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ONE SOURCE FOR MEDICARE SECONDARY PAYER COMPLIANCE

Case Law
Summaries of Relevant MSP Cases

CASE 1: Vernon Hadden v. United States

Hadden v. U.S., 661 F.3d 298 (2011), Court of Appeals, 6th Circuit

Facts: Plaintiff Vernon Hadden appeals the administrative decision of the Department of Health and Human Services denying his request for a waiver of recovery of a conditional payment made by Medicare for his medical expenses. On August 24, 2004, Plaintiff was severely injured when he was struck by a public utility vehicle in Todd, Kentucky. The vehicle, owned by Pennyrile Rural Electric Cooperative Corporation ("Pennyrile"), veered leftward and struck Plaintiff, a pedestrian, when an unidentified motorist ran a stop sign. Plaintiff settled his claims against Pennyrile and its driver for $125,000 in addition to receiving $10,000 in Kentucky basic reparations benefits. Under the terms of a release/indemnity agreement, Plaintiff agreed to pay and satisfy all medical expenses, liens, and/or claims related to the incident.

Plaintiff's medical expenses were conditionally paid for by Medicare pursuant to the Social Security Act, 42 U.S.C. § 1395 et seq. Under the Medicare Secondary Payer Act, the Administrator of the Centers for Medicare and Medicaid Services ("CMS") has a statutory right of recovery of conditional payments made by Medicare where a payment has been made under liability or no-fault insurance. 42 U.S.C. § 1395y(b)(2). CMS assessed Plaintiff's conditional payment in the amount of $62,338.07 and sought recovery pursuant to 42 C.F.R. § 411.23. In total, Plaintiff submitted payments to CMS for $64,252.37.

On August 28, 2008, the Medicare Appeals Council (“Council”) issued an amended decision finding no merit to Plaintiff's argument that the amount of recovery should be reduced to ten percent of the principal amount based on Kentucky comparative fault principles. Citing the Medicare Secondary Payer Manual, the Council explained 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 held 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 and, in this instance, payment was based on a settlement. Furthermore, the Council found that "the allocation of liability in this case is speculative since it was not determined by a judge or jury." The Council also held that Medicare does not recognize the "make whole" doctrine. The Council explained that Plaintiff had submitted no evidence demonstrating that the recovery would cause undue hardship, that he had changed his position to his detriment because of the recovery, or that he had been put in a worse position than before the accident. For these reasons, the Council determined that the recovery would not be against equity and good conscience and affirmed the ALJ's decision denying Plaintiff's waiver request.

District Court's Holding: As the Medicare Appeals Council explained, any allocation of liability proposed by Plaintiff would be purely speculative. Plaintiff offered no evidence demonstrating that recovery is against equity and good conscience. There is no evidence in the record, nor does Plaintiff argue, that the repayment would cause him undue hardship or that he changed his position for the worse or relinquished a valuable right because of the repayment. The case law cited by Plaintiff does not support his argument. For these reasons, the Court concluded that the findings of the Secretary are supported by substantial evidence.

In its amended decision, the Council held that Medicare did not recognize the "made whole" doctrine. As Plaintiff cited no legal authority in support of the "made whole" doctrine, nor explained its application in this case, the Court concluded that the findings of the Secretary were supported by substantial evidence.

The decision of the Department of Health and Human Services was upheld and dismissed with prejudice.

Court of Appeal's Holding: The Court of Appeals affirmed the district court's ruling for the reasons stated by the district court. The U.S. Supreme Court declined to hear the Hadden case.

CASE 2: Zinman v. Shalala

Zinman v. Shalala, 67 F.3d 841, 9th Circuit. (1995)

Facts: This is a class action challenging HHS's interpretation and implementation of the Medicare Secondary Payer provisions of the Social Security Act, 42 U.S.C. § 1395, et seq. As first enacted, Medicare was the primary payer for medical services supplied to a beneficiary, even when such services were covered by other insurance such as an employer group health plan or liability insurance. Responding to skyrocketing Medicare costs, Congress in 1980 enacted the Medicare Secondary Payer legislation (MSP legislation), requiring Medicare to serve as the secondary payer when a beneficiary has overlapping insurance coverage. 42 U.S.C. § 1395y(b).

