

MEDICARE SUBROGATION CLAIMS - DO YOU HAVE TO PAY?

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INTRODUCTION

Taking a page from the predatory practices of private subrogation vendors, the Department of Health & Human Services has attacked plaintiffs' tort settlements alleging a right under the Medicare Secondary Payer Act. ("MSPA") 42 USCS §1395y(b)(2). Many of us previously responded to Medicare's demands by escrowing funds out of our client's settlements. In the past few years, successful challenges have eroded the government's alleged "super lien."

Aggressive lawyers have successfully beaten back the government's reimbursement claims in a number of high profile cases: United States of America v. Phillip Morris, Inc., 116 F. Supp.2d 131 (2000); In re: Orthopedic Bone Screw Products Liability Litigation, 202 FRD 154 (2001); In re: Dow Corning Corporation, Debtor, 250 BR 298 (2000) .

Most recently, this issue received substantial press coverage in Thompson v. Goetzmann, 315 F.3rd 457 (5th Cir. 2002), and the re-issuance after petition for rehearing in Thompson v. Goetzmann, 2003 U.S. App. Lexis 13594 (2003). Each of these cases successfully challenged the government's attempt to use the MSPA to invade plaintiffs' settlements.

Given the strength of the arguments and the rulings of the various courts, the idea that Medicare has a claim for reimbursement in most tort cases appears on the way to extinction. It is now incumbent upon plaintiffs' counsel to familiarize themselves with the relevant authority on the

topic. The “traditional wisdom” that we must always honor Medicare reimbursement requests, is an invitation to potential malpractice.

THE MEDICARE SECONDARY PAYER ACT

42 USCS §1395y(b)(2)

The Medicare secondary payment provisions provide the government with statutory authority to obtain reimbursement for certain Medicare expenditures. The MSPA grants a right of recovery where Medicare is a secondary payer and has made a conditional payment. Under the MSPA, Medicare is a “secondary” payer where another entity is required to pay under a “primary plan” for the injured individual’s healthcare. If the “primary” payer has an obligation to pay for the healthcare costs but does not, Medicare may make a “conditional payment” and later demand reimbursement from the primary plan. 42 USC §1395y(b)(2)(B)(i)¹. If the entity administering the primary plan refuses to reimburse, the government may bring suit against it to recover Medicare payments. 42 USC §1395y(b)(2)(B)(ii).

It is extremely important to realize that the MSPA has a very narrow application. Reimbursement or recovery is only available where Medicare made a “conditional payment” and is the “secondary payer.” Payments made by Medicare as a primary payer are not subject to reimbursement. Consequently, a two-prong analysis needs to be employed:

1. Is there a primary payer, and if so,
2. Was there a conditional payment?

¹ The full text of the relevant subsections is reprinted at the end of this paper.

“PRIMARY PLAN”

It is the government’s burden to establish that a primary payer exists. Under 42 USC 1395y(b)(2)(A)(ii), primary payers are limited to:

1. Group health plan or large group plan;
2. Workers’ Compensation law or plan;
3. Auto or liability insurance policy (including a self-insured plan)²; and
4. No-fault insurance.

If the government establishes that a primary payer exists it then has the burden to establish that payments made by it were “conditional.”

CONDITIONAL PAYMENT

42 USC §1395(2)(b)(i)

Repayment Required. Any payment under this title [42 USCS § 1395 et seq.] with respect to any item or service to which subparagraph (A) applies shall be conditioned on reimbursement to the appropriate Trust Fund established by this title [42 USCS § 1395 et seq.] when notice or other information is received that payment for such item or service has been or could be made under such paragraph....

² A “self-insured plan” is defined as “an arrangement, oral or written ... to provide health benefits or medical care or assume legal liability for injury or illness (under which an entity “carries its own risk instead of taking out insurance with a carrier.”) 42 C.F.R. §§ 411.50(b), 411.21.

