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Annual San Francisco Seminar

Compliance with Medicare Secondary Payer Statute after MMSEA Section 111

presented by

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Medicare Secondary Payer

MSP Compliance Parts

- Past or reimbursement of "conditional payments" – *See 42 USC 1395y(b)(2)(B)(ii)*
- Present or "Reporting" – See 42 USC 1395y(b)(8) and 42 CFR §411.25
- Future or protecting Medicare's interest because "payment [by a primary plan] can reasonably be expected to be made" – See 42 USC 1395y(b)(2)(A)(ii)

Medicare Secondary Payer Act and the Medicare, Medicaid, and SCHIP Extension Act of 2007

What Do Risk Managers and Claims Adjusters Need o Consider in Resolving High Frequency, Low Severity Claims

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eneral verview – MSP Statue and Regulations

- Medicare Secondary Payer Statute (2 USC 1 y) has been in effect since December , 1 80
- he purpose of the statute is to make Medicare a secondary-payer to anyone else whenever there is other Health Insurance or Liability Insurance, including
  - Workers' compensation
  - No-fault insurance
  - Liability insurance (including self-insurance)
- An entity becomes a Primary payer responsible to reimburse Medicare whenever there has been a settlement, judgment, or other payment for a claim in which
  - Medicare has made a conditional payment or
  - Where the person may become Medicare eligible within 0 months of the settlement (for workers' compensation).

eneral verview – MSP Statue and Regulations

he following entities have a legal duty to report potential claims to Medicare

- Medicare beneficiaries (and their legal counsel)
- Providers of medical items or services (i.e. doctors, *et al.*)
- Insurers (and self-insurers) who had reason to believe they were dealing with a Medicare beneficiary (i.e. U!)

Medicare has historically focused its recovery efforts based on claims reported to them by these sources

Implications

□he MSP statutes are focused on reimbursement to Medicare.

- □here are no obligations to Medicare until AF□ER a settlement, judgment, or other payment.
- If Medicare has not paid □conditional payments□then there is no obligation to repay Medicare, even if the claimant is a Medicare beneficiary.
- Contrary to popular belief, there are no statutes or regulations that create a legal duty to □protect□Medicare's interests.
- Medicare does have strong rights of recovery against primary payers. □our primary duty is to protect your company against potential actions by Medicare.

□eneral □verview – MSP Statute and Regulations

- □he MSP statutes have been almost universally ignored since their inception
- Depletion of the Medicare □rust Fund has caused the Federal government to focus on enhancing revenue streams to Medicare
- □he enactment of the Medicare and Medicaid SCHIP Extension Act of 2007 added new stringent reporting requirements to the existing MSP statutes and regulations.

  It did not change any of the existing statutory or regulatory requirements that existed prior to MMSEA 111

- □he duties and obligations owed by a □primary payer□before MMSEA still exist after the enactment of the regulation

Implications

- □here are no absolute rights and wrongs when it comes to MSP compliance, only decisions and consequences.
- Decisions need to be based on a dispassionate analysis of the MSP statutes and regulations measured against potential consequences if the statutes are not followed.
- Purpose of MMSEA is to provide Medicare with a database for pursuing recovery of □conditional payments.□
- Simply put, Medicare can only pursue those claims it knows about.

Implications

- □here is N□□HIN□ in the statutes or regulations that creates a duty to □protect Medicare's interests.□
- Primary take-way□Risk Managers need to take steps to protect their companies' interests against potential claims□actions by Medicare.
- Risk Managers need to decide how or what claims need to be reported to Medicare and the associated risks associated with that decision for their company

Medicare needs to be involved: Mandatory Reporting Thresholds

- □ctober 1, 2011 to December □1, 2012 - □0 to □□,000□
- January 1, 201□through December □1, 201□ -□0 to □2,000□
- January 1, 201□through December □1, 201□ - □0 to □600
  ** and below are exempt from reporting*
- Note that Liability claims □also referred to as □total payment obligation to claimant' or □□P□C□□settled prior 10-1-2011 are not reportable under MMSEA
- Any □P□C claim settled after 10-1-11 in excess of the threshold will need to be reported during the RRE's reporting window □1 2012

Implications

- Because all claims involving a Medicare beneficiary need to be reported to Medicare, what does the Risk Manager or Claims Manager need to consider□
  - Risk Managers should weigh the risk to your firm if a claim involving a Medicare beneficiary is resolved but the settlement is not reported to Medicare
  - Risk Managers should determine your company's appetite for risk vs. the cost savings with your current handling procedures
  - If a claim involving a Medicare beneficiary falls outside my company's appetite for risk, how should those claims be managed differently□

Key Regulations involving MSP – Liability Claims Resolution 42 CFR 411, *et seq.*

Under the regulations, primary payers have always had a duty to report claims under the MSP. □2 CFR □11.2□(a) states□

> If a primary payer learns that CMS has made a Medicare primary payment for services for which the primary payer has made or should have made primary payment, it must give notice to that effect to the Medicare intermediary or carrier that paid the claim.

