

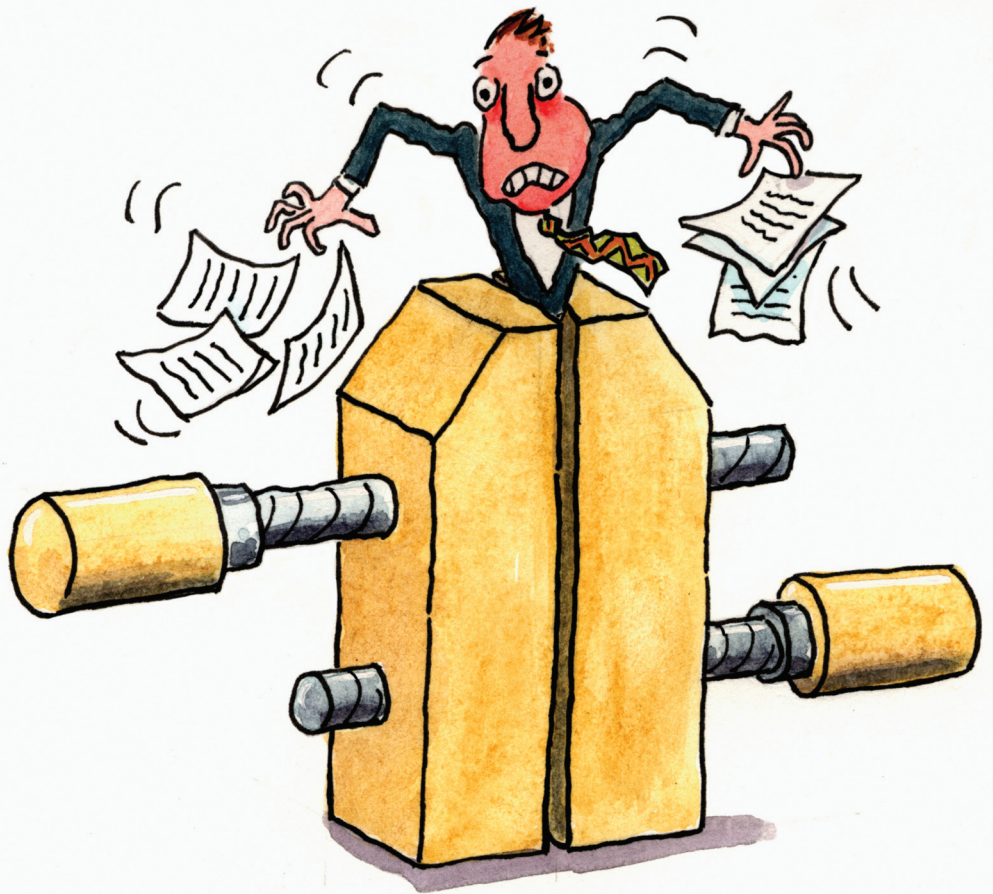


Making the Possible Impossible

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Until changes are made, careful planning is critical to avoiding the current system's many problems.

Medicare Reimbursement Problems



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Counsel representing plaintiffs, defendants, and liability insurers alike should be aware that Medicare's right to reimbursement may pose a risk of future liability and a significant obstacle to settlement. Imagine this simple

and common scenario: an elderly woman, Alice, slips and falls in a grocery store, breaking her hip. Alice receives medical treatment and eventually undergoes surgery. Alice files suit against your client, the grocery store. The grocery store settles with Alice for \$250,000. Months later, Medicare sends a demand to the grocery store and Alice, asserting its statutory right to reimbursement for \$150,000 in medical expenses provided to Alice as a result of the grocery store accident. Unfortunately, Alice has spent the entire settlement and has no assets. Can Medicare recover from your client? The answer is—in all likelihood—yes.

