MEDICARE LIEN INTERESTS IN LIABILITY SETTLEMENTS

Easy Solutions to Help Resolve Medicare Reimbursement Issues for Beneficiaries and Insurers

MEDICARE SECONDARY PAYER ACT REFORM TASK FORCE
44 Montgomery St., Ste. 2500
San Francisco, CA 94104
(415) 951-0535

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Jonathan Allan Klein, Esq.
jaklein@kelher.com
Annmarie M. Liermann, Esq.
aliermann@kelher.com
44 Montgomery St., Ste. 2500
San Francisco, CA 94104
(415) 951-0535

EXECUTIVE SUMMARY

In 2003, Congress revised Medicare's rights to reimbursement through the Medicare Secondary Payer ("MSP") statute. This revision was designed, in part, to ensure reimbursement to Medicare for Medicare payments on behalf of beneficiaries injured by "responsible" third parties. Although well intentioned, when coupled with problems inherent in Medicare's execution of its right to reimbursement, the statute has led to serious unintended consequences that ultimately have undermined Medicare's reimbursement objectives.

Without proper revision of the statute and Medicare's policies and practices with regard to seeking reimbursement, significant funds remain uncollected or uncollectible. The problems with the MSP recovery practices stem from a lack of predictable reimbursement obligations, firm deadlines for Medicare's internal and external claims processes, inadequate resources for promptly calculating reimbursement amounts, an inefficient division of work between Medicare's claims-handling contractors and its regional office, Medicare's late entrance into the liability claim settlement process, and general confusion as to the MSP recovery process.

Recommended solutions to these problems include: (i) the institution of formulas for determining Medicare's reimbursement; (ii) well-defined deadlines for Medicare to demand reimbursement; (iii) the adoption of efficient methods for tracking Medicare's conditionally paid expenses; (iv) a reorganization of work duties so that the Medicare personnel may compromise claims; (v) Medicare's pre-settlement participation in the liability process; and (vi)

improved efforts to educate personal injury practitioners on the MSP reimbursement process. The implementation of these reforms would not only further Medicare's reimbursement goals, but would also assist liability litigants by establishing clear parameters and dates certain for Medicare's reimbursement rights.

I. INTRODUCTION

MSP reimbursement rights and current operational constraints pertaining to settlements of personal injury disputes prevent Medicare from realizing full reimbursement intended by the 2003 MSP revision. Moreover, the current MSP practices expose all parties involved in the Medicare reimbursement process (including injured parties as well as liability insurers) to substantial risks and liabilities. Without reform of the MSP practices, Medicare will continue to miss significant reimbursement opportunities, while beneficiaries and "responsible" parties face exposure to future liability.

As a "secondary" payer, Medicare only conditionally pays for treatment for which a primary payer (such as a tortfeasor or its liability insurer) is "responsible." While well-intentioned, the MSP statute did not go far enough to ensure Medicare's recovery of its conditional payments. In fact, that statute created unanticipated consequences that stall, if not prevent, Medicare's recovery. Crucially, the lack of resources and clear administrative guidelines result not only in unwarranted risks to Medicare recipients and primary payers, but also in significant Medicare reimbursement shortfalls.

For example, when primary payers and Medicare beneficiaries (*i.e.*, persons who receive Medicare-covered health care) are ready to settle disputes and reimburse Medicare, Medicare's currently ineffective framework for recovery delays or altogether prevents settlement and/or reimbursement from occurring (*e.g.*, because the beneficiary may spend the settlement before Medicare demands the return of its conditional payments).

The problems with the Medicare reimbursement process are ripe for reform, since Medicare recently consolidated its claims administration into one vendor. As such, it is an ideal time to petition Medicare to install new internal guidelines, modify regulations, or amend statutes to expedite the satisfaction of reimbursement requirements.

Recommended solutions include: (i) adopting formulas for reimbursement similar to those California's Medicaid system uses for its reimbursement claims; (ii) establishing firm deadlines in Medicare's practice manual for issuing final demand letters; (iii) improving the claims recording methods so that reimbursement amounts are immediately available; (iv) amending Medicare's practice guide to allow Medicare contractors to compromise MSP reimbursement amounts; (v) reforming Medicare's practices so that it is involved in the negotiations of settlement of the underlying personal injury action; and (vi) educating personal injury practitioners on Medicare's expectations from and role in the MSP process.

