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Assisting Clients Seeking the Road to Decent Jobs: Job Training Advocacy

Medicare Secondary Payer Procedures for Recovery of Program Expenditures from Liability Insurance Payments

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I. Introduction

The Medicare Secondary Payer (MSP) Program seeks to recover Medicare expenditures for health services related to accidents from Medicare beneficiaries' liability insurance proceeds. The policies of the Health Care Financing Administration (HCFA) implementing the MSP program have had harsh effects on beneficiaries, who are sometimes left with no reimbursement for their injuries. Recently, as a result of litigation challenging certain of these policies, HCFA issued new rules concerning operations of the MSP program. These rules will be of special interest to personal-injury attorneys and elder-law attorneys whose clients' damage awards are claimed by Medicare.

II. The Medicare Secondary Payer Program

Medicare is a federal program established by title XVIII of the Social Security Act that provides health insurance for aged and disabled individuals. /1/ Legislation amending the program in 1980 provided that Medicare would pay for health services only after other responsible insurers have paid. /2/ The MSP program has been modified and expanded by subsequent legislation in the hope of shifting costs from the federal government to private insurers. /3/

The MSP program makes Medicare payment secondary to payment by two kinds of private insurers: first, those providing group health insurance for employees; and, second, those providing coverage under automobile, liability, and workers' compensation policies. /4/ This article will focus on the liability insurance part of the MSP program.

When an injured Medicare beneficiary's medical expenses are covered by liability or no-fault insurance, Medicare will pay for medical services only when the third-party (insurance) payment will not be "prompt." Such Medicare payments are described as "conditional," and the program expects to recover them when the private insurance payment "has been or could be made." /5/

The MSP statute gives Medicare strong collection powers with respect to its recovery claims. HCFA has both subrogation rights and the right to bring an independent action to recover its conditional payments. It is authorized to bring such actions against "any entity . . . required to pay .

. . under a primary plan" and to collect double damages against the primary plan. /6/ It is further authorized to bring actions against "any other entity (including any physician or provider) that has received payment from that [primary plan] entity." /7/

Under the Medicare statute, beneficiaries have rights to appeal the amount of the MSP recovery claim if they believe the claim is not correct. /8/ They also have the right to ask Medicare to waive or compromise recovery under several different provisions of the law. /9/

III. MSP Problems for Medicare Beneficiaries

Medicare has been aggressive in implementing the MSP recovery program, and as a result program beneficiaries have experienced a number of problems.

Medicare demands for MSP reimbursement often impose financial hardship on beneficiaries. Total insurance proceeds are frequently less than the amount of the beneficiaries' damages because of low policy limits or disputed elements of the claim, but Medicare nevertheless demands full reimbursement for its outlays. Under MSP regulations, Medicare's recovery may be reduced only by a pro-rated share of attorney fees and other costs -- an accommodation that helps secure the cooperation of the personal-injury bar with MSP recovery collection. Thus, beneficiaries are left with inadequate reimbursement for their injuries.

The following example shows how a beneficiary can be harmed by MSP recovery practices.

Ms. Hurt, an accident victim, received a settlement of $100,000, which was the maximum amount payable under her tort-feasor's liability policy. Her medical expenses were $80,000, of which Medicare paid $50,000; her pain and suffering were valued at $20,000; lost wages were $40,000; and her permanent loss of limb was valued at $60,000.

Although Ms. Hurt's settlement amounted to only 50 percent of her damages of $200,000, Medicare demanded recovery of its entire $50,000 outlay, minus its proportionate share of the procurement costs. Ultimately, Medicare took $35,000, and Ms. Hurt's personal-injury attorney received a fee of $30,000 (she had a 30-percent contingency fee arrangement with her lawyer). Ms. Hurt was left with only $35,000 to meet her needs resulting from the $150,000 in remaining losses.

Another problem for beneficiaries has been the coercive nature of Medicare's communications to them and their attorneys concerning MSP recovery claims. For example, letters and notices from Medicare advising beneficiaries or their attorneys of MSP claims have used the term "lien" to describe the MSP claim. Legally, a lien is a right to payment from a specific item of property that has been perfected by formal proceedings. The existence of a lien would impose special legal duties of cooperation in collection efforts on attorneys as well as beneficiaries.

