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COMMENT

FRUSTRATED SETTLEMENTS: COMMON PROBLEMS AND SOLUTIONS IN LIABILITY SETTLEMENTS INVOKING THE MEDICARE SECONDARY PAYER STATUTES

Jeffrey R. Kuchel*

I. INTRODUCTION

When a third party is responsible for injuring a Medicare-eligible individual and Medicare pays for the resulting medical treatment, the payment is considered conditional and repayment to Medicare is required. Medicare will typically be billed first and pay for the beneficiary's care, but when another party is responsible, Medicare has the right to recoup these "conditional payments" from the responsible party pursuant to the Medicare Secondary Payer Act ("MSP").¹ While Congress intended to reduce costs to protect the Medicare Trust Fund, the MSP is widely recognized as an administrative nightmare by both sides of the bar as it complicates and impedes settlements.² Additionally, under the MSP's authority, the government's ability to mete out stiff penalties against insurers, Medicare beneficiaries, attorneys, and others demands consideration when litigating or settling liability cases.³

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1. 42 U.S.C. § 1395y (2006).

2. David Ingram, *Odd Allies in Medicare Fight*, Natl. L. J. 1, 4 (Aug. 15, 2011).

3. See *infra* part III. In order to accomplish recoupment of conditional payments, CMS has a direct right of recovery, automatic right of subrogation, and a private right of action. If it must resort to

Imagine Fred, a Medicare beneficiary, suffers a broken hip because of a fall at Big Box Store. Fred is hospitalized and Medicare pays \$50,000 for Fred's health care. Fred later sues Big Box Store who denies responsibility but wants to settle. Fred is willing to accept a discounted settlement of \$65,000, but Big Box Store wants to ensure any Medicare liens are satisfied first. But if Big Box Store issues the \$65,000 to Fred, Medicare considers itself a secondary payer to Big Box Store and the \$50,000 is then considered a "conditional payment." Now, if Fred does not reimburse Medicare for the conditional payment, Medicare can seek repayment from Big Box Store, despite its settlement with Fred. Additionally, if Medicare must sue to recoup the conditional payment, it is statutorily entitled to double damages. Even further, anyone receiving payment from a "primary payer," as Big Box Store is in this example, is potentially liable to repay Medicare for the conditional payments in addition to being exposed to potential penalties.

This comment discusses current concerns and potential solutions for situations involving the MSP. While both workers' compensation and liability claims come within the ambit of the MSP, this comment primarily examines issues surrounding liability settlements.

II. BACKGROUND OF MEDICARE AND THE MEDICARE SECONDARY PAYER STATUTES

Medicare provides health insurance to eligible elderly and disabled beneficiaries.⁴ Medicare currently covers over forty-nine million Americans.⁵ The Centers for Medicare and Medicaid Services ("CMS"), an agency within the Department of Health and Human Services ("HHS"), is responsible for administering the Medicare program.⁶ In its infancy, Medicare was the primary payer for its beneficiaries' health care expenses in all circumstances except in cases where health care expenses were incurred as a result of work-related injuries.⁷ In response to the rapidly increasing costs of Medicare, in 1980, Congress enacted the Medicare Secondary Payer Act.⁸ The MSP requires Medicare to be a "secondary payer" behind other entities—so called "primary payers"—responsible for a beneficiary's health

litigation to recover conditional payments, CMS is statutorily allowed double damages plus interest. Additionally, the MSP requires primary payers to report settlements and judgments, and a failure to do so properly results in a \$1,000 per day, per claim penalty.

4. See generally 42 U.S.C. §§ 402–431.

5. The Henry J. Kaiser Family Foundation, *Fact Sheet: Medicare at a Glance* 1, <http://www.kff.org/medicare/upload/1066-14.pdf> (Nov. 21, 2011).

6. Centers for Medicaid and Medicare Servs., *Medicare General Information, Eligibility and Entitlement Manual*, CMS Publ'n 100-01, ch. 1, § 20 (rev. 1, 2002), <http://www.cms.gov/manuals/downloads/ge101c01.pdf>.

7. Pub. L. No. 89-97, 79 Stat. 286 (1965) (codified at 42 U.S.C. § 426a).

8. See *Zinman v. Shalala*, 67 F.3d 841, 843 (9th Cir. 1995); H.R. Rpt. 96-116 at 389 (1980).

care.⁹ Thus, the MSP bars Medicare payments when a primary payer either makes a payment or can be reasonably expected to do so promptly.¹⁰ But when a primary payer does not pay or is reasonably expected not to pay promptly, Medicare may conditionally pay for the beneficiary's services and recover its expenses if a primary payer makes a payment—hence the term “conditional payment.”¹¹

Congress set forth various amendments to clarify and strengthen the MSP in an effort to compensate for the original, 1980 legislation, which lacked the requisite enforcement options to ensure that Medicare was truly a secondary payer.¹² In 1984, Congress amended the MSP, specifically giving CMS a right of subrogation as well as a direct right of action to recover proceeds for conditional payments.¹³

In 2003, Congress enacted the Medicare Prescription Drug, Improvement, and Modernization Act (“MMA”).¹⁴ This Act enabled Medicare to make conditional payments when the primary payer had not paid or payment was not reasonably expected to be made promptly.¹⁵ The MMA provided for retroactive effectiveness of its amendments to the date of the original 1980 legislation,¹⁶ expanded the entities included in the definition of a

9. See 42 U.S.C. § 1395y(b). To avoid confusion, the term “primary payer” is used throughout this comment. However, the MSP and attending regulations use several terms, including “primary plan,” “responsible reporting entity,” and “applicable plan.” Each of these terms refers to the same entity, but in slightly different contexts. Thus, the definition for “primary plan” includes the definition of “primary payer.” The MSP defines “primary plan,” as private health insurance, a workers’ compensation law, an automobile or liability insurance policy or plan (including a self-insured plan), or no-fault insurance. 42 U.S.C. § 1395y(b)(2)(A); 42 C.F.R. § 411.21; see also *Zinman*, 67 F.3d at 845 (“The transformation of Medicare from the primary payer to the secondary payer with a right of reimbursement reflects the overarching statutory purpose of reducing Medicare costs.”).

10. 42 U.S.C. § 1395y(b)(2)(A). “Promptly” is defined as 120 days from the date of service. 42 C.F.R. §§ 411.21, 411.50.

11. 42 U.S.C. § 1395y(b)(2)(B)(i)–(iv); 42 C.F.R. § 411.52 (granting Medicare authority to make conditional payments; *U.S. v. Baxter Int’l, Inc.*, 345 F.3d 866, 875 (11th Cir. 2003) (“if payment for covered services has been or is reasonably expected to be made by someone else, Medicare does not have to pay. In order to accommodate its beneficiaries, however, Medicare does make conditional payment for covered services, even when another source may be obligated to pay, if that other source is not expected to pay promptly” (citing *Cochran v. U.S. Health Care Fin. Admin.*, 291 F.3d 775, 777 (11th Cir. 2002))).

12. Jennifer C. Jordan, *The Complete Guide to Medicare Secondary Payer Compliance*, ch. 1, § 4 (LexisNexis, Matthew Bender).

13. *Denekas v. Shalala*, 943 F. Supp. 1073, 1079 (S.D. Iowa 1996) (citing *U.S. v. Geier*, 816 F.Supp. 1332, 1336 (W.D. Wis. 1993)). Pursuant to 42 C.F.R. § 411.26(a), Medicare has an unfettered right to subrogate, and if it chooses to subrogate, its lien is superior to that of any other creditor entitled to payment by the primary payer. See also 42 U.S.C. § 1395y(b)(2)(B)(ii)–(iii).

14. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 103(b), 117 Stat. 2066, 2155–2158 (2003); 42 U.S.C. § 1395y.

15. Jordan, *supra* n. 12, at ch. 1, § 1.01(5).

16. *Id.* Courts have subsequently supported the retroactive application of the MMA, characterizing the amendments as clarifications of the original law rather than a substantial change in the law. *Id.*

primary plan, and provided the government with the ability to seek double damages if litigation was necessary to recover conditional payments.¹⁷

In 2007, Congress amended the MSP again with the Medicare, Medicaid, and SCHIP Extension Act (“MMSEA”),¹⁸ which, by imposing specific reporting obligations on primary payers, CMS would be better positioned to enforce its existing rights under the MSP.¹⁹ Section 111 of the MMSEA contains the reporting requirement, which is why it is colloquially known as “Section 111 reporting.” Regardless of any liability determination, § 111 requires primary payers to submit a specific report once a claim “is resolved through a settlement judgment, award, or other payment.”²⁰

Following these major amendments, the MSP, which was once difficult to enforce, now had the requisite “teeth” to effect compliance.²¹ Practitioners must be aware of these “teeth” in order to protect their client’s interests and themselves.

III. THE SO-CALLED TEETH

The enforcement enhancements provide a means to protect the Medicare Trust Fund. The amendments discussed above added rights enabling the government to recover conditional payments from various entities in addition to the ability to levy civil, monetary penalties. If a primary payer fails to properly complete the requisite Section 111 reporting following a settlement or payment made to a Medicare beneficiary, the MSP imposes a penalty of \$1,000 per claim, per day of noncompliance against the primary payer.²²

CMS has an automatic right of subrogation to recover conditional payments²³ and a direct right of action to obtain reimbursement from the pri-

17. Jordan, *supra* n. 12, at ch. 1-1, § 5.

18. Medicare, Medicaid and SCHIP Extension Act of 2007, Pub. L. No. 110-173, 121 Stat. 2492 (2007) (codified in relevant part at 42 U.S.C. § 1395y(b)(7–8)).

19. Jennifer Jordan, *Medicare Secondary Payer Enforcement: Shifting the Burden of Medicare to the Private Sector*, 39 *The Brief* 13, 14 (Tort Trial & Insurance Practice Section of the ABA, Fall 2009). Under the MMSEA, primary payers are referred to as “applicable plans” and “responsible reporting entities” and include liability insurance (including self-insurance), no fault insurance, and workers’ compensation laws or plans. 42 U.S.C. § 1395y(b)(8)(F). The MSP, attendant regulations, and the Medicare Secondary Payer Manual published by CMS use varying terminology in different situations.

20. 42 U.S.C. § 1395y(b)(8)(C).

21. See e.g. Kristopher R. Alderman, *The Sixth Circuit Gives Teeth to the Medicare Secondary Payer Act Private Cause of Action*, 8 ABA Health eSource (newsltr. of the ABA Sec. Health L.) (Nov. 2011) (available at http://www.americanbar.org/newsletter/publications/aba_health_esource_home/aba_health_law_esource_1111_alderman.html); Tamara Smith Holtslag & Jennifer L. Rousseau, *Business Law & Business Litigation: New Medicare Secondary Payer Act Has Teeth: How to Protect Your Clients*, 22 *Bar News* (newsltr. of the N.H. Bar Ass’n) 15 (Dec. 16, 2011) (available at <http://www.nhbar.org/publications/display-news-issue.asp?id=6240>).

22. 42 U.S.C. § 1395y(b)(8)(E)(i).

23. *Id.* at § 1395y(b)(2)(B)(iv); 42 C.F.R. at § 411.26.

mary payer and from the entity that receives payment from the primary plan when the claim is paid.²⁴ The MSP also provides for a private cause of action, allowing a beneficiary to bring suit for double damages against a primary payer who fails either to reimburse CMS or to make a primary payment.²⁵ If CMS exercises its rights of recovery by way of litigation to recover conditional payments, it is statutorily entitled to double damages plus interest.²⁶ If no legal action is required, CMS may recover the lesser of the conditional payment or the full payment that the primary payer is obligated to pay.²⁷ Further, if a primary payer pays an injured party, its duty to repay CMS is not extinguished; for if CMS is not reimbursed for the conditional payments as required, the primary payer must reimburse CMS even though it has already paid the beneficiary or other party.²⁸ For example, recall Fred from the earlier example and imagine that he deposits and then spends his entire settlement recovery. When CMS seeks repayment, Fred no longer has the money, but CMS may nonetheless bring suit and is entitled to recover from Big Box Store because it is considered a primary payer. This also applies if a primary payer makes a payment to an entity other than Medicare “when it is, or should be, aware that Medicare has made a conditional primary payment.”²⁹ Because CMS is able to recover with such force, the processes prescribed by CMS should be closely followed to ensure compliance.

IV. THE MEDICARE SECONDARY PAYER CLAIMS PROCESS

CMS contracts with the MSP Recovery Contractor to handle all the functions related to MSP recoveries.³⁰ CMS may be alerted to the existence of an MSP claim prior to any final settlement or judgment.³¹ When this

24. 42 U.S.C. at § 1395y(b)(2)(B)(ii); 42 C.F.R. at § 411.24(b), (e).

25. 42 C.F.R. § 1395y(b)(3)(A). A primary payment is merely a payment made by a primary payer. In situations where the MSP applies, Medicare is the secondary payer and the primary plan is the primary payer. Further, the private cause of action is not a *qui tam* action. *Stalley v. Catholic Health Initiatives*, 509 F.3d 517, 527 (8th Cir. 2007); Tamela J. White, *The Medicare Secondary Payer Act and Section 111 of the Medicare, Medicaid, SCHIP Extension Act of 2007: Implications for Claim Management and Resolution for Liability Insurance Plans*, 77 Def. Couns. J. 180, 186 (Apr. 2010).

26. 42 U.S.C. § 1395y(b)(2)(B)(ii)–(iii); 42 C.F.R. at § 411.24(c)(2), (h), (m).

27. 42 C.F.R. at § 411.24(c)(1).

28. 42 U.S.C. at § 1395y(b)(2)(B)(ii)–(iii); 42 C.F.R. § 411.24(c)(2), (i)(1), (m)(1)–(2).

29. 42 C.F.R. § 411.24(i)(2); *see also Haskell v. Graham*, 2010 WL 2350589 (N.D. Ill. June 10, 2010).

30. Centers for Medicare and Medicaid Services, *Medicare Secondary Payer General Information, Overview*, <https://www.cms.gov/MSPRGenInfo/> (accessed July 22, 2012).

31. *See* Centers for Medicaid and Medicare Servs., *Medicare Secondary Payer (MSP) Manual*, CMS Publ’n 100-05, ch. 6, §§ 10–10.1 (available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019017.html>) [hereinafter *MSP Manual*]. For instance, CMS may be alerted to situations when Medicare should be a secondary payer when notification is received from attorneys or Medicare beneficiaries, through Section 111 reporting, or

occurs, the MSP Recovery Contractor issues a Rights and Responsibilities letter to the beneficiary and his or her attorney, which notifies the recipients that CMS is aware that a primary payer exists and requests further information about any settlements or payments.³² The MSP Recovery Contractor simultaneously searches the beneficiary's health care claims to find any claims related to the accident or injury at issue.³³ Following this initial sweep, the MSP Recovery Contractor issues a Conditional Payment Letter identifying claims believed to have been paid conditionally and thus, the responsibility of the primary payer.³⁴ Importantly, the Conditional Payment Letter indicates only an interim amount.³⁵

When CMS is not notified of a claim until after a settlement or judgment, the MSP Recovery Contractor will conduct a search of health care claims and then issue a Conditional Payment Notice identifying health care claims believed to be the responsibility of the primary payer.³⁶ Parties in receipt of the Conditional Payment Notice have 30 days to provide specific information about the settlement, payment, or judgment, including the amount spent on attorneys' fees and costs and any documentation supporting challenges to specific charges included in the Conditional Payment Notice.³⁷ If the information is received within 30 days, the MSP Recovery Contractor considers any challenges to the initial charges listed and issues a final demand letter, reducing the total amount due proportionally for procurement costs.³⁸ If a timely response is not received, however, the final demand letter will issue requesting repayment of all conditional payments without a proportionate reduction for procurement costs.³⁹

through the Medicare claims process. *Id.* at § 10.0. The entity that initially receives the information is the Coordination of Benefits Contractor ("COBC") who, upon identifying an MSP situation, transfers the entire record to the MSP Recovery Contractor. *See id.*

32. MSPRC, *Rights and Responsibilities Letter Template*, (available at <http://www.msprc.info/forms/RightsAndResponsibilitiesLetter.pdf>).