Faced with significant funding shortfalls, these solutions represent significant steps in helping Medicare achieve better fiscal balance.

Furthermore, by establishing clear and concise ground rules, the suggested reforms would ease administrative headaches and enable Medicare to recover more of its conditional payments. As such, all parties involved with Medicare liens should support the long-overdue reforms.

A. 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, those with end-stage renal disease, and some disabled persons. In 2005, Medicare provided coverage to 42.5 million people, spending $330 billion on benefits. (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.*)

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 purpose of the amendment was to ensure that persons "responsible" for an injury to a Medicare recipient pay for medical care Medicare would otherwise cover, making Medicare only a "secondary" payer. Congress attempted to strengthen its reimbursement rights by: (i) expansively defining the definition of an insurance plan to include even uninsured businesses and (ii) clarifying when a primary plan's "responsibility" for reimbursement attaches. Noting that Medicare paid for lots of expenses for

which another, "responsible" party should have later reimbursed Medicare, Congress enhanced the MSP enforcement terms in the amendments.

B. Current Rules Regarding Repayment of Medicare

In part because of the 2003 amendments, the following secondary payer terms currently exist:

1. Medicare's Available Recovery

Anyone who received medical care for which Medicare paid and who later received payment from a "primary plan" (including a liability insurer, workers' compensation carrier, or "self-insured entity" – defined as an entity that bears its own risk) must, by statute and regulation, 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).[1] (42 C.F.R. § 411.24 (h), 42 U.S.C. § 1395y (b)(2)(A).) Although Medicare's practice is to first pursue reimbursement from the beneficiary (Medicare MSP Manual, Ch. 7, 50.5.2.1), it can, however, also recover from the primary plan and anyone who receives payment from that plan. (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" also reimburse Medicare "even though it has already reimbursed the beneficiary or other party."[2] (42 C.F.R. § 411.24 (i).)

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1. Although the MSP statute uses the term "primary plan," its implementing regulations use the term "primary payer." The two have the same meaning and will be used interchangeably throughout this paper.

2. This potential recovery *may* be further limited by the applicable regulation, 24 C.F.R. section 411.24. Subsection (i) of that regulation, called "Special Rules," reads that in the case

2. Right to Reimbursement Accrues at Settlement Payment

Medicare's right to reimbursement accrues when a primary plan pays an entity or the injured for an expense for which 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* (and thus establishes "responsibility" for payment of the injury-related treatment) regardless of whether there has been a determination or admission 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 might provide parties with an estimate of Medicare's conditionally-paid benefits, Medicare cannot *demand* reimbursement until the injured's claim is settled and will wait until after the settlement is paid to make a final demand. (Medicare MSP Manual, Ch. 7, 50.4.1.)

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of liability insurance settlements, if the beneficiary does not reimburse Medicare, the primary payer must reimburse Medicare even though the primary payer has already reimbursed the beneficiary. Take, for example, a personal injury case where Medicare paid $10,000 for accident-related treatment but the plaintiff settled for only $5,000. Subsection (i) appears to limit the liability insurer's exposure to the amount of the settlement received by the beneficiary – clearly, Medicare can take the entire $5,000 (less, perhaps, the beneficiary's proven procurement costs). If the plaintiff does not pay, subsection (i) *appears* to limit the liability insurer's exposure to what Medicare could have recovered from the beneficiary – using the example above, that would be capped at $5,000, not the entire $10,000. Although subsection (c) suggests that Medicare could recover $10,000 (its full payment), the more specific provisions of subsection (i) govern liability settlements under the rule of statutory construction that the specific governs over the general. Nonetheless, we do not know of any tests of this regulation's application.