Subparagraph (A) prohibits payment with respect to any item or service to the extent that (i) payment has been made or can reasonably be expected to be made under paragraph (1) or (ii) payment has been made or can reasonably be expected to be made “promptly”³ under a workman’s compensation law or plan of the United States or a State or under an automobile or liability insurance policy or plan or under no-fault insurance. Consequently, the MSPA limits the government’s right of reimbursement to payments made by Medicare when payment for the service had already been made by a primary payer, or could have been expected to be “promptly” paid by a primary payer.⁴

THE WINNING ARGUMENT

In United States of America v. Phillip Morris, Inc., the government brought claims against the tobacco company defendants under three theories: the Medical Care Recovery Act (MCRA), the MSPA and Civil RICO. Defendant’s motion for summary judgment with respect to the MSPA claim was granted. The District Court found that the government failed to establish that Phillip Morris, Inc., was a “primary payer.” In granting the motion, the court noted that courts have uniformly recognized MSPA’s clear purpose was to grant the government the right to recover Medicare costs from **insurance entities**. See, e.g., Perry v. United Food and Commercial Workers District Unions, 405 and 442 64 F.3rd 238, 243 (6th Cir. 1995); Baptist Memorial Hospital v. PanAm

³ Payment is made “promptly” within 120 days after, (the earlier of) the date care was provided or claim is filed with the insurer. 42 C.F.R. §§ 411.21, 411.50.

⁴The prompt payment aspect played a significant part in the Fifth Circuit’s original Thompson v. Goetzmann decision. On rehearing, the prompt payment analysis was abandoned.

Life Insurance Company, 45 F.3rd 992, 998 (6th Cir. 1995); Evanston Hosp. v. Hauck, 1 F.3rd 540, 544 (7th Cir. 1993). As the court observed, what little legislative history exists is consistent with that interpretation. See HR Conf. Rep. No. 96-1479 1980.

Later, in In re: Orthopedic Bone Screw Products Liability Litigation, a prevailing plaintiff filed suit asserting that the government had no right to recover Medicare payments on behalf of class members, and seeking to enjoin the government from attempting such recovery. The government sent letters to approximately 1800 Medicare beneficiaries in the settlement class demanding repayment stating:

Medicare has determined that you are required to reimburse the Medicare program \$_____ for amounts it paid for items or service relating to the Orthopedic Bone Screw settlement with Acromed Corporation. Federal law requires Medicare beneficiaries who obtain a liability recovery, to repay the United States the amount the Medicare Program paid for conditions related to that recovery ...

The District Court granted class certification as well as the preliminary injunction finding it was likely the class members would prevail on the merits. The District Court, comparing the MSPA to the Medical Care Recovery Act (MCRA), found that while the MCRA specifically addresses recovery from tortfeasors, the MSPA does not.

The court found that the government's claim failed as a matter of law because the term "self insurer" in the MSPA was not meant to encompass alleged tortfeasors who merely fund liability settlements with their own assets or corporate borrowings. The court found that there was "simply no basis to conclude that Congress intended the MSPA to create in the government a right to recover from alleged tortfeasors for injuries resulting in Medicare payments."

Some of the more pointed characterizations of the government's sophistry are contained in footnotes to In re: Dow Corning Corporation, where the bankruptcy court found that although the

MSPA is relatively simple, it has generated considerable debate. The court noted that part of this is due to the complex nature of the statute's subject matter ... the regulation of the business of insurance:

But sadly, a significant amount of the legal melee is the direct result of the government urging statutory constructions, as it has done in this case, that are entirely unsupported by the statute and which appear to be intended to convert the MSPA from an important and sensible fiscal cost cutting measure into a mere heavy-handed collection tool.

In cases where inadequate insurance coverage existed to cover the totality of the competing claims, the government argued that the MSPA was entitled to "absolute priority" over the competing claims of other parties. This argument was rejected after which the court noted its disappointment in "the government's overreaching interpretation of its authority under the [MSP] statute."

The most recent victory for plaintiffs arises out of the Fifth Circuit Court of Appeals' ruling in Thompson v. Goetzmann. In Thompson, the United States Government was seeking reimbursement from a tort settlement with a manufacturer of defective hip replacement joints. The Fifth Circuit had previously rejected the government's position but was reconsidering the matter after a petition for rehearing was filed by the Department of Health & Human Services. In Goetzmann II, the Fifth Circuit denied the requested rehearing en banc but did withdraw its previous opinion and issued a substitute opinion.

