



25th Annual Claims Handling Seminars

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Thursday, May 20, 2010 – Bloomington, Illinois

# MEDICARE AND FUTURE MEDICAL EXPENSES: DOES THE “SUPER LIEN” APPLY?

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## **MEDICARE AND FUTURE MEDICAL EXPENSES: DOES THE “SUPER LIEN” APPLY?**

### **I. INTRODUCTION**

A little known federal statute may soon become a significant factor with regard to settlements and judgments in liability cases. The Medicare Secondary Payer Act sets forth the statutory framework for what is commonly known as the Medicare “super lien.” 42 U.S.C. § 1395(y)(b)(2)(B)(iv). Indeed, Medicare has a statutory first right of recovery against all proceeds over all entities; the liens are statutory and notice thereof is not required. Simply stated, the statute provides that Medicare shall not pay for medical expenses incurred where coverage exists under workers’ compensation, automobile liability, or liability insurance policies, as well as no-fault insurance policies. 42 U.S.C. § 1395(y)(b)(2). Liability plans are identified as “primary” plans, 42 U.S.C. § 1395(y)(b)(2)(A)(ii), which are deemed foremost responsible for payment. Medicare is intended to be secondary to all other available healthcare payment sources and available only when the other sources are exhausted. 42 U.S.C. § 1395y(b)(2) and § 1862(b)(2)(A)(ii).

While addressing and ultimately satisfying Medicare liens in personal injury liability claims is common practice, a greater issue is arising, however, with regard to whether litigants have an obligation to protect Medicare as to *future* medical expenses that may be incurred by the plaintiff after settlement or judgment. As can be seen from the discussion below, the issue can be complex, and a lack of direction from the United States Department of Health and Human Services further complicates the issue.

### **II. THE MEDICARE SECONDARY PAYER ACT**

Medicare’s status as a secondary payer arises under the Medicare Secondary Payer Act (the “Act”). Significant provisions of the Act are found at 42 U.S.C. § 1395y(b)(2) which states, in relevant part:

(2) Medicare secondary payer

(A) In general

Payment under this subchapter may not be made, except as provided in subparagraph (B), with respect to any item or service to the extent that –

(i) payment has been made, or can reasonably be expected to be made, with respect to the item or service as required under paragraph (1), or

(ii) payment has been made or can reasonably be expected to be made under a workmen's compensation law or plan of the United States or a State or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance.

In this subsection, the term "primary plan" means a group health plan or large group health plan, to the extent that clause (i) applies, and a workmen's compensation law or plan, an automobile or liability insurance policy or plan (including a self-insured plan) or no fault insurance, to the extent that clause (ii) applies. An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.

42 U.S.C. § 1395y(b)(2).

Furthermore, subsection (B) provides:

(B) Repayment required

*(i) Authority to make conditional payment*

The Secretary may make payment under this subchapter with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.

*(ii) Primary plans*

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. 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. If reimbursement is not made to the appropriate Trust Fund before

the expiration of the 60-day period that begins on the date notice of, or information related to, a primary plan's responsibility for such payment or other information is received, the Secretary may charge interest (beginning with the date on which the notice or other information is received) on the amount of the reimbursement until reimbursement is made (at a rate determined by the Secretary in accordance with regulations of the Secretary of the Treasury applicable to charges for late payments).

42 U.S.C. § 1395y(b)(2)(B).

In addition, the statute further vests Medicare with subrogation of rights as well as enforcement provisions for violations of the Act. 42 U.S.C. § 1395(y)(b)(2)(B)(iii), (iv).