33. Jordan, *supra* n. 12, at ch. 3, § 3.06.

34. *Id.*; MSPRC, *Conditional Payment Letter*, (available at <http://www.msprc.info/includes/letters/docs/ML040NGHP.pdf>).

35. MSPRC, *Tool Kits, Liability Insurance, No-Fault Insurance, and Workers' Compensation Recovery, Reporting a Case*, <http://www.msprc.info/forms/reporting%20a%20case.pdf> (accessed July 30, 2012). This alone has the ability to frustrate settlement discussions, as the MSP Recovery Contractor's Conditional Payment Letters merely indicate an interim amount and not a final amount due if the case were to settle.

36. MSPRC, *New Conditional Payment Notice Process*, <http://www.msprc.info/forms/cpn.pdf> (accessed July 30, 2012).

37. *Id.*

38. *Id.*; *See* 42 C.F.R. § 411.37.

39. MSPRC, *New Conditional Payment Notice Process*, <http://www.msprc.info/forms/cpn.pdf> (accessed July 30, 2012). Despite the MSP Recovery Contractor's statement otherwise in these situations, courts may require repayment amounts to be reduced by the procurement fees as described in 42 C.F.R. § 411.37. *See e.g. Est. of Washington v. U.S., Sec. of Health & Hum. Servs.*, 53 F.3d 1173, 1175 (10th

Following a final sweep of claims, the MSP Recovery Contractor issues the final demand letter, which must be repaid within 60 days.⁴⁰ If payment is not received within 60 days, interest begins to accrue from the date the demand letter was issued.⁴¹ While Medicare has the option of reducing or waiving its recovery of conditional payments in certain situations,⁴² procurement costs are the only guaranteed deduction from a settlement amount.⁴³

V. PROBLEMS AND PRACTICAL STRATEGIES FOR SETTLING LIABILITY CLAIMS

Congress's amendments to the MSP provided the government several robust means to ensure recovery of conditional payments. These so-called "teeth," and the fact that the government may recover conditional payments from anyone who received a payment from a primary plan,⁴⁴ requires practitioners to take extra caution in liability settlement situations involving a Medicare beneficiary. Although the MSP claims process appears straightforward,⁴⁵ a number of obstacles arise when attempting to settle a claim invoking the MSP. All parties involved are potentially exposed to the MSP's "teeth," but a significant obstacle faced by primary payers is the possibility that it could be required to pay twice if repayment is not made from the original settlement funds.⁴⁶ The liability exposure faced by clients and attorneys warrants an understanding of the law and the diligence to settle a case involving the MSP.

A. *Confirming Medicare Eligibility Status*

The MSP only applies to claims involving Medicare beneficiaries. It follows, then, that the Medicare eligibility status of a plaintiff must be confirmed when approaching settlement discussions. Primary payers must ascertain whether a plaintiff is, in fact, a Medicare beneficiary to determine

Cir. 1985) (court reduced recovery amount, finding that Medicare must abide by the Code of Federal Regulations and must adjust its recovery by procurement costs).

40. 42 U.S.C. § 1395y(b)(2)(B)(ii); 42 C.F.R. § 411.24(h). Notably, "[i]f Medicare is not reimbursed [within 60 days], the primary payer must reimburse Medicare even though it has already reimbursed the beneficiary or other party." 42 C.F.R. § 411.24(i)(1).

41. 42 U.S.C. § 1395y(b)(2)(B)(ii).

42. 42 C.F.R. § 411.28(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."); *MSP Manual*, *supra* n. 31, at ch. 7, §§ 50.6–50.6.5.1.

43. Procurement costs include attorney's fees and costs necessary to procure the settlement or judgment. 42 C.F.R. § 411.37.

44. 42 U.S.C. § 1395y(b)(2)(B)(iii); *see* 42 C.F.R. § 411.24(g).

45. *See supra* part IV (discussing the MSP claims process).

46. 42 C.F.R. § 411.24(h), (i)(1).

whether Section 111 reporting is required.⁴⁷ Naturally, the simplest way for a primary payer to be alerted to a plaintiff's Medicare beneficiary status is by voluntary disclosure. But when the information is not known or disclosed, primary payers responsible for Section 111 reporting have access to a verification system that allows them to search for the plaintiff's Medicare beneficiary status by using the plaintiff's Social Security number or Medicare Health Insurance Claim number.⁴⁸ Unfortunately, this can be problematic as the primary payer may not possess this information, and nothing in the code requires an injured party to provide it.⁴⁹ Nonetheless, courts agree that this information is available through discovery requests.⁵⁰ One court even found it reasonable for an insurer to condition disbursement of settlement funds on a sixteen-year-old plaintiff's provision of her Social Security number in order to limit the insurer's liability under the MSP.⁵¹ Thus, counsel representing a primary payer would be wise to request this information during the early stages of discovery in order to determine if the MSP applies.

B. Providing for Future Medical Expenses: Medicare Set-Asides

An often discussed and troublesome area of the MSP is the use of Medicare set-asides in liability cases. A Medicare set-aside is essentially a trust fund, created by settling parties, to be used to pay for continued medi-

47. 42 U.S.C. § 1395y(b)(8)(A)(i) (providing that an applicable plan shall "determine whether a claimant (including an individual whose claim in unresolved) is entitled to benefits under the program under this subchapter on any basis").

48. See generally Centers for Medicare & Medicaid Services, *Section 111 GHP User Guide*, Version 3.0, 111–113. Available at <https://www.cms.gov/Medicare/Coordination-of-Benefits/MandatoryInsRep/downloads/GHPUserGuideV3.pdf>.

49. Jordan, *supra* n. 19, at 15. For injured Medicare beneficiaries, there is a legal duty to cooperate with Medicare's recovery efforts; otherwise, the beneficiary will face personal repayment responsibility. 42 C.F.R. § 411.23. However, for those that may not be Medicare beneficiaries, there is no similar duty imposed by statute or regulation. For instance, under I.R.C. § 104, compensation for personal injury is not taxable, thus removing one possible legal duty of an injured party to provide her Social Security Number ("SSN") or Health Insurance Care Number ("HICN") to the primary payer.

50. *Seeger v. Tank Connection, LLC*, 2010 WL 1665253 at ** 4–5 (D. Neb. Apr. 22, 2010) (reasoning that one purpose of 42 U.S.C. § 1395y(b)(8)(C) was to avoid having insurers "at the mercy" of plaintiffs when ascertaining Medicare eligibility, and finding that interrogatory requesting the plaintiff's SSN or HICN was reasonable in order to comply with the MSP reporting requirements); *Smith v. Sound Breeze of Groton Condominium Ass'n.*, 2011 WL 803067 at * 3 (Conn. Super. Feb. 3, 2011) (same).

