



26th Annual Claims Handling Seminars

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MEDICARE SET-ASIDE TRUSTS

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MEDICARE SET-ASIDE TRUSTS

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The cases and materials presented here are in summary and outline form. To be certain of their applicability and use for specific claims, we recommend the entire opinions and statutes be read and counsel consulted.

MEDICARE SET-ASIDE TRUSTS

I. MEDICARE'S REFUSAL TO COMPROMISE CONDITIONAL PAYMENTS RUNS CONTRARY TO THE PUBLIC POLICY IN FAVOR OF SETTLEMENTS

Bradley v. Sebelius, 621 F.3d 1330 (11th Cir. 2010) – A potentially important decision concerning Medicare conditional payments (liens) was handed down on September 29, 2010 by the United States Court of Appeals for the Eleventh Circuit (California). Medicare (CMS) occasionally takes the position that it will not compromise its conditional payments – even if the end result would be Medicare taking all of the settlement (minus attorney's fees). In *Bradley v. Sebelius*, 621 F.3d 1330 (11th Cir. 2010), CMS took just such a position. The court of appeals, however, took exception and affirmed a substantial reduction in the conditional payments lien.

In *Bradley*, the probate court was asked to apportion the settlement amount between Medicare and non-Medicare beneficiaries. The settlement amount was substantially less than the potential full value of the claim. The probate court effectively reduced the Medicare lien from \$38,875.08 to \$787.50. Medicare refused to accept the probate court's ruling. After the estate exhausted administrative remedies, the decision was appealed to the federal district court. The district court reversed, relying, in part, upon arguments by Medicare that pursuant to the Medicare Field Manual, its conditional payment lien was not subject to compromise based on allocation of fault.

On appeal, the Eleventh Circuit reversed the district court, noting "[h]istorically, there is a strong public interest in the expeditious resolution of lawsuits through settlement." *Bradley*, 621 F.3d at 1339. The court stated:

The Secretary's position would have a chilling effect on settlement. The Secretary's position compels plaintiffs to force their tort claims to trial, burdening the court system. It is a financial disincentive to accept otherwise reasonable settlement offers. It would allow tortfeasors to escape responsibility.

Id.

The court further found that Medicare's reliance on its field manual was unpersuasive, pointing out that Medicare policies and manuals are not "law" and would not be given deference under the *Chevron* Doctrine.

The *Bradley* case is particularly noteworthy because the Eleventh Circuit stated that Medicare cannot take an unreasonable position with regard to their liens that would thwart the public policy in favor of settlements. This case will likely be widely cited in future efforts seeking compromise of Medicare conditional payments.

The public policy analysis used by the court in *Bradley* could also be extended to civil cases where the parties choose to use a Medicare Set-Aside for future medical care. If a defendant wants to use a Medicare Set-Aside to protect itself from further claims by Medicare under the Medicare Secondary Payer Act, this case could provide a basis upon which to formulate a compromise value of the MSA. If, for example, the plaintiff reasonably appears to be 30 percent at-fault and the case is settled for 70 cents on the dollar with an MSA for future medical expense, the MSA could reasonably be reduced by 30 percent under the analysis employed in *Bradley*. Under that scenario, a good faith hearing should be held requesting the court to enter an order apportioning/compromising the MSA to a reasonable amount given the facts and circumstances of the case.

While we are in uncharted territory with regard to use of Medicare Set-Aside accounts in civil cases, the *Bradley* decision suggests that the judiciary will not hesitate to impose practical solutions to facilitate equitable settlements. In other words, this holding is a very positive development since it may result in more prompt resolution of compromised claims.

II. U.S. DISTRICT COURT FAILS TO APPLY COMPARATIVE FAULT PRINCIPLES TO CMS' CONDITIONAL PAYMENTS CLAIM

Hadden v. United States, No. 1:08-CV-10, 2009 WL 2423114 (W.D. Ky. Aug. 6, 2009) – In this case the plaintiff, Vernon Hadden, was struck by a utility vehicle belonging to Pennyryle Rural Electric Cooperative that swerved to avoid a vehicle that ran a stop sign. The driver of the vehicle that ran the stop sign was never identified. Hadden brought suit against Pennyryle for bodily injury. Ultimately, Hadden and Pennyryle settled the case for \$125,000. Hadden's counsel asserted that the settlement amount was approximately 10 percent of the total value of the claim and that the missing driver of the vehicle that ran the stop sign was 90 percent negligent.