Imagine the same facts as above, except during settlement negotiations you learn that Medicare provided Alice's medical care and know that Medicare has a right to reimbursement. However, Medicare refuses to participate in settlement discussions. Instead, Medicare advises the parties to settle, inform Medicare of the settlement, and wait for Medicare's final recovery demand letter. During the settlement discussions, Alice overestimates Medicare's reimbursement demand so as not to undercut her ultimate recovery. Now you are unable to settle. Can you force Medicare either to participate in the settlement or estimate its conditional payments? The answer to the former question is "no," and to the latter question, "not in a timely manner."

Thus, Medicare's right to reimbursement poses a risk that settling parties will be exposed to future liability after settlement if they do not reserve settlement proceeds to cover Medicare's conditional payments. Moreover, Medicare's lengthy approval process of settlements and its inconsistent enforcement of its rights can cause excessive delays and higher costs. This article discusses the pitfalls of the Medicare Secondary Payer Act (MSP) and provides tips for navigating settlement of claims where Medicare has a right to reimbursement.

Navigating the Maze

Background

Medicare is a federally funded public health plan, administered by the Center for Medicare and Medicaid Services ("CMS"), which pays health care expenses mostly for persons over 65 and some disabled persons. In 2005, Medicare provided coverage to 42.5 million people, spending \$330 billion on benefits. See 2006 Medicare Trustees' Report. Medicare expects that "without further reforms," its expenditures will increase significantly in the next 75 years, from 3.2 percent of the gross domestic product in 2006 to 11 percent in 2080. *Id.*

Development of the Medicare Secondary Payer Rules

Initially enacted in the 1980s, in 2003 Congress fortified the Medicare Secondary Payer statute, 42 U.S.C. section 1395y, out of concern for Medicare's rising costs. "The MSP assigns primary responsibility for medical bills of Medicare recipients to private health plans when a Medicare recipient is also covered by private insurance. These private plans are considered 'primary' under the MSP and Medicare acts as the 'secondary' payer responsible only for paying amounts not covered by the primary plan." *Fanning v. United States*, 346 F.3d 386, 389 (3d Cir. 2003). As a "secondary" payer, Medicare only conditionally pays for treatment, with the expectation of reimbursement.

Prior to the 2003 amendments, Medicare could only seek reimbursement from group health insurance plans and insurance plans "to the extent that... payment has been made or can reasonably be expected to be made promptly..." 42 U.S.C. §1395y(b)(2)(A)(ii) (2002); see also *Thompson v. Goetzmann*, 337 F.3d 489, 492 (5th Cir. 2003). This promoted self-insurance and a delay in payment to Medicare.

With the 2003 amendments, Congress sought to ensure that persons "responsi-

ble" for an injury to a Medicare recipient pay for medical care, instead of limiting repayment to instances where payment was expected to occur promptly. Congress attempted to strengthen its reimbursement rights by: (i) expansively defining an insurance plan to include even uninsured businesses; (ii) broadening the scope of persons subject to reimbursement to include the Medicare beneficiary who receives a settlement or award; and (iii) clarifying when a primary plan's "responsibility" for reimbursement attaches.

Current Rules Regarding Repayment of Medicare

The following secondary payer terms and conditions currently exist.

Shift to One National Contractor

Until October 2, 2006, Medicare sought reimbursement through the Medicare Coordination of Benefits (COB) program. The primary payer would contact the COB and provide pertinent information. The COB representative would then refer the primary payer to a regional contractor. The regional contractor then negotiated the Medicare lien.

However, in 2006, the Centers for Medicare & Medicaid Services (CMS) announced that they were awarding the contract for obtaining reimbursement to a national contractor, Chickasaw Nation Industries, Inc.—Administration Services, LLC ("Chickasaw Nation").

During the transition, Chickasaw Nation will utilize the previous COB system. Past Medicare contractors Empire, First Coast Service Options, Mutual of Omaha, Palmetto and Trailblazer will continue to be responsible for all further CMS collection actions where the initial recovery demand letter was issued before October 2, 2006. Chickasaw Nation will be responsible for all new recovery demand letters sent out after October 2, 2006, with limited exceptions. See CMS Press Release, *National Recovery Contractor for New Medicare Secondary Payer (MSP) Recovery Claims*, September 25, 2006.