A third problem for beneficiaries and their attorneys has been defective notice of MSP collection, waiver, and appeal rights. Until recently HCFA allowed individual intermediaries and contractors to design their own notices, which sometimes omitted information about beneficiaries' rights to appeal or request waiver of MSP recovery. Furthermore, if a personal-injury attorney was known to

the contractor, notices were sent only to the attorney; the beneficiary was given no notice of appeal and waiver rights, although the beneficiary had the interest in pursuing relief from collection. Finally, MSP notices often suggested that attorneys would be held personally liable for the MSP claim if they did not arrange for its prompt payment. /10/ Not surprisingly, in light of these Medicare practices, few requests for appeal or waiver of MSP claims were filed by beneficiaries.

IV. Zinman v. Shalala

In 1990, a class of Medicare beneficiaries alleged that the Secretary of Health and Human Services' operation of the MSP program violated the Medicare statute and the due process clause of the Constitution. /11/ The named plaintiffs were seven Medicare beneficiaries who had been severely injured in accidents and whose modest insurance settlements had been demanded by HCFA as reimbursement for Medicare-covered health services.

Plaintiffs asserted five claims in their complaint. Plaintiffs alleged (1) that the MSP statute required the Secretary to reduce MSP recoveries in proportion to the amount of a beneficiary's damages actually reimbursed by the primary insurer; (2) that HCFA's practice of giving notice only to a beneficiary's personal-injury attorney or insurance company violated due process; (3) that MSP collection letters failed to give adequate notice of beneficiaries' appeal rights; (4) that Medicare lacked adequate standards for deciding when to waive MSP recovery; and (5) that threats of double damages against personal injury attorneys who did not cooperate in the MSP collection process interfered with the attorney-client relationship.

The district court ordered the Secretary to institute significant reforms in the MSP program's collection practices. Most significantly, the court ordered a number of changes in HCFA notices concerning MSP recovery claims. It held that the government's practice of sending demand notices only to beneficiaries' personal-injury attorneys was inadequate and that notices must be sent to beneficiaries themselves. It also held that a uniform national notice, instead of the notices generated by individual intermediaries, was necessary. Finally, the court required HCFA to ensure that descriptions of beneficiaries' rights to request waiver and/or appeal with respect to MSP recovery would be provided earlier in the process of negotiations in personal-injury actions.

In addition, the court held that HCFA's practice of describing its MSP recovery claim as a "lien" on amounts recovered on behalf of beneficiaries in personal injury actions was misleading. The court agreed with plaintiffs that the Medicare statute does not give HCFA liens on insurance proceeds and that the agency's description of its claims as liens imposed a false sense of obligation on attorneys to turn their clients' funds over to Medicare. /12/

Finally, the court held that the standards used by HCFA in making decisions on beneficiary requests for waiver of MSP recovery were too restrictive. The court relied on the Ninth Circuit's decision in Quinlivan v. Sullivan, /13/ which held that, in making decisions on requests for waiver of social security overpayments on grounds of equity and good conscience, the Secretary of Health and Human Services must use concepts of fairness broader than those specified in 20 C.F.R. Sec. 404.509. The Secretary was ordered to develop new written guidelines setting out a more liberal standard for decision making.

However, the Zinman court rejected plaintiffs' claim that HCFA must reduce MSP recoveries when beneficiaries receive less than complete reimbursement for their damages in personal injury awards. Although plaintiffs argued that the language of the MSP statute, 42 U.S.C. Sec. 1395y, authorizes recovery only to the extent that the beneficiary actually receives insurance payments for medical services covered by Medicare, the court held otherwise. The court's decision turned on its finding that Congress had intended in enacting the MSP legislation to maximize Medicare program assets. /14/

V. Revised MSP Collection Policies

In November 1994, HCFA issued revised Medicare policy manual sections implementing the changes that resulted from the district court's decision in Zinman. /15/ These materials constitute the first comprehensive statement of MSP operating rules since the inception of the MSP program and announce agency policy on a number of points that had previously been unclear. The remainder of this article will describe MSP collection procedures as set out in the new Medicare Intermediary Manual (MIM) materials.

MIM Sec. 3418 -- General Effect of Liability Insurance on Medicare Payment. HCFA now recognizes that MSP recovery procedures are not the same as those used for recovery of Medicare overpayments and has abandoned its earlier reliance on sections of the manual dealing with overpayments (MIM Secs. 3700, 7100). As noted above, the MSP statute confers on HCFA both subrogation rights and an independent right to bring suit to recover its share of other insurance proceeds. Medicare claims a priority right of recovery; this means that among other insurers, such as state Medicaid programs, Medicare's right to recover insurance proceeds takes precedence.