### **A. History of the Secondary Payer Act**

The Act was enacted in 1980 to ensure that Medicare was not making payments for medical expenses where other insurance was available. 42 C.F.R. § 411.40 (2000). Later that same year, the Omnibus Reconciliation Act expanded Medicare's secondary payer status and right to reimbursement for conditional payments to include liability, auto liability, and no-fault insurance. P.L. 96-499, § 900, *et seq.* Early litigation as to application of the Act to tort claims focused on Medicare's ability to recover their liens (conditional payments). "Conditional payments" are those payments made by Medicare for services for which another payer is responsible, 42 C.F.R. §§ 411(C)-(H), 411.21, in tort settlements. Federal courts were divided as to the propriety of the federal government's attempts to recover Medicare expenditures under the Act in tort claims. Early attempts by Medicare to enforce the Act were rejected in several cases, including *Thompson v. Goetzmann*, 337 F.3d 489 (5th Cir. 2003); *In re Orthopedic Bone Screw Products Liability Litigation*, 202 F.R.D. 154, 163-169 (E.D. PA. 2001); and *Fanning v. United States*, 346 F.3d 386 (3d Cir. 2003). In many instances, the government's efforts were defeated when courts found that the tort defendants were not under an obligation to "pay promptly" under the Act. See *United States v. Baxter Intern., Inc.*, 345 F.3d 866 (11th Cir. 2003); *In re Zyprexa Products Liability Litigation*, 451 F.Supp.2d 458 (E.D. NY 2006).

Due to conflicting court decisions, amendments to the Act were enacted in 2003. Congress approved the Medicare Modernization Act, P.L. 108-173, 117 Stat. 2066 (2003), and therein amended the Act with regard to the definition of self-insurance and deleted "prompt payment" language from Section (A)(ii) of the Act. Such efforts were a clear attempt to cure problematic language in the statute that had led to the government's failed attempts to enforce the Act via the courts. Government litigation, however, has remained focused on claims involving Medicare liens for conditional payments made by Medicare as opposed to addressing the issue of future medical expenses. To date, there are no federal cases specifically addressing Medicare's interest under the Act with regard to future medical expenses in civil liability claims.

## **B. Future Medical Expenses**

The Act specifically identifies and addresses previous “conditional payments” by Medicare, yet does not set forth specific rights or obligations with regard to future medical expenses in liability and auto liability claims. Obligations for future medical expenses in workers’ compensation claims are, however, specifically addressed in the Code of Federal Regulations. 42 C.F.R. §§ 411.40 – 411.47. Enacted in 1989, Section 411.46 addresses the topic of lump sum settlements in workers’ compensation claims and provides, in pertinent part:

(a) Lump-sum commutation of future benefits. If a lump-sum compensation award stipulates that the amount paid is intended to compensate the individual for all future medical expenses required because of the work-related injury or disease, Medicare payments for such services are excluded until medical expenses related to the injury or disease equal the amount of the lump-sum payment.

(b) Lump-sum compromised settlement.

(1) A lump-sum compromise settlement is deemed to be a workers’ compensation payment for Medicare purposes, even if the settlement agreement stipulates that there is no liability under the workers’ compensation law or plan.

(2) If a settlement appears to represent an attempt to shift to Medicare the responsibility for payment of medical expenses for the treatment of a work-related condition, the settlement will not be recognized. For example, if the parties to a settlement attempt to maximize the amount of disability benefits paid under workers’ compensation by releasing the workers’ compensation carrier from liability for medical expenses for a particular condition even though the facts show that the condition is work-related, Medicare will not pay for treatment of that condition.

42 C.F.R. § 411.46.

Where there is an allocation for future medical expenses as a part of the workers’ compensation settlement, the Code provides:

(2) Exception. If the settlement agreement allocates certain amounts for specific future medical services, Medicare does not pay for those services until medical expenses related to the injury or disease equal the amount of the lump-sum settlement allocated to future medical expenses.

42 C.F.R. § 411.46(d)(2).

The Code of Federal Regulations contains no similar provisions with regard to liability settlements under the Act. Although the Code of Federal Regulations addresses recovery of conditional payments where there is a civil judgment or settlement, 42 C.F.R. § 411.37, the Code remains silent with regard to future medical expenses. This lack of regulatory direction from the Department of Health and Human Services significantly contributes to the ambiguity and confusion over parties' obligations to Medicare with regard to future medical expenses.

While the Act does not specifically address future medical expenses, language of the statute appears to create a basis for the proposition that parties should protect Medicare's interests with regard to future medical expenses in civil liability settlements and judgments. Of particular interest, the statute contains language framed in the past tense, suggesting that when liability for future medical expenses is extinguished through settlement or judgment, Medicare must still be protected. The Act requires repayment of conditional payments where it is demonstrated that the primary plan "has or had a responsibility to make payment with respect to such item or service." 42 U.S.C. § 1395(y)(b)(2)(B)(ii); *John J. Campbell, Medicare Set Aside Arrangements for Future Medical Expenses and Third Party Liability Settlements*, the Medicare Set Aside Bulletin, February 14, 2005, at <http://jjcelderlaw.com/CMSTPLNews.htm>. Such language suggests that an obligation to protect Medicare exists even where liability for future medical expenses has been extinguished through settlement or satisfaction of judgment.