Medicare's Available Recovery

Any Medicare beneficiary who receives payment from a "primary plan" (including a liability insurer, workers' compensation

carrier, or “self-insured entity”) must reimburse Medicare within 60 days from the beneficiary’s receipt of payment from that primary plan (*i.e.*, the beneficiary/personal injury plaintiff’s receipt of the settlement check from the primary plan/defendant). 42 C.F.R. §411.24 (h); 42 U.S.C. §1395y (b)(2)(A). Although in practice, Medicare pursues reimbursement from the bene-

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ficiary first, it can also recover from the primary plan and anyone who receives payment from that plan. MEDICARE MSP MANUAL, Ch. 7, 50.5.2.1; 42 C.F.R. §411.24 (e), (g), (i). In fact, if the beneficiary does not repay Medicare within 60 days from receipt of a settlement or judgment, the primary payer “must” reimburse Medicare “even though it has already reimbursed the beneficiary or other party.” 42 C.F.R. §411.24 (i).

Right to Reimbursement Accrues at Settlement Payment

Medicare’s right to reimbursement accrues when a primary plan pays for an expense that Medicare initially paid, whether by settlement, judgment, or “other means.” 42 U.S.C. §1395y (b)(2)(B)(ii). *Any payment by a tortfeasor*, except under a no-fault clause in a non-automobile policy, *constitutes a primary plan’s payment* regardless of whether there has been a determination of liability. 42 U.S.C. §1395y (b)(2)(B)(ii). As currently worded, although Medicare may give parties notice of an intent to pursue reimbursement and an estimate of its conditionally paid benefits, Medicare cannot *demand* reimbursement until the injured’s claim is settled. MEDICARE MSP MANUAL, Ch. 7, 50.4.1.

Costs Medicare Can Recover

Medicare has a right to reimbursement only for services that a primary plan has or had a “responsibility” to pay. 42 U.S.C. §1395y (b)(2)(B)(ii). At present, it appears that Medicare does not intend to recover for future medical expenses in liability cases. *See, e.g.*, MEDICARE MSP MANUAL, Ch. 7, 50.5 (stating “[t]here should be no recovery of benefits paid for services rendered after the date of a liability insurance settlement.”) Although Medicare instructed its contractors not to seek recovery for services unrelated to the injury-causing accident, Medicare appears to require beneficiaries to protest the inclusion of unrelated expenses before Medicare will reduce its reimbursement demand. MEDICARE MSP MANUAL, Ch. 7, 50.5; *Overview of MSP Claims Recovery Process*, see <http://www.cms.hhs.gov/MSPRecovClaimPro/>. Nonetheless, Medicare can recover the *entirety* of an award or settlement as reimbursement, regardless of whether the settlement characterized a portion of the alleged medical treatment as for pre-existing conditions or conditions otherwise unrelated to the accident. MEDICARE MSP MANUAL, Ch. 7, 50.4.4.4. The beneficiary may, pursuant to regulatory formulas, reduce Medicare’s lien by the amount expended to obtain reimbursement. 42 C.F.R. §411.37.

Time “Limit” on Medicare’s Recovery

A prolonged statute of limitations for case filing and ambiguous claims deadlines are Medicare’s only time constraints. Medicare has six years to sue for recovery of secondary payments after the right of action accrues. 28 U.S.C. §2415(a); *United States v. Weinberg*, No. No. 01 CV 0679, 2002 U.S. Dist. LEXIS 12289 (E.D.P.A. July 1, 2002). The claims filing period is confusing; it appears that the beneficiary and primary payer have a duty to inform Medicare of its potential right to reimbursement, not the other way around. In the absence of an insurer’s claims-filing deadline, Medicare must “seek to recover” payment from a primary plan for expenses within *three years* from the date when the “item or service was furnished.” 42 U.S.C. §1395y (b)(2)(B)(vi). With a claims-filing deadline, Medicare must file a claim for recovery by the end of the year following the year in which Medicare has notice that there is a primary payer. 42 C.F.R. §411.24 (f)(2).