MIM Sec. 3418.1 -- Effect of Payment by Liability Insurer on Deductibles and Utilization. When MSP recovery for services covered by Medicare is made from primary insurance payments, the amount recovered is credited toward deductibles and applied to copayments owed by the beneficiary for those services. Then, such reimbursed services do not count to reduce the number of services available to the beneficiary under the Medicare statute. /16/

MIM Sec. 3418.2 -- Definitions. This section includes, among other definitions useful in understanding MSP manual provisions, "med-pay" along with "no-fault" in the category of liability insurance subject to MSP recovery. Med-pay is an insurance payment to cover medical expenses without regard to fault of any party. No-fault is insurance that pays for medical and other expenses resulting from an accident without regard to fault of any party.

MIM Sec. 3418.3 -- Procedures for Actions with Legal Implications in MSP Liability Situations. Contractors are instructed to refer to their HCFA regional offices all notices concerning lawsuits in which Medicare has been made a party or an MSP claim for reimbursement has been placed in issue. Requests for subpoenas should also be referred to the regional office.

MIM Sec. 3418.4 -- Provider Actions. Hospitals and other health care providers are required to inquire whether Medicare patients' services resulted from accidents, obtain information about insurers, and bill such insurers as primary payers for covered medical services.

MIM Sec. 3418.5 -- Identification of Liability Situations. Contractors are required to identify situations where there may be a liability insurer. Specified situations include those where (1) the contractor receives information indicating that other insurers may exist; (2) the diagnosis shown on the Medicare claim form is one likely to have resulted from an accident; (3) endorsement on an insurance check is requested; (4) a liability insurer previously paid benefits related to the current treatment; or (5) a provider requests Medicare payment information on behalf of an attorney or insurer.

MIM Sec. 3418.6 -- Presettlement Issues. When a liability situation is identified, the contractor should take a number of steps to identify the possibility of future recovery.

Although Medicare has no claim until a settlement has actually been reached between the beneficiary and a liable third party, Medicare should send the beneficiary and the beneficiary's attorney notices of possible MSP recovery. Standard form notice letters are included in the manual.

Unless the liability insurer was to pay promptly, the contractor should make a conditional payment for services and send the standard notices of potential recovery. The contractor should then determine from the provider whether there was an accident and determine whether a liability claim was filed, unless the amount paid by Medicare was low (e.g., under $1,000).

The manual emphasizes the need for immediate action to recover the MSP claim if settlement funds have already been received. It recognizes that beneficiary requests for waiver and compromise are more compelling if the funds have been disposed of before the MSP reimbursement claim has been asserted.

The manual states that recovery cannot be made for Medicare services provided for medical conditions not related to the accident. However, it does instruct the contractor to claim MSP recovery if such unrelated services were nevertheless used (e.g., as evidence of damages suffered by the beneficiary) to procure the primary insurance payment. /17/

The manual instructs contractors that they may make an MSP recovery claim after settlement for services rendered before settlement only if the contractor did not know of such services until after the time of settlement.

If there is both automobile-medical or no-fault and other liability insurance, Medicare contractors may not pay for services until after there has been an automobile-medical or no-fault determination. If these payers cover some portion of the expenses, Medicare will then make conditional payment of the balance subject to later recovery from the liability insurance.

If a beneficiary or the beneficiary's attorney wishes to discuss compromise of the MSP claim as part of a total liability-settlement package, the contractor must refer the case to the HCFA regional

office. Such a compromise, whether before or after settlement of the liability action, may be made under the Federal Claims Collection Act /18/ only by regional offices.

When the beneficiary or the beneficiary's attorney attempts to settle a claim prior to initiating litigation, the Medicare contractor must advise the insurer as well as the beneficiary and attorney of the MSP recovery demand.

MIM Sec. 3418.7 -- Designations in Settlements. Medicare does not recognize designations of reimbursed loss items in settlement agreements. Medicare presumes that liability payments are made with respect to medical services rather than pain and suffering or other losses. /19/ This policy extends to wrongful death actions brought by survivors of injured parties. /20/ However, Medicare contractors are instructed that Medicare does recognize allocations to nonmedical losses that are made in judicial or other adjudications on the merits.