In July of 2001, the Center for Medicare and Medicaid Services (CMS) published the "Patel Memo" setting forth the first written policy with regard to the need to protect Medicare's interests as to future medical expenses in workers' compensation settlements. The CMS, as well as its Coordination of Benefits Office, oversees administration of the Medicare Set-Aside (MSA) Trusts in workers' compensation matters. Since 2001, no less than a dozen memoranda have been issued by Medicare clarifying – and at times changing – policies and procedures with regard to handling future medical expenses in workers' compensation claims. The vehicle used to satisfy obligations for future medical expenses is commonly referred to as a MSA Trust. In accordance with CMS policy, funds are set-aside in an MSA Trust and are only to be used by the workers' compensation claimant for future medical expenses related to the industrial injury. These accounts may be established as bank accounts or investment accounts and are funded at the time of settlement of the case or through periodic payments to the MSA fund. The MSA may be managed professionally or by the claimant. Once exhausted, Medicare will agree to cover additional future medical expenses under Medicare. Settlement thresholds have also been established by Medicare as to when a proposed Medicare Set-Aside arrangement should be submitted to CMS for their approval. Memo, July 23, 2001, Parashar B. Patel, Deputy Director Purchasing Policy Group, Center for Medicare Management to all associate regional administrators, available at <http://www.cms.hhs.gov/WorkersCompAgencyServices/Downloads/72301MEMO.pdf>. A workers' compensation MSA may be submitted to CMS for review and approval where (1) the claimant is currently a Medicare beneficiary and the total settlement exceeds \$25,000, or (2) the claimant has a "reasonable expectation" of entering Medicare within 30 months of the settlement date and the anticipated total settlement amount for future medical expenses and lost wages

exceeds \$250,000. An MSA is not necessary when the settlement leaves future medical expenses open.

### **C. Application to Liability Claims Uncertain**

Unlike its position respecting workers' compensation cases, CMS has failed to set forth any policy memoranda or state a clear policy with regard to requirements for Medicare Set-Asides in liability settlements. Unofficially, CMS has become more forthcoming. Representatives of the CMS Chicago Regional Office will advise that CMS' position is that the Act requires liability insurers and auto liability insurers to protect Medicare's interests with regard to future medical expenses where there is an allocation for future medical as a part of the settlement. CMS regional offices have reportedly made the following statements regarding litigants' obligations to Medicare.

CMS' position is that we expect any funds that are allocated for future medicals to be spent before any claims are submitted to Medicare for payment and the beneficiary will probably be asked about it on the initial enrollment questionnaire that is systems generated, but, we are not asking that MSAs be established in those cases, nor are we reviewing/approving/denying them. *John J. Campbell, Medicare Set-Aside Arrangements for Future Medical Expenses and Third Party Liability Settlements*, The Medicare Set-Aside Bulletin, February 14, 2005, located at <http://jjcelderlaw.com/CMSTPLNews.htm>. The Center for Lien Resolution further advised in June 2004 that during a Medicare Set-Aside conference a representative of the Office of General Counsel for the United States confirmed the intention of Medicare to begin enforcement of the Act in liability cases. See [http://www.thecenterforlienresolution.com/medicare\\_medicaid.shtml](http://www.thecenterforlienresolution.com/medicare_medicaid.shtml).

In addition, the San Francisco Regional Office has promulgated a written statement which states:

The Centers for Medicare & Medicaid Services (CMS) has no current plans for a formal process for reviewing and approving Liability Medicare set-aside arrangements. However, even though no formal process exists, there is an obligation to inform CMS when future medicals were a consideration in reaching the Liability settlement, judgment, or award as well as any instances where a Liability settlement, judgment, or award specifically provides for medicals in general or future medicals. Letter from Department of Health & Human Services, Centers for Medicare & Medicaid Services, San Francisco Regional Office (on file with author).

Accordingly, it is clear, at least informally, that the Center for Medicare Services interprets the Act as requiring litigants to protect Medicare's interests with regard to settlement or satisfaction of judgment in liability claims.

