this Code in greater detail, please contact Gregory Knight or Dale Forsythe here at gknight@waymanlaw.com or dforsythe@waymanlaw.com.



NEW ROLE OF MEDICARE SECONDARY PAYER ACT

By: Jonathan M. Gesk, Esq.

Introduction

Pursuant to the Medicare Secondary Payer Act 42 U.S.C. §1395y (“The Act”), Medicare assumes the role of secondary payer in cases where a primary payer exists. A primary payer is considered any workers’ compensation, liability or automobile policy or no fault insurance. In other words, if a portion of the proceeds of a workers’ compensation or personal injury settlement agreement are intended to cover future medical expenses that would normally be covered by Medicare, Medicare becomes a secondary payer which is only responsible for paying the excess medical expenses if or when the anticipated annual amount is exhausted.

To facilitate compliance with this statute, all parties to a settlement involving a potentially Medicare-eligible person must propose a Medicare Set Aside (“MSA”), i.e. a separate trust account that is intended solely to cover future medical costs that would otherwise be covered by Medicare. If the account is properly administered and the MSA is adequate, once those funds have been exhausted Medicare will resume making payments on behalf of the claimant for and Medicare-covered treatment.

Medicare is authorized by statute to seek reimbursement, interest and penalties for any payment it makes that was the responsibility of the primary payer. By establishing an MSA account, parties to a settlement are protecting Medicare’s interest, their clients’ interests, and their own interests and are complying with the Medicare Secondary Payer Act.

History

This statute was enacted in 1980; however the Centers for Medicare and Medicaid Services (CMS) did not begin enforcing it until approximately 2000-2001. The statute applies to workers’ compensation, no fault, liability and automobile plans, but was typically only enforced in workers’ compensation cases.

However, recent legislative amendments to The Act have led those in the industry to anticipate stricter enforcement in liability and automobile policy cases. Most notably, the SCHIP Extension Act was passed in December 2007, and is scheduled to go into effect on July 1, 2009. Specifically, Section 111 of the SCHIP Extension Act details new heightened reporting requirements for primary payers. Failure to comply with the new reporting requirements subjects a primary payer to substantial penalties, including a \$1,000.00 fine per day per claimant.

Because these new reporting requirements will make it exponentially easier to track whether it is a secondary payer, the legal and insurance fields have correctly concluded that the long-standing MSA requirements need to be adhered to.

Applicability

The Act applies to all settlements where an injured party has foreseeable future medical treatment that will arise at a time when he is Medicare eligible (regardless of whether he or she is Medicare-enrolled) and Medicare would otherwise cover that treatment. Thus, whether a claimant is a Medicare beneficiary at the time of settlement is not determinative of whether an MSA is required. The issue is whether it is reasonably likely that the subject-injuries will necessitate future medical treatment at a time when the party is Medicare eligible. Generally speaking, almost all claimants will eventually become Medicare eligible and thus MSAs should always be considered.

To clarify the most common misconception regarding MSAs, the monetary value of the settlement and the age of the claimant are not determinative of whether an MSA is necessary. Often, the Centers for Medicare & Medicaid Services’ (“CMS”) guidelines for limiting the review of MSAs are erroneously interpreted as “safe harbor” provisions, obviating the need for an MSA. CMS has stated that MSAs related to workers’ compensation settlements need to be reviewed where either (a) the claimant is currently eligible for Medicare and the settlement is greater than \$25,000.00; or (b) the claimant is reasonably expected to become eligible for Medicare within 30 months of the settlement and the total settlement is greater than \$250,000.00. These thresholds are to limit the amount of MSAs CMS must review, and in no way eliminate the need for MSAs.

The need for an MSA is governed strictly by whether Medicare will be responsible for payments that are the responsibility of a primary payer.

MSA Creation and Review

The preparation of an MSA appears to require some specialization in that area of law. Generally, the claimant’s medical background and illness and/or injury are reviewed. Based upon the past treatment for that particular illness and/or injury and treating physicians’ recommendations, an MSA is created that is intended to include all reasonably anticipated costs that could fall under Medicare’s responsibility. The MSA and all necessary settlement language/information are then forwarded to Medicare for approval. If it is approved, the settlement funds allocated to the MSA are placed in a trust and limited to use for Medicare-covered treatment for that particular injury.

Failure to create an MSA subjects the entire settlement to Medicare’s subrogation. For instance, suppose a claimant receives a \$100,000.00 settlement, \$25,000.00 of which is a

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reasonable estimate as to the portion of the settlement dedicated to future medical payments. If an MSA is not created, Medicare has the right to recover the entire \$100,000.00 should that amount ultimately be exhausted by the claimant.

Liens v. MSAs

It is important to note the distinction between Medicare liens and Medicare Set-Asides. Attorneys are still responsible for determining whether Medicare has made any past payments for treatment and are entitled to reimbursement from any settlement or judgment proceeds. Thus, the attorneys should conduct a lien inquiry prior to any settlement so that they are aware of the funds that must be repaid. Attorneys are also responsible for any future payments made by Medicare, which are covered by the MSAs. Liens deal with past payments and MSAs deal with potential future payments.

SCHIP Extension Act Compliance

Section 111 of the SCHIP Extension Act requires insurers to determine benefit status of all claimants and report all claims to the Centers for Medicare & Medicaid Services – a division of the Department of Health and Human Services –

so that Medicare is on notice and its interests remain protected. The failure to comply with the reporting requirements can lead to a fine of \$1,000 per day per claimant.

Section 111 applies to Responsible Reporting Entities (“RREs”), which in the context of liability and automobile policy claims is the insurer. The RREs will first register online with CMS and setup a data reporting and response process. The RREs will then submit the relevant information (claimant’s name, SSN, DOB and gender) for each particular claim electronically to CMS’ Coordination of Benefits Contractor (“COBC”). Note that electronic registration for all RREs is currently being conducted via the Coordination of Benefits secured website. Additionally, the RRE is responsible for a “timely” reporting to CMS of any settlement, judgment or award to a Medicare-eligible party.

Clearly, the new concentration on enforcement of the provisions discussed creates sometimes onerous burdens upon carriers and other potential RREs. Full familiarity with the cited provisions and an understanding of their impact is going to become absolutely essential moving forward.

For a more detailed version of this article, please visit the resources section of www.waymanlaw.com. Also, should you care to discuss these issues further, please feel free to contact Jon Gesk at jgesk@waymanlaw.com.

Wayman Watch...

- Congratulations to Gregory Knight, Esquire, who has recently been appointed to the Board of Directors for the Southwest Chapter of the Pennsylvania Motor Truck Association.
- Dale Forsythe, Esq., Gregory Knight, Esq. and Jeffrey Kubay, Esq., recently presented the 2009 Update on the Home Valuation Code of Conduct and Certificate of Merit for Victor O. Schinnerer Agency and CNA Insurance, in Chevy Chase, Maryland.
- Congratulations also go out to Kate Fagan, who secured a defense verdict in Indiana County after a one week long trial in an auto case involving complex issues related to admission of alcohol use and BAC levels.