MIM Sec. 3418.8 -- Calculation of Medicare's Claim and Procurement Expenses when the Beneficiary Has Been Paid by the Liability Insurer. In calculating Medicare's claim, contractors are instructed to include the cost of services for health conditions that existed prior to the accident if the beneficiary argued that such conditions were exacerbated by the accident. In a seemingly illogical extension of this rule, the manual states that these costs should be included in MSP recovery claims even when all parties agreed prior to settlement that the services were not accident related.

The amount recovered by Medicare is reduced by a proportionate share of the actual cost of procuring a judgment or settlement, which normally includes attorney fees and court costs. Figures supplied by the personal-injury attorney are used to calculate the ratio of actual procurement costs to the insurance proceeds. This ratio is applied to the MSP claim, and the resulting Medicare share of procurement costs is subtracted from the total MSP claim to determine the amount of Medicare's recovery.

Under the prospective payment system, the Medicare flat payment may be more than the provider's charge for services. /21/ In such cases the MSP recovery is limited to the lower provider's charge.

If the primary insurer's payment is less than the MSP claim, Medicare will take it all, minus the costs of procurement.

MIM Sec. 3418.9 -- Settlement Communications/Correspondence. In recognition of Zinman, Medicare now requires beneficiaries to be notified of all written communications to their attorneys. Also, beneficiaries and their attorneys must be notified of Medicare communications to insurers seeking MSP reimbursement.

A form letter attached to the manual sections must be used by Medicare contractors in making initial recovery demands to beneficiaries. This letter advises beneficiaries of the amount claimed by Medicare and about the repayment process and describes the waiver and appeal procedures. It also advises beneficiaries that Medicare may claim interest on unpaid claims during unsuccessful requests for waiver and/or appeal. /22/

MIM Sec. 3418.10 -- Beneficiary Refunds to Medicare. Beneficiaries are allowed to repay Medicare in installments, according to instructions at MIM Sec. 371.9 and the Medicare Carriers' Manual Sec. 7120.9.

If the insurer prepares a check made out jointly to Medicare and the beneficiary, Medicare attempts to obtain the beneficiary's endorsement first, promising to deposit the check in an interest-bearing account pending disbursement.

After the beneficiary has agreed to repay the amount claimed by Medicare or there has been a final decision in an appeal or waiver request, Medicare will give the beneficiary a release. The release agreement form (which is attached to the manual provisions) releases both Medicare and the beneficiary from all claims arising from the accident.

MIM Sec. 3418.11 -- Beneficiary Requests for Reduction or Waiver of Medicare's Claim. Medicare distinguishes among the three statutory bases for waiver. The contractor is empowered only to consider waiver requests under Social Security Act Sec. 1870(c). /23/ Waiver requests under Social Security Act Sec. 1862(b) /24/ and the Federal Claims Collection Act /25/ are referred to HCFA regional offices for resolution. The criteria and procedures for obtaining waiver of MSP recovery are discussed in the following sections of the manual.

MIM Sec. 3418.12 -- Steps in Making a Waiver Determination Under Section 1870(c). When a beneficiary requests waiver under section 1870(c), the contractor is instructed to send both the beneficiary and the beneficiary's attorney a letter requesting completion of an SSA Form 632-BK, which requires specific information concerning the grounds for waiver. /26/ This information includes documentation of procurement costs, accident-related out-of-pocket medical expenses, and expenses and income information that support any claim of financial hardship.

The contractor will then make an initial decision on the waiver request by applying the waiver criteria to the documented facts supplied. /27/ Form letters, which are included in the manual, must be used to advise the beneficiary whether the waiver request is granted in whole or in part, or denied.

MIM Sec. 3418.13 -- Criteria for Waiver Determinations. Under section 1870(c) of the Medicare statute, HCFA may waive recovery of all or part of an overpayment when the beneficiary is without fault and recovery would either (1) defeat the purpose of the Social Security Act or Medicare laws, or (2) be against equity and good conscience. /28/

Factors that contractors should consider include out-of-pocket expenses incurred by the beneficiary; the age of the beneficiary; the beneficiary's assets, monthly income, and expenses; and whether the beneficiary has any physical or mental impairments.