The Medicare Secondary Payer manual is also contributing to the ambiguity as to the CMS position. The manual was amended in 2009 to define set-aside arrangements in such a manner that included liability and no fault cases. Medicare Secondary Payer (MSP) manual – chapter 1 –

Background and Overview, Section 20-definitions (2009). The Medicare manual, however, further states that “[t]here should be no recovery of benefits paid for services rendered after the date of a liability insurance settlement.” Medicare Secondary Payer (MSP) manual – chapter 7 – Contractor MSP Recovery Rules, Section 50.5 (2009). Therefore the Medicare manual is expanding the definition of Medicare Set-Aside arrangements to include liability and no-fault liability cases while at the same time suggesting Medicare benefits should not be paid for injury related services following a liability settlement.

Currently the Center for Medicare and Medicaid Services lacks a regulatory framework upon which it may base enforcement. Until regulations are promulgated similar to those in workers’ compensation, 42 C.F.R. § 411.46, litigants will continue to be left with only informal policy statements. Furthermore, it is foreseeable that any effort by Medicare to undertake legal action to enforce the statute with regard to future medical expenses in liability claims will be met with statutory challenges. If clear direction is not forthcoming from the Center for Medicare and Medicaid Services, such direction will likely be left to the judiciary.

Assuming, *arguendo*, that CMS has statutory authority to require litigants to protect its interests in future medical expenses, then one must attempt to determine CMS policy. As set forth above, CMS’ unwritten policy has been to communicate that Medicare must be protected where there is an allocation for future medical expenses in the settlement of a tort claim. It is, in fact, extremely rare that litigants would specifically allocate settlement funds to a plaintiff’s particular element of damages. The overwhelming majority of settled cases are resolved with a lump-sum payment for all forms of damages in exchange for a comprehensive release. Currently there does not appear to be an obligation to protect Medicare’s interests in the absence of a specific allocation for future medical expenses as a part of a settlement. The King Kong Contingent: Should the Medicare Secondary Payer Statute Reach to Future Medical Expenses in Personal Injury Settlements? *Norma S. Schmidt*, 68 U. Pitt. L. Rev. 469, 489 (Winter, 2006). It has been further noted that Medicare lacks regulatory authority to reapportion a settlement in a personal injury case where it has simply been resolved by lump-sum without a specific allocation for future medical expenses. It is anticipated that when Medicare learns of an allocation for future medical expense in a civil case, Medicare will then deny Medicare coverage for related expenses until a sum equal to the allocation has been expended on related medical expenses by the Medicare beneficiary.

Currently, litigants are left without direction by CMS as to what constitutes an “allocation” of future medical expenses pursuant to a settlement. Common examples of when specific allocations may arise in tort settlements include settlements involving mentally disabled adults or minors where court approval of specific settlement terms is required. Left unanswered is the question of whether litigants have an affirmative duty to allocate settlement funds for future medical expenses where future medical expenses are reasonably anticipated and the plaintiff is Medicare eligible or soon to become Medicare eligible. In workers’ compensation claims, Medicare requires that its interests be protected with a Medicare Set-Aside arrangement where petitioners are Medicare beneficiaries or where petitioners are deemed future beneficiaries under standards set forth in CMS policy memoranda.

#### **D. The Impact of SCHIP**

The Medicare Set-Aside issue has received renewed attention in the litigation community with the enactment of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA). P.L. 110-173, 121 Stat. 2492. The new statute created mandatory reporting requirements for claims involving Medicare eligible individuals. Specific obligations were placed on liability insurers, as well as workers' compensation insurers, to report such claims. While these reporting requirements constitute a further effort by Medicare to enforce the Act, 42 U.S.C. § 1395(y)(b)(2), the MMSEA does not explicitly address or change any standards with regard to Medicare Set-Aside requirements. In fact, the user guide to the MMSEA emphasizes that Section 111 of the Act did not change or remove any existing Medicare Secondary Payer rules or requirements. Act II: Reporting Obligations for Settling Insurers Where Medicare is a Secondary Payer: The Medicare, Medicaid and SCHIP Extension Act of 2007, Matthew Garretson and Sylvius Von Saucken (May 21, 2009), available at <http://www.garretsonfirm.com/garretson/news/?newsID=13>. While the MMSEA will enable Medicare to identify claims where conditional payments may need to be reimbursed, there is no indication it was intended to change or expand obligations with regard to future medical expenses in liability claims.

