

Medicare Secondary Payer Enforcement: Shifting the Burden of Medicare to the Private Sector

By Jennifer C. Jordan

The Medicare Secondary Payer Act (the MSP)¹ was passed in 1980 with the intent of reducing Medicare spending by prohibiting the program from making payment in situations where another entity possessed a legal or contractual obligation to provide medical treatment. Although under the MSP Medicare retains the right to make conditional payments under certain circumstances and subject to statutory recovery rights, the reality is that Medicare makes payment because the intermediary or insurance carrier representing the government program is unaware that a primary payer exists. For nearly three decades, the Medicare program has made payments that should have been made by primary payers and has had little success recovering them. In light of that experience and considering that the Medicare Hospital Insurance Trust Fund's predicted depletion is growing ever closer,² Congress finally took action to fortify the government's Medicare secondary payer efforts.

With virtually no congressional discussion, the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA)³ was signed into law by President George W. Bush on December 29, 2007. Section 111 of the Act amended the MSP by adding mandatory provisions for insurers to regularly report settlements or open claims with an ongoing responsibility for medical treatment. While this reporting requirement appeared seemingly innocuous, the legislation has caused quite a stir in the insurance industry beyond the threat of the \$1,000 per day penalty per claim for noncompliance.

Historically, common practice has been to sit back and wait until

Medicare makes a demand for repayment, which rarely occurs if Medicare is unaware of the primary payer. It is even more common to allow Medicare to pay for postsettlement medical treatment despite the Medicare beneficiary already having been compensated for the treatment as a component of the insurance settlement. In the wake of MMSEA reporting, conditional payments and Medicare set-aside arrangements (MSAs) are going to take a prominent role in any insurance settlement negotiation. While the workers' compensation market has become increasingly MSP compliant since 2001, the same cannot be said about the liability insurance market.

This article examines the impact the MMSEA Section 111 reporting requirement may have on the government's MSP efforts, as well as how it is likely to impact MSP compliance in liability settlements. Although it is beneficial to learn to navigate the timely and confusing MSP tasks themselves, it is even more important to truly understand the MSP and avoid the kind of unnecessary acceptance of arbitrary policies of the Centers for Medicare and Medicaid Services (CMS) that has occurred in the workers' compensation sector. CMS, in its workers' compensation Medicare set-aside arrangement (WCMSA) review program, has abused its authority under the Administrative Procedures Act⁴ and issued random policies that in many instances exceed its rights under the MSP as well as the laws that give rise to the claim. Should the liability market follow suit, there is real potential that CMS would be able to subsidize the underfunded Medicare

program solely through its existing rights under the MSP.

History of the MSP

As originally enacted in 1965, Medicare was intended to be the primary insurer of the elderly and disabled, with the exception of treatment of work-related injuries or illnesses.⁵ It did not take the government long to realize that the program could not sustain that level of spending, and the statute was amended in 1980 as part of the Omnibus Reconciliation Act⁶ to exclude other forms of insurance as well. With little discussion or debate,⁷ the Medicare and Medicaid Amendments of 1980 were passed by Congress and signed into law by President Jimmy Carter on December 5, 1980, with the intent of eliminating fraud and waste in the system.

Section 953 of the 1980 legislation, dubbed the Medicare Secondary Payer Act, expanded the original exclusion from Medicare coverage of claims covered under workers' compensation insurance by also excluding claims covered by other forms of insurance such as automobile, liability, and no-fault. The intent was to preserve the fiscal integrity of the Medicare program by preventing it from making payment where another entity carries a legal or contractual obligation to provide coverage. Interestingly, Congress did not believe that the savings would amount to much; perhaps this is why little attention was paid at that time to this significant piece of legislation.⁸

Although Medicare is prohibited from making primary payments, the statute left the program with the option to pay for

treatment under certain circumstances to ensure that prescribed treatment would be received, subject to a statutory primary right of recovery. The MSP provided for penalties and interest, subrogation rights, and—most importantly—a right to double damages if the government had to file suit to

government successfully recovered from a claimant's attorney for the recovery of an unpaid conditional payment demand.

The *Federal Register* contains discussions concerning changes made to various Medicare and Medicaid regulations,¹⁴ but virtually no legislative history exists for any

23 provisions, primarily concerned with payment and coverage issues of the various programs, was the most significant amendment to the MSP made in more than 30 years.

MMSEA Section 111 amends the MSP by adding two sections to the statute—short in length but powerful in purported effect—imposing a specific reporting requirement for those considered primary payers. The intent was to better position CMS to enforce its existing rights under the MSP, as frequently CMS is unaware of its entitlement to recovery given that liability insurance settlements are more often than not subject to confidentiality agreements and not part of a public record. Although federal regulations have always provided a duty to report settlements to the Coordination of Benefits Contractor (COB) under certain circumstances,¹⁷ they failed to provide any type of ramifications for noncompliance—and therefore claims and settlements have rarely been reported voluntarily. The only statutory penalties provided occur after demand for repayment is not satisfied.¹⁸ In contrast, under the MMSEA, the failure to report an insurance settlement for a Medicare beneficiary carries a \$1,000 per day, per claim penalty, a threat that has struck fear in the hearts of all affected.¹⁹

It is important to understand that this reporting requirement imposes a new duty on primary payers and changes nothing with regard to prior MSP obligations. It is not that the requirements are unrelated, only that they are separate and distinct obligations under the statute. In every liability settlement involving a Medicare beneficiary, the parties now have three separate and distinct obligations: report the settlement to CMS, resolve any conditional payments, and provide for the payment of future medical expenses as a term of the settlement so that Medicare payment for the

Under the MMSEA, the failure to report an insurance settlement for a Medicare beneficiary carries a \$1,000 per day, per claim penalty.

recover payment. The Code of Federal Regulations was used to flesh out the program by adding and amending regulations that govern the recovery rights.

From time to time, the MSP was amended to expand its scope. The most notable changes were found in the Medicare Modernization Act of 2003 (MMA),⁹ which amended the MSP to define and include self-insurance plans as a primary payer.¹⁰ Before this change, the government had not fared well under inconsistent judicial interpretations.¹¹ This little publicized or debated amendment also made it possible for Medicare to recover from any entity in receipt of payment from the primary payer.¹² The significance of the reach of this provision was just demonstrated in March 2009 in *United States v. Harris*,¹³ which is the first known case in which the

of the MSP amendments. In most instances, the legislation was totally overshadowed by more publicized issues and/or passed at the eleventh hour just before session recess. Besides the MMA primarily being recognized for creating the Part D prescription drug program, the MSP amendment itself was downplayed right in the body of the bill as being merely a “technical amendment concerning [the Secretary of Health and Human Services’s] authority to make conditional payment when certain primary plans do not pay promptly.”¹⁵ It is unclear why the government consistently chooses to clarify its MSP rights under such a veil of secrecy when it is doing nothing more than enforcing the intent of the original statute.