51. *Hackley v. Garofano*, 2010 WL 3025597 at * 4 (Conn. Super. Jul. 1, 2010) (finding that the insurer could condition disbursement of a sixteen-year-old's settlement proceeds upon provision of her SSN in order to comply with Section 111 verification and reporting). The Court also noted that because the SSN or HICN "is essential to the administration of the Medicare program . . . [c]ollection of SSNs for the purpose of coordinating benefits with Medicare is a required, legitimate and necessary use of the SSN under federal law and is thus permitted by HIPAA" *Id.* at *3 n. 2.

cal care relating to the original incident.⁵² By establishing a set-aside for this purpose, the settling parties protect Medicare's future interests.⁵³ While the legal obligations of a tortfeasor or insurer terminate upon settlement, under the MSP, the obligations of a primary payer with regard to future medical treatment do not.⁵⁴ Set-asides are commonplace in workers' compensation settlements, and they have developed with substantial guidance from CMS.⁵⁵ In fact, CMS has provided guidelines for situations requiring a set-aside in workers' compensation cases.⁵⁶ Unfortunately, the MSP and regulations are bereft of clear guidance for liability claims. Nevertheless, set-asides in liability claims should be utilized when the plaintiff will require future medical care.

Although set-aside requirements are not codified, if a plaintiff requires post-settlement medical services because of the original injury, the MSP instructs that Medicare should be the secondary payer. Indeed, all payments made by Medicare are considered conditional—that is to say that Medicare is the secondary payer—when “payment has been made or reasonably can be expected to be made” by a primary payer.⁵⁷ Thus, a settlement between parties does not cause Medicare to relinquish its right of recovery, because if Medicare pays for a beneficiary's post-settlement medical services that relate to the original injury giving rise to the settlement, then the statute applies as though “payment has been made.”⁵⁸ In spite of the lack of express statutory language requiring Medicare set-asides in liability cases, CMS takes the position that they are required.

One of the myriad memorandums distributed by CMS—dubbed the “Patel Memo”⁵⁹—outlined CMS's position that Medicare's interests need to be protected when determining future medical costs. Although the Patel Memo discussed set-asides only in the workers' compensation context, it stated the basic premise—that the set-aside requirement was designed to

52. See Jordan, *supra* n. 19, at 19. CMS defines a Medicare set-aside as “an administrative mechanism used to allocate a portion of a settlement, judgment or award for future medical and/or future prescription drug expenses. For practical purposes, Medicare set-asides are typically referred to as ‘MSAs.’ A set-aside arrangement may be in the form of a Workers' Compensation Medicare Set-Aside Arrangement (WCMSA), No-Fault Liability Medicare Set-Aside Arrangement (NFSA), or Liability Medicare Set-Aside Arrangement (LMSA).” *MSP Manual*, *supra* n. 30, at ch. 1, § 20. To avoid confusion, the term “Medicare set-aside” is often substituted for “medical set-aside.” *Id.*

53. See Jordan, *supra* n. 12, at ch. 4, § 4.01.

54. Jordan, *supra* n. 19, at 19.

55. See 42 C.F.R. §§ 411.46, 411.47.

56. *MSP Manual*, *supra* n. 31, at ch. 1, § 10.4.1; see Memo. from Parashar B. Patel, Deputy Dir., Purchasing Policy Group, Ctr. for Medicare Management, to All Associated Regulations Administrators, *Workers' Compensation: Commutation of Future Benefits* (July 23, 2001) (available at <https://www.cms.gov/WorkersCompAgencyServices/Downloads/72301Memo.pdf>) [hereinafter Patel Memo.].

57. 42 U.S.C. § 1395y(b)(2)(A)(ii).

58. See *id.*

59. See generally Patel Memo., *supra* n. 56.

prevent Medicare from paying for future medical care covered by a primary payer.⁶⁰

Specifically discussing set-asides in the liability context, the moderator of a 2010 teleconference conducted by CMS stated, without further explanation, that while the workers' compensation set-aside process was "formalized," the process for liability set-asides was informal.⁶¹ The informal process referenced was apparently a party's ability to contact the appropriate CMS regional office, which could choose to review a proposed set-aside amount "if they believe there is [sic] significant dollars at issue."⁶² The moderator further noted that even in the absence of a formalized process, the underlying statutory obligation remains the same.⁶³

As is common with the MSP, change appears to be on the horizon. On June 15, 2012, CMS issued an Advance Notice of Proposed Rulemaking to solicit comment on Medicare set-asides in liability situations.⁶⁴ The proposed rule would expressly require the party receiving a settlement to "satisfy Medicare's interest with respect to 'future medicals'" related to the settlement in one of several proposed ways, including a set-aside.⁶⁵

Until such a rule is codified, though, there appears to be no infallible way to consider Medicare's interest with respect to future medical expenses. One commentator describes the issue of whether a Medicare set-aside should be completed as "[o]ne of the most important questions in MSP compliance," which warrants four general questions. If any are answered affirmatively, the MSP may be implicated along with a set-aside:

1. Does the settlement involve compensation for a medical claim from which defendant will be released from responsibility?

60. *See id.* at 1–3.

61. Barbara Wright, Moderator, Town Hall Teleconference, *Section 111 of the Medicare, Medicaid & SCHIP Extension Act of 2007: 42 U.S.C. 1395y(b)(8)* at 41 (Centers for Medicare & Medicaid Services, Mar. 16, 2010) (copy of transcript available at <http://www4a.cms.gov/MandatoryInsRep/Downloads/March16NGHPTranscript.pdf>).

62. *Id.*

63. *Id.*

64. 77 Fed. Reg. 35917–35918 (June 15, 2012).

65. *Id.* at 35917, 35919–35920 (proposed June 15, 2012). Additionally, CMS recently distributed a memorandum announcing that when a beneficiary's treating physician certifies in writing that the treatment for the alleged injury has been completed as of the date of the settlement, Medicare considers its interest satisfied with respect to future medical expenses for that particular settlement. Memo. from Charlotte Benson, Acting Dir., Financial Services Group, Office of Financial Management, to Consortium Administrator for Financial Management and Fee-for-Service Operations, *Medicare Secondary Payer—Liability Insurance (Including Self-Insurance) Settlements, Judgments, Awards, or Other Payments and Future Medicals—Information* (Sep. 30, 2011) (available at <http://www.cms.gov/COBGeneralInformation/Downloads/FutureMedicals.pdf>). Importantly, CMS specified that it would not provide settling parties with confirmation that Medicare's interest with respect to future medicals for that settlement has been satisfied, but encouraged beneficiaries and their representatives to maintain the physician's certification.

2. Is it reasonably likely that the injured person will have ongoing or future medical expenses related to the claimed injury?
3. Are these medical expenses otherwise covered by Medicare?
4. Is the beneficiary likely to be a Medicare beneficiary when such medical expenses are incurred?⁶⁶

Even in liability cases when a Medicare set-aside appears necessary, though, the distinct possibility exists that Medicare may never review, much less approve the set-aside, because unlike workers' compensation set-asides, Medicare does not typically review liability set-asides.⁶⁷ Regardless, settling parties should request a review of a liability set-aside, at least to demonstrate their efforts to comply with MSP.⁶⁸ It is also prudent to include general language in a settlement agreement acknowledging Medicare's rights and how its future interest was considered.⁶⁹

Even absent review or approval, courts may provide a way of demonstrating that Medicare's interests were considered when settling with a Medicare set-aside.⁷⁰ Courts appear willing to issue declaratory judgments finding that parties considered and protected Medicare's future interests when the parties agree to pay any conditional payments and set aside money for possible future medical issues that Medicare could potentially pay.⁷¹ However, despite its pecuniary interest, CMS has been reluctant to join or participate in litigation or settlement proceedings and the judiciary has acquiesced.⁷²

66. Jordan, *supra* n. 12, at ch. 4, § 4.02.

67. Though the CMS regional offices are permitted at their discretion to review cases deemed worthy. Jordan, *supra* n. 19, at 23.