- □here were no reporting thresholds or penalties for not reporting claims prior to MMSEA
- Subsequent to MMSEA there are reporting thresholds and a □1,000 per day □per claim penalty for not reporting claims to Medicare.

Implications

- With the MMSEA legislation there are now specific penalties for not reporting claims to Medicare (□1,000 per day □per claim).
- Medicare will not accept □P□C claims that are reported that fall UNDER the established thresholds
- Medicare's recovery efforts have historically been dependent on Medicare beneficiaries, providers of items and services, and □primary payers' reporting those situations to Medicare
- Post-MMSEA, with mandatory reporting of Medicare claims, Risk Managers need to decide how to report, and what claims need to be reported to Medicare.

Key Regulations involving MSP – Liability Claims Resolution 42 CFR 411, *et seq.*

Medicare's right to pursue recovery is broad and strong

Medicare has both a direct right of recovery as well as subrogation rights:

> **411.26 Subrogation and right to intervene.**
>
> *(a) Subrogation.* With respect to services for which Medicare paid, CMS is subrogated to any individual, provider, supplier, physician, private insurer, State agency, attorney, or any other entity entitled to payment by a primary payer.
>
> *(b) Right to intervene.* CMS may join or intervene in any action related to the events that gave rise to the need for services for which Medicare paid.

Key Regulations involving MSP – Liability Claims Resolution 42 CFR 411, *et seq*

Under the statutes and regulations, what is Medicare entitled to recover?

Under 42 CFR 411.22(c)(1)(i) and (ii), Medicare is entitled to the lesser of:

(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 primary payment recipient, the amount of the primary payment.

- If Medicare is required to file suit to recover their conditional payments they are entitled to **twice the amount of their recovery**.
- Once a "primary payment" is made by a primary payer, they are subject to the MSP.

Key Regulations involving MSP – Liability Claims Resolution 42 CFR 411, *et seq.*

Will Medicare pursue recovery against ALL Primary Payers, regardless of the amount?

- **§ 411.28 Waiver of recovery and compromise of claims.**
  (a) CMS may waive recovery, in whole or in part, if the probability of recovery, or the amount involved, does not warrant pursuit of the claim
- Current legislation sponsored by the Medicare Advocacy Recovery Coalition ("MARC") may create new statutory thresholds - Stay tuned!
- Thresholds will likely be based on the federal government's cost calculus of cost/benefit of recovery

Key Regulations Involving MSP – Liability Claims Resolution 42 CFR 411, *et seq.*

- **Special Rules (42 CFR 411.24(i)):**

  In the case of liability insurance settlements and disputed claims under employer group health plans, workers' compensation insurance or plan, and no-fault insurance, the following rule applies:

  If Medicare is not reimbursed as required – the primary payer must reimburse Medicare **even though it has already reimbursed the beneficiary or other party**

Implications

- If claim is settled with Medicare beneficiary without resolving Medicare's reimbursement rights, your company may have to pay that claim twice (potentially x if litigation is initiated by the federal government)
- Medicare may pursue recovery from either the Medicare beneficiary or the primary payer
- Medicare's rights are not limited by the settlement agreement between the parties. Medicare chooses who they want to pursue
- Medicare has the right to cut-off a Medicare beneficiary's future benefits (either social security or Medicare benefits) if Medicare is not reimbursed its conditional payments
- Currently three () year statute of limitations (pending appeal in *US v. Stricker*)

Your Questions on Settling the Low Severity High Frequency Claim

- Can minor L claims continue to be resolved at the corporate level

A – es, depending on the Risk Manager's and company's tolerance for Risk

– At what point does Medicare need to be involved

A – If claims fall outside the reporting thresholds they do not need to be reported. If claims fall within the reporting thresholds, **reporting is mandatory**.

Your Questions on Settling the Low Severity High Frequency Claim

– How should a corporate risk department report to Medicare

A – Potential Medicare claims can be reported by a hird Party Administrator, a registered reporting agent or directly to Medicare.