Medicare, Medicaid and SCHIP Extension Act of 2007

The most recent amendment to the MSP is found in the MMSEA.¹⁶ This Act amended Titles XVIII, XIX, and XXI of the Social Security Act to extend provisions under Medicare, Medicaid, and the State Children’s Health Insurance Program. Buried among the statute’s

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injury or illness in question is not required. The failure to address any of these three obligations carries its own separate penalty.

There is no evidence that Section 111 met any resistance or debate in Congress.²⁰ In retrospect, however, it is unlikely that the true impact of the legislation could have been foreseen. The amendment was proposed to the Senate as merely a means to “improve the Secretary’s ability to identify beneficiaries for whom Medicare is the secondary payer by requiring group health plans and liability insurers to submit data to the Secretary [of HHS].”²¹ Much like previous MSP amendments, the legislation was passed on the last day of the Senate session before Christmas in 2007 and was totally overshadowed by the extension of several expiring provisions, such as the extension of the State Children’s Health Insurance Program funding through March 31, 2009.

There was no way for Congress to recognize just how onerous the reporting requirement would be for the insurance industry because the amendment actually left the form and manner of reporting to be later determined by the Secretary of Health and Human Services (HHS). By virtue of HHS’s division of labor, the determination falls upon CMS for enforcement.²² As with its other MSP programs, CMS gave little consideration to the various underlying laws that give rise to the primary payer obligation, or the claim adjudication process, and issued very broad-stroked desires for the information to be reported. There are currently 132 fields in the claim input file, many of which are for information not routinely captured by any insurer and many that do not apply to all types of insurances.²³ It remains unclear as to whether failure to fill in all fields will generate an error in the file submission for noncompliance determination purposes.

Issues as simple as the date of incident (DOI) have caused great debate between the insurance industry and CMS. The insurance industry generally is concerned with the date of loss, and for the most part that date carries legal significance, similar to the tolling of a statute of limitations. With exposure injuries, the insurance industry typically uses the last date of exposure as the date of loss, while Medicare considers the date of first exposure to be the DOI that must be reported.²⁴ Although CMS acknowledges that the date of loss is important to liability insurers and permits that information to be reported in a different field, it emphasizes that it is the CMS definition that will be used in its recovery efforts.²⁵ For example, although CMS acknowledges that it will not recover anything for injuries that occurred before December 5, 1980, it will be the CMS-defined DOI that is used to make that determination.

Because the CMS DOI may not be known or even easily discernible by the insurer, it is certainly not something regularly captured in the claim management process. Typically, the last day of exposure can be directly associated with the identifiable onset of symptoms or actual treatment, which is likely why that date is the more widely accepted legal standard. Use of the earlier DOI date basically gives CMS a larger window for recovery. Although the DOI may not be known, leaving the data field empty will cause the file to return an error disposition code, with 90 potential penalty days passing before it can be corrected. The insurer could guess and provide any date, but so doing could subject the insurer to a claim that it knowingly provided the government false information or, at the least, that it failed to comply with the MMSEA.

Not only are some of the information fields like DOI not routinely captured, some require

information not freely given by the injured parties. In the age of identity theft, people are very protective of Social Security numbers and therefore absent a legal requirement to disclose the information, they may not do so freely. Because compensation for personal injury is not taxable under I.R.C. § 104, there is no legal obligation to provide a Social Security number as a term of an insurance settlement payment. While some may be fostering irrational concerns, others may be deliberately avoiding an outcome in which MSP compliance might encumber their settlement funds. Disclosure of a Social Security number may not be required under any of the laws related to the claim or settlement, but it is a critical piece of information in determining Medicare entitlement.²⁶

Under the new Section 111 requirements, the burden is on the responsible reporting entity (RRE) to determine the Medicare status of its claimants and report only those claims or settlements where the injured party is entitled to—but not necessarily enrolled in—Medicare.²⁷ Although this information could always be obtained from the Social Security Administration, it traditionally was never provided absent a release that contained the Social Security number and was signed by the injured party. After much internal legal debate, CMS created a query function that RREs could use once a month to check Medicare entitlement. However, once again, a Social Security number would be needed.

Not only is the Social Security number essential in obtaining the desired information from the query, it also must be accurate. If an inaccurate number is used, the query will not return a match, indicating no Medicare eligibility or an error. CMS believes that insurers can confirm accuracy of the number by requesting a copy of the Social Security card. Given that this

assistance is needed only when dealing with evasive beneficiaries, that copy is not likely forthcoming. CMS also has stated a preference for the health insurance claim number (HICN), believing it is easier to obtain; however, the same problems would apply.²⁸

Section 111 reporting for group health plans (GHPs) took effect on January 1, 2009,²⁹ so many of the foreseeable problems non-group health plans (NGHPs) (e.g., liability insurance, self-insurance, no-fault insurance, and workers' compensation) are likely to encounter have already been realized, and the inability to obtain Social Security numbers is among them. On May 26, 2009, CMS issued an alert regarding compliance guidance for obtaining this information.³⁰ The alert basically acknowledges that Medicare beneficiaries are not legally obligated to volunteer their HICNs or Social Security numbers upon the request of an RRE. CMS has stated that Medicare beneficiaries have a duty to cooperate as a term of their Medicare entitlement, but that duty is to Medicare, not to the RRE.³¹ Under the new policy, GHP RREs are required to attempt to obtain the information on an annual basis by sending some form of the model language provided by CMS to the beneficiary.³² As long as the individual affirmatively opts out by signing and returning the requisite form, the RRE will not be penalized for noncompliance even if it turns out that the individual was Medicare-entitled. Given that an individual has no legal obligation to provide the information to the RRE, the chances of having the form voluntarily signed and returned would seem rather slim. On August 24, 2009, CMS released NGHP model language. Although it did not publish a corresponding alert, one can infer that the same problems are anticipated and that similar policies will apply.³³

Reporting Problems

Although the requirements imposed in Section 111 itself are simple, implementing the program created by CMS was not as easy as the agency might have envisioned. CMS has held a number of teleconferences in which several questions have been raised that CMS has proven unable or unwilling to answer.³⁴ These unresolved issues are likely reasons for the extension of the registration period through September 30, 2009, delay of the testing period until first quarter 2010, and delay of the first actual live reporting until second quarter 2010 despite the July 1, 2009, effective date.³⁵

The first task under the MMSEA requirements is determining who bears a reporting requirement. As it turns out, that question may not be as straightforward as it seems. Take, for example, an exposure injury involving a self-insured with a retention fund and a deductible, covering multiple policy periods written by different insurers and an excess policy. Each of those entities may be an RRE for reporting purposes for that same single claim if all layers of coverage were tapped in the settlement. In contrast, there are entities that have met the CMS definition of RRE even though they would never have considered themselves self-insured from a legal standpoint. In between, there are bankruptcy and receivership situations with payments to be reported, but it is unclear as to who carries the reporting requirement. The most recent guidance from CMS tends to place the reporting responsibility on the entity physically making payment to the Medicare beneficiary.³⁶ Unfortunately for those facing the potential penalty, a more definitive answer for many situations is currently not available from CMS.