3. Costs Medicare Can Recover

Medicare has a right to reimbursement only for services for which a primary plan has or had a "responsibility" to pay.[3] (42 U.S.C. § 1395y (b)(2)(B)(ii).) Although Medicare instructed its contractors not to seek recovery for services unrelated to the injury-causing accident (Medicare MSP Manual, Ch. 7, 50.5) it appears to require beneficiaries to protest the inclusion of unrelated expenses before Medicare will reduce its reimbursement demand by the same. ("Overview of MSP Claims Recovery Process" webpage.) Nonetheless, Medicare can recover payment from the *entirety* of an award or settlement, 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 entity that procured payment from the primary plan (*i.e.*, the beneficiary, or the plaintiff in a personal injury lawsuit) may, pursuant to regulatory formulas,[4, 5,]

3. Medicare's intention with regard to recovery of payment for future medical expenses in liability cases is a significant unknown. In the workers' compensation context, regulations clearly require a primary payer to set aside money for future medical expenses, and include consequences to the beneficiary and primary plan for insufficient delegation of money for future expenses. The lack of similar regulations in the liability context could be mere oversight by Medicare or a desire to avoid "entering the fray" of liability litigation. Of note, Medicare's MSP Manual states, "There should be no recovery of benefits paid for services rendered after the date of a liability insurance settlement." (Medicare MSP Manual, Ch. 7, 50.5.) The Manual, however, is merely an internal practice guide and not a statute or regulation on which parties can rely.

4. When Medicare payments are less than the settlement or judgment, Medicare's recovery is calculated by (a) determining the ratio of procurement costs to total judgment/settlement; (b) applying the ratio to Medicare's payment to obtain the Medicare recovery amount; and (c) subtracting Medicare's share of procurement costs from Medicare payments. (42 C.F.R. § 411.37 (c).)

5. When Medicare payments exceed the settlement/judgment, Medicare's recovery is the total judgment/settlement less procurement cost. (42 C.F.R. § 411.37 (d).)

reduce Medicare's lien by the amount expended to obtain that reimbursement, (42 C.F.R. § 411.37.)

4. Available Compromise of the Reimbursement Amount

Furthermore, the Federal Claims Collection Act, 31 U.S.C. section 3711, grants Medicare the right to compromise claims of less than $100,000 or suspend or terminate recovery actions.[6] Medicare policy, however, permits only CMS's *regional offices* to compromise claims – third-party contractors may not, "under any circumstances," enter into negotiations to compromise Medicare claims.[7] (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. (Medicare MSP Manual, Ch. 7, 50.4.2.) A contractor may only waive a claim for need (*i.e.*, upon a showing from the beneficiary that full reimbursement of the claim would cause him/her hardship), and/or reduce a claim for the beneficiary's costs of procurement (which is automatic, if documentation supports the alleged costs). (Medicare MSP Manual, Ch. 7, 50.5.2.2.)

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6. Now, Medicare may only consider the following factors when compromising claims: the debtor's inability to pay, the government's inability to promptly collect, 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.)

7. Medicare has retained third-party contractor~~s~~ to handle recovery activities against the "responsible" party. The contractor is charged with the duties of providing conditional payment and the final recovery claim amounts and answering questions about repaying Medicare.

5. Time "Limit" on Medicare's Recovery

Very long statutes of limitation 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 (here, after the primary plan makes the payment). (28 U.S.C. § 2415(a); *United States v. Weinberg* (E.D. Penn. 2002) 2002 U.S. Dist. LEXIS 12289.) In the absence of a claims-filing deadline, Medicare must "seek to recover" payment from a primary plan for expenses it covered 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 a third party is a primary plan to Medicare for particular services (a notice received during the last three months of a year is considered received during the following year).[8] (42 C.F.R. § 411.24 (f)(2).) However, the inclusion of a claims filing period in a statute is confusing, as 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.

8. Furthermore, as the applicable laws are currently worded, the start of the claims-filing period is ambiguous. Does it begin to run when the injury-related treatment begins or when it ends (if more than one service)? A review of the MSP statute's legislative history (including committee transcripts, the historical index, historical congressional record, and public laws) reveals no discussion regarding the specific event that starts the claims-filing period. In addition, no case law specifically addresses this issue. A review of online articles and other Medicare-related sources indicates the statute begins to run when the initial treatment begins. There is no indication that anything but the initial date of treatment sets the claim-filing period running if more than one service is provided.