The "without fault" criterion is deemed met in the case of MSP waiver requests.

The "defeat the purposes of the Social Security Act or Medicare laws" criterion is met when a beneficiary does not have an income or resources sufficient to meet the beneficiary's ordinary and necessary expenses. Such expenses include food, shelter, utilities, insurance, medical and other

health expenses not covered by other insurance, support payments, and other expenses necessary to maintain the beneficiary's standard of living. Financial hardship would include situations in which the beneficiary has already spent the insurance proceeds and would have inadequate income to support living expenses if required to repay Medicare; in which the beneficiary already lives at the poverty level (although preexisting poverty is not in itself enough to justify waiver); or in which some unforeseen financial circumstance occurs, such as grandchildren becoming the financial responsibility of the beneficiary. Examples set out in the manual indicate that full or partial waiver under the this criterion is likely to occur when the amount of the settlement is very small (e.g., under $5,000,) when there are present or future uncovered medical expenses, and when the beneficiary's income is both low and lower than the beneficiary's expenses.

The "against equity and good conscience" criterion looks to several factors, including whether (1) the beneficiary contributed to causing the overpayment, (2) Medicare contributed to causing the overpayment, (3) repayment would cause undue hardship to the beneficiary, (4) the beneficiary would be unjustly enriched by waiver, and (5) the beneficiary was harmed by relying on erroneous Medicare information. The manual indicates that partial waiver under this criterion should occur in situations in which, for example, a beneficiary has properly documented out-of-pocket auto replacement expenses that she cannot pay without using part of the insurance proceeds, or in which a beneficiary is permanently disabled with predictable, future out-of-pocket medical expenses.

The manual also gives some examples of situations in which waiver should not be granted. Generally, they involve larger settlement amounts (over $20,000), in which the beneficiary's income exceeds the beneficiary's living expenses and in which the beneficiary has substantial assets.

MIM Sec. 3418.14 -- Allowing Out-of-Pocket Expenses in Waiver Determinations. The manual broadly defines out-of-pocket medical expenses not covered by Medicare to include such health-related costs as housing renovation to accommodate a disabled beneficiary, adult diapers, and coinsurance payments. They do not include funeral expenses or travel costs of relatives.

However, the manual states that out-of-pocket expenses are not automatically allowed and may be denied when the beneficiary can afford to pay them out of other funds.

Documentation in the form of sworn statements, actual bills, or canceled checks is required for waiver of out-of-pocket medical expenses.

MIM Sec. 3418.15 -- Waiver Under Section 1862(b) of the Social Security Act. The MSP section of the Medicare statute specifically authorizes the granting of another kind of waiver when to do so would be "in the best interests of the program." Only HCFA staff in the central or regional offices may exercise this discretionary authority, and the manual states that there is no appeal from their decisions.

MIM Sec. 3418.16 -- Compromise of Claim, or Suspension or Termination of Collection, Under the Federal Claims Collection Act. The Federal Claims Collection Act /29/ authorizes compromise of claims when the cost of collection does not justify collecting the full amount, when the

beneficiary cannot pay in a reasonable time, or when the success of enforcement litigation is questionable. /30/

MIM Sec. 3418.17 -- Beneficiary Appeal of a Waiver Denial or Overpayment Determination. See discussion at MIM Sec. 3419.

MIM Sec. 3418.19 -- Beneficiary Failure to Respond to Requests for Payment. When the beneficiary fails to respond to two collection letters, the contractor is advised to send the file to the HCFA regional office. In such cases the regional office will decide whether to terminate collection efforts under the Federal Claims Collection Act or, perhaps, to refer the case to the Social Security Administration for offset of title II benefits. /31/

MIM Sec. 3418.20 -- Recovery from Estate of Deceased Beneficiary. Medicare retains the right to claim MSP recovery from the estate of a deceased beneficiary if it has not already succeeded in blocking distribution of proceeds from the insurance company or attorney to the estate. The manual urges contractors to act quickly to effectuate MSP demands before distribution of the estate occurs.