CMS made the actual registration and reporting activities fairly straightforward. All reporting is electronic, with three different

methods provided to accommodate different sized RREs, and each is provided with a dedicated electronic data interchange (EDI) representative for assistance with training and reporting. Although CMS lightened the burden by only requiring quarterly reporting, that leaves a potential minimum of 90 days that can pass before a mistakenly omitted claim can next be reported, potentially carrying a minimum \$90,000 penalty for a single incident of noncompliance.

Although workers' compensation insurers, in addition to reporting settlements, have an enormous burden of gathering and reporting open claim data for any claimants who are Medicare beneficiaries and monitoring open claims for newly entitled individuals, liability insurers only have to report their settlements, or in MMSEA lingo, the total payment obligation to the claimant (TPOC) amounts, that occur starting January 1, 2010. Again, CMS policies that are inconsistent with general legal practices complicate the matter because CMS states that verdicts or awards trigger the reporting requirement, when in reality the case is likely to be on appeal and not final.³⁷ Considering that no insurance payment will have been made at that point, there is no TPOC and, by its own terms, nothing to report. The question is which interpretation will prevail in determining noncompliance.

Although CMS states that its objective is gathering information needed for its MSP efforts and not to pursue noncompliance penalties, the fact is that the potential for abuse exists. The statute specifically funnels all penalties collected into the Medicare Hospital Insurance Trust Fund, which is predicted to exhaust in 2016. Given that the penalty is \$1,000 per day, per claim and that reporting only occurs every 90 days, large insurers potentially could be writing very large checks directly into the trust on a

regular basis. Take, for example, a large book of open workers' compensation claims that includes 5,000 Medicare-entitled claimants. If 0.5 percent of those claims are overlooked or Medicare entitlement was not verified, given that the correction cannot be made for 90 days, that quarter's penalty is potentially \$2.25 million. Although CMS states that is not their intention, the agency is authorized by statute to enforce that penalty and, given that the trust is in desperate need of additional funds, may pursue such claims at any time.

Conditional Payments

The most important thing to recognize about Section 111 of the MMSEA is that the purpose of the reporting requirement was not just to gather insurance data but for CMS to use the data in its MSP recovery efforts. To that end, the first logical act for CMS is to use the information to match against existing data in the Medicare claims system and find situations where Medicare is entitled to recovery of payments that should have been paid by or on behalf of RREs. As noted above, Medicare is prohibited by the MSP statute from making payment in circumstances where there is a primary payer. However, the statute provides for an exception in circumstances in which payment is not expected to be made by the primary payer in a timely manner in order to ensure that treatment is provided, conditioned on repayment. Additionally, 42 C.F.R. § 411.52 permits a conditional Medicare payment to be made in a liability case if CMS has information that services for which Medicare benefits have been claimed are for treatment of an injury or illness that was allegedly caused by another party.

Interestingly, CMS should be on notice of a possible liability claim or refusal of a potential primary payer to make timely payment in order for payments to be technically

considered conditional under the statute or regulations. For the most part, payments that Medicare considers conditional are the result of beneficiaries presenting a Medicare health insurance claim card to service providers without any notice of the potential claim, depriving medical providers of the decision to elect to accept the Medicare rate and leave the recovery against the liability insurer to Medicare, or to assert their own liens for the full value of their services against any settlement or judgment that may be forthcoming. There is no duty of a Medicare beneficiary to notify CMS of its potential liability claim, only one to cooperate if Medicare takes action to recover conditional payments.³⁸ There is no duty of a third-party payer to report that a liability claim has been made, only one to report if it is demonstrated that Medicare has made related payments.³⁹ CMS may initiate conditional payment recovery as soon as it learns that payment has been made or could be made under workers' compensation, any liability or no-fault insurance, or an employer group health plan.⁴⁰ However, if the payment was not technically a conditional payment as provided by the statute or regulations, the question is whether the payment was really subject to recovery at all.

Regardless of the statutory interpretation, CMS considers all payments related to an insurance claim conditional, subject to the statutory recovery rights provided by the MSP statute. However, CMS does not call such payments liens; that is a common misnomer in the legal community. By definition, a lien is an encumbrance upon property for the satisfaction of a debt. Because the statutory obligation to repay Medicare does not arise until a settlement, judgment, or insurance payment occurs, a Medicare payment is simply considered "overpayment" under a federal health insurance program until

GLOSSARY OF MEDICARE ACRONYMS

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| AWP | average wholesale price |
| CMS | Centers for Medicare and Medicaid Services (formerly the Health Care Financing Administration (HCFA)) |
| COB | coordination of benefits contractor |
| DOI | date of incident |
| GHP | group health plan |
| HICN | health insurance claim number |
| ICD-9 | International Classification of Diseases, 9th edition |
| MMA | Medicare Modernization Act of 2003 |
| MMSEA | Medicare, Medicaid and SCHIP Enforcement Act of 2007 |
| MSA | Medicare set-aside |
| MSP | Medicare secondary payer |
| MSPRC | Medicare secondary payer recovery contractor |
| the MSP | the Medicare Secondary Payer Act of 1980 |
| NGHP | nongroup health plan (liability insurance (including self-insurance), no-fault insurance, and workers' compensation laws and plans) |
| RRE | responsible reporting entity |
| SCHIP | State Children's Health Insurance Program |
| SSA | Social Security Administration |
| TPOC | total payment obligation to the claimant |
| WCMSA | workers' compensation Medicare set-aside arrangement |
| WCRC | Workers' Compensation Review Center |

some acceptance or imposition of liability occurs. Then and only then does the obligation to repay Medicare arise by operation of law. Once the MSP is triggered, Medicare has both a direct priority right of recovery and subrogation rights based on federal law, giving Medicare a superior recovery claim over those of any other entities.

Much confusion exists regarding conditional payments with regard to the MMSEA. One misconception is that the noncompliance

Penalties related to conditional payments are not limited to primary payers, so all parties to a liability settlement must understand how the recovery process works.

penalty somehow applies to the recovery of conditional payments. Remember that the MMSEA is merely a reporting requirement. The interplay between the MMSEA and conditional payment recovery is that once the government is provided liability settlement data, it is assumed that CMS will use the information to pursue money owed and prevent future Medicare payments from being made post-settlement. The failure to address conditional payment recovery efforts carries statutory penalties completely separate from the \$1,000 per day, per claim Section 111 non-compliance penalty for the failure to report liability settlements.