Under the MSP legislation, when a Medicare beneficiary suffers an injury covered by a group health plan or liability, workers' compensation, automobile or no-fault insurance, Medicare conditionally pays for the beneficiary's medical expenses. 42 U.S.C. § 1395y(b)(2)(B)(i). If the beneficiary receives a settlement from the primary insurer, Medicare is entitled to reimbursement from the beneficiary for its conditional outlays. 42 U.S.C. § 1395y(b)(2)(B)(ii). HHS has interpreted the MSP legislation to allow full recovery of conditional Medicare payments even when the beneficiary's settlement is for less than her total damages (i.e., a discounted settlement). This interpretation is set forth in 42 C.F.R. § 411.24(c). This regulation provides in pertinent part that the Health Care Financing Administration "may recover an amount equal to the Medicare payment or the amount payable by the third party, whichever is less." Id.

The beneficiaries argue that ascertaining the dollar amounts of a victim's elements of damages is not a prohibitive burden. We reject this argument because it analogizes workers' compensation cases to tort cases. The analogy is inapt. Workers' compensation schemes generally determine recovery on the basis of a rigid formula, often with a statutory maximum. See Larson, The Law of Workmen's Compensation, Vol. 1, § 1.10 at 1-2, § 2.20 at 1-10 (1993). Apportionment in workers' compensation settlements therefore involves a relatively simple comparison of the total settlement to the measure of damages allowed for individual components of the settlement, pursuant to a prescribed formula. Tort cases, in contrast, involve non-economic damages not available in workers' compensation cases, and a victim's damages are not determined by an established formula. Apportionment of Medicare's recovery in tort cases would either require 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.

Holding: HHS construed the legislation to permit it to recover up to the full amount of its conditional Medicare payments. This is a permissible construction of the statute. Accordingly, the court upheld this construction, and affirmed the district court's summary judgment in favor of HHS.

Current Disposition: No further appeals.

CASE 3: U.S. v. Paul J. Harris

U.S. v. Paul J. Harris, Civil Action No. 5: 08CV102, United States District Court for the Northern District of West Virginia 2009 U.S. Dist. Lexis 23956 March 26, 2009, Decided; March 26, 2009; Filed

Facts: On or about May 22, 2002, Mr. James Ritchea, a Medicare beneficiary, sustained injuries when he fell off a ladder. As a result of his Medicare status, the Centers for Medicare and Medicaid Services "CMS" paid approximately $22,549.67 in Medicare claims submitted on behalf of Mr. Ritchea for medical services. Mr. Richtea and his wife retained the attorney Paul J. Harris to sue the ladder retailer. The action was settled in July 2005 and Mr. Ritchea and attorney Harris received the sum of $25,000. Mr. Harris forwarded to Medicare details of this settlement payment. As well as his attorney's fees and costs. Medicare, based on this information, calculated that it was owed approximately $10, 253.59 out of the $25,000 settlement. CMS informed Mr. Harris of this decision and of his appeal rights. Neither Mr. Harris nor his clients filed an appeal and the debt was not paid. Now, because the amount was not paid to Medicare within the 60 day time period, CMS claims it is entitled to its calculated share of the settlement plus interest. Accordingly, CMS seeks $11,367.78 plus interest from Mr. Harris for the Medicare claims paid on behalf of Mr. Ritchea.

Holding: The plaintiff's motion for summary judgment was granted and the motion was denied as moot. CMS is entitled to judgment in the amount of $11,367.78 plus the amount of interest to be calculated.

Current Disposition: Appealed to the 4th Circuit Court of appeals where it was affirmed finding no reversible error and affirmed for reasons stated by the district court for the northern district of West Virginia.

CASE 4: Humana Medical Plan, Inc. v. Cooke

Humana Medical Plan, Inc. v. Cooke, Humana Medical Plan, Inc. v. Mary Reale and Donna B. Michaelson, P.A., No.10-21493-Civ-COOKE/BANSTRA, United States District Court for Southern District of Florida, 2011 U.S. Dist. Lexus 8909, January 31, 2011, Decided; January 31, 2011, Entered on Docket.