At the outset, the court revisited and withdrew its "prompt payment" basis and redirected its focus on the primary payer issue. The government once again was advancing the argument that the tort settlement constituted "self-insurance" for the liability to cover the medical care of the plaintiff/Medicare recipient. The court noted that although the government had litigated similar cases in several district courts, the Fifth Circuit was the

...first appellate court to address the issue of an alleged tortfeasor's reimbursement liability under the MSPA statute. Notably, the government's prior efforts have proved uniformly feckless. Every court that has heard its argument on this issue, including the District Court in the instant case, has rejected the government's expansive interpretation of the MSPA statute.

The court found that the language of the federal statute was plain and ambiguous stating:

...the structure of the MSPA statute is relatively simple. If a Medicare recipient has medical insurance provided through a "primary" plan, then Medicare is precluded from paying for medical service except to provide secondary coverage. Stated differently, "Medicare serves as a backup insurance plan to cover that which is not paid for by a primary insurance plan.

The court agreed along "with the other district courts that have concluded that an alleged tortfeasor who settles with the plaintiff is not, ipso facto, a "self-insurer" under the MSPA statute."

The Fifth Circuit revisited the doctrine of *expressio unius est exclusio alterius* comparing the MSPA to the MCRA, finding that Congress clearly was capable of drafting a statute which explicitly provides for a right of reimbursement and subrogation in tort claims as it had done in the MCRA. The court further relied on the canon of harmonious interpretation of statutes to find that what MCRA explicitly provided for could not have been included by implication in the MSPA.

PENDING MOTIONS IN BAYCOL LITIGATION

Liaison counsel for plaintiffs in the Baycol products liability litigation, pending in Philadelphia, filed a motion seeking a ruling from Judge Ackerman that (1) no government liens exist under MSPA or MCRA, and (2) that the government be enjoined from asserting such liens on any cases in the Baycol Mass Tort Program in Philadelphia County. As of the writing of this paper, that motion has not been ruled upon.

Plaintiffs' counsel has also filed a motion to declare that Medicare is not entitled to any lien interest in the MDL litigation. It is expected that motion may be heard in September, 2003.

CONCLUSION

Opposition to Medicare's reimbursement request should stress the narrowness of the MSPA's application. Only conditional payments are properly subject to reimbursement claims. The government must have been a secondary payer at the time it made the payment. If prompt payment could not have been anticipated at the time Medicare paid for the services, there was not a "primary" plan. It is unlikely that the Department of Health & Human Services will concede the issue. Until a final resolution merely sending our clients money to HCFA without adequately testing the sufficiency of the alleged lien could be dangerous.

MEDICARE SECONDARY PAYER

(A) In general. Payment under this title [42 USCS §§ 1395 et seq.] 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 promptly (as determined in accordance with regulations) 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.

II Conditional payment.

(i) Repayment required. Any payment under this title [42 USCS §§ 1395 et seq.] with respect to any item or service to which subparagraph (A) applies shall be conditioned on reimbursement to the appropriate Trust Fund established by this title [42 USCS §§ 1395 et seq.] when notice or other information is received that payment for such item or service has been or could be made under such subparagraph. If reimbursement is not made to the appropriate Trust Fund before the expiration of the 60-day period that begins on the date such notice 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).

(ii) Action by United States. In order to recover payment under this title [42 USCS §§ 1395 et seq.] for such an item or service, the United States may bring an action against any entity which is required or responsible (directly, as a third-party administrator, or otherwise) to make payment with respect to such item or service (or any portion thereof) under a primary plan (and may, in accordance with paragraph (3)(A) collect double damages against that entity), or against any other entity (including any physician or provider) that has received payment from that entity with respect to the item or service, and may join or intervene in any action related to the events that gave rise to the need for the item or service. The United States may not recover from a third-party administrator under this clause in cases where the third-party administrator would not be able to recover the amount at issue from the employer or group health plan and is not employed by or under contract with the employer or group health plan at the time the action for recovery is initiated by the United States or for whom it provides administrative services due to the insolvency or bankruptcy of the employer or plan.