Unlike those under the MMSEA, penalties related to conditional payments are not limited to primary payers, so it is important for all parties to a liability settlement to understand how the recovery process works. The Medicare secondary payer recovery contractor (MSPRC) is responsible for all MSP recovery efforts.⁴¹ Until the passing of the MMSEA, the MSPRC could only really pursue claims it was made aware of through voluntarily reporting to the COB or those in which WCMSAs were submitted for review. Although the COB states certain requirements to report claims of Medicare beneficiaries,⁴² the reality is that there is only one regulation that mandates reporting claims and that only places a duty on a third-party payer to report

claims in which it is “demonstrated” that Medicare made a primary payment the third-party payer should have made.⁴³ There is no penalty for failing to report. Consequently, it has always been common practice among insurers to wait and see if CMS ever makes a demand for repayment and handle it at that time because penalties, interest, and statutory damages do not apply until after the failure to satisfy such a demand. And frankly, more often than not, such a demand is rarely forthcoming because CMS seldom learns of insurance settlements.

The MSPRC also will search the Medicare claims system upon request by any of the parties to a pending insurance settlement and look for payments for treatment related to ICD-9 codes associated with the claim.⁴⁴ The MSPRC will supply an itemized list of related services to the requesting party for review. Upon final settlement,⁴⁵ the injured party will report the total settlement amount, procurement costs, and any disputed services, and will request a final repayment amount.⁴⁶ Following a final search of its records for any additional related payments, the MSPRC will make a final demand for repayment.

Once demand is made, payment must be made within 60 days, otherwise interest starts to accrue. If repayment is not made even though provided to the beneficiary for that purpose, CMS may request payment from the third-party payer

again.⁴⁷ If litigation is necessary to recover conditional payments, the government may obtain statutory double damages and will no longer prorate its recovery for attorney fees and expenses incurred by the beneficiary. And do not forget that CMS has the right to recover from anyone in receipt of funds from the settlement. Because recovery efforts are likely to become more prevalent in the very near future, it is imperative that MSP obligations are understood and addressed prior to any of these enforcement provisions being evoked.

The MSP statute states that demand for repayment must be made within three years of the date of service.⁴⁸ It is important to note that, in practice, courts have granted the government longer periods to make demands on MSP recovery actions.⁴⁹ In the interest of treating Medicare recovery as a federal priority, courts have been very liberal in their MSP interpretations and have borrowed federal limitations periods such as the six-year statute of limitations provided by the False Claims Act,⁵⁰ citing the similar purpose of assisting the government in exposing fraud and recovering erroneously issued payments as the rationale.

A serious problem exists in many liability settlements involving conditional payments: sometimes there is no incentive to bring the claim. Frequently, demand for overpayment recovery exceeds the total settlement, leaving the injured party recovering nothing. CMS will limit its recovery to discount for procurement costs, which at least allows for the attorney to receive payment. But plaintiffs attorneys should seriously consider whether it is worthwhile to receive those fees considering that those fees are subject to recovery should CMS make any further demands.⁵¹ Bearing in mind that MMSEA Section 111 reporting will occur after funds are distributed, CMS potentially will be scrutinizing

settlements after the fact. In workers' compensation, an unfavorable determination could result in CMS disregarding the settlement.⁵²

A Medicare beneficiary may request a waiver of overpayment generally by demonstrating financial hardship or inequity.⁵³ CMS has a right to reduce or waive its recovery, in whole or in part, if the probability of recovery, or the amount involved, does not warrant pursuit.⁵⁴ The very same reasons that would justify compromising recovery and accepting less than full value in a settlement would likely prevent CMS from pursuing the subrogation right altogether. If injured parties are disincentivized to pursue claims because they will not receive any of the proceeds, Medicare likely recovers nothing. If a liability insurance settlement is not reached, CMS's recovery rights do not arise by operation of law, nor is there a Section 111 reporting requirement, so CMS is again in a position of being unaware of its ability to subrogate. Therefore, it is fairly astounding that CMS continues to take such aggressive positions with regard to its priority right of recovery against those who are actually trying to comply with the MSP.

On a final note with regard to conditional payments, CMS generally will only negotiate final repayment with the beneficiary because the obligation does not arise until the insurance payment is made. Accordingly, many insurers prefer to make settlement checks payable jointly to Medicare and its beneficiary to ensure that Medicare obtains its share and CMS does not seek a second payment. The current practice is for the beneficiary to endorse and mail the check to CMS, which will then cash the check, satisfy the obligation, and return the remainder to the beneficiary. There have been attempts by Medicare beneficiaries to file suit against insurers for this practice, calling it bad faith or a predeprivation due process

violation.⁵⁵ To date there have been no rulings against an insurer, nor are there likely to be any, given that Medicare has a primary right of recovery and should therefore be in a position to be repaid first from the settlement proceeds.

Medicare Set-Aside Arrangements

The more burdensome effect of mandatory insurer reporting under the MMSEA will be realized in the form of MSAs. The legal obligations of the insurer or tortfeasor terminate upon settlement but its obligations as primary payer under the MSP with regard to future medical treatment do not. Although the MSP obligations always have extended to liability insurance, parties to liability settlements have been reluctant to accept that MSAs are necessary, operating under the assumption that because CMS currently enforces only WCMSAs, MSAs are not applicable in liability situations. While it is true that neither the MSP nor its MMSEA amendments impose an express duty to set aside settlement funds to pay for future related medical treatment, the duty is certainly implied because how else is the primary payer to prevent Medicare from being billed for such treatment? If Medicare is prohibited by statute from making payment for related medical treatment, the insurance settlement proceeds are the only available source.

In general, when an injury or illness calls for it, future medical expenses are a component of the TPOC. Future medical expenses factored into the reserve on the claim. They also factored in the demand made and were certainly represented in a portion of the total settlement amount, whether specifically labeled as such or not. CMS does not care how the proceeds were labeled or whether liability was admitted. CMS is concerned only that an insurance payment was made and, under its guidelines, that

is enough to trigger all of its MSP rights, including the right to exclude future payments for any treatment related to the settled claim.

One argument maintains that there is no obligation in liability settlements to allocate for future medical expenses because the regulations do not call for it as they do for workers' compensation settlements. In workers' compensation, 42 C.F.R. § 411.46 and § 411.47 specifically provide guidance related to future medical provisions in lump sum settlements. Similar provisions cannot be found in the portion of the title dedicated to liability and no-fault insurance exclusions. A defense based simply on the technicality of omission is weak when the obligation to not pay arises from the plain meaning of the statute itself.

Similarly, arguments have been made that because CMS has no review program for liability MSAs as it does for WCMSAs, no obligation exists. Even the president of the American Association of Justice mistakenly claims that CMS does not require liability MSAs, erroneously citing CMS clarification that Section 111 does not require a set-aside be made, however completely ignoring the fact that it is the MSP itself that requires it.⁵⁶ Others accept that a liability MSA is proper but believe that settlement dollar thresholds used by CMS in the WCMSA program create safe harbors or dictate when an MSA is appropriate. These beliefs are completely unfounded as the parameters for the WCMSA program are not found in the MSP or any of its corresponding regulations; instead they are the product of CMS's interpretation of the MSP. It is difficult to appreciate this distinction without some exposure to the WCMSA program.