– How should releases be drafted

A – Complex issue
- ne size does not fit all.
- Language needs to be customized to fit the company's appetite for risk and with customer service issues in mind
  - Example If Medicare asserts its rights, and release of Medicare is left to your customers claimants, how will they view your company when their Medicare benefits are suspended Release documents need to be customized to meet your goals.

Your Questions on Settling the Low Severity High Frequency Claim

□ – How should checks be issued□

A – It will depend upon how your company decides how to manage the claim. Simply putting Medicare's name on the check without prior agreement with the claimant as a condition of the settlement generally are not enforceable.

□ – Do we simply need to notify Medicare or do we need to □set aside□ funds□

A – At this time there are no statutes, regulations, CMS Manuals or internal CMS memoranda (as there are with WC claims) that require future medicals be □set aside□ for Medicare. Some have suggested that if the settlement agreement makes an allocation for future benefits, then these future benefits are subject to future Medicare recovery. □his is a controversial issue. We generally do not recommend allocations in a release under current statutes and regulations, especially in small value, high frequency claims.

Your Questions on Settling the Low Severity High Frequency Claim

□ – Are gift cards considered part of the settlement□

A – □es. All forms of payment that serve as consideration to release responsibility of a primary payer for injuries to a Medicare beneficiary in which Medicare has paid conditional payments are subject to the MSP and MMSEA. □he market value of the gift card and not the gift card costs to your company will be considered when applying MMSEA thresholds for reporting to Medicare. If multiple gift cards are given, it will be the total amount of the multiple gift cards that will be used (in addition to any cash payments) to establish if the MMSEA threshold has been reached.

Important Web-sites

MARC (Medicare Advocacy Recovery Coalition)

www.marccoalition.com

CMS

www.cms.hhs.gov/MandatoryInsRep/01_Overview.asp

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Medicare set-asides and personal injury cases - what is the practitioner to do?

By David J. Berg (reprinted and used with author's permission)

Medicare set-asides and personal injury cases - what is the practitioner to do?[1]

The Medicare Secondary Payer ("MSP") statute makes Medicare the secondary payer "in any case where care can be paid for under any liability insurance policy."[2] The MSP statute affects personal injury and workers' compensation clients and attorneys in two ways.

The first has to do with any medical bills related to the client's personal injury or workers' compensation case that Medicare pays for prior to any settlement or judgment in that case. In such a situation, Medicare has a statutory lien on the client's file for the amount of its payments, and, if the client settles the case or receives a judgment in the case, the client must repay Medicare for all bills that Medicare paid.

The second has to do with settlements of most workers' compensation cases exceeding $25,000 where the settlement will close out medical expenses. In this type of settlement, if the client anticipates receiving medical treatment for the injury after the settlement and is either on Medicare or reasonably expects to become a Medicare beneficiary within 30 months of the settlement date, the client must allocate a specified portion of the settlement to what is called a Medicare set-aside account ("MSA").

An MSA is a separate account that the client will use to fund his/her reasonably expected post-settlement medical bills that are related to the injury in question. Medicare will not pay for future related medical expenses until the properly funded and approved MSA is exhausted.

The size of the MSA is usually determined by a financial consultant who is retained by either the client's lawyer or the insurer. The consultant will review the client's medical records and make a recommendation as to how much money should be placed in the MSA. The consultant's report will then be sent to the administrator of Medicare, the Centers for Medicare & Medicaid Services ("CMS"), formerly known as the Health Care Financing Administration ("HCFA"), for approval. Upon approval, the MSA will be funded from the settlement proceeds. After it is funded, the client must file yearly accountings with CMS until the account is exhausted. If an MSA is not set up in a case where CMS thinks that it should be, CMS may suspend or stop Medicare payments.

Recently, personal injury lawyers have been questioning whether MSAs must be funded in settlements of personal injury cases where the client anticipates incurring future related medical expenses and is either on Medicare or reasonably expects to be on Medicare within 30 months of settlement. A thorough review of the MSP statute, its legislative history, its related regulations, CMS's manuals and memoranda, the case law, and the federal government's pleadings in litigation involving MSAs shows that MSAs are not currently required in settlements of personal injury cases. The American Association for Justice ("AAJ") takes the same position. In a message dated Aug. 11, 2009, that was e-mailed to all AAJ members, AAJ President Anthony Tarricone wrote that "statements from CMS, and other federal entities, make clear that the agency does not require set-asides for liability claims."

As previously stated, the MSP statute makes Medicare the secondary payer "in any case where care can be paid for under any liability insurance policy." This language can be read to implicitly authorize, but not require MSAs. Neither the MSP statute, nor its legislative history,[3] contains any language that addresses or describes MSAs or explains how the MSP statute is to be applied to medical bills incurred after a personal injury or workers compensation settlement or verdict.

