No. 09-6072

IN THE
UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

VERNON HADDEN,

Plaintiff – Appellant,

v.

UNITED STATES OF AMERICA,

Defendant – Appellee.

On Appeal from the United States District Court
for the Western District of Kentucky

AMICUS BRIEF

The Medicare Rights Center, Inc. is a national, non-profit consumer service organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs and public policy initiatives.

The attached amicus brief supports the positions advanced to this court by Appellant Vernon Hadden and seeks reversal of the judgment of the district court in this matter.

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CORPORATE DISCLOSURE STATEMENT
(Rule 26.1)

The undersigned, counsel of record for Amicus certifies that the Medicare Rights Center, Inc., is a registered domestic not-for-profit corporation. No parent corporation and/or publicly held corporation owns 10% or more of stock in the Medicare Rights Center, Inc.

/s/
Paul Caleo

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All parties have consented to the filing of this amicus brief.

I. Both Existing Law and Public Policy Demands the Equitable Allocation of Settlement Proceeds for Medicare Beneficiary Plaintiffs

Both existing federal law and the compelling public policy promoting settlements over trials requires Medicare to limit its recovery to a proportionate amount of a discounted settlement. Medicare recognizes and accepts allocations of payments when the payment is based on a jury verdict and/or a court's ruling on the merits, and it should do the same when a tort case resolves by way of a settlement. Medicare's refusal to do so causes significant hardship to Medicare beneficiaries and only undermines the Congressional intent of the original Medicare legislation, but it will also cause considerable unforeseen consequences to our already overburdened court system by forcing more lawsuits to trial, and/or impact the financial fisc by disincentivizing Medicare beneficiaries from filing tort lawsuits in the first place, which in turn will create societal concerns because tortfeasors will not take steps to prevent harm. Additionally, existing federal law requires proportionate allocation of recoveries in other federal programs that provide medical care, and there is no legal or policy reason why this same principle should not control Medicare's recovery efforts under the Medicare Secondary Payer Act ("MSPA").

a. The Implementation of Medicare's 'Full Reimbursement Rule' Causes Significant Hardships to Medicare Beneficiaries

Medicare beneficiaries comprise and make up the most "at risk" members of our community. Medicare beneficiaries whose personal injury proceeds are subject to MSPA claims are, by definition, elderly and/or disabled individuals. Statistics indicate people in these sectors of the population are poor or near poor. In 2002, the median Medicare beneficiary family income was just $20,400. *Kaiser Medicare Chart Book,* 2005, p. 6. Eighteen percent of Medicare beneficiaries have income at only 100% of the Federal Poverty Level ("FPL"). Ten percent have income between 100% and 125% of the FPL, and 21% have income between 125% and 200% of the FPL. June 2007 *MedPac Data Book,* p. 23. Thus, nearly one half of Medicare beneficiaries have income below 200% of the FPL. This portion of our community is not only the most vulnerable, but will grow exponentially over the next 10 to 20 years, given the demographics of the baby boomers. The MedPac analysis of the Social Security Administration 2006 Trustees' report supports the conclusion that the total number of people enrolled in the Medicare Program will nearly double between 2000 and 2030, from approximately 40 million to 79 million beneficiaries. *See* www.medpac.gov/publication/congressional_reports/jun06DataBookSec2.pdf at p. 22. Furthermore, the impacted population is not only near poverty, but injured as well, in most cases

through no fault of their own, just like Mr. Hadden.

Even if the statutory purpose of the MSPA statutes of reducing Medicare's costs is cited in support of the full reimbursement rule, it is difficult to give much persuasive weight to this intent when it cannot be reconciled with the Congressional purpose behind the original 1965 Medicare legislation.

When a tort settlement does not provide complete payment for the beneficiary's total losses, Medicare's recovery should be limited to the proportionate share of the settlement that is allocable to Medicare covered medical expenses. Congress could not have intended for Medicare to recover more than its fair share of liability settlements if it leaves the elderly and disabled beneficiary without the funds they need to be compensated for their injuries. If the inequities of Medicare implementing its full reimbursement rule is not ably demonstrated by Mr. Hadden's circumstances, then it can be further illustrated by the hypothetical relied on by Judith Stein and Alfred J. Chiplin, Jr., in the *Medicare Handbook* textbook that is described as follows:

> Following her auto accident, for which liability was disputed, Vicki Victim received a settlement of $50,000. Her medical expenses were $40,000 of which Medicare paid $25,000; her pain and suffering were valued at $10,000; lost wages were $20,000; and her permanent loss of limb was valued at $30,000.
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> ***
>
> Despite the fact that Vicki's settlement was only 50% of her $100,000 damages, Medicare would demand recovery of its entire $25,000 outlay, reduced only by its proportionate share of the procurement

> costs. Assuming a 30% contingency fee arrangement, Medicare would actually take $17,500, Victim's personal injury attorney would receive a fee of $15,000, and Vicki would receive only $17,500, leaving $82,500 in uncompensated losses.