The Center for Medicare and Medicaid Services asserted a conditional payments claim for \$62,338.07. Hadden's counsel sought a compromise and waiver or reduction of the conditional payments amount from CMS. CMS refused to compromise the amount of its claim. Plaintiff's counsel argued that Hadden's recovery was reduced under applicable comparative fault principles and that CMS' claim for conditional payments should be similarly reduced. CMS and the Department of Health and Human Services rejected the request for compromise and waiver. CMS pointed out that recoveries under the Medicare Secondary Payer Act did not account for state tort law. Hadden's counsel exhausted administrative appeals and ultimately filed suit in the federal district court for the Western Division of Kentucky.

The district court rejected Hadden's arguments and noted that the underlying personal injury claim against Pennyryle Rural Electric had not proceeded to trial and accordingly the allocation of fault was purely speculative. In dismissing the suit, the district court noted:

The primary payer in this case is the insurer who paid [the settlement] . . . between plaintiff and [defendant.] 'More importantly, the underlying claim in this

case was not adjudicated on the merits; it was settled. In other words, had Plaintiff wanted equitable allocation and subrogation principles to apply in this case, then he should have proceeded to trial on the merits of his tort claim in state court . . . [as the] allocation of liability proposed by Plaintiff would be purely speculative.'

Hadden, 2009 WL 2423114 at *6-7.

The *Hadden* case is seen as a test of the legal question of whether CMS must consider state law comparative fault principles in compromise requests of its conditional payments claim. The Medicare Advocacy Recovery Coalition has underwritten the appeal of the district court decision to the Sixth Circuit. Arguments were held in the Sixth Circuit on October 13, 2010. If the Sixth Circuit reverses the district court and applies comparative fault principles to the conditional payments claim, this will provide considerable benefit to litigants who seek compromise or waiver of conditional payments claims. As set forth in the *Bradley* case, the public policy in favor of settlement certainly supports requiring CMS to apply comparative fault principles in the compromise of its conditional payments claims.

III. NO ALLOCATION FOR FUTURE MEDICAL EXPENSES NECESSARY UNDER MSPA WHERE PLAINTIFF COVERED BY GROUP HEALTH INSURANCE

Finke v. Hunter's View, Ltd., No. 07:4267, 2009 WL 6326944 (D. Minn. 2009) – The United States District Court for Minnesota was asked to approve a personal injury suit and specifically address whether the settlement adequately protected Medicare's interests with regard to future medical expenses. Plaintiff Darius Finke was paralyzed from the chest down after falling from a deer stand manufactured by Hunter's View and sold at Wal-Mart. The plaintiff brought suit against both Hunter's View and Wal-Mart. The case was settled for \$1.5 million. The district court approved the settlement and did not require any form of allocation of settlement proceeds to cover future medical expenses. The court specifically found that the parties had adequately considered Medicare's interests, and it was not reasonably foreseeable that Medicare would be responsible for such future expenses. The court reasoned that the plaintiff was covered under group health insurance and that benefits available through the group policy were more than adequate to cover all reasonably anticipated medical expenses for the foreseeable future. The court pointed out that the group policy would continue to be primary to Medicare. The court approved the settlement and did not require any form of Set-Aside. In its order the court provided that:

The parties have reasonably and adequately considered the interest of Medicare in this settlement, and Plaintiffs Darius Finke and Shea Finke and Defendants Wal-Mart and Hunter's View will not be subject to any claim, demand or penalty from

Medicare, Medicaid, or any other party, as a result of its settlement payments in this matter.

Finke, 2009 WL 6326944 at *4.