Since the MSP statute and its legislative history do not explicitly require MSAs in tort cases, the regulations promulgated in support of the statute, 42 C.F.R. Part 411, Subparts C and D, should be reviewed. Subpart C addresses workers' compensation cases and subpart D addresses personal injury cases. However, subpart D contains no regulations that mention the settlement of tort cases. The only regulations in subparts C or D that address what must be done when a client expects to incur future medical bills after settling a case are §§411.46 and 47 in subpart C, but these regulations are specifically limited to settlement of workers' compensation cases.

A review of the original Notice of Proposed Rules in the Federal Register confirms this reading of the regulations. In outlining the proposed Subpart C, HCFA wrote, "The workers' compensation rules need revision to remove outdated content and to make them consistent with the rules pertaining to other types of insurance that are primary to Medicare."[4]

In summarizing the proposed subpart D, HCFA wrote nothing about settlement of tort lawsuits. One can thus reasonably conclude that the regulations indeed neither require MSAs in tort settlements, nor authorize CMS to demand an MSA in tort settlements.

Since the statute and its related regulations do not address MSAs in tort settlements, CMS's memoranda and manuals should be reviewed to determine if CMS ever put the public on notice that it contended that MSAs were required in tort settlements. Although Congress enacted the MSP statute in 1980, and the Department of Health and Human Services ("DHHS"), the parent agency of CMS, promulgated the regulations in 1989, CMS did not lay out a procedure for setting up and filing MSAs until July 2001, when it disseminated a memorandum by then CMS Deputy Director Parashar B. Patel titled

"Workers' Compensation: Commutation of Future Benefits" ("the Patel Memo").[5] The Patel Memo begins as follows:

> *Medicare's regulations (42 C.F.R. 411.46) and manuals (MIM 3407.7 & 3407.8 and MCM 2370.7 & 2370.8)[6] make a distinction between lump sum settlements that are commutations of future benefits and those that are due to a compromise between the Workers' Compensation (WC) carrier and the injured individual. This Regional Office letter clarifies the Centers for Medicare & Medicaid Services (CMS) policy regarding a number of questions raised recently by several Regional Offices (RO) concerning how the RO should evaluate and approve WC lump sum settlements to help ensure that Medicare's interests are properly considered.*

The Patel Memo continues, "It is important to note that set-aside arrangements are **only** used in WC cases that possess a commutation aspect: they are not used in WC cases that are strictly or solely compromised cases."[7] Since the Patel Memo, CMS has issued a number of other formal Memoranda on MSAs. All can be found on CMS's Web site, and all repeatedly refer to "WC," "WC cases," "WC carriers" and "WC benefits," but not to personal injury cases. Only one memorandum refers to third-party liability cases or settlements in liability cases: the April 22, 2003 memorandum, which addressed liability cases only in the context of a work-related injury in which a third party case also exists. The relevant language is in FAQ #19, which states:

> *19) Does CMS require that a Medicare set-aside arrangement be established in situations that involve both a WC claim and a third party liability claim? Answer: Third party liability insurance proceeds are also primary to Medicare. To the extent that a liability settlement is made that relieves a WC carrier from any future medical expenses, a CMS approved Medicare set-aside arrangement is appropriate. This set-aside would need sufficient funds to cover future medical expenses incurred once the total third party liability settlement is exhausted. The only exception to establishing a Medicare set-aside arrangement would be if it can be documented that the beneficiary does not require any further WC claim related medical services. A Medicare set-aside arrangement is also unnecessary if the medical portion of the WC claim remains open, and WC continues to be responsible for related services once the liability settlement is exhausted.*[8]

CMS's manuals only address the application of MSAs in the context of workers' compensation cases. No manual refers to MSAs in the context of liability settlements. A brief example of CMS's position can be seen in its MSP manual, which addresses the procedure that CMS will follow in processing settlements in workers' compensation cases. The MSP manual has a subchapter titled "Recoveries from Liability Insurance Including No-Fault Insurance, Uninsured, or Under-Insured Motorist Insurance." This subchapter addresses Medicare's right to a payback from the settlement proceeds of a tort case, but only in the framework of Medicare's lien for payments previously made.[9] This subchapter contains no language about MSAs.[10]

The review of CMS's regulations, memoranda and manuals has shown that the regulations requiring MSAs indeed apply only to workers' compensation cases, that CMS has only considered those regulations to apply to workers' compensation cases, and that CMS has never considered the regulations to apply to personal injury cases.