Penalties for Non-Payment

Practitioners thinking they can sweep their Medicare obligations under the rug should think twice before doing so.

Legally, practitioners opting to ignore Medicare risk exposing their clients to repayment of *double the amount* initially paid by Medicare. If Medicare is forced to initiate suit to recoup its conditional payment, then primary plans and beneficiaries could have to pay interest on the amount of reimbursement as well as damages in the amount of double Medicare’s conditional payments. 42 U.S.C. §1395y (b)(2)(B)(ii), (iii); 42 C.F.R. §411.24 (c)(2), (h). Interest accrues 60 days from the primary plan’s payment to the beneficiary. In practice, Medicare does not seem to adhere to the regulatory timing. Instead, Medicare’s *MSP Manual* states that interest is charged 60 days from Medicare’s final demand. MEDICARE MSP MANUAL, Ch. 7, 50.5.2.3. Although Medicare’s practice manual suggests that Medicare will pursue the beneficiary for reimbursement first, how and when Medicare switches from seeking reimbursement from the beneficiary to pursuing the primary payer is unclear from available materials and investigation.

Ignoring Medicare’s reimbursement rights also has practical consequences. Should the defense practitioner pay the Medicare beneficiary and assume that the beneficiary will pay Medicare, the defense practitioner takes the risk of exposing his or her client to having to repay Medicare at double the reimbursement amount, with interest, if the Medicare beneficiary fails to repay the agency. For the beneficiary’s attorney, failure to involve Medicare promptly may mean less bargaining power in settlement negotiations. Moreover, should the beneficiary’s attorney fail to notify Medicare of the injury claim and release all settlement or judgment funds to the beneficiary, the beneficiary may spend all of those funds and have nothing left for Medicare when Medicare learns of the primary payment.

MSP in Practice: Discouraging Settlement and Increasing Costs

While well-intentioned, the MSP statute did not go far enough to ensure Medicare’s quick and easy reimbursement. Moreover, the re-

vised statute created unanticipated consequences that stall, if not prevent, Medicare's recovery, causing delay and uncertainty that harms Medicare, its beneficiaries, and "responsible" parties. If a lawsuit does settle, beneficiaries' attorneys either need to retain significant portions of settlement funds indefinitely in client trust accounts (even though beneficiaries may need the money), or give the beneficiary the settlement and risk the imposition of interest on the claim amount should the beneficiary be unable to repay Medicare promptly. Likewise, primary plans must maintain adequate reserves in case a Medicare beneficiary does not or cannot promptly reimburse Medicare. This all assumes that Medicare makes a demand at all, as the agency's lack of clear guidelines and formulas has led Medicare to effectively abandon or fail to collect on significant claims.

Unpredictable Reimbursement Obligations

Presently, beneficiaries and primary plans operate without any guidance as to how much Medicare actually intends to recover. As no clear rules exist to determine reimbursement amounts, both parties must guess the amount of funds to reserve for Medicare. Moreover, because no formulas for reimbursement presently exist, the parties cannot promptly pay Medicare after the settlement or judgment. They must instead wait until Medicare sends a recovery demand letter and processes requests for exclusion of unrelated treatment, waiver, or compromise.

Virtually Non-Existent Time Limits

Moreover, other than the six-year statute of limitations for the government to sue, Medicare appears under no time limit to provide a final reimbursement demand. The onus is on the beneficiary and/or primary plan to inform Medicare of its potential right of reimbursement. Most problematic is Medicare's failure to adhere to a strict time limit to issue final recovery letters. The *Medicare MSP Manual* states that the contractor should "try" to recover Medicare's payments between the date of the settlement but before the funds are disbursed. *MEDICARE MSP MANUAL*, Ch. 7, 50.3.3. *Practically, we have never known this to occur. It typically takes months, if not years, for Medicare representatives to issue a final demand.*

Incomplete Standards for Compromise

Medicare does not recognize significant legal concepts in its compromise considerations. Often, parties to a liability claim know of evidence of the beneficiary's contributory negligence or evidence problems in establishing liability. They will accordingly settle cases for less than the beneficiary might receive in the absence of such problems. Yet, unlike the litigants, Medicare does not presently consider issues of its beneficiary's contribution to the injury-related expenses, nor evidentiary problems that may preclude recovery by the beneficiary. Knowing such, the beneficiary may push for a settlement unjustified by the available evidence.

