By Michele Hale DeShazo

An Intersection Between the Medicare Secondary Payer Act and Courts

Few subjects have caused more uncertainty and confusion for attorneys than the difficult issue of ensuring that Medicare's interests are adequately protected in a settlement. The Medicare Secondary Payer Act (MSPA) at 42 U.S.C. §1395y, provides the federal government with a priority right of reimbursement for expenses paid by Medicare. Two recent court opinions have analyzed the scope of the MSPA, and offer guidance to practitioners confronted with often perplexing secondary payer issues. Another case regarding Medicare's role in settlements was argued to the United States Court of Appeals for the Sixth Circuit on October 13, 2010, with a decision outstanding.

On September 30, 2010, the United States District Court for the Northern District of Alabama analyzed the reach of the MSPA in *U.S. v. Stricker, et al.*, Northern District of Alabama, Eastern Division, Case No. CV-09-PT-2423-E. The *Stricker* court granted certain defendants' Motions to Dismiss the federal government's suit seeking reimbursement of Medicare benefits in connection with a 2003 class tort settlement. In the September 29, 2010, decision of *Bradley v. Sebelius*, 621 F.3d 1330 (C.A.11 (Fla.) 2010), the United States Court of Appeals for the Eleventh Circuit rebuked Medicare for not recognizing a Florida probate court's allocation of Medicare's recovery amount under the MSPA in a wrongful death settlement. While both cases address different aspects of the MSPA, the common thread present in each is the analysis of often complex issues facing legal practitioners in settlements every day. The third case, *Hadden v. U.S.*, Case No. 1:08-CV-102009, was argued before the United States Court of Appeals for the Sixth Circuit on October 13, 2010, following the appeal of a U.S. District Court for the Western District of Kentucky decision requiring a settling plaintiff to reimburse Medicare for his entire Medicare lien. Many are awaiting the Sixth Circuit's opinion in *Hadden*.

In *Stricker*, the federal government filed suit on December 1, 2009, against the attorneys and corporations involved in a 2003 class tort settlement in order to obtain reimbursement of Medicare benefits paid to the plaintiffs in the settlement class. Defendants filed a Fed. R. Civ. P. 12(b)(6) Motion to Dismiss to argue that the suit was time-barred by the applicable statute of limitations period. The underlying settlement resolved the claims of thousands of plaintiffs who filed toxic tort claims ("the *Abernathy* litigation") beginning in the mid-1990s against Monsanto Company and its related entities due to alleged produced polychlorinated biphenyls ("PCB") contamination in Anniston, Alabama. The global settlement agreement of $300 million dispensed with the claims of 20,500 individuals. The settlement was later approved by an Alabama Circuit Court judge on September 10, 2003, and money was deposited into a settlement account. The settlement was not considered "final" until December 2, 2003 when plaintiffs' counsel filed a certification with the court. The government's filings referenced the December date as the date of the settlement. Conversely, counsel for defendants argued that September 10, 2003 was the relevant date for purposes of determining when the statute of limitations began to accrue since the earlier date is when settlement funds were deposited into the court's account.

More than 14 years after litigation was initiated against Monsanto, the federal government filed *Stricker* to recover reimbursement for its Medicare payments from the corporate defendants named in the *Abernathy* litigation, their insurance carriers and subsidiaries, and certain attorneys who represented the *Abernathy* plaintiffs and allegedly received the settlement funds. Notably, none of the Medicare beneficiaries alleged to have received payments were named as defendants in *Stricker*, nor were they identified by the government in any pleadings. The federal government claimed that 907 recipients of the *Abernathy* settlement funds also received Medicare payments for injuries related to their exposure to PCB. Those payments were alleged to have qualified as reimbursable to Medicare under the MSPA, but were not reimbursed to Medicare within 60 days under 42 C.F.R. §411.22(a), 411.24(h) (2006). The suit also claimed that the corporate entities involved in the settlement were "primary payers" under 42 C.F.R. §411.24(e), and therefore had a responsibility to reimburse Medicare. Section 411.22(b) of the MSPA specifically lists a "judgment," "settlement," or an "award" as examples which may demonstrate "responsibility for payment" by a primary payer, ultimately triggering the obligation to reimburse Medicare.