IV. COURT ESTABLISHES STATUTE OF LIMITATIONS UNDER MEDICARE SECONDARY PAYER ACT OF THREE YEARS FOR ACTIONS ARISING OUT OF TORT AND SIX YEARS FOR ACTIONS ARISING OUT OF CONTRACT

U.S. v. Stricker, CV-09-BE-2423-E, slip op. (N.D. Ala. Sep. 30, 2010) – On September 30, 2010, the United States District Court for the Northern Division of Alabama, Eastern Division, clarified the applicable statute of limitations with regard to government actions for violations of the Medicare Secondary Payer Act. In December 2009, the United States sued numerous defendants, including plaintiff’s lawyers, law firms, corporations and insurance carriers alleging a violation of the Medicare Secondary Payer Act with regard to conditional payments to Medicare beneficiaries for treatment related to PCB chemical contamination. In 2003 the Medicare beneficiaries, among others, reached a global settlement for \$300 million with the defendants, including Monsanto, Pharmacia and Solutia. In what is commonly known as the *Abernathy* settlement, the defendants initially funded the settlement with a payment of \$75 million in 2003. Future payments were also required as a part of funding the settlement, including \$2.5 million annual installments from 2004 to 2013.

In December 2009 the United States brought suit claiming that conditional payments were made subsequent to the initial 2003 global settlement and were not reimbursed upon funding of the future periodic payments. The corporate defendants argued that the government’s action to recover conditional payments was based in tort and subject to a three-year statute of limitations under the Federal Claims Collection Act, 28 U.S.C. § 2415 (2008). In its decision, the court distinguished between the corporate defendants (manufacturers and insurers) and the attorney/law firm defendants. The court held that the three-year statute of limitations for claims founded upon tort applied to the corporate defendants and, therefore, the government’s action was time barred.

As to the attorney/law firm defendants, the court concluded that the six-year statute of limitations applied, since an attorney’s responsibility for reimbursement of conditional payments is founded upon the contractual relationship between attorney and client. The court nevertheless ruled that the government’s action against the attorney defendants was also time barred because the limitations period began running no later than October 29, 2003, when the initial \$275 million settlement payment was made. The court rejected the government’s argument that the statute would not begin to run until the settlement funds were distributed to the plaintiffs. The court further rejected the government’s argument that the limitation had been tolled.

V. FEDERAL DISTRICT COURT APPROVES MEDICARE SET-ASIDE AND LIABILITY SETTLEMENT

The question of whether Medicare Set-Aside accounts for future medical expense need to be established in liability cases under the Medicare Secondary Payer Act is subject to debate. A recent Federal District Court Order from the Western District of Louisiana has been frequently cited (and often mis-cited) with regard to this very issue.

In *Big R Towing v. Benoit*, No. 10-538, 2011 WL 43219 (W.D. La. Jan. 5, 2011), David Benoit was injured while working as the captain of a towboat owned by Big R Towing, Inc. He was paid maintenance and cure benefits pursuant to general maritime law. When a dispute arose as to additional medical treatment, Big R filed a declaratory judgment action as to whether maintenance and cure benefits were owed for the procedure. Benoit filed a counter-claim seeking damages under the Jones Act as well as under general maritime principles. Ultimately, pursuant to a settlement conference with the federal court, a settlement was reached in the amount of \$150,000. Consideration for that settlement included Benoit agreeing to be responsible to protect Medicare's interests under the Medicare Secondary Payer Act, 42 U.S.C. § 1395(y). The parties consented to allow a U.S. Magistrate Judge to decide the issue of future medical expenses under the Medicare Secondary Payer Act. The magistrate's order pointed out that Medicare does not currently have a policy or procedure in effect for reviewing or providing an opinion regarding the adequacy of future medical expenses of liability settlements. After a hearing on the merits, the magistrate ordered that \$52,500 be set aside to protect Medicare under the Medicare Secondary Payer Act. The sum reflected the cost associated with a future back surgery and left hip replacement. No consideration was made for the ancillary expenses one would anticipate with such surgical procedures, such as post-operative follow-up and therapy.

The court specifically found that the amount was sufficient to protect Medicare's interests under the Medicare Secondary Payer Act. The court's order will effectively preclude CMS from later claiming that its interests are not protected.