68. *Id.*

69. Jordan, *supra* n. 12, at ch. 7, § 7.03(c). This language may include a general statement that Medicare's future interests were considered when settling followed by an explanation as to how the consideration was accomplished. *Id.*

70. See e.g. *Schexnayder v. Scottsdale Ins. Co.*, 2011 WL 3273547 at *8 (W.D. La. July 29, 2011) (finding that Medicare's interests were "adequately protected" after liability MSA approval was sought from CMS, who responded that approval may not ever be forthcoming); see also *Guidry v. Chevron USA, Inc.*, 2011 WL 6815626 at *5 (W.D. La. Dec. 28, 2011) (same).

71. See e.g. *Frank v. Gateway Ins. Co.*, 2012 WL 868872 (W.D. La. Mar. 13, 2012) (court determined that Medicare set-aside amount was sufficient when CMS refused to intervene); see also *Finke v. Hunter's View*, 2009 WL 6326944 (D. Minn. Aug. 25, 2009) (declaratory judgment requiring repayment of conditional payments, that no MSA was required as the plaintiff was no longer entitled to Medicare and did not possess a reasonable expectation of entitlement to Medicare within 30 months, and that the parties had considered and protected Medicare's future interest); see also *Big R Towing, Inc. v. Benoit*, 2011 WL 43219 at ** 2-3 (W.D. La. Jan. 5, 2011) (declaratory judgment entered ordering plaintiff, who would reasonably be Medicare beneficiary in the future, to set-aside money for forecasted medical care, thereby protecting Medicare's interests).

72. See e.g. *Truett v. Bowman*, 288 F. Supp. 2d 909, 911-912 (W.D. Tenn. 2003) (dismissing CMS for want of subject matter jurisdiction due to sovereign immunity and determining that agency appeal process must be exhausted); see also *Hoste v. Shanty Creek Mgmt., Inc.*, 246 F. Supp. 2d 784, 788-790 (W.D. Mich. 2002) (finding sovereign immunity and a lack of statutory support precluded state court from requiring CMS to attend settlement conference); see also Christopher C. Yearout, *Big Brother is*

VI. MEDICARE'S RECOVERY OF CONDITIONAL PAYMENTS

When Medicare makes conditional payments, the MSP requires repayment once it is established that another individual or entity is responsible as a primary payer. A primary payer's responsibility is generally demonstrated by a settlement, judgment, or other payment.⁷³ The MSP allows CMS to recover conditional payments from any entity that received payment from a primary payer.⁷⁴ As soon as CMS learns that a payment has been, or could be made by a primary payer, it may initiate recovery.⁷⁵

Of course, it seems rather simple that the next step of the process is to submit a payment to Medicare for the amount requested in the demand letter. But in practice, the process can be frustrated by the fact that primary payers do not want to be exposed to additional liability.⁷⁶ Such liability includes the possibility of double payment or a suit from CMS with the potential for double damage and interest.⁷⁷ In cases where Medicare has not yet issued a final demand letter or even a conditional payment letter, the total amount of conditional payments requiring repayment may be hard to calculate.⁷⁸ In these situations, issuing two checks—one to the plaintiff and one to CMS—is risky as the amount of the Medicare lien is not available. Therefore, in order to ensure CMS is repaid from settlement proceeds, primary payers—most often insurers—may add Medicare as a payee on settlement checks.

There is no requirement that Medicare be added as a payee on any check,⁷⁹ but doing so may afford the primary payer the best protection.⁸⁰ However, practitioners should ensure that doing so is a mutually agreed

Not Just Watching, He's Suing: Medicare's Secondary Payer Statute Evolves in Aggressive Pursuit of Fiscal Integrity, 41 *Cumb. L. Rev.* 117, 151–153 (2011).

73. 42 U.S.C. § 1395y(b)(2)(B)(ii) (“a primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary . . . if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means.”).

74. *Id.* at § 1395y(b)(2)(B)(iii).

75. 42 C.F.R. § 411.24(b); *supra*, part IV (discussing the MSP claims process).

76. *See* Jordan, *supra* n. 12, at ch. 3, § 3.06(f); *see also* 42 U.S.C. § 1395y(b)(2)(B)(ii)–(iii); 42 C.F.R. § 411.24(c)(2), (h), (m).

77. *See* 42 U.S.C. § 1395y(b)(2)(B)(iii); *see also* 42 C.F.R. § 411.24(c)(2).

78. CMS implemented a procedure to self-calculate conditional payments amounts in settlements of \$25,000.00 or less when certain requirements are met in order to avoid delay. *See* MSPRC, *New Option to Self-Calculate Your Conditional Payment Amount*, <http://www.msprc.info/forms/Fixed%20Percentage%20Option%20Information.pdf> (accessed July 30, 2012).

79. *See e.g. Hearn v. Dollar Rent A Car, Inc.*, 726 S.E.2d 661 (Ga. App. 2012).

80. Roy A. Franco & Jeffrey J. Signor, *Medicare Secondary Payer Compliance: How to Mitigate Exposure in the Medicare Beneficiary Personal Injury Case* 48 (Juris Publishing, Inc. 2010).

upon term of a settlement as courts may refuse to enforce settlement agreements in the absence of mutual assent.⁸¹ Regardless, in the context of failure-to-pay claims against insurers, some courts have determined that it is reasonable for an insurer to list Medicare as a payee even absent a specific agreement to do so.⁸²

Another way settling parties can avoid future liability under the MSP is by requiring a general indemnification in settlement agreements. Unfortunately, the existence of indemnifications between settling parties does not obviate any responsibilities imposed by the MSP as any agreements are limited in interaction between the settling parties only.⁸³

CMS recently carved out two exceptions to the traditional recovery process, most likely to minimize administrative burden. First, CMS recently announced that it will not recover against a beneficiary's liability settlement, judgment, or other payment if a minimum \$300.00 threshold is not met.⁸⁴ Second, CMS implemented what it calls the "Fixed Percentage Option," allowing beneficiaries receiving a settlement of \$50,000.00 or less to pay 25 percent of the gross settlement, irrespective of the amount of conditional payments made.⁸⁵

81. See e.g. *Tomlinson v. Landers*, 2009 WL 1117399 (M.D. Fla. Apr. 24, 2009) (motion to enforce settlement denied as adding Medicare as payee was not mutually agreed upon and because federal law does not require an insurance company to include Medicare as a payee on a check).

82. See e.g. *Porter v. Farmers Ins. Co.*, 2012 WL 256014 (N.D. Okla. 2012) (reasonable for insurer to initially list Medicare a co-payee on uninsured motorist benefits check before issues regarding Medicare claim resolved); *Wilson v. State Farm etc., Ins. Co.*, 795 F. Supp. 2d 604, 607 (W.D. Ky. 2011) (no bad faith when insurer sought to make Medicare a payee on check before paying limits of uninsured motorist policy); *Lewis v. Allstate Ins. Co.*, 2006 WL 665790 (Tex. App.—Beaumont 2006) (insurer did not breach obligation to pay uninsured motorist benefits by listing Medicare as co-payee on check).