In analyzing the MSPA, the court stated: Though it has been called "convoluted and complex" by some courts and labeled a "model of un-clarity," *Estate of Urso v. Thompson*, 309 F. Supp. 2d 253, 259 (D. Conn. 2004), the Medicare Secondary Payer Act ("MSPA" or the "MSP

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statute"), put simply, is a statutory reimbursement mechanism for the Government to recover expenses conditionally paid by Medicare. *See* 42 U.S.C. §1395y. The history and purpose of the MSPA "plainly indicate that Congress wanted Medicare's payments to be secondary and subject to recoupment in all situations where one of the statutorily enumerated sources of primary coverage [termed 'primary payers'] could pay instead."

United States v. Baxter Int'l, Inc., 345 F.3d 866, 888 (11th Cir. 2003).

The federal government's suit to recover Medicare payments from the *Abernathy* defendants was dismissed after the court determined that the applicable statute of limitation periods had run with respect to the claims against the corporate defendants and attorney defendants alike. Medicare, therefore, could not recover any payments from the 2003 class settlement. Subsequent to the dismissal of the claims for reimbursement on September 13, 2010, the government filed a Motion for Reconsideration regarding the ruling to argue that the claims were not untimely since each settlement payment constituted a "primary payment" under the MSPA. The government stated that tolling occurred such that the statute of limitations period had not expired on the claims. The court heard the government's Motion for Reconsideration on January 26, 2011, but has not yet ruled on it. A written order is expected.

On September 29, 2010, the Eleventh Circuit handed down the much anticipated *Bradley* decision to limit the ability of Medicare, under the MSPA, to refuse to recognize decisions from state courts regarding Medicare's recovery of payments. In *Bradley*, the underlying facts involved the surviving children of a man who died in a nursing home settling their wrongful death claims with the nursing home and its insurance carrier. The decedent's children entered into a settlement for the tort claims for $52,500, the limits of the nursing home's liability insurance policy. No suit was ever instituted. Later, the decedent's estate notified Medicare of the settlement and corresponding legal fees since Medicare paid for $38,875.08 of decedent's medical care. Medicare would not recognize that the medical claim had been paid, and Medicare's interests fulfilled, until the total amount of medical expenses paid by Medicare less procurement costs, or a net amount of $22,480.89, was paid to Medicare within 60 days. As a result of Medicare's pronouncement, the estate filed an application for an Alabama probate court to adjudicate the rights of the estate and children regarding the compromised sum received for the settlement of the wrongful death claims. Medicare did not take part in the Alabama probate court proceeding, although it received notice and was invited to participate by the estate. The state probate court assessed Medicare's recovery interest at only $787.50, rather than the approximately $22,000 Medicare was seeking to recoup.

Although both *Stricker* and *Sebelius* analyze different aspects of the MSPA, each touches on the critical issue of how far Medicare can go to enforce the MSPA.

However, Medicare would not accept the Alabama probate court's assessment of the value of Medicare's interest in the settlement, relying upon the language contained in the "Medicare Secondary Payer Manual" at Chapter 7, §50.4.4 ("the only situation in which Medicare recognizes allocations of liability payments….is when payment is based on a court order on the merits of a case."). Medicare argued that the probate court's decision was advisory, and thus, was not on the "merits of the case." The estate and children paid Medicare under protest, filed an administrative appeal, and later exhausted all administrative remedies. At the district court level, Medicare's assessment of the estate's liability was upheld as great deference was given to the language included in the Medicare manual.