Facts: Humana Medical Plan, Inc. (Humana) paid for treatment Ms. Mary Reale underwent due to a slip and fall accident. Humana made the payments as a Medicare Advantage plan providing Medicare benefits to Ms. Reale. Ms. Reale eventually sued and recovered damages in relation to the slip and fall from the Condominium Association. The amount she recovered was greater than the amount that Humana paid. Humana sought recovery of the amount it paid arguing it was entitled to reimbursement under 42 U.S.C. § 1395y(b)(2) (MSP).

Defendants argued the court did not have subject matter jurisdiction as Humana should not have a private cause of action under the MSP. Humana argued the court had subject matter jurisdiction as there was "an important and 'substantial' issue of federal law." (ECF No. 19 at 2).

Holding: The court ruled that Medicare Advantage plans have the same reimbursement rights as the Secretary

under the MSP. The court further noted the Secretary did not have the right to seek reimbursement, only the United States did. As the Secretary did not have the right to recover, neither did Humana.

Current Disposition: The defendant's Motion to Dismiss was granted on January 31, 2011.

CASE 5: Bradley v. Sebilius

Bradley v. Sebilius, 621 F. 3d 1330, 11th Cir. (2010)

Facts: The Plaintiffs had settled a wrongful death claim against a Florida nursing home for the death of their mother. During the decedent's stay in the nursing home, Medicare paid $38,875.08 for the decedent's medical care. CMS was notified of the settlement proceeds and associated legal fees and costs. CMS refused to recognize that the medical expenses had been settled for less than 100% and claimed that CMS had the authority to claim the total amount less the procurement costs. The estate was given sixty days to pay Medicare.

Plaintiffs, the surviving children and estate, filed with the probate court an application for the court to adjudicate the rights of the estate and rights of the children in regards to the compromised sum received in settlement of the case. CMS declined to participate in the proceedings. The state probate court determined that based upon principles of equity, the medical expense recovery in the case was $787.50. CMS refused to accept the probate court's determination and contended that it was pre-empted by federal law. CMS also argued that it was contrary to language contained in MSP Manual Chapter 7 sub-section 50.44 which states that the only situation in which Medicare recognizes allocations of liability payments to non-medical losses is when payment is based on a court order on the merits of the case. On appeal, the District Court upheld the Secretary's decision which is the subject of this appeal.

Holding: The Court found that the District Court erred in upholding the decision of the Secretary because it was unsupported by substantial evidence in the record taken as a whole. In reaching this decision, the Court noted that Florida law and Florida courts have consistently found that the proceeds from a wrongful death action are the property of the survivors and not the estate. In light of this, only the estate's allocated share of the proceeds is subject to the province of the Secretary. Although the Secretary was given notice of the probate court's hearing on the issue, the Secretary declined to participate.

The Court further found that the Secretary's deference to the language in the MSP Manual was misplaced and did not have the effect of law. In addition, there is a strong public interest in the resolution of lawsuits by settlement which would be adversely affected by condoning the Secretary's position.

Current Disposition: The case was remanded back to the District Court for further proceedings.

CASE 6: Seger v. Tank Connection, LLC

Seger v. Tank Connection, LLC, 2010 U.S. Dist. LEXIS 49013

Facts: Mr. Gary Seger sustained injuries on December 13, 2006, while employed by Valmont Industries, Inc. Mr. Seger was splattered by molten zinc which caused third degree burns over at least 60% of his body. Mr. Seger also suffered amputation of his left foot along with a portion of his right foot. He further lost some fingers on both his left and right hand. Mr. Seger further suffered a heart attack and multiple strokes. Mr. Seger

contended that the I-beams he was working with were not manufactured correctly.

As part of the litigation process, Mr. Seger was asked about his Medicare and Social Security Disability statuses. Mr. Seger argued he did not need to provide his information until after settlement.