#### **E. Options to Address Ambiguities**

As it now stands, litigants are left with several options as to how to address and comply with the Act. The most conservative approach would be to specifically allocate settlement funds towards future medical expenses where the claim involves a current Medicare beneficiary or a future beneficiary under the current workers' compensation standard. The current workers' compensation standard requires that Medicare's interests be protected through a Medicare Set-Aside under which workers' compensation claimants meet one of the following criteria: (1) the claimant has applied for social security disability; (2) the claimant has applied for and been denied social security disability; (3) the individual is in the process of appealing and/or refiling for social security disability benefits; (4) the claimant is 62 ½ years of age or older; or (5) the claimant has end stage renal disease. Memo, July 23, 2001, Parashar B. Patel, Deputy Director Purchasing Policy Group, Center for Medicare Management to all associate regional administrators, available at <http://www.cms.hhs.gov/WorkersCompAgencyServices/Downloads/72301MEMO.pdf>.

A workers' compensation MSA may be submitted to CMA for review and approval where (1) the claimant is currently a Medicare beneficiary and the total settlement exceeds \$25,000, or (2) the claimant has a "reasonable expectation" of entering Medicare within 30 months of the settlement date and the anticipated total settlement amount for future medical expenses and lost wages exceeds \$250,000. An MSA is not necessary when the settlement leaves future medical expenses open. Settlement terms would be subject to negotiation and require the plaintiff to place settlement funds allocated for future medical expenses into a self-directed Medicare Set-Aside account similar to those used in workers' compensation settlements. Where such an allocation involves a substantial sum, litigants may further consider submitting the

proposed Medicare Set-Aside to CMS for approval, although CMS currently does not have a formal review procedure in place for liability claims.

A less conservative approach is to only use Medicare Set-Aside arrangements in cases involving catastrophic injury with substantial future medical expenses as an element of damages. Medicare eligibility would be a prerequisite to use of this strategy. Where a substantial element of damages is the plaintiff's future medical expenses, the use of a Medicare Set-Aside account may be advisable. Furthermore, parties can consider the use of annuities as a means of funding future medical expenses to help ensure the preservation of funds over time and to further protect Medicare's interests.

The least conservative approach would be to only employ the use of a Medicare Set-Aside where the settlement or judgment specifically requires an allocation of future medical expenses. As stated, examples of such settlements would be those involving mentally disabled adults and minors. In either instance, a set-aside should only be required where the plaintiff is either Medicare eligible or otherwise meets the current Medicare standard for future beneficiaries under workers' compensation. 42 U.S.C. § 1395y(b)(2).

#### **F. What About Cases Tried to a Jury?**

Cases that are tried to verdict raise an additional issue concerning compliance with the Act. Where future medical expenses are sought *as an element of damages*, such damages are awarded on itemized verdict forms. In such instances, it is arguable that an allocation of future medical expenses has been rendered as a result of the verdict. Defendants attempting to satisfy the judgment are left with no procedural or legal means to protect Medicare's interests by requiring the use of a Medicare Set-Aside by the judgment plaintiff. The SCHIP Extension Act, however, will provide a means through which Medicare is advised of the satisfaction of the judgment. The provisions of SCHIP will require notification to Medicare that a judgment involving a Medicare-eligible individual has been satisfied and that the judgment included an itemized verdict for future medical expenses. At that juncture, Medicare will certainly be on notice of the plaintiff's receipt of funds for future medical expenses; however, this would not necessarily *per se* satisfy one's obligation to protect Medicare's interests. It is likely that Medicare will require that the plaintiff expend the award in full for future medical expenses before Medicare will pay related treatment.