83. See *Jordan*, *supra* n. 12, at ch. 3, § 3.03(b).

84. MSPRC, *\$300 Threshold for Some Liability Insurance (including Self-Insurance) Settlements*, <http://www.msprc.info/forms/300%20Threshold%20on%20Liability%20Settlements.pdf> (accessed Feb. 19, 2012). To be eligible for the \$300 threshold exclusion, the settlement, judgment, award or other payment must be related to an alleged physical trauma-based incident (but does not apply to cases involving alleged ingestion, implantation, or exposure); the liability insurance (including self-insurance) settlement, judgment, award, or other payment is less than or equal to \$300; the beneficiary has not and does not expect to receive any other settlements, judgments, awards, or other payments related to the incident; and Medicare has not previously issued a recovery demand letter. The \$300 threshold does not apply to cases where an insurer is paying or has paid the beneficiary's medical bills directly or on an ongoing basis. *Id.*

85. MSPRC, *Fixed Percentage Option for Medicare's Recovery Claim*, <http://www.msprc.info/forms/Fixed%20Percentage%20Option%20Information.pdf> (accessed July 26, 2012). In order to qualify, the settlement must come from a liability insurance, including self-insurance, but no-fault or workers' compensation settlements do not qualify. *Id.* The settlement must be for a physical trauma-based injury (not related to ingestion, exposure, or medical implant) for a total amount of \$5,000 or less. *Id.* The Fixed Percentage Option must be elected before a demand letter is issued and the beneficiary must not receive any other payments related to the incident. *Id.* No deduction for procurement costs is allowed when using the Fixed Percentage Option. *Id.*

A. *Medicare's Recovery of Conditional Payments from Discounted Settlements*

One of the most highly litigated aspects of the MSP is the amount of conditional payments that CMS is able to recover from a settlement. While the MSP expressly requires that conditional payments made on behalf of a beneficiary be repaid by a primary plan,⁸⁶ neither the MSP nor its attending regulations provide guidance as to the amount of conditional payment recovery in situations involving settlements. Rather, CMS relies on the Medicare Secondary Payer Manual (“MSP Manual”), which provides that a reduction or waiver of recovery will only be permitted where a court order on the merits of the case allocates damages among medical and nonmedical expenses.⁸⁷ This interpretation allows CMS to fully recover conditional payments even where a beneficiary’s settlement is less than the beneficiary’s total damages.⁸⁸ Further, when a settlement is silent as to damages for medical expenses, CMS considers the entire liability payment as being “made ‘with respect to’ medical services related to the injury.”⁸⁹

While CMS’s interpretation undoubtedly provides a means for protecting the Medicare Trust Fund, in practice, its application produces curious results, as the following hypotheticals demonstrate:

First, suppose a case involving \$100,000 in conditional payments. If the case settles for \$50,000, CMS will apply its reimbursement claim of \$100,000 against the entire settlement amount and demand the entire \$50,000, less procurement costs. The Medicare beneficiary would receive nothing.

Now, suppose the same case was tried or arbitrated and the plaintiff was awarded a \$50,000 judgment that apportioned \$10,000 to medical expense and \$40,000 to pain and suffering. Pursuant to the MSP Manual, CMS would direct its reimbursement claim against the \$10,000 allocated for medical expense, less procurement costs. If procurement costs exceeded \$10,000, CMS would receive nothing.

The litigated outcome in the second scenario provides the Medicare beneficiary a more favorable result, but not without cost elsewhere. The Medicare Trust Fund is repaid only a fraction of conditional payments—if at all. Litigation costs are high, and forcing parties to trial severely impedes the well-settled public policy of promoting settlement.⁹⁰ Additionally, in-

86. 42 U.S.C. § 1395y(b)(2)(B)(ii) (“A primary plan . . . shall reimburse [CMS] for any [conditional payment] if it is demonstrated that such primary plan has or had a responsibility to make payment.”).

87. See *MSP Manual*, *supra* n. 31, at ch. 7, § 50.4.4.

88. See *id.*

89. *Id.* (quotations in original).

90. See *Bradley v. Sebelius*, 621 F.3d 1330, 1339 (11th Cir. 2010) (“[CMS’s] position . . . would have a chilling effect on settlement. [CMS’s] position compels plaintiffs to force their tort claims to trial”).

jured Medicare beneficiaries with valid claims may be dissuaded from pursuing tortfeasors.⁹¹ Of course, the hypothetical is possibly so basic that it may be blind to reality. But it is important to note that apportioning arises in various contexts—often by way of state law concerning issues of wrongful death, survivor claims, “made whole” doctrines, and apportioned liability. Despite the apparent fallacies inhering in CMS’s position, though, it has withstood the review of most courts.

Most courts agree that CMS’s interpretation of the MSP, which entitles it to full recovery from settlements, is reasonable and that it comports with Congress’s legislative intent.⁹² In *Zinman v. Shalala*,⁹³ the Ninth Circuit stated, “[r]eading the MSP legislation to allow full reimbursement of conditional Medicare payments even though a beneficiary receives a discounted settlement from a third party is a rational construction of the statute . . . [and is] consistent with the statute’s purpose.”⁹⁴ *Zinman* involved a class action suit filed by Medicare beneficiaries challenging the full recovery of conditional payments from discounted third-party settlements. The class argued that CMS⁹⁵ was required to accept a *pro rata* reduction of a Medicare conditional payment claim when the beneficiary accepted a settlement for less than full value.⁹⁶ In the first of its three arguments, the class argued that the language of the MSP statute required CMS to reduce its recovery.⁹⁷ Second, the class argued that, because CMS had a right of subrogation to effect recovery and because subrogation was equitable in nature, the principle of equitable apportionment was applicable.⁹⁸ Third, the class argued that CMS’s statutory ability to issue a partial payment in some circum-

91. See e.g. *In re Zyprexa Prods. Liab. Litig.*, 451 F. Supp. 2d 458, 469–470 (E.D.N.Y. 2006) (“[T]he full reimbursement approach gives many beneficiaries little incentive to pursue valid claims or, if they do, to accept otherwise reasonable settlement offers, thereby tending to push them into uncertain litigation that burdens the courts and may result in little or no recovery for either the [beneficiary] or for Medicare”); see also Rick Swedloff, *Can’t Settle, Can’t Sue: How Congress Stole Tort Remedies From Medicare Beneficiaries*, 41 Akron L. Rev. 557, 600 (2008).

92. See e.g. *Zinman*, 67 F.3d at 845; *Baxter Int’l*, 345 F.3d at 889 n. 27 (“Courts have uniformly concluded that a settlement agreement that includes a non-itemized element of compensation for a plaintiff’s medical care is ‘for’ medical expenses, even if the exact share or amount is indeterminate”); *contra Bradley*, 621 F.3d at 1338 (CMS’s “*ipse dixit* contained in the field manual does not control the law”).

93. *Zinman*, 67 F.3d at 841.

94. *Id.* at 845.

95. At the time of the decision in 1995, the agency now known as the Centers for Medicare and Medicaid Services (“CMS”) was called the Health Care Financing Administration (“HCFA”). In 2001, the Department of Health and Human Services renamed HCFA to CMS.

96. *Zinman*, 67 F.3d at 843.

97. *Id.* at 844. The class argued that 42 U.S.C. § 1395y(b)(2)(B)(ii), on its face, limited CMS’s reimbursement right. *Id.* The court, however, disagreed. *Id.* at 846. In 2003, the MMA amended the specific language challenged in *Zinman*, seemingly strengthening an argument that the statute itself does not contemplate a diminished recovery in settlements. See *Hadden v. United States*, 661 F.3d 298, 302 (6th Cir. 2011), for a discussion on the amendment’s effect in this context.