Copies of earlier demands for payment are supposed to be sent by the contractor to the executor/administrator. Waiver rights for equity and good-conscience grounds under section 1870(c) are available only to a surviving spouse or dependent of the deceased. /32/

In the case of wrongful death actions, the manual recognizes that Medicare's right to recovery from proceeds is authorized only when the particular state's wrongful death statute expressly permits damages based on medical expenses of the decedent. However, the manual states that, if the state statute does allow such damages, Medicare should presume that all damages are for medical expenses and demand full recovery, even if the actual cause of action requested only damages suffered by the survivors. /33/ In this situation, the only limitation recognized by Medicare on the amount of its claim would be a statutory cap on the amounts recoverable from the tort-feasor for past medical expenses. /34/

MIM Sec. 3418.21 -- Recovery from Liability Insurers. Medicare asserts a right to pursue recovery of the balance of MSP claims against liability insurers who have agreed to settlements on which Medicare was not consulted. The statute also gives Medicare the right to initiate legal action for double damages against liability insurers who do not properly reimburse it. /35/ HCFA presumes the liability insurer knows about the MSP claim when it makes payment to an injured insured 65 years of age or older.

The manual requires that all correspondence with insurers about MSP claims must be sent to beneficiaries as well.

MIM Sec. 3418.22 -- Lead Contractor Responsibilities. The lead contractor is the one who has paid the most in benefits as of the date when an MSP claim is first identified.

This contractor coordinates all matters related to the MSP claim. It logs charges from all contractors related to the liability settlement; keeps the regional office informed; acts as a conduit

for all communications among contractors, /36/ the regional office, and the beneficiary and the beneficiary's representative; and processes requests for appeals.

MIM Sec. 3418.23 -- Lead Contractor's Responsibility to Notify Beneficiary/Attorney and Liability Insurer of Medicare's Interest. The lead contractor should contact the beneficiary, the beneficiary's attorney, and the liability insurer and inform them of Medicare's claim as soon as possible after learning that litigation has been or may be initiated.

Standard form letters that must be used for contacting the beneficiary and the beneficiary's attorney are attached to the manual provision. Both letters state that Medicare must be paid immediately from any settlement proceeds before they are distributed to the beneficiary or spent; however, the letters fail to cite any legal authority that supports this demand.

MIM Sec. 3418.24 -- Nonlead Contractor Responsibilities. Other contractors should confirm the lead contractor's status and forward to it information about benefits to be included in the MSP claim and communications from beneficiaries and other parties.

MIM Sec. 3418.25 -- Calculation of Savings for the MSP Savings Report. Reported savings to the Medicare program consist of the amounts recovered plus procurement costs (but not in excess of amounts paid in benefits). When multiple contractors are involved, priority in being credited with savings goes first to the contractor who paid the largest amount of exhaustible benefits, then to those with declining amounts of exhaustible benefits, and finally to those with declining amounts of nonexhaustible benefits.

MIM Sec. 3418.26 -- Liability Settlement Tracking Report. Contractors are required to send quarterly reports to their regional offices with respect to all cases where a final disposition has been reached (including waiver, appeal, or reimbursement). The report shows the total both of Medicare conditional payments and MSP recoveries for specific cases.

MIM Sec. 3418.27 -- Documenting an MSP Liability Case. The lead contractor must maintain a complete file in each case, with documentation as indicated on a work sheet included with the manual. The file must be maintained by the contractor for at least five years after initial contact with the beneficiary.

MIM Sec. 3418.28 -- Collection of Interest on the Liability Claim. Medicare asserts a right to collect interest on the MSP claim if it is not paid within 60 days after a demand letter is mailed following the beneficiary's receipt of insurance proceeds. If the beneficiary requests waiver or appeal but is not successful, interest will be collected. In the case of more than one debtor, Medicare asserts the right to collect the entire amount with interest from either debtor.

Medicare makes this claim of right to interest under "common law authority that is consistent with the Federal Claims Collection Act . . . and implementing regulations." /37/

The rate of interest will be the higher of the private consumer rate or the current value of funds rate. /38/ It can be charged only on the actual Medicare payment or the provider's charges, if less.

MIM Sec. 3418.29 -- Medicare Health Maintenance Organization Contracts. Both health maintenance organizations and competitive medical plans that contract with HCFA on a cost basis are required to perform MSP recovery functions in the same manner as carrier and intermediary contractors described above. /39/

VI. Conclusion

Despite the success of beneficiaries in Zinman v. Shalala, HCFA continues to assert powers with respect to MSP collections that exceed its authority under the Medicare statute. Mindful of their duties to assist their clients in retaining settlement proceeds, /40/ personal-injury attorneys and other beneficiary advocates should object to HCFA's overzealous collection policies through administrative appeals and litigation.