This was also the conclusion of a University of Pittsburgh law student who published a note in the *University of Pittsburgh Law Review* in 2006 that stated, *inter alia*, "The regulations dealing with Medicare as a secondary payer to post-settlement medical expenses are specific to worker's compensation, [which weakens] the argument that the MSP statute applies to future medical expenses in personal injury cases."[11] The note continued, "Even if the MSP statute arguably applies to a specific allocation of future medical expenses in personal injury cases, Medicare's authority to disregard a settlement allocation that appears to shift costs onto Medicare refers only to the treatment of a 'work-related condition.'"[12]

The case law was reviewed next. However, there is no case law that addresses how MSAs should be applied. There are not even any recorded appeals from CMS's reviews of proposed MSAs in workers' compensation cases. Accordingly, the pleadings in the very few cases against DHHS with respect to the MSP statute were reviewed in order to determine if DHHS has ever taken a legal position on the purpose of MSAs. Such pleadings would of course constitute judicial admissions. At least two such cases exist and, in each of these cases, DHHS explained the need for MSAs only in the context of the settlement of workers' compensation cases, and even conceded that MSAs are not mandatory in workers' compensation cases.[13] These judicial admissions by DHHS strengthen the points that the MSA process is for workers' compensation settlements only, that current Medicare regulations do not require MSAs in tort settlements, and that DHHS (and thus, CMS) does not take the position that MSAs are required in tort settlements.

Even though CMS does not currently take the position that MSAs are required in tort settlements, it could certainly begin to take such a position at any time. If, however, CMS were to take this position without promulgating regulations authorizing it to do so, its action would be unenforceable as a matter of administrative law for several reasons.

First, there are no regulations that require MSAs in tort settlements, so any attempt by CMS to require them would be invalid unless DHHS promulgated such regulations.[14] Review of the MSP statute shows that Congress did not delegate the authority to DHHS to require MSAs in the settlement of tort cases without promulgating regulations that authorize CMS to do so. The MSP statute provides:

> ***No rule, requirement, or other statement of policy (other than a national coverage determination) that establishes or changes a substantive legal standard governing the scope of benefits, the payment for services, or the eligibility of individuals, entities, or organizations to furnish or receive services or benefits under this subchapter shall take effect unless it is promulgated by the Secretary by regulation under paragraph (1).***[15]

The Supreme Court has held that a "substantive rule" is a legal standard "affecting individual rights and obligations,"[16] or one that "implement[s]" a statute.[17] Another well-known description of "substantive rule[]" is one that "effect[s] a change in existing law or policy."[18] In contrast, an interpretive rule is a rule that is "issued by an agency to advise the public of the agency's construction of the statutes and rules which it administers."[19]

Accordingly, if CMS were to decide that its existing regulations and/or manuals require an MSA in a tort settlement, such an action would clearly effect a change in existing law or policy, and would thus create a new substantive legal standard which could not be implemented without being properly promulgated.[20] For the same reason, CMS could not simply amend its manuals to require an MSA in a tort settlement without properly promulgating them.

Second, if CMS were to require an MSA in a tort settlement without promulgating new regulations authorizing it to do so, CMS would not be entitled to the deference that courts accord an administrative agency's construction of its own regulations under *Chevron, U.S.A., Inc. v. Natural Resources Defense Council*.[21] Even the revision of the CMS manuals or the issuance of a new memorandum would be an insufficient basis for this new practice. In this regard, the Supreme Court has held, "Interpretations such as those in opinion letters - like interpretations contained in policy statements, agency manuals, and enforcement guidelines, all of which lack the force of law - do not warrant *Chevron*-style deference."[22]

Without specific regulations requiring MSAs in tort settlements, any demand by CMS that a Medicare recipient create an MSA in a tort settlement, or any threat by CMS to cease a Medicare recipient's Medicare benefits, should be deemed as nothing more than an agency litigating position. The Supreme Court has held that *Chevron* deference will not be applied to "agency litigating positions that are wholly unsupported by regulations, rulings, or administrative practice."[23]

Third, any demand by CMS that a Medicare recipient create an MSA upon settling a personal injury case or any threat by CMS to cease a Medicare recipient's Medicare benefits on the grounds that the recipient would violate the administrative law fair notice doctrine. This rule holds that the public is entitled to fair notice of an administrative agency's interpretation of the statutes that it administers and of the regulations that it has enacted. The District of Columbia Court of Appeals has summarized this doctrine as follows:

> *If, by reviewing the regulations and other public statements issued by the agency, a regulated party acting in good faith would be able to identify, with 'ascertainable certainty,' the standards with which the agency expects parties to conform, then the agency has fairly notified a petitioner of the agency's interpretation.*[24]

The court continued by stating that when "the regulations and other policy statements are unclear, where the petitioner's interpretation is reasonable, and

where the agency itself struggles to provide a definitive reading of the regulatory requirements, a regulated party is not 'on notice' of the agency's ultimate interpretation of the regulations, and may not be punished."[25] Because neither the Medicare regulations, nor CMS's manuals, letters and memoranda, require MSAs in personal injury settlements, CMS has not to date provided the public with fair notice that MSAs are required in personal injury settlements.[26]

Of course, CMS may make this whole argument moot by promulgating regulations requiring MSAs in personal injury settlements, but, for now, personal injury lawyers should take the position that MSAs are not required in settlements of non-workers' compensation personal injury cases.

Notes

1. This article is based on a brief filed in January 2009, in the case of *Wilson v. Pacific Gulf Marine, et. al.*, Case No. 07-60879-CIV-ALTONAGA (USDC - Southern District of Florida, Miami Division). In that case, the defendants had filed a post-settlement motion to require the plaintiff to create an MSA and asked the court to decide whether an MSA was necessary. *See generally* Defendants and Third Party Defendants' Joint Motion to Require Plaintiff to Set Aside Funds for Medicare or in the Alternative Motion for Clarification, Wilson v. Pacific Gulf, No. 07-60879 (S.D. Fla. filed Jan. 20, 2009). Ralph Mellusi of New York represented the plaintiff, and intended to object on the grounds that an MSA was not required in a tort case. Prior to that time, I had researched this issue for a case in my own office, and had already begun drafting a memo for my office's use. Mellusi and I ended up in touch on this issue, and agreed that, because our firms viewed this issue similarly and because I had already done extensive research on the issue, we should use my research and work together to prepare an objection to the defendants' motion. *See generally* Plantiffs' Opposition to Defendants and Third Party Defendants' Joint Motion to Require Plaintiff to Set Aside Funds for Medicare or in the Alternative, Motion for Clarification, Wilson v. Pacific Gulf, No. 07-60879 (S.D. Fla. filed Feb. 6, 2009). However, the court refused to rule on the merits of the motion, stating that it "declines the parties' invitations to interpret the legal requirements of the Medicare Secondary Payer Act or the Medicare Recovery Act." Wilson v. Pacific Gulf, No. 07-60879, at 3 (S.D. Fla. Mar. 6, 2009) (Order denying Defendants and Third Party Defendants' Joint Motion to Require Plaintiff to Set Aside Funds for Medicare or in the Alternative, Motion for Clarification).

2. 42 U.S.C. §1395y(b)(2)(A) (2006).

3. H.R. Rep. 96-1479, at 133 (1980) (Conf. Rep.), *reprinted in* 1980 U.S.C.C.A.N. 5903, 5924.

4. Proposed Rules, Medicare as Secondary Payer and Medicare Recovery Against Third Parties, 53 Fed. Reg. 22,335-01, 22,339 (June 15, 1988).

5. Parashar B. Patel, Workers' Compensation: Commutation of Future Benefits [hereinafter "the Patel Memo"] (2001). *See also* Frazer v. CNA Insurance Company, 374 F. Supp. 2d 1067, 1075 (N.D. Ala. 2005) (the Patel Memo "clarifies CMS's policy regarding Medicare and workers' compensation settlements").

6. These documents are the Medicare Intermediary Manual and the Medicare Carriers Manual, which are both available on CMS's Web site. See Centers for Medicare and Medicaid Services, Paper-Based Manuals, www.cms.gov/Manuals/PBM/.

7. The Patel Memo, *supra* note 5, at 2.

8. Centers for Medicare & Medicaid Services, Medicare Secondary Payer - Workers' Compensation (WC) Frequently Asked Questions, 7 (Apr. 22, 2003) www.cms.gov/WorkersCompAgencyServices/Downloads/42203Memo.pdf.

9. Medicare Secondary Payer Manual, Chapter 7, ¶50.4.4 *available at* www.cms.gov/manuals/downloads/msp105c07.pdf.

10. *Id. See also* Medicare Secondary Payer Manual, Chapter 2, ¶40, 50 www.cms.gov/manuals/downloads/msp105c02.pdf.

11. Norma S. Schmidt, Note: *The King Kong Contingent: Should the Medicare Secondary Payer Statute Reach to Future Medical Expenses in Personal Injury Settlements?*, 68 U. Pitt. L. Rev. 469, 478-479 & n.58 (2006) (citing 42 C.F.R. §411.46).