The CMS WCMSA Review Program

In July 2001, CMS published what was written as an interoffice

memorandum to its regional offices establishing a manner in which the public could obtain a written opinion that MSP measures related to future medical expenses were an adequate protection of Medicare's interests in a workers' compensation settlement. Since that time, CMS has randomly issued 11 additional memos adding, rescinding, and amending existing provisions,

a certain time frame relative to the settlement. What that memo failed to articulate was that the purpose of this provision was to limit the number of cases submitted for review because the regional office personnel could not handle the workload, not because CMS did not have a vested interest in every settlement.⁵⁸

CMS soon discovered that it still could not handle the number

The WCRC was rumored to have contracted to perform independent reviews of approximately 17,000 cases per year at less than \$200 per case within a narrow turnaround window. To do so, it established what could be considered a formula in which a course of treatment for a particular injury is projected, rather than one specifically tailored to an individual's medical condition, based to some extent upon Medicare coverage limits. Because CMS had not even considered releasing operational guidelines until October 2008,⁶¹ the medical services, frequencies, and pricing were moving targets for a number of years. Once the WCRC established the regular frequencies for things such as imaging, it started using pricing for the most costly option, such as contrast for every MRI or the maximum number of views for X-rays despite the fact that most injuries rarely routinely call for such extensive imaging. Additionally, WCRC reviews were riddled with inconsistencies in the mathematical computations and inclusion of non-Medicare-covered medical services. While CMS maintains the final word, it typically supports its contractor, and this final determination is not appealable.

Although challenged legally for its arbitrary policy-making methods as early as 2005, there have been no judicial rulings to date to reign in the program.⁶² Beginning in April 2008, the memoranda released by CMS started containing policies that have been questioned from a legal standpoint, with no response from CMS other than that the program is voluntary. This response represents a total reverse in position: CMS's previous outreach efforts essentially purported mandatory review, if available, evidenced by the industry belief of the same.

The policies in question started with the determination that only Table 1, representing the general population, of the CDC life

With the MMSEA, CMS will obtain data enabling it not only to collect for prior payments related to a settlement but also to deny future related payments.

published only on its Web site and, until recently, without any notice to the public. It is vital to note that these memos have never been subject to any form of the federal rulemaking process. CMS currently states that this is a voluntary review program and all of its related policies contained in the memos are merely the agency's interpretation of the MSP statute it is charged with enforcing. Because review is not mandatory, the policies are not considered rules subject to publication in the *Federal Register* or to public comment and likely are only published at all because the Administrative Procedures Act requires it.⁵⁷

In that first memorandum, commonly referred to as the Patel Memo, CMS stated that it was not in the best interest of the program to review every workers' compensation settlement nationwide and therefore limited the availability of the review program to existing Medicare beneficiaries and those persons with a reasonable expectation of Medicare eligibility within

of requests, as it took in excess of a year for it to respond in most cases, and each response generally just accepted what was proposed. In April 2003, CMS defined "reasonable expectation," limiting requests from non-Medicare-eligible claimants with settlements in excess of \$250,000 to six particular criteria of achieving Medicare entitlement. In July 2005, the Medicare beneficiaries with settlements under \$10,000 were excluded from review,⁵⁹ further amended to \$25,000 in April 2006.⁶⁰

In addition to narrowing the number of cases eligible for review, CMS took further steps to speed up the review process and contracted with the Workers' Compensation Review Center (WCRC) in 2005 to conduct the actual review of the proposals submitted and to make recommendations to the regional offices as to the adequacy. This eventually solved the timeliness problem; however, it created other more significant problems as the program evolved.

expectancy tables would be used in the review program. The problem with that policy is that life expectancy is affected by gender and race, a fact supported by years of empirical data collected by the CDC, and this results in certain protected classes of persons not receiving funding representing their particular future medical needs, while others are receiving a windfall. A few months later, CMS issued a memo stating that it would disregard a diminished life expectancy altogether if it did not care for the manner in which it was submitted, a determination that would not be appealable.

Most recently CMS mandated that it would price future prescription drug allocations using average wholesale prices (AWP) with no consideration of discounting methods, such as consideration of patent expirations. Beside the fact that no one pays AWP, given that it is a recognized benchmark from which market pricing is determined, the fact is that some state workers' compensation programs have fee schedules that limit the amount paid for drugs under state law, and AWP frequently exceed that amount. Furthermore, the Medicare program does not even use AWP to establish Part D reimbursement rates, and the supposed purpose of this exercise is to provide funds to substitute for the Medicare portion of future care. While these are but a few of the questionable acts of CMS in its recent MSP efforts, the problem is that they represent a trend in CMS's behavior with regard to establishing unlimited expectations regarding primary payer obligations in excess of benefits actually provided by the Medicare program.

With the MMSEA reporting requirement, CMS will obtain data enabling it not only to look back to collect for payments already made for treatment related to an insurance settlement, but it will also be on notice to immediately deny

future related payments.⁶³ Absent an MSA, Medicare beneficiaries may be faced with denied benefits and the possibility of the entire settlement amount acting as a deductible against future Medicare coverage of the related injury or illness if CMS decides that Medicare's interests are inadequately protected.⁶⁴ Unfortunately, CMS has the benefit of making that determination at any time in the future because a prior opinion is not available as it is in workers' compensation settlements. Given that CMS provides no guidance as to how to allocate for future medical expenses in anything but workers' compensation settlements, and even that is of questionable value and limited applicability to liability insurance, risk management decisions have to be made as how to comply with MSP requirements, and they have to be made by all parties to a settlement because all parties share equally in the potential future uncertainty.

The term "settlement" infers that a compromise occurred. In a compromise, it is highly unlikely that an injured party is truly compensated for 100 percent of his or her potential future medical exposure. However, as evidenced in the WCMSA process and the conditional payment recovery regulations, CMS clearly believes that it should be compensated for 100 percent of past and future related medical expenses with no regard to preexisting conditions or legal factors affecting the total settlement value. CMS policies for WCMSAs are somewhat justifiable from a legal standpoint considering they are based on the premise that workers' compensation is essentially a form of no-fault insurance that pays for all related medical expenses. In tort law, defenses come into play that limit liability and that, in a courtroom setting, could prohibit recovery altogether. Therefore, it is difficult to apply WCMSA policies directly to liability settlements because so

many legal factors affect settlement value determinations.