98. *Zinman*, 67 F.3d at 844–845.

stances involving a third party plan indicated that CMS was required to reduce proportionally its conditional payment claim.⁹⁹

The Ninth Circuit rejected each of the class's three arguments, finding that CMS's statutory right of reimbursement allowed for complete recovery. Applying *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*,¹⁰⁰ the court held that CMS's interpretation was a permissible construction of the MSP and consistent with the statute's purpose.¹⁰¹ Additionally, the court buttressed its logic stating, "[a]pportionment of Medicare's recovery in tort cases would require either a fact-finding process to determine actual damages or would place Medicare at the mercy of a victim's or personal injury attorney's estimate of damages."¹⁰² CMS often cites this language from *Zinman* in support of the MSP Manual, specifically to disregard apportioned liability payments.¹⁰³

Despite a rather long legacy,¹⁰⁴ the Eleventh Circuit completely rejected *Zinman*'s deference to CMS's interpretation of the MSP in *Bradley v. Sebelius*.¹⁰⁵ In *Bradley*, CMS sought full recovery of its conditional payments where a beneficiary's estate obtained a discounted settlement for a wrongful death claim.¹⁰⁶ Even after a probate court allocated a percentage of the recovery to medical expenses, CMS relied on the MSP Manual to argue that the court's decision was "merely advisory in nature" and that CMS was, therefore, entitled to recovery from the entire settlement rather than just the portion allocated to medical expenses.¹⁰⁷ CMS appealed the probate court's order and a federal district court determined the MSP Man-

99. *Id.* at 845.

100. *Chevron, U.S.A., Inc. v. Nat. Resources Def. Council, Inc.*, 467 U.S. 837, 842–843 (1984). When reviewing an agency's interpretation of a statute that it administers, courts use a two-step process: (1) If "Congress has directly spoken to the precise question at issue[,] . . . the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress" . . . and (2) if "the statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute." *Id.* at 843. An agency's interpretation of a statute, as expressed in a regulation, is entitled to deference unless it is "arbitrary, capricious, or manifestly contrary to the statute." *Id.* at 844.

101. *Zinman*, 67 F.3d at 845.

102. *Id.* at 846.

103. See e.g. Br. of Appellee at 10, *Bradley*, 621 F.3d 1330, 1338 ("But when, as here, a claimant enters into a settlement that resolves medical-expense claims along with other claims, the entire settlement payment is available for reimbursement. In such situations, Congress has sensibly declined to require 'a factfinding process to determine actual damages' or to 'place Medicare at the mercy of a victim's or personal injury attorney's estimate of damages.'" (citing *Zinman*, 67 F.3d at 846)).

104. See e.g. *Farmers Ins. Exch. v. Forkey*, 764 F. Supp. 2d 1205 (D. Nev. 2010) (Medicare's claim for reimbursement of conditional payments is not limited by equitable apportionment); *State Farm Mut. Automobile Ins. Co. v. Cal.*, 1997 U.S. Dist. LEXIS 13564 (Feb. 26, 1997) (state rules of equity do not trump Medicare's statutory right of reimbursement).

105. *Bradley*, 621 F.3d at 1332–1333.

106. *Id.* at 1333.

107. See *id.* at 1334.

ual was entitled to deference, and thus, CMS was entitled to full reimbursement.¹⁰⁸

On appeal,¹⁰⁹ the Eleventh Circuit held that the MSP Manual was not entitled to *Chevron*-deference¹¹⁰ and that CMS's position in regards to apportionments created an "absurd Catch-22 result."¹¹¹ Moreover, the Eleventh Circuit chided CMS for its position, stating that it had a "chilling effect" on settlements and was contrary to the strong public interest in resolution of lawsuits via settlement.¹¹²

The Sixth Circuit recently took a different view in *Hadden v. United States*.¹¹³ In *Hadden*, contrary to the Eleventh Circuit's approach in *Bradley*, the Sixth Circuit treated apportionment and the MSP very similarly to the Ninth Circuit in *Zinman*. Mr. Hadden received a settlement from one of two tortfeasors for approximately ten percent of the total damages.¹¹⁴ Accordingly, he argued that CMS should be limited to only ten percent of its total conditional payment claim, making two of the same points argued by the class in *Zinman*, which the *Hadden* court rejected.

While *Zinman* recognized ambiguity in the MSP,¹¹⁵ it nonetheless found CMS's interpretation of 42 U.S.C. § 1395y(b)(2)(B)(ii)—in that it was allowed to fully recover conditional payments from a settlement—a permissible construction of the statute and thus afforded it *Chevron*-defer-

108. *Id.* at 1335.

109. In defense of its position taken in the MSP Manual, CMS used *Zinman*'s reasoning, arguing that the probate court merely approved the distribution plan provided by the plaintiff's counsel, in effect placing Medicare at the mercy of the estate's attorney to estimate damages. Br. of Appellee at 10, *Bradley*, 621 F.3d at 1338 (citing *Zinman*, 67 F.3d at 846).

110. *Bradley*, 621 F.3d at 1338 ("[CMS's] *ipse dixit* contained in the field manual does not control the law"). The court pointed out that "agency interpretations contained in policy statements, manuals, and enforcement guidelines are not entitled to the force of law." *Id.* (citing *Christensen v. Harris Co.*, 529 U.S. 576, 587 (2000) ("policy statements, agency manuals, and enforcement guidelines, all of which lack the force of law—do not warrant *Chevron*-style deference."); *Shalala v. Guernsey Mem'l Hosp.*, 514 U.S. 87, 99 (1995) (definition in [CMS's] Medicare Provider Reimbursement Manual "is a prototypical example of an interpretive rule" that does not require notice and comment, and therefore "do[es] not have the force and effect of law and [is] not accorded that weight in the adjudicatory process") (internal citations omitted).

111. *Bradley*, 621 F.3d at 1338–1339 ("Clearly if the language of the field manual applied, in practice, it would lead to an absurd Catch-22 result. Forcing counsel to file a lawsuit would incur additional costs, further diminishing the already paltry sum available for settlement. This flies in the face of judicial and public policy.") (footnote omitted). The Court also pointed out that CMS's refusal to participate in the probate court's allocation proceedings and failure to recognize the probate court's order as valid because CMS did not participate is a paradox that has been compared "to the oft-told story of the child defendant found guilty of murdering his parents, only to throw himself upon the mercy of the court because he is an orphan." *Id.* at 1338 n. 19.

112. *Id.* at 1338.

113. *Hadden*, 661 F.3d at 304 (6th Cir. 2011), *pet. for cert. filed*, 80 U.S.L.W. 3573 (U.S. Mar. 30, 2012) (No. 11-1197).

114. *Hadden*, 661 F.3d at 300–301.

115. *Zinman*, 67 F.3d at 845.

ence.¹¹⁶ The court in *Hadden* interpreted the identical statute, but with additional language as amended by the MMA in 2003.¹¹⁷ The *Hadden* court, unlike both the *Zinman* and *Bradley* courts, found no ambiguity in the statute, determining that it explicitly allowed CMS to fully recover conditional payments.¹¹⁸ The court looked specifically to the definition of “responsibility,” as used in the statute,¹¹⁹ which provides that “a primary plan’s responsibility for [repayment of conditional payments] may be demonstrated by . . . a payment conditioned upon the recipient’s compromise, waiver or release . . . of payment for items or services included in a claim against the primary plan.”¹²⁰ By the court’s logic, then, Mr. Hadden’s acceptance of the settlement payment in return for a release of claims made the primary plan responsible; Mr. Hadden’s claim against the third party (the primary payer) defined the scope of the primary plan’s responsibility.¹²¹ The court made a key distinction based on its own statutory interpretation—because Mr. Hadden did not claim just ten percent of the total damages, but rather claimed *all* damages—the scope of the primary plan’s responsibility included all the conditional payments, thus making Mr. Hadden responsible for fully reimbursing CMS.¹²²

Dissenting in *Hadden*, Judge White argued that verbiage in the statute relied on by the majority was not unambiguous,¹²³ and in fact, as interpreted by the majority, created an “absurd result.”¹²⁴ Moreover, the dissent argued, the statute was silent as to whether CMS could recover the entire amount of conditional payments from a beneficiary’s tort recovery without regard to whether the recovery included full payment for the items or services paid for by Medicare.¹²⁵ Importantly, the dissent contended that

116. *Id.*

117. At the time *Zinman* was decided, § 1395y(b)(2)(B)(ii) did not define “responsibility” and read: “A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this subchapter with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service.” 42 U.S.C. § 1395y(b)(2)(B)(ii) (amended 2003). In 2003, Congress enacted the MMA, adding the following language: “A primary plan’s responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient’s compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan’s insured, or by other means.” 42 U.S.C. § 1395y(b)(2)(B)(ii).