12. *Id*. at 479.

13. Walters v. Leavitt, 376 F. Supp. 2d 746, 750 (E.D. Mich. 2005); Brief in Support of Defendant's Motion to Dismiss, *5, n.4, 2005 WL 3873326; Protocols, LLC v. Leavitt, 2007 WL 757644 (D. Colo. 2007), rev'd, 549 F.3d 1294 (10th Cir. 2008); Protocols, LLC v. Leavitt, No. 05-cv-01492-BNB-PAC, Defendant's Motion for Summary Judgment and Supporting Brief, *2-4 (D. Col. 2006).

14. Vitarelli v. Seaton, 359 U.S. 535, 539-540 (1959) (executive agency must obey its own regulations).

15. 42 U.S.C. §1395hh(a)(1) and (2) (2006).

16. Chrysler Corp. v. Brown, 441 U.S. 281, 301-02 (1979) (citations omitted).

17. *Id*. at 302, n.31 (quoting the Attorney General's Manual on the Administrative Procedure Act (1947)).

18. Powderly v. Schweiker, 704 F.2d 1092, 1098 (9th Cir. 1983); *see also* Linoz v. Heckler, 800 F.2d 871, 878-88 (9th Cir. 1986) (where a rule in a CMS manual is substantive and "neither required nor specifically authorized by the enabling legislation,"

the agency "was required to conform with the notice and comment procedure of section 553 of the APA").

19. *Chrysler Corp*., 441 U.S. at 302 n.31. *See also* Shalala v. Guernsey Memorial Hospital, 514 U.S. 87, 99 (1995) (CMS's Provider Reimbursement Manual "is a prototypical example of an interpretive rule 'issued by an agency to advise the public of the agency's construction of the statutes and rules which it administers'").

20. *Cf. Chrysler Corp*., 441 U.S. at 302 n.31. *See Shalala* 514 U.S. at 100 ("APA rulemaking would still be required if [the CMS manual] adopted a new position inconsistent with any of the Secretary's existing regulations.").

21. 467 U.S. 837, 843-44 (1984).

22. Christensen v. Harris County, 529 U.S. 576, 587 (2000).

23. Bowen v. Georgetown Univ. Hosp., 488 U.S. 204, 212 (1988).

24. Gen. Elec. Co. v. U.S. Envtl Prot. Agency, 53 F.3d 1324, 1329 (D.C. Cir. 1995).

25. *Id*. at 1333-1334. *See also* United States v. S. Ind. Gas and Elec. Co., 245 F. Supp. 2d 994, 1011 (S.D. Ind. 2003) ("The inquiry is taken from the perspective of the regulated party (not the agency), and analyzes whether that party could have predicted the agency's interpretation of the regulation at the time of the conduct at issue.").

26. Schmidt, *supra* note 11, at 480.

The Author

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Roy Franco

Roy A. Franco is one of three original founding members of Franco Signor LLC.

Roy is a former risk manager for Safeway Inc. and in his role as the Director of Casualty Claims was responsible for the Company's self-administration liability claims operations involving 1700 facilities in 26 states. It was in this position he was exposed to the Medicare Secondary Payer Act and its adverse impact to closing claims. He originally formed a grassroots organization that developed into the Medicare Advocacy Recovery Coalition (MARC) to advocate responsible changes in the law.

Roy presently serves as the co-chair of MARC and speaks regularly about the Medicare Secondary Payer topic across the country. He is a published author and stays current with the growing cases on the topic by posting blogs on the company's website. His perspective as a former litigation attorney for the defense, labor relations executive, claims manager and risk director provides him with a unique insight on the problem and its possible solutions.

Roy is a graduate of Chaminade University of Honolulu with a double major in Economics and Business Administration. He also holds a law degree from Santa Clara University and licensed to practice in two states – California and Hawai'i.

In 2008, Roy was nominated by Lexis Nexis as one of the most notable people in Workers' Compensation for his work on Medicare Secondary Payer. In 2010 he co-wrote a book for juris publishing on Medicare Secondary Payer Compliance with his partner, Jeff Signor. He now works full-time in this field to protect his clients from the exposures to the Medicare Secondary Payer Act.