Inefficient Conditional Payment Calculation Methods

Moreover, Medicare lacks a prompt method of recording and identifying conditional payments. In fact, Medicare's practice manual states that contractors should refer primary plans asking for the amount of Medicare's current claim to the beneficiary's representative. *MEDICARE MSP MANUAL*, Ch. 7, 50.5.1.1. This makes little sense for any involved parties, including Medicare itself, as beneficiaries are typically ill-suited to identify the amount of Medicare's current claim (e.g., to review a bill and separate treatment related to the accident from unrelated treatment).

Inability to Participate in Pre-Settlement Negotiations

As previously described, Medicare's right to reimbursement does not accrue until the settlement is paid. But Medicare's involvement *after* a settlement simply comes too late. By then, the parties have lost their ability to negotiate with Medicare and to utilize the claim to help settle their case. Rather, the lack of a certain claim could lead parties to conclude that they *cannot* resolve their claim.

Ignorance of the MSP Recovery Process

Finally, many beneficiaries and primary plans are simply unaware of the operation of Medicare's recovery process. Confusion also exists as to what each party to a personal injury claim must do and when, further delaying the reimbursement process. The section on Medicare's website describ-

ing the MSP process is both difficult to locate and fails to address the compromise process and Medicare's role (or lack thereof) in the settlement of the underlying personal injury claim.

Applying the MSP in the Future

Contributing to the confusion is uncertainty regarding whether Chickasaw

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Nation will follow the precedents set by previous contractors or whether Chickasaw Nation will seek reimbursement more aggressively. For example, commentators have speculated whether Chickasaw Nation will seek to recover future medical expenses in liability cases. This has always been the case with workers' compensation claims. Under the current state of the MSP, authority exists that suggests Medicare may recover future medical expenses in liability cases; however, Medicare has thus far not done so.

Strategies (or the Lack Thereof) in Addressing Medicare's Right to Recovery

In the three-plus years since Congress amended the MSP, no strategy in settling cases with Medicare-provided treatment has emerged to instill confidence that the parties have adequately addressed Medicare's right to reimbursement.

Strategies: From Bad to Worse *Interpleader*

An action in interpleader may provide an option under certain circumstances, but would require the primary payer to deposit into the court an estimated amount of Medicare's recovery entitlement; if the esti-

mate is too high, the primary payer would not be entitled to reimbursement of the remainder.

Characterizing the Nature of Settlement Proceeds

Attempts to characterize settlements have met with varying results and practitioners should be careful that such a characteriza-

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Medicare's right to reimbursement has generally been upheld where the parties have not characterized the nature of the settlement proceeds and/or have characterized settlement proceeds as compensating noneconomic losses. *Zinman v. Shalala*, 835 F. Supp. 1163, 1167 (N.D. Cal. 1993) (rejecting plaintiff's argument that Medicare's reimbursement should be proportionately reduced where the settlement did not identify proceeds as compensating medical expenses, pain and suffering or other types of losses).