In its review of WCMSAs, if a legal basis exists for not providing 100 percent of future medical treatment in a WCMSA, the burden is on the submitter to explain that persuasively to CMS and provide the supporting authority; otherwise, CMS will counter with an unappealable fully funded WCMSA. In liability settlements, even concepts as basic as contributory and comparative negligence will affect settlement value in ways that will prevent liability MSAs from ever being fully funded. CMS defines liability insurance as a "contractual obligation to compensate the alleged tortfeasor for any damages the alleged tortfeasor must pay to an injured party."⁶⁵ Although this may be viewed as an acknowledgment by CMS that claims may settle for less than perceived full value, CMS still takes the position that it is entitled to repayment in full regardless of the settlement amount.⁶⁶ Absent any guidance or ability to seek a written opinion from CMS before settlement, there is no way of knowing what CMS's position in any given settlement will be until some point in the future when it refuses payment or makes demand for repayment, which may be made on anyone in receipt of funds from the settlement.

Solutions

The question to address is this: What do parties to liability settlements do to make sure that all liabilities, especially those for future medical treatment, are foreclosed in an insurance settlement absent any guidance from CMS? The answer will be found in cooperation among all parties to the settlement in reaching reasonable, defensible, and mutually agreeable allocations based only upon the MSP itself and all of the factors that contributed to settlement value determination. As opposed to the adversarial process

up to this point in the claim, all parties should be on the same page as they all carry potential future exposure to Medicare. Because only Medicare benefits from higher MSAs, it makes no sense to demand a higher MSA because in most instances it only lowers the unencumbered recovery of the injured party and makes the prospect of settlement less attractive and therefore less likely to occur. An MSA that meets the baseline requirements of all parties under the MSP should be the common goal in the settlement.

Rather than the general use of life care plans, where the plaintiff obtains an estimate to make a settlement demand and the defense counters with a lower plan, the medical portion of an MSA should be the same amount regardless of which side obtains it. Medicare coverage guidelines dictate a fairly basic course of care, and although a person might prefer to see his or her treating physician more often, Medicare will cover only services that it considers medically necessary to treat the injury. Furthermore, because the object is to protect Medicare's interest in the settlement, only Medicare covered services as defined by CMS⁶⁷ should be allocated for and only at the cost Medicare would pay under its fee schedule.⁶⁸ With just about any common injury, there should only be one predictable Medicare covered course of treatment addressed in the settlement, regardless of who requests the estimate.

Another issue to be considered with regard to liability MSAs is procurement costs. Although CMS's position in its review program is that WCMSAs may not be reduced by procurement costs,⁶⁹ there is no rational basis for the decision given that the regulations provide for the deduction of those costs from Medicare conditional payment recovery. 42 C.F.R. § 411.37 permits all conditional payments owed to Medicare to be reduced by the costs associated

in procuring the settlement. Because the same efforts are used to procure both the past and future related medical expenses, and because attorney fees are calculated upon some percentage of the overall total settlement, there is no rationale for not applying the Code of Federal Regulations provisions equally to all medical expense recoveries.

In the past, liability insurers and attorneys who acknowledged MSP obligations primarily turned to WCMSA vendors for liability MSA determinations. While that approach is fine to obtain the future medical estimate, the product of a WCMSA vendor will generally exceed an insurer's obligations under the MSP. CMS prohibits a percentage approach to conditional payment recovery based on the rationale that such a ratio takes into account unreasonable demands made by the plaintiffs. If a plaintiff demanded \$1,000,000 but settled for \$100,000, the theory presented by most attorneys is that only 10 percent of any demands made by Medicare should be funded. The reality is that even CMS recognizes that the claim was never worth \$1,000,000; otherwise the plaintiff would have gone to trial rather than accept such a nominal amount.

Determining the probable liability of the tortfeasor to arrive at the amount the tortfeasor will ultimately be obligated to pay the injured party—i.e., the contractual obligation of the insurer—would be a more practical and likely acceptable method of determining what portion of the plaintiff's future care would be funded by the insurer. Because the medical estimate portion of the MSA is essentially a fixed variable, the task is to determine what portion becomes the obligation of the insurer to fund. Absent an award or judgment, the only manner to determine that percentage is to achieve mutual agreement of the parties and abandonment of the adversarial process.

The only objective accomplished by funding more than one's obligations under the MSP is permitting Medicare to shift the burden of treating its beneficiaries to the private sector. Under tort law there is a general duty to make the injured party whole again. However, in the case of a so-called eggshell plaintiff, the victim already suffers from a condition that is then exacerbated by an act of negligence. But for the accident, Medicare would have eventually treated the condition, but the program is now freed from that burden because it is impossible to return an injured party to his or her previous medical status. For example, when an individual with a history of back problems who continually refused to explore recommended fusion surgery is suddenly involved in an automobile accident that necessitates the surgery, it is impossible not to treat the entire problem or to return that person to the exact level of his or her previous state of pain. Rather than acknowledge a contribution to a foreseeable expense, Medicare prefers the position of being totally excused from any obligation to ever treat that injury. Not only is the insurer responsible for the surgery, but inferences from CMS's WCMSA policies call for a lifetime of monitoring the injury site as related to the claim.⁷⁰

Conclusion

While the July 1, 2009, effective date of the NGHP MMSEA Section 111 reporting requirement has come and gone, the liability insurance industry continues to await the true impact of the new legislation. Predictable implementation delays by CMS have extended registration and testing periods, pushing the first actual mandatory reporting well into 2010.⁷¹ Yet the full weight of the amendment will not be realized until some time long after that when the federal government

manages to process the myriad of accumulated data and we begin to see what it intends to do with it all.

Conditional payment recovery will take precedence in the MSP efforts because it will help immediately replenish the Medicare trust fund, but it will be a far easier task to prevent new conditional payments from being made. As evidenced in the WCMSA arena, CMS's task is as simple as monitoring a beneficiary's common working file (where all of the MMSEA information will be housed) to prevent primary payments from being made.⁷²

There is no liability MSA review program, and none is anticipated. CMS regional offices, however, are permitted at their discretion to review cases they deem worthy if their workload permits. Accordingly, it is always prudent to request a review if for no other reason than to put CMS on notice that MSP compliance efforts were taken. At the end of the day, CMS will have to determine who, in the program's best interests, it is necessary to pursue because it will not have the bandwidth to go after everyone. That decision likely will come down to those who made reasonable efforts absent any guidance, versus those who did nothing.

Unfortunately, the heaviest burdens of MSP compliance will fall upon the injured beneficiary. From postsettlement day one, plaintiffs will need to understand what the MSA is and how to properly use it or face the possibility of additional loss of Medicare benefits. The burden will be upon them to pay providers, keep an accounting and records, communicate with CMS when funds exhaust, and prevail themselves of their Medicare appeal rights in a timely manner, if necessary. They need to understand that Medicare will not make payment for any treatments related to their insurance settlement and that it is incumbent upon them to

From postsettlement day one, plaintiffs need to understand what the MSA is and how to properly use it or face the possibility of additional loss of Medicare benefits.

explain the situation to their medical service providers.