LOW, BALL & LYNCH
ATTORNEYS AT LAW

ROBERT J. FRASSETTO

ROBERT FRASSETTO was admitted to practice in California in 1982 and has extensive litigation experience throughout Northern and Central California, including substantive expertise in the defense of claims involving premises liability, strict product liability, closed head injury, sports, leisure, recreational and entertainment liability, catastrophic loss, wrongful death, fire, construction defect and delay, environmental and multiple chemical exposure claims, and Medicare issues in third party litigation. Bob has also served as a private and court-appointed mediator for more than fifteen years, assisting hundreds of litigants in resolving a wide array of tort and contract disputes. He regularly defends major professional sports organizations, amateur athletic clubs and organizations, amusement parks, raceways, theaters, large commercial retailers, and industrial product manufacturers. Bob's Martindale-Hubbell rating is "AV Preeminent."

Bob serves on the Boards of Directors of the Alameda County Bar Association (2010-present) and Friends of UCLA Rowing (2004-present). He is a Panel Mediator, California Court of Appeal, First Appellate District; Settlement Mentor and Panel Mediator, Contra Costa County Superior Court; and Panel Arbitrator, Alameda County Bar Association Attorney-Client Fee Dispute Committee. Bob has also served as a Director (2002-2007) and two-term Education Committee Chair (2004, 2005) of the Association of Defense Counsel of Northern California and Nevada ("ADC"). He is the immediate past two-term Chair and an existing Executive Committee member of the Alameda County Bar Association Alternative Dispute Resolution Section. He is a member of the Bar Associations of Alameda, Contra Costa, Monterey, and San Francisco Counties, the State Bar of California, the Association of Defense Counsel of Northern California and Nevada, and the Defense Research Institute and has lectured and presented on an array of subjects including legal ethics, mediation, closed head injuries, neck and back injury claims, indoor air quality, effective cross-examination techniques, and California's adoption of CACI jury instructions. Along with Roy Franco, Jim Price, and three others, he is one of the founding members of the grass-roots Medicare Reform Task Force (which held its first meeting in January 2006) which formed the Medicare Advocacy Recovery Coalition (MARC) in 2008 to advocate the improvement of the Medicare Secondary Payer program for beneficiaries and affected companies.

Bob attended UCLA (B.A., 1979, English Lit.), earning three Varsity letters and serving as Team Captain (Rowing) for three years, and he attended law school at Santa Clara University (J.D., 1982; American Jurisprudence Award, Torts; Comments Editor, Santa Clara Law Review; Editor-in-Chief, The Advocate) and at Magdalen College, Oxford University (1980).

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Lola Hogan

□ice President of Claims
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Lola Hogan is the □ice President of Claims for Sequoia Insurance, a California based Commercial Property Casualty Company. Prior to joining Sequoia, she served seven years as the □ice President of Claims for the Nonprofits Insurance Alliance of California, a member-owned charitable risk pool for □01(c) □ nonprofit organizations.

Lola began her insurance career in 1□7□ with Safeco Insurance. She has held claims positions with major carriers including Hartford, American States, and □hio Casualty. She earned her CPCU and ARM designations and also holds a Self Insured Administrator's Certificate for Workers' Compensation for California.

Lola is a past two term President of the Central California Chapter of CPCU, and Past President of the Pacific Claim Executives Association.

Her presentations include *"Arbitration and Mediation, New Tricks for Old Claims", □Special Event Insurance", "Alternative Dispute Resolution", "You can Learn to Survive: Living Through Litigation With Mission Intact", and "Lions and Tigers and Bears. Oh My! The Perils, Pitfalls and Passions of Writing Nonprofits"*. She is the also co-author of *What Nonprofit Managers Need to Know About Lawsuits*.

Jim Price

Senior Consultant
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Jim Price is a Senior Consultant at Aon Global Risk Consulting in San Francisco. Jim has over twenty-seven years of experience working for a variety of insurance carriers in senior technical and managerial positions. His chief responsibilities are to support his clients and risk management teams on a variety of claim-technical and risk management issues. These services include coverage analysis and client advocacy; strategic and tactical consulting on specific claim issues; contract; insurance program reviews; insurance policy; risk exposure analysis; program management on self-insured and self-directed insurance programs; development, implementation, and monitoring of claims; risk control "Blueprints"; developing and implementing claims best practices; application of analytical tools in the evaluation of complex claims through weighted probability analysis (decision trees); loss development trending analysis including the use of regression analysis; and implementation of claim cost reduction strategies. Jim currently leads Aon's MMSEA Section 111 task force and is a founding member of the Medicare Advocacy Recovery Coalition (MARC), the chief industry advocacy group working for Medicare Secondary Payer reform.

Jim received his BA degree from the University of California at Santa Cruz with degrees in Economics and Planning and Public Policy in Environmental Studies. He also holds the Associate of Risk Management professional designation awarded by the Insurance Institute of America.