That being said, courts have concluded Medicare's right to reimbursement does not trump separate claimants' property rights, noting, "...sadly, a significant amount of the legal melee is the direct result of the Government urging statutory constructions [of the MSP] that are entirely unsupported by the statute and which appear to be intended to convert the MSP from an important and sensibly fashioned fiscal cost-cutting measure into a mere, heavy-handed collection tool." *In re Dow Corning Corp.*, 250 B.R. 298, 336 (Bankr. D. Mich. 2000). Specifically, courts have concluded that Medicare does not have a right to reimbursement from a settlement for loss of consortium that does not compensate for medical expenses because Medicare can

still proceed directly against the primary payer, absent evidence that the settlement is a sham. *Estate of Foster by Foster v. Shalala*, 926 F. Supp. 850, 865 (D. Iowa 1996) (concluding that Medicare was not entitled to reimbursement for claims paid in settlement of decedent's children's loss of consortium claim because the settlement did not compensate for medical expenses and Medicare failed to proffer evidence that the settlement was structured to avoid Medicare's right to reimbursement); see also *Smith v. Travelers Indem. Co.*, 763 F. Supp. 554, 562 (D. Fla. 1989) (permitting the government recovery under MSP for only the portion of settlement proceeds that had been identified as being for medical expenses of a Medicare beneficiary). Thus, while an injured plaintiff may want a settlement characterized as simply compensating a non-injured plaintiff's loss of consortium claim (*i.e.*, because such would indirectly provide compensation to the injured plaintiff seemingly unreachable by Medicare), a primary payer may find that after paying the settlement, it still must reimburse Medicare for the treatment it provided to the injured plaintiff.

Compromise

Medicare has authority to compromise claims of less than \$100,000. 31 U.S.C. §3711. Medicare currently considers the following factors when compromising claims: the debtor's inability to pay, the government's inability to collect promptly, the cost of collecting the debt versus the costs of collecting the full amount, and the existence of significant doubt as to the government's ability to prove its case in court. 41 C.F.R. §902.2. Medicare policy, however, permits only CMS's regional offices to compromise claims—Medicare's third-party contractor, Chickasaw Nation, may not, "under any circumstances," enter into negotiations to compromise Medicare claims. MEDICARE MSP MANUAL, Ch. 7, 50.4.2. If a party to a liability claim wants to reduce the reimbursement amount, the party must contact the Medicare regional office or inform the contractor, who must then transfer the file to CMS' regional office where someone unfamiliar with the injury and treatment will assume responsibility for the file. MEDICARE MSP MANUAL, Ch. 7, 50.4.2.

Waiting for a Demand Letter

Another option is to forestall settlement discussions and wait for the recovery contractor to issue an initial demand letter. However, this is an unsatisfactory approach as it invites the unnecessary filing of civil actions where liability is given and the damages are apparent or, at least, agreed upon.

Specifying the Party Responsible for the Medicare Lien

While a primary payer may also try to protect itself with a clause in the settlement agreement stating that the beneficiary will pay Medicare and/or indemnify the primary payer for any payments it must make to Medicare, that clause will not protect a primary payer if the beneficiary has no money to pay Medicare directly because if the beneficiary cannot repay Medicare, he or she does not have the funds to indemnify the primary payer.

Conditioning Reimbursement Based upon the Primary Payer's Terms

Courts have uniformly concluded that Medicare's right to reimbursement stands independent rather than contingent on a subrogation right to medical payments due a Medicare beneficiary. See, *e.g.*, *United States v Travelers Ins. Co.*, 815 F. Supp. 521, 525 (D. Conn. 1992) (holding that Medicare's right to reimbursement under MSP is separate and distinct from its subrogation right). Based on this rationale, courts have rejected arguments that the terms of the primary payer's health care contract precludes Medicare's recovery, such as arguments that the expiration of time limits included in the health plan, preclude the government from seeking reimbursement outside the health care plans applicable time period. Instead, courts have concluded time limits are statutory and are not proscribed by discrete health care plans.

Declaratory Relief Action

Courts simply will not interfere with an ongoing administrative process. One personal injury plaintiff sued for declaratory relief, asking the court to order Medicare to provide it with a final reimbursement demand, but the court dismissed the complaint on the grounds that the plaintiff first had to exhaust his administrative reme-

Medicare, continued on page 53

Medicare, from page 12 dies. In other words, the beneficiary just had to wait. See, e.g., *Walters v. Leavitt*, 376 F. Supp. 2d 746 (E.D. Mich. 2005).