Some vendors of Medicare Set-Aside allocation services are promoting this decision as a federal court ruling 'recognizing' the need for a Medicare Set-Aside in liability cases in order to protect Medicare's interests under the Medicare Secondary Payer Act. Such representations are misleading. First of all, it is unclear whether the U.S. Department of Health & Human Services was provided notice of the settlement terms and provided an opportunity to object. Secondly, the court simply adopted the terms of settlement proposed by the parties during a settlement conference with the court. Practically speaking, the *Big R Towing* case simply represents an example of a liability case in which the parties, by mutual agreement, agreed to use a Medicare Set-Aside and the court acquiesced to their proposed allocation.

VI. CMS GIVEN A PRIORITY RIGHT OF RECOVERY IN UNDER-INSURED MOTORIST CLAIM

Farmers Ins. Exchange v. Forkey, No. 2:09-CV-00462, 2010 WL 5804529 (D. Nev. Dec. 29, 2010) – The United States District Court for the District of Nevada granted summary judgment in favor of CMS with regard to the government’s claim of entitlement to a portion of underinsured motorist benefits. CMS claimed \$10,070.22 of a \$35,000 underinsured motorist policy. The policy holder was deceased; however, his spouse claimed entitlement to the underinsured benefits under the Nevada wrongful death statute. She argued that her claim had a value of \$500,000 and that Medicare’s claim of \$10,070.22 merely represented about two percent of all potential claims and, therefore, should be limited in recovery to approximately \$200 (two percent). The court indeed ruled that CMS was entitled to the full \$10,070.22. The court held that the government’s direct right of reimbursement from proceeds of the liability insurance payment took precedence over all other claims, including the state law of wrongful death claim.

The decision in *Farmers Ins. Exchange v. Forkey* illustrates that a split remains with regard to apportionment of settlement proceeds. The *Farmers* case appears to be contrary to the Eleventh Circuit Court of Appeals decision in *Bradley v. Sebelius*, 2010 WL 3769132 (11th Circuit) in which the court applied principles of apportionment to reduce the CMS claim based upon public policy favoring settlements.

VII. MSPA/SCHIP LEGISLATIVE UPDATE – H.R. 4796

On March 9, 2010, the Medicare Secondary Payer Enhancement Act of 2010 was introduced as H.R. 4796. The bill seeks to address several problems that exist with regard to Medicare’s reimbursement of conditional payments as well as difficulties with SCHIP § 111 reporting. Oftentimes settlements are held up indefinitely while parties await a conditional payments determination from the Center for Medicare and Medicaid Services. Furthermore, the conditional payments calculation provided by CMS is often inaccurate and contains claims for reimbursement for disputed or otherwise unrelated medical treatment which are not at issue in the underlying litigation. H.R. 4796 is intended to remedy some of these difficulties.

Provisions of H.R. 4796 include the following:

A. Voluntary Reimbursement Payment

H.R. 4796 provides that claimants or the applicable plan will be able to voluntarily submit a proposal of conditional payment calculations to the Center for Medicare/Medicaid Services at least 90 days prior to settlement, judgment or award. The voluntary submission will contain an estimate of the amount of Medicare payments for the injury/claim for CMS’ review. CMS will be entitled to contest the submission, but only within 90 days. If CMS fails to respond within 90 days, the voluntary payment proposal will be deemed the proper MSP conditional payment amount.

B. Deadline for Final Demand Letter

Applicable insurance plans, as well as claimants, will have the option of requesting a final demand letter from CMS for conditional payments within 120 days of settlement, judgment or award or other payment. The bill will impose a deadline on CMS of 60 days to respond to such requests. Where the claimant or applicable plan reimburses CMS within 60 days of the CMS final demand letter, the reimbursement is deemed total satisfaction of the obligations of the claimant and applicable plan for conditional payments.

C. Right to Appeal

H.R. 4796 provides a right to appeal for liability, self insurance, workers' compensation and no-fault insurance plans. The appellate rights and procedure will be similar to those currently provided to group health plans.

D. MSP Thresholds

H.R. 4796 also sets a minimum settlement threshold of \$5,000 for Medicare Secondary Payer Act recovery. Settlements, judgments, awards or other payments below \$5,000 will be exempt from the Medicare Secondary Payer Act and, thus, not subject to conditional payment claims.

E. Section 111 Privacy Provision

The bill proposes implementation of a section 111 reporting process that would exclude the reporting of health insurance claim numbers and Social Security numbers.