Holding: The court ruled that defendants met the burden indicating the Medicare and Social Security Disability information was relevant. There was no harm to Mr. Seger in providing the information pre-settlement. The court further ruled that providing the information was not unduly burdensome.

Current Disposition: No further appeals.

CASE 7: Protocols, LLC v. Leavitt

Protocols, LLC v. Leavitt, 549 F.3d 1294, (10th Cir. 2008)

Facts: In December of 2008, Protocols, LLC brought a declaratory judgment action against Defendants Leavitt, the Secretary of the U.S. Department of Health and Human Services (HHS) and Dr. McClellan, then the Administrator of the Centers for Medicare and Medicaid Services (CMS). The suit claimed that a CMS memorandum issued in 2005 misinterprets the Medicare statute and exposes Protocols to unexpected liabilities arising out of settlements it has structured. The 2005 CMS memorandum specifically addressed the compromising of future medical expenses based on 42 C.F.R. sections 411.47. It stated that "the compromise language in this regulation only addressed conditional (past) Medicare payments. It also noted that CMS does not allow the compromise of future medical expenses related to a workers' compensation injury." Protocols argued that this memorandum was invalid since it conflicts with the MSP statute and 42 C.F.R. section 411.47. It also argued that the government bears the burden to prove noncompliance with 42 C.F.R. section 411.46 and that the memo was promulgated without compliance with the rulemaking procedures established by the Administrative Procedure Act (APA).

The Defendants filed a motion for summary judgment. The district court granted the motion which was appealed by Protocols. The Court of Appeals found that Protocols had standing since their potential liability presented a sufficient injury to confer standing under Article III of the U.S. Constitution. The case was remanded to the district court for further proceedings and was subsequently withdrawn by Protocols since they were bought out by another company.

Holding: The Court found that Protocols had established Article III of the U.S. Constitution standing to bring suit. The contingent liability which Protocols had identified presented an injury should CMS refuse to recognize the validity of settlements structured by Protocols, and a ruling favorable to Protocols would eliminate Protocols' potential liability and the consequences of that potential liability.

Current Disposition: The case was remanded to the district court for further proceedings, including a decision on Defendants' other arguments for summary judgment.

CASE 8: U.S. v. Stricker, et al.

U.S. v. Stricker, et al., Case No. CV-09-KOB-2423-E, U.S. District Court for the Northern District of Alabama

Facts: In December of 2009, the U.S. Department of Justice, pursuant to the Medicare Secondary Payer ("MSP") Act filed a civil action to recover conditional payments made to a group of 907 Medicare beneficiaries involved in a $300,000,000.00 class action liability lawsuit that was settled. The settlement called for continuous payments through 2013 to be made by the insurers to the Medicare beneficiaries. The Defendants in the current action involved parties to the settlement such as the plaintiff's attorneys, the Defendants in the earlier class action suit and the insurers among others.

The MSP states that Medicare will be a secondary rather than primary payer for its insured parties. In light of this, Medicare has the power to recoup its payments from both the primary payer and from the recipient of such payment. The statute of limitations for the Government's claims is governed by the Federal Claims Collection Act ("FCCA"). It provides that tort actions must be filed within three years after the right of action first accrues, while contract actions must be filed within six years after the right of action first accrues. According to 42 C.F.R. section 411.24(b) the Government's right to initiate recovery of the conditional payments begins "as soon as it learns that payment has been made or could be made under workers' compensation, any liability or no-fault insurance, or an employer group health plan".

In the instant case, the Court noted that the applicable statute of limitations depended upon the type of defendant being sued in this case. The Court characterized the Corporate Defendants as "primary plans" and the Attorney Defendants as "entities that received payment from the primary plan". The Court found that the Government's action was founded on the Corporate Defendant's tortious activity and applied the three year statute of limitations to conclude that the claims were barred. The Court also determined that the Attorney Defendant's MSPA obligation was essentially founded upon a contractual obligation resulting in a six year statute of limitations. Using this statute of limitations, the Government's claims against the Attorney Defendant's were also filed too late.