6. Penalties for Non-Payment

The biggest danger in not promptly paying Medicare is the exposure to significant penalties. Primary plans and beneficiaries could have to pay interest on the amount of reimbursement[9], plus damages in the amount of double the amount of Medicare's conditional payments, if Medicare must initiate a formal action against the primary plan to recoup the conditional payment. (42 U.S.C. § 1395y (b)(2)(B)(ii), (iii); 42 C.F.R. § 411.24 (c)(2), (h).) How and when Medicare switches from pursuing the beneficiary to pursuing the primary payer is unclear from available materials.

C. Medicare's Recovery of Conditional Payments is Inefficient

Medicare's current procedure for recovery of its conditional payments is inefficient and often prevents Medicare from fulfilling Congress' objectives. A hypothetical example sheds light on this inefficiency:

Assume that a person over 65 (the "beneficiary") suffers a personal injury, for which she sues an insured entity. The beneficiary likely received treatment for the injury for which Medicare paid and for which Medicare can seek reimbursement from the alleged tortfeasor. In this situation, both the liability insurer and beneficiary have a duty to inform Medicare of its potential recovery in the liability situation. ("Overview of MSP Recovery Claim Process" webpage.) The beneficiary must notify Medicare's Coordination of Benefits Contractor that she has made a claim against an alleged tortfeasor with

9. In practice, Medicare does not seem to adhere to this regulation. Though the regulation says interest begins accruing 60 days from the primary plan's payment to the beneficiary, Medicare's MSP Manual says interest is charged 60 days from Medicare's final demand. (Medicare MSP Manual, Ch. 7, 50.5.2.3.)

liability insurance. (*Id.*) When requested, Medicare may issue an "interim conditional payment letter" while the parties attempt to resolve the underlying matter, but current law precludes Medicare from issuing a formal demand letter until after settlement or judgment. (*Id.*)

In such situations, beneficiaries often wish to demonstrate that certain payments included in the list of conditionally paid benefits are not related to the injury. Simultaneously, the liability parties typically exchange information (or conduct formal discovery during a lawsuit) that may disclose the existence of the beneficiary's contribution to his injury and/or pre-existing injuries unrelated to the accident (thus reducing the beneficiaries' potential recovery at trial).

To resolve their dispute out of court, parties typically try to negotiate a settlement that considers the plaintiff's contributory negligence and pre-existing injuries, if any. However, Medicare will not participate in the negotiation process, such as by making a representative available to discuss the amount of the conditional payments nor a potential compromise of the reimbursement amount. Thus, the parties are typically left to guess what Medicare will ultimately do with its reimbursement claim, and, unable to properly allocate monies, may even be unable to settle at all. O*nly after the settlement process is complete (if at all) does Medicare step into the process.*

II. STATEMENT OF THE PROBLEM

The most notable impediments to the swift resolution of Medicare's reimbursement claims arise from a few key provisions (and lack thereof) in the MSP statute, implementing regulations, and Medicare practice guides. These problems delay (or preclude) Medicare's recovery of payments on behalf of beneficiaries by impeding resolution of liability suits. Furthermore, personal injury lawyers' desire to avoid dealing with Medicare in its present form disenfranchises a class of citizens (namely, seniors) who cannot procure legal representation to prosecute their injury claims. This inability to find legal representation has the secondary effect of precluding Medicare from recovering its conditional payments. The serious problems described below require reform.

- **Unpredictable Reimbursement Obligations:** Presently, beneficiaries and primary plans operate without any guidance as to what part of the paid benefits Medicare actually intends to recover. Furthermore, guidelines for compromise are unclear (as discussed further below). As no clear rules exist to determine reimbursement amount, both parties must guess as to the amount of funds to reserve for Medicare's reimbursement amount. 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.[10] 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 to the beneficiary (*i.e.*, while they may still be in a client trust fund.) (Medicare MSP Manual, Ch. 7, 50.3.3.) *Practically, we have never known this to occur.* In fact, Medicare's mandatory final recovery letter (the demand for reimbursement) has standard language that 60 days from the primary payment has already passed and that the beneficiary has 60 days from the date of the notice to pay Medicare. As Medicare is under virtually no time constraint to make a final demand, ***it typically takes months, if not years***, for Medicare representatives to issue a final demand. The delay in finalizing the reimbursement amounts after a liability settlement leaves the responsibility and amount to pay in limbo. Accordingly, litigants must try to maintain adequate reserves to pay Medicare if and when Medicare makes a final demand. Liability litigants must also expend manpower to remain aware of the status of payment.