2010 Medicare Handbook by Stein and Chiplin, Jr., editors in chief, 9-15 to 16.

Plaintiffs subject to MSPA reimbursement claims are also, by definition, individuals who have suffered injuries in incidents that gave rise to damages and have waited some period of time for the damages to have been determined and paid. Access to their settlement monies would be of significant value to many of these people, helping them to meet the immediate costs of daily living, as well as paying for assistance needed as a result of their injuries. There can be no doubt that Medicare beneficiaries have a significant interest in receiving the proceeds of their liability claim as quickly as possible.

The practical effect of Medicare seeking full reimbursement of its conditional payments when a settlement only partially compensates a beneficiary for a portion of his damages is that it will discourage beneficiaries and their contingency fee attorneys from filing the tort lawsuit in the first place. Medicare will relent, however, and exercise its right of reimbursement only against damages found for medical expenses where the medical and non-medical losses are determined by court judgment or other adjudicator. *See, Medicare Secondary Payer Manual,* CMS Pub. 110-5, ch. 7, § 50.4.4 (2008). The end result of this policy is that the beneficiary and his attorney will be reluctant to file the lawsuit,

because the only way they can obtain an equitable allocation of the payment toward the beneficiary's medical treatment costs is by taking the matter all the way through to trial. Forcing cases to jury verdict increases the cost and thereby reduces recovery to the beneficiary and the attorney. *See* Rick Swedloff, *Can't Settle, Can't Sue: How Congress Stole Tort Remedies from Medicare Beneficiaries,* 41 Akron L. Rev. 557, 600 (2008). The end result is that fewer tort lawsuits will be filed by and on behalf of injured and deserving Medicare beneficiaries.

Just as happened with Mr. Hadden in this case, the full reimbursement rule deprives poor and injured beneficiaries of needed compensation for their pain and suffering, lost wages and other non-medical damages. *See, e.g., Id.* at fn. 140. *In Re Zyprexa Prods. Liab. Litig.,* 451 F. Supp. 2d 458, 470 (E.D.N.Y. 2006).

When Congress made changes to the scope of the MSPA statute in 2003, the Congressional Budget Office's estimate predicted that these " technical" and "clarifying" amendments would produce savings to the Medicare Trust Fund of $9 billion over ten years. *See* Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 301, 117 Stat. 2066, 2221 (2003) ("MMA"), and S15584-S15585, 108th Cong. (2003). Notwithstanding the Congressional Budget Office's estimate that predicted that this statute would produce savings to the Medicare Trust Fund, these predicted savings were based on

an assumption that beneficiaries would continue to file lawsuits and settle their cases. However, it is clear that the implementation of the full reimbursement rule will result in less lawsuits being filed by Medicare beneficiaries, and more of the lawsuits that are filed, not settling prior to trial.

II. Federal Law Requires Proportionate Allocation of Recoveries by Other Federal Programs in the Context of Tort Settlements

a. The Employee Retirement Insurance Security Act (ERISA)

Copeland Oaks v. Haupt, 209 F.3d 811 (6th Cir. 2000) analyzed an analogous recoupment provision in the Employee Retirement Insurance Security Act ("ERISA"). In a *per curiam* opinion, this Court reversed the district court's finding that a minor claimant was made whole by her monetary recovery and remanded for a specific factual determination of the claimant's total damages so that an ERISA plan's subrogation rights could be equitably applied.

The *Copeland Oaks* holding invoked black letter principles of subrogation:

"No right of subrogation against the insured exists upon the part of the insurer where the insured's actual loss exceeds the amount recovered **both from the insurer and the wrongdoer."** *Id.* at 814, *citing* 16 Couch on Insurance 2d § 61:64 (emphasis in the original). This same principle should control MSPA recovery efforts.

The "made whole" doctrine embraced in *Copeland Oaks* is a long-

recognized and continuous principle in this Circuit. *E.g., Hiney Printing Co. v. Brantner,* 243 F.3d 956 (6th Cir. 2001); *Wausau Benefits v. Progressive Ins. Co.,* 270 F. Supp. 2d 980 (S.D. Ohio 2003). "Such a rule is consistent with the equitable principle that an insurer does not have a right of subrogation until the insured has been fully compensated." *Marshall v. Employers Health Insurance Co.,* Nos. 96-6063/6112, 1997 WL 809997 (6th Cir. Dec. 30, 1997).

Although other circuits might take a different view of the "made whole" doctrine, *see Cutting v. Jerome Foods Inc.,* 993 F.2d 1293 (7th Cir. 1993), the economic equity behind the doctrine is easily recognized. As Judge Posner puts it:

> A legal right, for example a tort victim's right to sue his tortfeasor for damages, is like a lottery ticket. Its payoff is highly uncertain. Subrogation, consistent with the objective of insurance, transfers the lottery ticket from the individual policyholder to the collectivity of the policyholders. The risk is spread, and by being spread eliminated or at least greatly reduced.