118. *Hadden*, 661 F.3d at 302. By contrast, the court in *Bradley* found the identical language to be ambiguous and therefore underwent an analysis to determine if CMS’s interpretation of the statute was entitled to deference. *Bradley*, 621 F.3d at 1337–1338.

119. *Hadden*, 661 F.3d at 302.

120. 42 U.S.C. § 1395y(b)(2)(B)(ii).

121. *Hadden*, 661 F.3d at 302.

122. *Id.* (emphasis added).

123. *Id.* at 306 (White, J., dissenting).

124. *Id.*

125. *Id.*

Chevron is “not the answer to the [MSP]’s silence” since the issue involves an interpretation in the MSP Manual rather than the statute or attending regulations.¹²⁶ Instead, because it is not the product of formal, notice-and-comment rulemaking, the MSP Manual is “‘entitled to respect,’ but only to the extent [it has] the ‘power to persuade.’”¹²⁷

Because of the circuit split, the United States Supreme Court could grant certiorari to review *Hadden*, perhaps resolving the ongoing dilemma regarding CMS’s recovery from apportionments. If (or when) certiorari is accepted, the Court could possibly resolve the issue much as it did in *Arkansas Department of Health and Human Services v. Ahlborn*,¹²⁸ where it limited the government’s right to reimbursement of Medicaid payments to the amount allocated to medical expenses in a settlement. The *Hadden* court distinguished *Ahlborn*, finding that the Medicaid statute contained language limiting the state’s obligation to recover from settlement proceeds paid to a Medicaid beneficiary whereas the MSP did not.¹²⁹ The dissent, however, pointed out that CMS’s suspicion that recognition of non-judicial allocations would allow settlement manipulation, leaving CMS with little to recover was “considered and unanimously rejected” by the Supreme Court in *Ahlborn*.¹³⁰ By granting certiorari in *Hadden* and finding similar to *Ahlborn*, the Supreme Court could settle the dilemma about recovery from discounted settlements.

VII. PROPOSED LEGISLATION

Change may come from the legislative branch as well. In March 2011, Congressmen Tim Murphy (R–PA) and Ron Kind (D–WI) introduced House Bill 1063, entitled “The Strengthening Medicare and Repaying Tax-payers” (SMART) Act,¹³¹ which seeks to improve the efficiency of the MSP recovery system. As discussed above, the obligation to repay Medicare arises only when a settlement, judgment, or insurance payment oc-

126. *Id.*

127. *Hadden*, 661 F.3d at 307 (quoting *Christensen*, 529 U.S. at 587).

128. *Ark. Dep’t of Health and Human Servs. v. Ahlborn*, 547 U.S. 268, 284–285 (2006) (applying the Medicaid statutes, 42 U.S.C. §§ 1396k(a)(1)(A), 1396a(a)(25)(A), to strike down an Arkansas statute that automatically imposed a lien in favor of the State upon settlement payments to Medicaid beneficiaries, which limited the state’s obligation to seek reimbursement from settlement proceeds paid to a Medicaid beneficiary).

129. *Hadden*, 661 F.3d at 303–304 (majority). Arguably, the majority dismissed Mr. Hadden’s argument that *Ahlborn* was apposite by merely characterizing the cases as interpreting “a different term in a different statute.” See Pet. for Writ of Cert. at 23, *Hadden v. U.S.*, ___ U.S. ___ (No. 11-1197).

130. *Hadden*, 661 F.3d at 308 (White, J., dissenting) (discussing *Ahlborn*, 547 U.S. at 288) (“[T]he risk that parties to a tort suit will allocate away the State’s interest can be avoided either by obtaining the State’s advance agreement to an allocation or, if necessary, by submitting the matter to a court for decision.”).

131. H.R. 1063, 112th Cong. (Mar. 14, 2011).

curs.¹³² Medicare, therefore, cannot assert a demand for reimbursement until settlement has occurred. Enactment of the SMART Act would apparently rectify current issues that impede timely settlements.¹³³

The SMART Act would amend the MSP in five significant ways. First, the amendment would allow settling parties to notify CMS up to 120 days prior to a settlement, judgment, award, or other payment, at which point CMS would have 65 days to respond by providing a statement of reimbursement.¹³⁴ If CMS failed to respond, it would waive its right to recovery.¹³⁵ This would allow parties to receive a final determination of the amount of conditional payments made, thus expediting settlement. Second, the SMART Act would require CMS to establish a minimum threshold that would exempt small claims from reporting requirements.¹³⁶ Third, the SMART Act would modify the currently mandatory MSP penalties, making them discretionary.¹³⁷ Fourth, the amendment would require CMS to modify the reporting process so that primary payers do not have to access or report Social Security numbers or health identification numbers.¹³⁸

Finally, the SMART Act provides that the statute of limitations for MSP recovery actions would be three years from receipt of the Section 111 report.¹³⁹ Currently, the statute of limitations applied by federal courts is six years pursuant to 28 U.S.C. § 2415(a).¹⁴⁰ The SMART Act, if enacted, could have a profound effect on settlements implicating the MSP as it would resolve several of the major confusions of the MSP.

VIII. CONCLUSION

From the toothless 1980 statute, the MSP has evolved to a point where parties must be exceptionally cautious when settling in order to avoid the MSP's current "teeth." Although the MSP's evolution has strengthened the government's ability to recoup conditional payments, difficulties remain due to a lack of clear statutory guidance. This difficulty is seen in most areas involving the MSP, but especially in cases involving discounted set-

132. 42 U.S.C. § 1395y(b)(2)(B)(ii).

133. Ingram, *supra* n. 2, at 1, 4.

134. H.R. 1063, 112th Cong. at § 2.

135. *Id.* The proposed legislation, though, does provide a requirement that the parties who requested the statement of reimbursement notify CMS of the failure to respond. In turn, CMS would have an additional 30 days to provide the statement of reimbursement. Otherwise CMS would effectively waive its right to reimbursement absent "exceptional circumstances."

136. *Id.* at § 3.

137. *Id.* at § 4.

138. *Id.* at § 5.

139. *Id.* at § 6.

140. See e.g. *Manning v. Utilities Mut. Ins. Co., Inc.*, 254 F.3d 387, 397–398 (2d Cir. 2001); *Provident Life & Accident Ins. Co.*, 740 F. Supp 492, 505 (E.D. Tenn. 1990).

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tlements and future medical expenses that require a Medicare set-aside. While proposed regulations may resolve some issues concerning Medicare set asides and future expenses, the United States Supreme Court is potentially poised to resolve the amount of recovery that the government can seek from discounted settlements. While these issues await resolution, practitioners would be well served to approach MSP cases proactively by addressing conditional payments amounts and Medicare eligibility during preliminary settlement discussions. Further, diligent efforts to protect Medicare's interests—both past and future—will protect clients and attorneys from the MSP's onerous penalties.