Endorsing Medicare and Beneficiary as Payees on Settlement Proceeds

Including Medicare as a payee on a settlement check would seem to ensure payment to Medicare and the beneficiary. However, an Orange County Superior Court judge recently ordered a retailer-defendant to endorse the settlement check to only the plaintiff, after the retailer initially included both the plaintiff and Medicare as payees. There, the parties did not expressly agree that the defendant could include Medicare as a payee. Presumably, had the beneficiary agreed to such a term, the retailer's check made payable to both the plaintiff-beneficiary and Medicare would have been proper. However, a Medicare beneficiary would likely not agree to include Medicare as a payee, recognizing that Medicare could take a long time to endorse the check.

The Only Workable Solution: Putting Money in Reserve

The only practical option available to beneficiaries, primary payers, tortfeasors and liability risk professionals alike is to reserve some of a settlement in the estimated amount of Medicare's payments. Hopefully, the estimated amount will be sufficient to reimburse Medicare for its costs once the recovery contractor has sufficient time to focus on the merits of that particular claim. However, there are no guarantees that the estimated set-aside amount will satisfy the Medicare lien. It simply represents the best guess by the claim professional and the claimant as to what it will take to satisfy the Medicare lien. The upside to this strat-

egy is both sides know that Medicare will be repaid, and so can release their concerns about the penalties associated with non-payment. The downside is that primary payers cannot close their books on a particular claim for several months after a matter settles. This strategy, while imperfect, may be the safest one until and unless Congress reforms its MSP recovery process.

In the meantime, counsel can ease the Medicare reimbursement process by: 1) quickly establishing a claim with Medicare, and 2) frequently requesting updated calculations of benefits paid by Medicare. Counsel should also obtain bills from the health care providers themselves, which should indicate payments made by Medicare and can help provide an estimate as to the amount Medicare may seek. While these actions will not force Medicare's involvement in a case or give parties an amount certain to use at settlement, these suggested actions will at least expedite the process post-settlement and minimize exposure to penalties.

Conclusion

Unfortunately, the adage "the only thing that saves us from the bureaucracy is inefficiency" has the reverse outcome in settling lawsuits where Medicare has a right to reimbursement, because its inefficiency discourages settlement and increases costs. Medicare and its beneficiaries, plaintiff and defense bar, along with insurance companies and risk managers, have a united interest in reforming Medicare's outdated and ineffective secondary payment recovery system. The government wants to both collect its money, and do so in a timely, orderly fashion. Injured beneficiaries and primary plans want to ensure timely payment of Medicare, to avoid exposure to significant

penalties, as well as to quickly resolve their disputes.

A few suggested changes would aid in these joint goals, relieve over-crowded court dockets, allow insurers to close their books, and permit personal injury plaintiffs to move past their injuries. The institution of set formulas for recovery, such as those used by California's Medicaid system, would give the parties a means to predict the ultimate demand amount and for Medicare to promptly receive its payments. Instituting a firm time limit for Medicare to issue demand letters at 30 days from notice of the settlement payment (instead of its current "goal" of 60 days) would ensure prompt payment and allow litigants to close their books. Moreover, establishing a billing code for health care providers to designate expenses related to an injury would allow a Medicare claims handler to provide an updated lien amount instantly. Furthermore, amending Medicare's practices to give Chickasaw Nation the right to compromise claims would expedite compromise. Also, Medicare should consider problems of establishing liability and the beneficiary's contributory negligence in compromising Medicare's reimbursement claims. Lastly, Medicare should allow its claims handlers to participate in the underlying settlement so that all claims could be resolved simultaneously. With these suggested changes, litigants could settle their claims expeditiously while Medicare would recover its expenses from beneficiaries before beneficiaries had time to spend a settlement.

In the meantime, counsel should diligently observe Medicare's reimbursement right and expect a demand. With careful planning, practitioners can avoid some of the most obvious problems with the Medicare reimbursement process. 