F. Section 111 Statute of Limitations

The proposal would set forth a statute of limitations on Medicare Secondary Payer Act recovery actions to three years following the submission of the section 111 report.

G. Section 111 Penalties

Concern exists with regard to penalty provisions for non-compliance with section 111. The current version of 42 U.S.C. § 1395y(b)(8)(E) provides that if the RRE fails to properly comply with section 111, the RRE "shall be subject to a civil monetary penalty of \$1,000 for each day of non-compliance with respect to each claimant." Use of the term 'shall' implies that the penalty will be applied regardless of surrounding facts, circumstances or mitigating details. H.R. 4796 proposes to amend the penalty provision by replacing the term 'shall' with the term 'may.' If enacted, H.R. 4796 will thus provide some degree of discretion with regard to application of the penalty provision.

H. Safe Harbor

Finally, H.R. 4796 proposes that the Center for Medicare and Medicaid Services be required to prepare safe harbor provisions with regard to section 111 compliance. Although specific provisions are not identified, the bill requires CMS to solicit proposals from the industry and initiate a process for establishing such safe harbor provisions.



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- Partner

After passing the Bar in 1987, Brad joined the Urbana office of Heyl Royster and has spent his entire career there. His practice focus is divided between workers' compensation and civil litigation, where he is experienced in the defense of products liability, construction and insurance coverage. In recent years, Brad has taken a special interest in Medicare Set-Aside Trusts and the Medicare Secondary Payer Act, and has written and spoken extensively on those issues. In fact, Brad was one of the first attorneys in the State of Illinois to author a published article regarding the application of the Medicare Secondary Payer Act to workers' compensation claims: "Medicare, Workers' Compensation and Set-Aside Trusts," *Southern Illinois Law Journal* (2002).

Brad is a member of the Champaign County, Illinois State, and American Bar Associations. He served a number of terms in the Illinois State Bar Association Assembly. Brad has also been a member of the ISBA Bench and Bar Section Council and served as its Chair in 2000-2001. Currently, he serves as an officer of the ISBA Workers' Compensation Council and is a past editor of the Workers' Compensation Section Newsletter. Brad currently serves as the contributing editor of the Workers' Compensation Report for the *Illinois Defense Counsel Quarterly*.

Significant Cases

- *Johnson v. Daimler Chrysler Corporation, Blane Warren and Aladdin Electric* - Obtained favorable settlement (structured settlement with cost in low seven figures) in negligent entrustment and product liability action involving death of an accountant with wife and two children.
- *Tracy Green v. Freitag-Weinhardt* - Obtained favorable settlement of workers' compensation claim and third-party liability claim against petitioner/plaintiff's employer. Plaintiff suffered from fractures to the T11-T12 vertebra with resulting paraplegia. Seven figure settlement reached with primary defendants and third-party liability claim as well as workers' compensation claim resolved through workers' compensation lien waiver and partial satisfaction of future medical expense.

Publications

- "Medicare and Future Medical Expenses; Does the Super Lien Apply?" *Illinois Bar Journal* (2010)
- "Illinois Workers' Compensation and the Medicare Secondary Payer Act," *Illinois Workers' Compensation Law*, Chapter 27 (2009-2010 Edition)
- "The Workers' Compensation Experience; The Medicare Secondary Payer Act and Medicare Set-Aside Issues; Medicare and Medicaid Awarding Post-Judgment and Post-Settlement Litigation," *Illinois Defense Counsel Quarterly* (2009)

Public Speaking

- "Mock Trial Participant"
ISBA Workers' Compensation Section Council (2010)
- "What You Need to Know about Medicare Liens, Conditional Payments and Set-Aside Trusts; Winning Strategies for Difficult Times"
Heyl Royster 24th Annual Claims Handling Seminar (2009)

Professional Associations

- Champaign County Bar Association
- Illinois State Bar Association
- American Bar Association
- Illinois Association of Defense Trial Counsel
- The National Association of Medicare Set-Aside Professionals

Court Admissions

- State Courts of Illinois
- United States District Court, Central District of Illinois
- United States Court of Appeals, Seventh Circuit
- United States Supreme Court

Education

- Juris Doctor, Southern Illinois University, 1987
- Bachelor of Science (with honors), Illinois State University, 1984