Service providers in turn will have to cooperate because there is no legal obligation that they bill a Medicare-entitled person at the Medicare fee schedule rate when the patient is not using Medicare benefits. CMS outreach efforts would be well served at this point by educating its service providers about MSAs. Because CMS carries contractual power over its providers, CMS could easily implement provisions where beneficiaries with MSAs would be entitled to billing at the lower Medicare reimbursement rates without physically billing Medicare. In exchange, the providers could be guaranteed payment in full at the time of service.

Truly, it may be CMS that needs to be educated first. If it continues with its all-or-nothing approach, it will find more cases going to jury verdict or not being pursued at all, considering that injured parties have nothing to gain when all of their recovery is tied up in MSP compliance and attorney fees. CMS may find itself pursuing its subrogation rights more often because potential plaintiffs no longer have the incentive to bring the claims on their own behalf or cannot obtain representation in light of the threat of attorney fees being recoverable. Under its own guidelines, CMS must determine if recovery efforts

are in the best interest of the MSP program. In so doing, all of the legal factors that would have led to the compromise settlement decision to begin with would come back into play and questionable recovery against the insurer likely would remain unpursued. The MSP program overall would recover in more cases by issuing some compromise guidance for liability insurers than it would by attempting to enforce the same provisions used in WCMSA review and conditional payment recovery efforts.

It is clear that our federal government has very little understanding or regard for how complicated our insurance market has become. In its MMSEA teleconferences, CMS states that it is only interested in gathering the necessary data and not in actively pursuing the noncompliance penalty at this time. However, as soon as the MMSEA penalty program is up and running, it is only a matter of time before those penalties start accruing because the statute directs payment of the penalty into the Medicare Hospital Insurance Trust Fund, which currently is predicted to run out of funds in 2016. Between overfunded MSAs and MMSEA penalties, CMS has the potential to shift a great portion of its Medicare burden onto the private sector on the back of the insurance industry and to the detriment of its beneficiaries. ■

Endnotes

1. Pub. L. No. 96-499, 42 U.S.C. § 1395y(b)(2).
2. See Social Security and Medicare Board of Trustees, *Summary of the 2009 Annual Reports*, www.ssa.gov/OACT/TRSUM/index.html.
3. Pub. L. No. 110-173, 42 U.S.C. § 1395y(b)(7) & (8), <http://thomas.loc.gov/cgi-bin/bdquery/z?d110:SN02499:@@X>.
4. Pub. L. No. 79-404, 5 U.S.C. § 500 et al.
5. Pub. L. No. 89-97, 42 U.S.C. § 426a.
6. Pub. L. No. 96-499, 42 U.S.C. § 1395y(b).
7. See generally H.R. REP. NO. 96-1167 (1980).
8. See H.R. REP. NO. 96-1167, at 522 (1980).
9. Pub. L. No. 108-173 (2003), http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=108_cong_public_laws&docid=f:publ173.108.pdf.
10. 42 U.S.C. § 1395y(b)(2)(B)(iii).
11. Cases before the enactment of the MMA resulted in conflicting opinions; see generally *Thompson v. Goetzmann*, 337 F.3d 489 (5th Cir. 2003); *Brown v. Thompson*, 374 F.3d 253 (4th Cir. 2004); *United States v. Baxter Int'l, Inc.*, 345 F.3d 866 (11th Cir. 2003); *Mason v. Am. Tobacco Co.*, 346 F.3d 36, 41–42 (2d Cir. 2003).
12. 42 U.S.C. § 1395y(b)(2)(B)(iii).
13. *United States v. Harris*, Civ.A.5:08CV102, 2009 WL 891931 (N.D. W. Va. 2009).
14. For an example of such a discussion, see generally 72 Fed. Reg. 9679 (2008).
15. Pub. L. No. 108-173, § 301(a) (2003).
16. Pub. L. No. 110-173, 42 U.S.C. 1395y(b)(7) & (8) (2008).
17. 42 C.F.R. § 411.25.
18. 42 U.S.C. § 1395y(b)(2)(B)(ii) & (iii).
19. *Id.* § 1395y(b)(8)(E).
20. The bill was introduced on December 18, 2007, and passed the next day without any committee meeting noted or debate on the record. See S. 2499, All Actions, <http://thomas.loc.gov/cgi-bin/bdquery/z?d110:SN02499:@@X>.
21. CONG. REC. S15834 (daily ed. Dec. 18, 2007) (statement of Sen. Grassley).
22. 42 U.S.C. § 1395y(b)(8)(A)(ii).
23. See Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Workers' Compensation User Guide, Version 2.0 (Ju1y 31, 2009), www.cms.hhs.gov/MandatoryInsRep/Downloads/NGHPUserGuide2ndRev082009.pdf. Concerns as to failure to fill all fields triggering error reports and in turn noncompliance have not been fully addressed by CMS at this time.
24. *Id.* at 87, data field 12.
25. See Town Hall Teleconference Transcript: Section 111 of the Medicare, Medicaid & SCHIP Extension Act of 2007 (Dec. 11, 2008), www.cms.hhs.gov/MandatoryInsRep/Downloads/Dec11Transcripts.pdf.
26. 42 C.F.R. § 411.23 imposes a duty upon the Medicare beneficiary to cooperate with its recovery efforts, otherwise he or she will possibly be faced with personal repayment responsibility.
27. 42 U.S.C. § 1395y(b)(8)(A)(i), stating that the applicable plan shall “determine whether a claimant (including an individual whose claim is unresolved) is entitled to benefits under the program under this title on any basis.” CMS has routinely used this same standard in WCMSA review policies as well.
28. See Town Hall Teleconference Transcript: Section 111 of the Medicare, Medicaid & SCHIP Extension Act of 2007 (June 9, 2009), www.cms.hhs.gov/MandatoryInsRep/Downloads/NGHPTranscript06092009.pdf.
29. See 42 U.S.C. § 1395y(b)(7).
30. CMS, ALERT: Compliance Guidance Regarding Obtaining Individual HICNs and/or SSNs for Group Health Plan (GHP) Reporting Under 42 U.S.C. § 1395y(b)(7), www.cms.hhs.gov/MandatoryInsRep/Downloads/ALERT-Guidance%20ForHICNsSSns.pdf.
31. See Town Hall Teleconference Transcript, *supra* note 28.
32. HICN Social Security Number Benefit Form, www.cms.hhs.gov/MandatoryInsRep/Downloads/HICNSSNBENEFORM.pdf.
33. NGHP Model Language (Aug. 24, 2009) www.cms.hhs.gov/MandatoryInsRep/Downloads/NGHHICNSSNNGHPForm.pdf.
34. NGHP Transcripts, www.cms.hhs.gov/MandatoryInsRep/07_NGHP_Transcripts.asp#TopOfPage.
35. See CMS, ALERT for Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Workers' Compensation Responsible Reporting Entities (May 11, 2009), www.cms.hhs.gov/MandatoryInsRep/Downloads/NGHPV10UserGuide051109.pdf.
36. See Town Hall Teleconference Transcript: Section 111 of the Medicare, Medicaid & SCHIP Extension Act of 2007 (July 14, 2009), www.cms.hhs.gov/MandatoryInsRep/Downloads/July142009NGHPTranscript.pdf.
37. See Town Hall Teleconference Transcript, *supra* note 25.
38. 42 C.F.R. § 411.23.
39. *Id.* § 411.25.
40. *Id.* § 411.24(b).
41. Effective October 2, 2006, CMS contracted all the functions and workloads related to MSP postpayment recoveries to the MSPRC. See www.msprc.info for more information.
42. See CMS, Medicare Second Payer and You: Overview, www.cms.hhs.gov/MedicareSecondPayerandYou/. Note that CMS states here that attorneys *must* inform the COB of a potential liability lawsuit and that NGHP insurers *must* report when their insureds are Medicare beneficiaries, which is interesting considering the insured may not be the injured party, even though there is no statutory duty to perform these tasks.
43. 42 C.F.R. § 411.25(a) (as amended 2008), http://edocket.access.gpo.gov/cfr_2008/octqtr/pdf/42cfr411.26.pdf. Note that before the amendment, the regulation used the term “learned” rather than “demonstrated,” implying a more affirmative act of determining that a secondary payment situation existed. See a prior version available at http://edocket.access.gpo.gov/cfr_2003/octqtr/pdf/42cfr411.25.pdf.
44. ICD-9 stands for *International Classification of Diseases*, 9th edition—a standardized international classification