#### **G. Thoughts for the Future**

Regardless of how liberally or conservatively one approaches the Act compliance issue, litigants are left with the unresolved issue of how to protect Medicare's interests regarding future medical expenses where settlements involve a substantial compromise. Issues of liability as well as issues of comparative fault often result in settlements of substantially less than full value. Existing CMS methodologies for evaluating the amount of Medicare Set-Aside proposals are geared toward the full value or no-fault nature of workers' compensation statutes. Making Sense of Medicare Set-Asides, Matthew L. Garretson, Trial (May 2006). Accessed on 8/31/09 at:

<http://garretsonfirm.com/garretson/pdf/MakingSenseofMedicareSetAsides.pdf>. Litigants will potentially violate the Act if the settlement is construed as an improper attempt to shift liability to Medicare for the plaintiff's future medical expenses. 42 C.F.R. § 411.46(b)(2)(2005). As such, litigants must employ a standard of reasonableness in determining what, if any, amount may need to be placed into a Medicare Set-Aside in those instances where there is a compromise settlement.

One approach is to calculate the amount of the compromised settlement as a percentage of the full value of the claim. A Medicare Set-Aside can be funded using the same percentage for funding in relation to the full amount of anticipated future medical expenses. For example, if the claim is being settled at approximately 75 percent of full value, it would be reasonable to fund future medical expenses in a set-aside at 75 percent of the full future medical expense reasonably expected to arise in the future. One would expect that such an approach would be deemed a reasonable attempt to protect Medicare's interests and further avoid the appearance that parties are attempting to improperly shift liability for future medical expenses on to Medicare.

Clearly many questions remain unanswered regarding the scope of the Act and the position of CMS respecting statutory compliance. What is clear, however, is that the Department of Health and Human Services and the Center for Medicare Services have failed to promulgate any regulations specifically addressing the issue of future medical expenses in liability and auto liability claims. In the absence of regulatory direction from Medicare, questions will continue as to whether the Act is even enforceable with regard to liability settlements. While not all statutes require regulations, for practical purposes it can generally be considered that a statute for which an implementing regulation has never been created has no administrative or judicially cognizable consequence for failing to follow the statute. Code of Federal Regulations available at: <http://www.originalintent.org/edu/federalreg.php>. In addition, while CMS has made informal statements with regard to Medicare Set-Asides in liability and auto liability cases, they have failed to promulgate any written policies or directives. As such, litigants will continue to face considerable ambiguity with regard to the parties' obligations to Medicare under the Act.

Currently, litigants may take several views of what may constitute compliance with the Act. Those views will range from not employing Medicare Set-Asides in any case, to using Medicare Set-Asides in all personal injury settlements involving Medicare-eligible individuals with future accident-related medical expenses. Although further clarification and direction from CMS is anticipated, it remains speculation as to when, or even if, such action may be undertaken. In any event, the best advice is to anticipate that there may well be Medicare implications for your case and to continue to monitor developments in this field.

### **III. RECENT MEDICARE CASES**

#### **A. Must Medicare Reduce Its Lien in Recognition of Comparative Fault Principles?**

In *Hadden v. U.S.*, No. 1:08-CV-10, 2009 WL 2423114 (W.D. Ky., Aug. 6, 2009), the United States District Court for the Western District of Kentucky was recently faced with an argument by plaintiff's counsel that Medicare's conditional payments (lien) must be reduced based on Kentucky state law principles of comparative fault. Vernon Hadden, plaintiff, was a pedestrian struck by a utility truck belonging to Pennyrile Rural Electric Cooperative on August 24, 2005. The Pennyrile vehicle had swerved to avoid a car that had run through a stop sign. The identity of the operator of the vehicle which had run the stop sign was never identified. Hadden sued Pennyrile for negligence and ultimately the case settled for \$125,000. Medicare asserted a lien after accounting for recovery costs totaling \$62,338.07. Upon settlement, the plaintiff sent a letter to CMS requesting that conditional payments be waived under principles of comparative fault. Plaintiff's counsel argued that a reasonable allocation of fault would be ten percent to the Public Utility (Pennyrile) and 90 percent as to the unknown vehicle which had run the stop sign. Plaintiff, therefore reasoned, that CMS should recover no more than ten percent of its conditional payment amount. The request for a waiver or compromise was denied and the plaintiff appealed the decision. Upon exhausting administrative appeals he filed suit in the United States District Court for the Western District of Kentucky.

The federal district court denied the request for waiver or compromise of the conditional payments amount and held that the plaintiff was responsible for the full \$62,338.07 claimed by CMS. The court found against the plaintiff ruling that there was not a basis in the law to apply comparative fault principles to the CMS lien. The court further found that the settlement did not meet the "equity and good conscience" test for reduction under the Medicare Recovery Statute.