10. Although claims-filing limitations exist by statute, Medicare's internal procedures do not appear to require Medicare to file or assert a formal claim in the procedure. Rather, the onus is on the beneficiary and/or primary plan to inform Medicare of its potential right of reimbursement.

- **Convoluted Division of Work:** Thirdly, Medicare divides its recovery tasks in an inefficient manner, as only a Medicare regional office can compromise an MSP claim. Therefore, a beneficiary may be precluded from negotiating Medicare's reimbursement claim (other than to reduce it for procurement costs or a waiver for financial hardship) with the contractor who is familiar with the injury and attorneys. Rather, when a party requests compromise, the request and file are sent to the Medicare regional office. This transfer, with the consequent "ramp up" time the regional office requires to acquaint itself with the matter, causes further significant delay.
- **Incomplete Standards for Compromise:** Not only does Medicare not allow its contractor to compromise its claims, it also 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 witness problems. They will accordingly settle cases for less than the beneficiary may 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, such that a current reimbursement amount is immediately available. 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. Furthermore, as currently situated, the method for reducing Medicare's reimbursement claim for unrelated costs is unclear – though it appears to rely on protestation from the beneficiary.

- **Inability to Participate in Pre-Settlement Negotiations**: As previously described, Medicare's right to reimbursement does not accrue until the settlement is paid (and thus the responsible party established). Thus, Medicare does not participate in settlement negotiations. But Medicare's involvement *after* a settlement simply comes too late. By then, it has lost its ability to advocate for its portion of the settlement reimbursement. It has also caused additional procurement costs (which, by regulation, Medicare must deduct from its claim) to build during the litigation. The parties have likewise 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 decide they *cannot* resolve their claim. If so, Medicare obviously loses.

- **Ignorance of the MSP Recovery Process:** Finally, many beneficiaries and primary plans are simply unaware of the operation of Medicare's secondary payer recovery process, especially as changed by the 2003 amendments to the MSP statute. Some personal injury practitioners, unaware of the 2003 amendments, still rely on case holdings interpreting the MSP statute's *pre-amendment* definition of "primary payer,"[11] though the 2003 amendments dramatically expanded the definition of "primary payer." 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 describing 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.

These problems cause delay and uncertainty that harm Medicare, its beneficiaries, and "responsible" parties. If a lawsuit does settle, beneficiaries' attorneys either need to indefinitely retain significant portions of settlement funds 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 promptly repay Medicare when it finally demands reimbursement. Since beneficiaries are unaware of the final Medicare claim, they may be unable to pay at all.

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11. *See, e.g.*, the well-known opinion in *Thompson v. Goetzmann*, 337 F.3d 489 (5th Cir. 2003).

Primary plans must also maintain adequate reserves in case a Medicare beneficiary does not or cannot promptly reimburse Medicare. The primary plan must also stay in touch with the beneficiary and/or Medicare to ensure that the time to pay has not lapsed and that payment has been made. 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 with potential of immediate reimbursement.

III. OPPORTUNITY FOR CHANGE

Reforms that would enable Medicare to recover more of its overpayments and litigants to finalize their settlements are long overdue. Now is an ideal time to address these problems to Medicare, as Medicare consolidated its claims to one contractor on October 2, 2006. Now all secondary payer recovery actions (including liability) go through the so-called Medicare Secondary Payer Recovery Contractor. As such, Medicare should establish new policies and procedures for handling liability recovery claims.

IV. RECOMMENDED RESOLUTIONS TO EASE RECOVERY PROCESS

Expediting the conditional payments recovery process would help all parties involved. A few simple changes could dramatically reduce the problems that liability litigants have with repaying Medicare and quickly increase the amount of Medicare's recoveries. Obviously, the litigants could release their concerns about the debt and reserves sooner. Similarly, Medicare would recover its expenses from beneficiaries before beneficiaries had time to spend a

settlement (which could increase the chance of a waiver or compromise application) and could collect on more of its MSP claims.