used in assigning codes to patient diagnoses and injuries and their various complications and comorbidities. A request for a search of the Medicare claims system will generally require a consent to release form signed by the Medicare beneficiary; see CMS, Consent to Release Form, www.msprc.info/forms/Consent_to_Release.pdf.

45. In MSP liability situations, before a settlement is reached between the beneficiary and the liable party, or a court renders a judgment, there is no overpayment. Medicare's claim comes into existence by operation of law. See *MEDICARE SECONDARY PAYER MANUAL* § 50.4.1.

46. See 42 C.F.R. § 411.27(c).
Formula = [(attorney fees + expenses) / total settlement] X conditional payments. See Final Settlement Detail Document, www.msprc.info/forms/Final_Settlement_Detail.pdf.

47. 42 C.F.R. § 411.24(i).

48. *Id.* § 1395y(2)(B)(vi).

49. *Manning v. Utils. Mut. Ins. Co.*, 254 F.3d 387, 396–97 (2d Cir. 2001).

50. 31 U.S.C. § 3731(b)(1).

51. See *United States v. Harris*, Civ. A. 5:08CV102, 2009 WL 891931 (N.D. W. Va. 2009) (demonstrating a successful suit against a claimant's attorney under 42 C.F.R. § 411.24(g) for conditional payment recovery from the attorney fee).

52. 42 C.F.R. § 411.46(b).

53. *MSP Manual*, Pub. L. No. 100-5, ch. 7, §§ 50.5.4.4–50.7.3; see also Social Security Administration, Request for Waiver of Overpayment Recovery or Change in Repayment Rate, www.ssa.gov/online/ssa-632.pdf.

54. 42 U.S.C. § 1395y(b)(2)(B)(v); 42 C.F.R. § 411.28(a).

55. See *Wall v. Leavitt*, Civ. No. S-05-2553, 2008 WL 4737164 (E.D. Cal. 2008).

56. Anthony Tarricone, *Emergency Medicare Set Aside Information*, www.magnetmail.net/actions/email_web_version.cfm?recipient_id=230424257&message_id=793392&user_id=ATLA.

57. 5 U.S.C. § 552.

58. Clarification of that issue was made July 11, 2005. See CMS Memo:

Medicare Secondary Payer (MSP)—Workers' Compensation (WC), Additional Frequently Asked Questions, Question and Answer 1, www.cms.hhs.gov/WorkersCompAgencyServices/Downloads/71105Memo.pdf.

59. *Id.*, Question and Answer 2.

60. CMS Memo: Workers' Compensation Medicare Set-Aside Arrangements (WCMSAs) and Revision of the Low Dollar Threshold for Medicare Beneficiaries (Apr. 26, 2006), www.cms.hhs.gov/WorkersCompAgencyServices/Downloads/42506Memo.pdf.

61. WCMSA Review Operating Rules (Oct. 28, 2008), www.cms.hhs.gov/WorkersCompAgencyServices/Downloads/OperatingRulesRedacted102708.pdf.

62. See generally *Protocols v. Leavitt*, Civ. Act. No. 05-cv-01492-BNB-PAC (D. Colo. 2005).

63. CMS, Medicare Learning Network No. MM5371, New Common Working File (CWF) Medicare Secondary Payer (MSP) Type for Workers' Compensation Medicare Set-Aside Arrangements (WCMSAs), to Stop Conditional Payments, www.cms.hhs.gov/MLNMattersArticles/downloads/MM5371.pdf.

64. Such provisions already exist for workers' compensation claims so the possibility of easy adoption for liability situations is not unimaginable. See 42 C.F.R. § 411.46(b)(2).

65. *MEDICARE SECONDARY PAYER MANUAL*, ch. 2, § 40.2(A).

66. 42 C.F.R. § 411.24. "If it is not necessary for CMS to take legal action to recover, CMS recovers the lesser of

the following: (i) The amount of the Medicare primary payment. (ii) The full primary payment amount that the primary payer is obligated to pay under this part without regard to any payment, other than a full primary payment that the primary payer has paid or will make, or, in the case of a third party payment recipient, the amount of the third party payment."

67. 42 C.F.R. § 411.54(a). "Medicare-covered services means services for which Medicare benefits are payable or would be payable except for applicable Medicare deductible and coinsurance provisions."

68. See CMS, Physician Fee Schedule: Overview, www.cms.hhs.gov/PhysicianFeeSched/.

69. See CMS Memo (July 11, 2005), *supra* note 58, Question and Answer 11. "Some submitters have argued that 42 C.F.R. § 411.47 justifies reduction to the amount of a WCMSA. The compromise language in this regulation only addresses conditional (past) Medicare payments. The CMS does not allow the compromise of future medical expenses related to a WC injury." See also *Protocols v. Leavitt*, Civ. Act. No. 05-cv-01492-BNB-PAC (D. Colo. 2005).

70. Note that in conditional payment recovery CMS does not accept any allegations of preexisting conditions to reduce repayment. See *MEDICARE SECONDARY PAYER MANUAL* § 50.4.5.

71. CMS, ALERT (May 11, 2009), *supra* note 35.

72. CMS Manual System, Pub. L. No. 100-04, Medicare Claims Processing, Transmittal 1703 (Mar. 20, 2009).

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