Id. at 1298.

Equitable principles of subrogation recognized and applied in ERISA cases unquestionably apply to Mr. Hadden's dilemma. HHS did not assert a statutory action against its Medicare beneficiary; the fact that HHS allowed for Mr. Hadden's modest recovery expense evidences the government's willingness to let others do the work of recovery so long as Medicare can exercise the subrogation right granted by 42 U.S.D. § 1395y(b)(2)(B)(iv). Having elected the subrogation route, HHS should be bound by the equitable principles that underlie

all forms of subrogation.

b. The Medical Care Recovery Act (MCRA)

Cockerham v. Garvin, 768 F.2d 784 (6th Cir. 1985), analyzed a provision in the Medical Care Recovery Act ("MCRA") similar to the MSPA. In *Cockerham,* a veteran was seriously injured in a motorcycle accident and subsequently brought a tort action against several entities for damages. *Id.* at 785. Despite that the injured veteran received only a discounted settlement, the Veteran's Administration ("VA") nevertheless sought full recovery for the medical expenses it incurred on the injured veteran's behalf. *Id.*

On appeal, the court held that "the government should not be reimbursed for the full amount of its claim in this case because it passively has allowed the veteran to bear all the risks and costs of pursuing litigation." *Id.* at 787.

> The government is not suing the tortfeasor. It seeks recovery only as a beneficiary of the fund, and therefore equitable considerations apply. If an injured veteran has accepted a discounted settlement for his claims of wage loss, pain and suffering, loss of future earning potential, and the like, it is not equitable to require full reimbursement for services the government was duty-bound to render. If *Cockerham* establishes on remand that his settlement was discounted, the government's portion should be reduced accordingly.

Id.

Similar to the MSPA, the MCRA is designed to ensure that the government recovers its expenditures in the context of a tort lawsuit wherever possible. However, like the MCRA, recovery under the MSPA must be limited to the costs

of the items and services of medical care it provides. It is simply inequitable to allow the Government to recover its full expenditure of medical expenses where the Medicare beneficiary whom is ostensibly the very type of citizen Medicare is designed to protect, is unable to recover other proper damages under tort. A proper allocation to Medicare is the only equitable solution and encourages settlement while discouraging needless litigation.

In *Arkansas Department of Health & Human Services v. Ahlborn,* 547 U.S. 268 (2006), the United States Supreme Court held that the state Medicaid agency was entitled only to a proportionate share of a settlement between a Medicaid beneficiary and a third-party tortfeasor. In *Ahlborn,* the plaintiff suffered permanent injuries in a motor vehicle accident, and subsequently received Medicaid benefits. The plaintiff later settled with several defendants at a discounted rate. *Id.* at 274. The Arkansas Department of Health & Human Services ("ADHS") asserted a lien on the settlement equal to its total expenditures, regardless of the fact that ADHS agreed that the settlement plaintiff received amounted to approximately one-sixth of her total damages. *Id.* at 280. The plaintiff brought a declaratory judgment action to limit ADHS's reimbursement to its proportionate share of the settlement, or approximately one-sixth of ADHS's stated claim. *Id.* at 274.

As noted *supra,* the United States Supreme Court held that the state

Medicaid agency was entitled only to a proportionate share of a settlement between a Medicaid beneficiary and a third-party tortfeasor. *Id.* at 282. The Supreme Court rejected the Government's argument that full reimbursement is required to avoid settlement manipulation noting:

> … the risk that the parties to a tort suit will allocate away the State's interest can be avoided either by obtaining the State's advance agreement to an allocation or, if necessary, by submitting the matter to a court for decision. For just as there are risks in underestimating the value of readily calculable damages in settlement negotiations, so also is there a countervailing concern that a rule of absolute priority might preclude settlement in a large number of cases, and be unfair to the recipient in others."

Id. at 288.

The Supreme Court also rejected the State's argument that similar statutory language allowed the State to recover up to the amount it paid out on the recipients behalf, and was not limited by the third-party tortfeasor's particular liability for medical expenses, noting:

> [b]ut that reading ignores the rest of the provision, which makes clear that the State must be assigned 'the rights of [the recipient] to payment by any other party *for such health care items or services.*' § 1396a(a)(25)(H) (emphasis added). Again, the statute does not sanction an assignment of rights to payment for anything other than medical expenses—not lost wages, not pain and suffering, not an inheritance.

Id. at 281 (emphasis original).