We recommend the following changes:

- **Employ Formulas for Calculating Reimbursement:** The institution of set formulas for recovery would give the parties a means to predict the ultimate demand amount, and for Medicare to promptly receive its payments. California's Medicaid system, Medi-Cal, enacted such formulas by regulation. From a settlement, Medi-Cal is entitled to the lesser of: 1) 50 percent of the net settlement (less attorney's fees and costs), up to the amount of the claim or 2) Medi-Cal's claim less a 25 percent reduction for procurement costs. (Cal. Welf. & Inst. Code §§ 14124.78, 14124.72 (d).) From judgment or award, Medi-Cal is entitled to its claim less the 25 percent procurement costs. (Cal. Welf. & Inst. Code § 14124.72(d).) If Medicare instituted similar formulas (either using the current procurement cost calculation or substituting the 25 percent reduction), once a case concluded by judgment, settlement, or award, not only would everyone involved know the amount of Medi-Cal's reimbursement. The parties could also *immediately* reimburse Medicare – without the necessity of a formal recovery demand letter. Moreover, the parties to the liability claim could consider the exact amount of Medicare's reimbursement in their settlement negotiations. Furthermore,

with the automatic reductions, fewer beneficiaries would apply for waiver or compromise of Medicare's reimbursement claim. Although Medicare would not recover the full amount of any of its claims, it would recover at least half of nearly **all** of its claims.[12] Perhaps most importantly, under formulas similar to Medi-Cal's Medicare would almost certainly recover more on each claim than it does under the current system, which allows for a procurement cost reduction of up to 40 percent (compared with Medi-Cal's 25 percent).[13] Medicare would also save on enforcement costs, as the parties could repay Medicare immediately after settlement and without the necessity of additional work from Medicare.

- **Reduce and Define Medicare's Time to Recover Its Conditional Payments:** Should Medicare adhere to its current system of reimbursement calculation, Medicare should at a minimum install firm time limits for the issuance of final recovery demands. Medicare's present "goal" of issuing a final demand letter within 60 days of notification of settlement is a farce; indeed, its sample demand letter *assumes* the contractor's failure to meet the 60-day

12. Even if Medicare institutes the formula system, it should still allow beneficiaries to request a compromise or waiver of their reimbursement obligations. Medi-Cal does the same. (Cal. Welf. & Inst. Code § 14124.71(b).) However, the instant reductions should reduce the number of waiver and compromise requests.

13. Take, for example, a settlement of $10,000 in a case where the plaintiff/beneficiary had $2,700 in injury-related treatment paid by Medicare. The beneficiary's attorney worked on a contingency fee basis of 33 percent and incurred $150 in costs. Under Medicare's current procurement cost reduction formula, it could only recover $1,759.50. Yet, Medicare could recover $1,985 under Medi-Cal's 25 percent rule, and the entire claim amount under the 50 percent rule.

goal. We recommend including in Medicare's practice manual a firm time limit for the issuance of a demand letter at 30 days from notice of the settlement payment.[14] Although it is unclear whether Medicare must even file a claim to recover its overpayment, in the event that such a claim is required, Medicare's statutory time to file a claim should be reduced and the triggering time specified. We recommend amending 42 U.S.C. section 1395y (b)(2)(B)(iv) to set Medicare's claims filing time at two years from the first service in a course of treatment for which a primary plan may be "responsible." With these firm time limitations, Medicare can ensure that it promptly recovers as much of its conditional payments as possible while also allowing the parties to release reserves after easily determined dates.

- **Adopt Efficient Methods for Recording Conditional Payments:** Medicare should also adopt more efficient claim calculation methods. Medicare's contractor should be able to disclose the current claim amount at any time, so that even if Medicare cannot participate in the settlement discussions (*i.e.*, because its right to demand repayment has not yet arisen), the parties have a figure on which they can rely in their settlement negotiations. Medicare's

14. Perhaps because it principally addresses difficulties with Medicare in the workers' compensation realm, a bill proceeding through Congress at the time of this paper's completion, H.R. 5309, is soft in recommending amendments to the MSP statute with regard to finalizing conditional payment amounts. It would allow Medicare 60 days to provide a quote to a requesting party.

contractor's agents should also have the ability – both technologically and intellectually – to remove unrelated items from the lien rather than rely on beneficiaries' protests (the presentation and decision of which could delay the reimbursement process). To this end, we recommend that Medicare establish a code that health care professionals could use to designate expenses related to an injury. This code, entered by the health care professional treating the injury, would supplement the treatment codes already entered for billing. The supplemental code would merely "tag" a procedure as one related to an injury.