Footnotes

/1/ 42 U.S.C. Secs. 1395 et seq.

/2/ The Omnibus Budget Reconciliation Act of 1980, Pub. L. No. 96-499, Sec. 953, 94 Stat. 2620 et seq. (Dec. 5, 1980), established the Medicare Secondary Payer (MSP) Program. 42 U.S.C. Sec. 1395y(b).

/3/ The Deficit Reduction Act of 1984, Pub. L. No. 98-369, Sec. 2344, 98 Stat. 1063 et seq. (July 18, 1984), gave Medicare subrogation rights against primary obligors and payees. The Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, Sec. 9201, 100 Stat. 170 (Apr. 7, 1986), removed the 70-year age limit for application of the Employer Group Health Plan (EGHP) provisions of MSP to older workers and their spouses. The Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, Sec. 9319, 100 Stat. 2007 et seq. (Oct. 21, 1986), created a private right of action with double damages for beneficiaries against primary obligors, and extended the EGHP provisions to disabled workers and workers' spouses covered under large group health plans. The Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203, Sec. 4036(a), 101 Stat 1330 et seq. (Dec. 22, 1987), included persons with end-stage renal disease in the EGHP part of the MSP program. The Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, Sec. 6202(a)(2), 103 Stat. 2154 et seq. (Dec. 19, 1989), authorized exchanges of information among the Internal Revenue Service, beneficiary employers, and Medicare contractors to facilitate more effective identification of beneficiaries who are covered by an EGHP.

/4/ EGHPs of specified sizes are prohibited from discriminating in health insurance benefits available to workers and their spouses who are eligible for Medicare because they are disabled or aged 65 or older. Medicare provides only secondary coverage for such EGHP-eligible beneficiaries. 42 U.S.C. Secs. 1395y(b)(1), (b)(2)(A)(i).

/5/ 42 U.S.C. Secs. 1395y(b)(2)(A)(ii), (b)(2)(B).

/6/ The double-damages provision gives Medicare the right to obtain a judgment for twice the amount owed by a private insurer who refuses to pay primarily to Medicare. It is designed to provide a disincentive for withholding funds to insurance companies, which have historically been uncooperative with the MSP program.

/7/ 42 U.S.C. Secs. 1395y(b)(2)(B), (b)(3).

/8/ Id. Secs. 1395ff.

/9/ Id. Sec. 1395y(b)(2)(B)(iv) (waiver provisions in the MSP statute); id. Sec. 1395gg(c) (general provisions for waiver of Medicare overpayments); 31 U.S.C. Sec. 3711 (the Federal Claims Collection Act).

/10/ For more information on the legal and ethical obligations of personal-injury attorneys with respect to MSP claims, see S. Wilson, Medicare Recoveries from Personal Injury Settlement Awards, Arizona Attorney, Mar. 1991, at 25 -- 29. Despite the MSP program's threat of punitive authority over attorneys, the comprehensive new manual provisions described infra do not discuss attorneys' duties to Medicare, and the author knows of no situations where the MSP program has actually taken action against an attorney.

/11/ Zinman v. Shalala, 835 F. Supp. 1163 (N.D. Cal. 1993) (Clearinghouse No. 47,783).

/12/ Although the district court did not specifically rule that attorneys are not liable to HCFA if they distribute settlement awards to their clients without paying Medicare first, the new manual provisions discussed infra make no mention of attorney liability in their extensive discussion of collection procedures.

/13/ Quinlivan v. Sullivan, 916 F.2d 524 (9th Cir. 1990) (Clearinghouse No. 46,188).

/14/ This part of the decision is now on appeal to the Ninth Circuit, awaiting oral argument. Zinman v. Shalala, No. 94-15198 (9th Cir. filed 1994) (Clearinghouse No. 47,783).

/15/ The revised Medicare Intermediary Manual Secs. 3418 and 3419 were effective on November 21, 1994.

/16/ E.g., the 90 days of inpatient hospitalization available in a spell of illness under 42 U.S.C. Sec. 1395d are not reduced to 80 days if MSP reimbursement is received for 10 of those days.

/17/ This would be fair only if the liability insurer or the court actually took the unrelated medical services into account by increasing the amount of the primary payment accordingly. If the insurance payment was not increased by the cost of the unrelated services, the beneficiary has a good argument that there should be no MSP recovery for them.