The case drew significant interest in the insurance industry. The Medicare Advocacy Recovery Coalition has undertaken to fund the appeal of the district court decision to the United States Court of Appeals for the Sixth Circuit. The Appellate Court will be asked to address the legal question of whether CMS must consider state comparative fault principles in its Medicare lien recovery process. A decision is expected from the Appellate Court late in the summer or early fall of 2010.

#### **B. Can Medicare Recover for Conditional Payment of Medical Bills Incurred After Settlement Date?**

In *U.S. v. Stricker*, 1:09-CV-02423, filed December 1, 2009, the United States of America brought suit in the Northern District of Alabama against defendants who had previously been involved in the settlement of a class action lawsuit that had been brought against Monsanto Company, Solutia, Inc., and Pharmacia Corporation. The United States additionally is seeking recovery of its conditional payments against plaintiff's counsel involved in the class action as well as the Travelers Insurance and AIG. The government claims that Medicare paid \$67,156,770.01 for

medical treatment on behalf of Medicare beneficiaries who are plaintiffs or class members in the underlying lawsuit. The class action litigation was settled in 2003, for an approximate sum of \$300,000,000.

What is particularly significant about the *Stricker* case is that CMS is essentially seeking, not only prior conditional payments made previous to the 2003 settlement but, additional conditional payments made between the time of settlement and suit. Under the class action settlement the *Stricker* plaintiffs will be receiving annual installments through 2013. CMS is seeking a declaratory judgment that future payments due under the settlement agreement must not be made until Medicare is first repaid its lien (conditional payments). The *Stricker* case presents a case of first impression with regard to the declaratory relief being sought by the United States (CMS). Concerns have arisen in the insurance industry that the complaint in this case signals an intent by CMS to expand the Act to future medical expenses that may arise from a tort related injury. The United States has filed a Motion for Summary Judgment arguing that it is entitled to judgment as a matter of law. Currently the parties are briefing various motions to dismiss which raise issues other than the future payment issue. By this fall it is anticipated that the summary judgment motion will be fully briefed and argued in the event defendants are not entirely successful on their motions to dismiss.



## Bradford J. Peterson

- Partner

Brad has spent his entire career with Heyl Royster beginning in 1987, in the Urbana office. He became a partner with the firm in 1997. Brad concentrates his practice in the defense of workers' compensation, construction litigation, auto liability, premises liability and insurance coverage issues. In recent years, Brad has become a leader in the field on issues of Medicare Set-Aside trusts and workers' compensation claims. He has written and spoken frequently on the issue. He was one of the first attorneys in the State of Illinois to publish an 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 currently serves on the Illinois State Bar Association Assembly and has also served several previous terms. He has also been a member of the ISBA Bench and Bar Section Council and served as its chairman 2000-2001. Currently, he serves as a member of the ISBA Workers' Compensation Council and is past editor of the Workers' Compensation Section Newsletter.

### Significant Cases

- *West v. Kirkham*, 207 Ill. App. 3d 954 (4th Dist. 1991), Recognized that trial court may find plaintiff contributorily negligent as a matter of law.
- *Propst v. Weir*, 937 F. 2d 338 (7th Cir. 1991), Application of qualified immunity for university officials in First Amendment Retaliatory Transfer claim.

### Publications

- "Medicare, Workers' Compensation and Set Aside Trusts," *Southern Illinois University Law Journal* (2002)
- "Survey of Illinois Law-Workers' Compensation," *Southern Illinois University Law Journal* (1991)

### Public Speaking

- "Medicare Set-Asides and the SCHIP Extension Act"  
Illinois State Bar Association Advanced Workers' Compensation Seminar 2008
- "Medicare Set Aside Issues and Update"  
22nd Annual HRVA Claims Handling Seminar 2007
- "Workers' Compensation and Medicare Set Aside Proposals"  
Illinois State Bar Association Hot Topics and Workers' Compensation 2005
- "Aggressive and Successful Workers' Compensation Defense Strategies for Today's Industrial Commission"  
19th Annual HRVA Claims Handling Seminar 2004

### Professional Associations

- Champaign County Bar Association
- Illinois State Bar Association
- American Bar Association
- Illinois Association of Defense Trial Counsel

### 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