- **Grant the Contractor the Right to Compromise Claims:** Amending Medicare's practices to give the Medicare contractor the right to compromise claims would allow the contractor's claim handler, who is already familiar with the injury, medical treatment, and parties, to quickly compromise Medicare claims. Presently, the contractor must transfer claims with a compromise request to CMS regional offices. The Federal Claims Collection Act does not prohibit a Medicare contractor from compromising reimbursement claims, so Medicare's procedure of referring compromise cases to a regional office adds unnecessary bureaucracy and delays to the lien recovery process. Of course, along with granting the contractor the right to compromise, the contractor's agents should be trained on how to excuse unrelated medical care – that is, to

recognize unrelated treatment and reduce the lien accordingly – without relying on beneficiary protests of the unrelated amounts.

- **Consider Legal Issues That Impacted the Settlement in Compromising Claims:** Along with allowing the contractor to compromise claims, Medicare should also consider the factors of proof problems and the beneficiary's contributory negligence in compromising Medicare's reimbursement claims. The parties consider these factors in their settlement discussions; logically, then, Medicare should consider them as well in its compromise discussions with the beneficiaries. This may require an amendment to 31 C.F.R. section 902.2(a). However, such a modification would allow the beneficiary to comfortably accept a lesser settlement, knowing that he can ask for a reduction of the recovery claim based on the same factors present in the liability claim.
- **Allow the Medicare Contractor to Participate In Settlement Negotiations of the Underlying Claim:** Presently, Medicare cannot demand reimbursement until *after* a primary plan pays the beneficiary for his/her injuries, thus (by statute) identifying the primary plan as the person "responsible" for reimbursing Medicare. However, no statute or regulation prevents Medicare from merely *participating* in the negotiations of the underlying personal injury claim. If a Medicare representative with authority to compromise

Medicare's lien could participate in the negotiations of the underlying claim, negotiations with all parties involved could conclude simultaneously. All litigants would know what Medicare expected of the settlement and could negotiate with that figure in mind. Furthermore, with the knowledge of Medicare's expectation from the settlement, the beneficiary could pay Medicare immediately after receiving the settlement check. Moreover, procurement costs (under the current regulations) would be reduced by Medicare's early entry into the litigation. To this end, we recommend a change in Medicare's practices to allow the contractor to participate in settlement discussions.

- **Commence an Educational Campaign:** If nothing else, Medicare should improve the communication of the MSP recovery process. Lack of clear information about the process impedes the settlement of liability claims and thus delays Medicare's reimbursement. Although Medicare's website currently contains a page with an "overview" of the MSP recovery process, that page does not clearly explain important issues such as Medicare's involvement (or lack thereof) in the underlying claim pre-settlement nor the beneficiary's ability to request a waiver or compromise. In the past, Medicare has held conference calls with the public to discuss workers' compensation-related issues. Such calls would give personal injury practitioners the ability to ask questions and allow

Medicare to answer them (hopefully) just once. Furthermore, Medicare should develop a simple pamphlet detailing the MSP process.

V. CONCLUSION

Medicare and its beneficiaries, along with third party tortfeasors and insurance companies, 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. The minor 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. Most importantly, Medicare could easily, and promptly, recover payments. Congress' intent in passing the 2003 amendments is currently stymied, and these suggestions will serve greatly to realize those intentions. To join the reform process, contact Jonathan Klein at (415) 951-0535 or jaklein@kelher.com.

Jonathan Allan Klein, Esq. and Annmarie M. Liermann, Esq. of Kelly, Herlihy & Klein, LLP wrote this paper, with contributions by Roy Franco, Esq. of Safeway Inc., Paul Caleo, Esq. and Patrick Perez, Esq. of Burnham Brown, and Jeff Braun, Esq. of McNeil Tropp Braun & Kennedy.