The Court noted that the Government's right to initiate recovery against the Corporate Defendants began when the Corporations made the $275 million in settlement payments in August and September of 2003. In regards to the Attorney Defendants who were "recipients" of payments from the Corporate Defendants, the Government's right to recovery against them began on October 29, 2003 when they received their last payment in the case.

The Plaintiffs filed a motion for summary judgment on liability against certain defendants. Several Defendants filed motions to dismiss arguing that the Plaintiff's claims should be time barred by the applicable statute of limitations, among other defenses. As of September 30, 2010, the Plaintiff's motion for partial summary judgment on the question of liability was denied, while the motions to dismiss were granted. This case is still pending.

Holding: The Court found that the longest applicable statute of limitations of six years had expired prior to December 1, 2009 when the Government filed suit and dismissed the claims against certain defendants. In light of this, the other issues were not resolved.

Current Disposition: The Court of Appeals for the 11th Circuit heard oral arguments in this case on July 26, 2012.

CASE 9: Big R Towing, Inc. v. Benoit

Big R Towing, Inc v. Benoit, 2011 WL 43219 (W.D.La., 2011)

Facts: David Wayne Benoit was employed by Big R Towing when Benoit allegedly injured his back and hip

while performing deck work on the tow. Dispute arose among whether Benoit needed surgery on his back and a hip replacement. Big R ultimately agreed to fund a settlement in the amount of $150,000 in exchange for a complete release of all claims by Benoit against Big R.

Benoit and Big R Towing asked the court to determine future medical expenses to allocate settlement proceeds taking Medicare's interests into consideration per the MSP.

According to Mr. Benoit's providers, the future costs of low back surgery are $32,000 and the costs of a left hip replacement are $20,500 for an overall cost of $52,500 to be set-aside. This amount will not materially change in the event Benoit opts not to have hip surgery and instead goes through palliative treatment.

Holding: The court agreed that $52,500 should be set-aside to protect Medicare's interests for future medical expenses arising out of workers' compensation injuries.

Current Disposition: No further appeals.

CASE 10: Zaleppa v. Seiwell

Zaleppa v. Seiwell, 9 A.3d 632 (2010)

Facts: Seiwell backed her 1998 Saturn out of her driveway and struck the passenger side of a Chevy Tracker in which Zaleppa was a front seat passenger. Sixty-nine year old Zaleppa sustained bodily injury to her cervical, thoracic and lumbar spine as a result of the accident. Seiwell admitted liability. A jury entered a verdict in the amount of $15,000, which considered $5,000 for "future medical expenses."

On appeal, Seiwell argued that the MSP requires all parties in litigation to project Medicare's interests in claims involving conditional payments made by Medicare. Seiwell further argued that the MSP obligates her to confirm that all potential Medicare liens have been satisfied before paying the verdict award. In her post-trial motion, Seiwell asked the court to permit her to satisfy the verdict by adding Medicare as a payee to the award payment or by paying the verdict into the trial court pending notification from Medicare that no outstanding liens exist.

The Superior Court of Pennsylvania found that Seiwell's statutory obligation to reimburse Medicare is distinct from Medicare's statutory right of reimbursement. The MSP does not expressly authorize a primary plan to assert Medicare's right to reimbursement as a preemptive means of guarding against its own risk of liability. Only the U.S. Government is authorized to pursue its own right to reimbursement. This is done by a recovery demand letter, issued by Medicare to the primary plan. This demand letter triggers the primary plan's duty to reimburse Medicare.

Holding: The court held that Seiwell could not satisfy the judgment if she added Medicare as a payee to the award check, as in doing so, she would fail to discharge all of her obligations pursuant to the judgment. The United States is not a party to this action and consequently, the obligations owed to Medicare by Seiwell and Zaleppa are irrelevant regarding satisfying the judgment entered in this case.

Current Disposition: No further appeals.