/18/ Federal Claims Collection Act, 31 U.S.C. Sec. 3711.

/19/ Plaintiffs in Zinman argued unsuccessfully in the district court that the Medicare statute directs Medicare to apportion its recovery when the settlement is less than the beneficiary's total damages. If they are successful in their pending appeal, the agency will have to liberalize this section of the Medicare Intermediary Manual.

/20/ This harsh policy appears to be unjustified on the basis of the language and purposes of the MSP statute. Advocates for beneficiaries should consider challenging it in appropriate cases.

/21/ The prospective payment system, adopted by Medicare in the mid-1980s, bases the amount of payment to a hospital on the average cost of services for patients with a particular diagnosis. Thus the hospital receives a flat fee from Medicare regardless of the costs of the package of services actually required to treat any particular individual.

/22/ In the past, the MSP program has not collected interest, and this statement may intimidate beneficiaries into immediately paying Medicare. In any event, this reference to potential interest charges is likely to have a chilling effect on beneficiary appeals and waiver requests. Similarly, the letter states that Medicare may arrange for the MSP check to be deducted from the beneficiary's social security check. Because Medicare has very rarely done this in the past, the inclusion of the threat to reduce social security benefits appears to be unfairly coercive. Finally, in describing the test for waiver of MSP recovery, the letter recites the condition that the beneficiary not have been at fault in causing the overpayment. However, since in other places the manual provisions concede that beneficiaries are never at fault in MSP situations, this statement also seems to be included in the notice form for the purpose of deterring beneficiaries from exercising their appeal and waiver rights.

/23/ 42 U.S.C. Sec. 1395gg(c).

/24/ Id. Sec. 1395y(b).

/25/ Federal Claims Collection Act, 31 U.S.C. Sec. 3711.

/26/ 42 U.S.C. Sec. 1395gg(c).

/27/ Medicare Intermediary Manual Sec. 3418.13.

/28/ 42 U.S.C. Sec. 1395gg(c).

/29/ Federal Claims Collection Act, 31 U.S.C. Sec. 3711.

/30/ Attorneys for beneficiaries who wish to obtain a reduction of the Medicare claim before pursuing litigation or agreeing to a settlement with the primary insurer should pursue this waiver route. Contractors are advised to refer such inquiries concerning compromise to HCFA regional offices.

/31/ As noted above, offset against social security benefits has rarely been pursued in MSP situations. Presumably the beneficiary would have another chance to request waiver or appeal under social security procedures before offset could actually occur.

/32/ 42 U.S.C. Sec. 1395gg(c).

/33/ This presumption violates the logical underpinnings of such wrongful-death actions and should be challenged by the survivors in such cases.

/34/ The manual section distinguishes this limitation from state law limiting the amount of a tort recovery payable to creditors for past medical expenses. In the latter case, Medicare asserts the right to full recovery of past payments.

/35/ HCFA letters to beneficiaries' attorneys have hinted, without clearly stating, that the attorneys will be held personally liable to Medicare if the amount claimed is not paid. However, the statute and regulations provide no authority for such liability, as the double-damages provision applies only to liability insurers. Attorneys should be encouraged to protect their clients' interests vigorously by the new manual provisions, like the statute and regulations, containing no reference to recovery from attorneys who disburse settlement proceeds to their clients.

/36/ Included in this function is determining how much savings for the Medicare program each contractor is allowed to claim as a result of the MSP recovery. Because contractors are evaluated by Medicare according to the amount "saved" for the program by MSP recoveries, they are motivated to maximize such amounts.

/37/ There is nothing in the MSP statute that suggests Congress intended to incorporate into MSP recovery procedures either common-law debt collection remedies (if these include presumed interest on debts not reduced to judgment) or the powers created by the Federal Claims Collection Act.

/38/ See 45 C.F.R. Sec. 30.13.

/39/ The manual is silent as to MSP recovery rules applicable to Medicare risk-based health maintenance organizations (HMOs). Since a significant percentage of Medicare beneficiaries are now enrolled in such HMOs, it is hoped that HCFA will clarify its rules concerning MSP recovery in such situations soon.

/40/ See In re Schwartz, 141 Ariz. 266, 274 -- 276, 686 P.2d 1236, 1244 -- 46 (1984).