On appeal to the Eleventh Circuit, the court found that the loss of consortium claims asserted by the decedent's children were property of the children, and not the estate, such that the MSPA had no interest in the settlement concerning those claims. The children's loss of consortium claims did not include the decedent's medical expenses, *i.e.*, the Medicare payments, since a claim for medical expenses belongs only to the estate. The court's opinion contained strong language regarding Medicare's actions, finding that the reliance on a policy field manual over a state probate court's ruling was misguided, and also, admonishing Medicare's failure to participate in the Alabama probate court proceeding. The court also noted that "the Secretary's (Medicare) position would have a chilling effect on settlement" since the Medicare policy manual seemed to encourage Medicare administrators to ignore out-of-court settlements in favor of full-blown trials. *Sebelius* at 1339.

Although both *Stricker* and *Sebelius* analyze different aspects of the MSPA, each touches on the critical issue of how far Medicare can go to enforce the MSPA. *Hadden*, in which the Sixth Circuit's decision is still pending following the recent argument, also addresses Medicare's role in settlements.

In *Hadden*, the U.S. District Court for the Western District of Kentucky dismissed plaintiff, Vernon Hadden's administrative appeal on August 6, 2009, of Medicare's denial of his request for a waiver of recovery of a payment made by Medicare for his medical treatment. Mr. Hadden was injured after being hit by a public utility truck, and subsequently settled his total claims for the injuries with the utility company for $135,000. The terms of the settlement agreement required Mr. Hadden to pay and satisfy all medical liens/expenses associated with the accident. Mr. Hadden's underlying medical treatment was paid for by Medicare, which assessed the conditional payment at $62,338.07 and sought recovery from Mr. Hadden under the MSPA.

Thereafter, Mr. Hadden requested a complete waiver of any Medicare subrogation claim under the MSPA. He argued that Medicare could expect to recover no more than 10 percent of the total principle

amount of any Medicare subrogation claim due to the fact that Mr. Hadden assessed the unidentified motorist who caused the accident to have 90 percent of the fault for the accident. Medicare denied Mr. Hadden's request for compromise under 42 C.F.R. §401.613(c)(2), and upheld the denial after Mr. Hadden sought reconsideration of the decision.

Mr. Hadden later requested a waiver of recovery based on the principles of comparative fault—the entity that Mr. Hadden settled his claims with would have only been assessed 10 percent fault for the accident such that the recovery of Medicare payments should only be 10 percent of the principal amount. Medicare denied Mr. Hadden's application for a waiver of recovery. Mr. Hadden then instituted an administrative appeal of Medicare's decision.

The Medicare Appeals Council adopted the decision of Medicare and the administrative law judge on January 9, 2008. Citing the Medicare Secondary Payer Manual, the same manual discussed in *Bradley*, the council stated that "Medicare policy requires recovering payments from liability awards or settlements, whether the settlement arises from a personal injury action or a survivor action, without regard to how the settlement agreement stipulates disbursement should be made." The council ruled that it would not reduce the recovery amount because Medicare recognizes allocations of liability payments only when payment is based on a court order or adjudged on the merits of the case. The recovery issues in the *Hadden* case, like *Bradley*, are based on a settlement in which allocation of payments to Medicare were not "adjudged on the merits of the case."

The district court in *Hadden* upheld the administrative decisions denying plaintiff's request for a waiver of recovery, relying upon the Medicare Appeals Council's finding that in order to have subrogation principles apply the case must have gone to trial on the merits. Mr. Hadden's suit against Medicare was therefore dismissed, and he appealed that decision to the Sixth Circuit. Arguments took place before the Sixth Circuit on October 13, 2010, although a decision has not yet been issued. If the Sixth Circuit adopts the reasoning applied in the Eleventh Circuit's opinion in *Bradley*, it will not give deference to the Medicare Secondary Payer Manual, and instead, allow for a waiver of recovery in order to encourage out-of-court settlements as a public policy goal.

A practitioner who encounters MSPA questions in settlements, either from the in-house or outside counsel perspective, would be well served to study both the *Bradley* and *Stricker* opinions, and, when it is released, *Hadden*.