CASE 11: ArvinMeritor, Inc. v. Clifton Johnson

ArvinMeritor, Inc. v. Clifton Johnson, 68 So.3d 870 (2011)

Facts: Clifton Johnson, an employee of Arvin Meritor, Inc., contracted an occupational disease resulting in 100% permanent and total disability. The judgment required ArvinMeritor to pay workers' compensation benefits and all future medical expenses related to his work injury. Johnson pursued a claim against alleged third-party tortfeasors for the same occupational disease. Johnson negotiated a confidential settlement with the third parties that exceeded the past amounts of workers' compensation and medical benefits paid by ArvinMeritor. The employer and the employee negotiated a settlement of the employer's rights. The settlement included a provision whereby a Medicare set-aside will be established in the amount of $83,936.17. This set-aside amount was presented by ArvinMeritor. It was agreed that ArvinMeritor would contribute up to $65,000 to fund the set-aside, with the balance of the amount necessary to fund the Medicare set-aside to be paid by the employee.

Five months later Johnson filed a petition with the trial court asserting no Medicare Set-aside had been established per the approved settlement and that the employer had ceased paying his medical expenses. Johnson claimed he was willing and able to pay $18,936.17 toward the cost of the set-aside. ArvinMeritor informed him that per CMS, those funds would be inadequate to cover the employee's portion of the set-aside, the cost of which exceeded the $83,936.17 amount presented to Johnson prior to settlement. ArvinMeritor agreed that it would pay $65,000 toward the set-aside but no more. It argued that Johnson was obligated to pay the difference as he received funds from the third-party settlement that exceeded ArvinMeritor's liability for Johnson's medical expenses. On April 20, 2010, the trial court found that the parties had agreed ArvinMeritor would pay $65,000 and that Johnson would be responsible for amounts required to fund the set-aside if it exceeded $65,000. The court also ruled that ArvinMeritor is to pay the difference between what it represented was the cost of the set-aside and is responsible for medical expenses until the set-aside is established. ArvinMeritor appealed this judgment.

The court rejected the contention that Johnson or ArvinMeritor is required to pay a different amount not approved by the trial court and thus reversed that portion of the trial court's judgment requiring ArvinMeritor to pay the additional cost of funding the set-aside.

The court additional cited Bussen v. BE & K and confirmed that because an employer has only a right to subrogation and not reimbursement as to future medical expenses, an employer may withhold payment of future medical expenses only until the future medical expenses received from the third-party have been exhausted, after which time the employer must resume payment. To withhold payment, an employer must first prove the amount an employee recovered from the third-party settlement that was attributable to his future medical expenses.

Holding: The court held that the mere fact Johnson recovered an unstated amount from a third-party that exceeds the past amounts paid by ArvinMeritor for workers' compensation disability and medical benefits does not entitle ArvinMeritor to withhold payment of medical expenses. ArvinMeritor remains obligated by the judgment to continue to pay those expenses, unless and until it is expressly relieved of that obligation by the trial court.

Current Disposition: Affirmed in part and remanded to the trial court.

CASE 12: Avandia Marketing, Sales Practices and Products Liability Litigation vs. GlaxoSmithKline, LLC and GlaxoSmithKline PLC Humana Medical Plan, Inc. and Humana Insurance Company, individually and on behalf of all others similarly situated.

Appellants, 685 F.3d 353 (3rd Ccircuit 2012)

Facts: Humana brought suit against GlaxoSmithKline (Glaxo) alleging that Glaxo had to reimburse Humana for expenses that Humana had incurred treating its' insureds injuries resulting from the use of Glaxo's drug, Avandia. Since Humana ran a Medicare Advantage Plan, Humana argued that under the Medicare Act, Glaxo was a "primary payer" and Humana was a "secondary payer." Glaxo prevailed on a motion to dismiss the action in District Court arguing that the Medicare Act did not provide Medicare Advantage organizations (MAOs) with a private cause of action to seek such reimbursement.

Holding: The Medicare Secondary Payer Act provides MAOs such as Humana with the same right to recover as the Medicare Trust Fund. This conclusion is supported by the plain language of the MSP Act. In addition, CMS regulations clearly state that an MAO will exercise the same rights to recover from a primary plan, entity, or individual that the Secretary exercises under the MSP regulations. Granting MAOs access to the private cause of action for double damages is also consistent with and furthers the broader policy goals of this program.

Current Disposition: The decision of the District Court was reversed and the case was remanded for further proceedings.