Thus in the context of Medicaid and the MCRA, the government is entitled to recover only that allocation of a tort settlement that is attributable to medical

"items and services" provided. Moreover, where a tort settlement is discounted and does not reflect the total "value" of the claim, the government is entitled only to the percentage of the total claim that is recovered. That is where a beneficiary recovers 20% of their total tort damages, the government is entitled to a 20% reimbursement of its expended medical items and services. Just as in cases involving Medicaid and the MCRA, Medicare should be entitled to recover a proper allocation of its damages where a Medicare beneficiary settles a tort claim, but no more. That Medicare will accept allocation in the context of a court order but not in settlement is a distinction without merit. As Justice Stevens noted in *Ahlborn,* judicial mechanisms are available to ensure the Government's interests are protected in the context of settlement. *Ahlborn* at 288.

III. The Unforeseen Consequences of the 'Full Reimbursement Rule' when a Tort Case Settles Prior to Trial

It is universally accepted that the settlement of a tort lawsuit requires compromise from all the interested parties. A settlement also recognizes that the plaintiff or injured party is receiving less than the full value of his/her damages. The compromise by the parties to the lawsuit can be for many reasons, ranging from questionable liability to burden of proof problems, to the plaintiff deciding to take a lower guaranteed recovery sooner rather than risking the uncertainty of a jury trial and the accompanying delay that goes with it. Every element of our civil

justice system that administers and manages tort lawsuits understands what a settlement means. Why doesn't Medicare? Especially when Medicare's failure to accept an equitable allocation based on a discounted settlement directly impacts the beneficiaries the program is meant to help. What we also understand is that our civil justice system operates on the basis that a majority of tort lawsuits settle long before trial.

a. There Will Be an Increased Burden on our Civil Justice System

In hindsight, based on the way Medicare implements its MSPA reimbursement claims, Mr. Hadden would have been better off taking his case all the way through trial and obtaining a jury verdict that allocated his award among each of the components of his damages, including his past injury related medical treatment paid for by Medicare. Continued implementation of Medicare's full reimbursement rule likely will result in many Medicare beneficiary plaintiffs taking their cases through to jury verdict to ensure that they are adequately compensated for their injuries and damages and avoid potential financial hardship. On the other side, many defendants will see no choice but to defend a matter through trial to ensure that their obligation to Medicare is based on their proportionate share of liability to the Medicare beneficiary plaintiff. Thus, both sides in tort lawsuits will be motivated to take the case through to jury verdict as a result of Medicare's full reimbursement rule, especially after April 1, 2010, when

the reporting conditions enacted by section 111 of the Medicare, Medicaid, and SCHIP Extension Act ("MMSEA") formally commences. *See* Medicare, Medicaid, and SCHIP Extension Act of 2007, Pub. L. No. 110-173, § 111 (2007).

The irony of Medicare's reimbursement policy effecting an *increase* in the likelihood of a given tort case going to trial will not be lost on federal and state judges. According to data published by the American College of Trial Lawyers, the percentage of federal civil cases being tried dropped from 11.5% in 1962 to 1.8% in 2002. *The "Vanishing Trial:" The College, The Profession, The Civil Justice System* 5-6 (ACTL October 2004) (*citing* M. Galanter, *The Vanishing Trial: An Examination of Trials and Related Matters in Federal and State Court,* The Journal of Empirical Legal Studies, vol. 1, no. 3 (2004).[1] At the same time, however, the total number of cases being handled by the federal courts is rapidly increasing. In 1962, there were 50,320 total cases disposed of in federal courts. By 2002, that number had more than quintupled to 258,876. *Id.* The total case filings in late 2009 are almost certainly higher.

Basic mathematics predict that even a small percentage increase in the number of cases that litigants are motivated to take to trial—due to the federal government's interpretation of MSPA policy—will generate a significantly greater workload for the judiciary. The recent decision in *Haro v. Sebelius,* 2009 U.S.

[1] The same trend holds in state trial courts. Based on data gathered from 75 of the largest U. S. counties, the incidence of civil trials dropped 47% from 22,451 to 11,908) in the years between 1992 and 2001. *Id.*

Dist. Lexis 111053 at fn. 5 indicates that three to five percent of an Arizona plaintiff attorney's eighty open cases involve personal injury claims by Medicare beneficiaries who will be subject to reimbursement claims under the MSPA procedures. *Haro v. Sebelius,* 2009 U.S. Dist. Lexis 111053 at fn. 5. Applying the *Haro* percentages to the number of civil cases filed in federal courts, district courts could easily be called upon to handle an additional 8,000 to 13,000 trials. Even assuming that only half of an average attorney's Medicare beneficiary cases are propelled to trial because of MSPA policies, the number of additional trials could easily be between 4,000 and 6,500.

Regardless of the effect on court systems, an artificial increase in the number of cases tried instead of settled will cause an inordinate hardship on the elderly beneficiary. A Medicare beneficiary who is also a tort plaintiff will not only have to wait longer for "his day in court" to be compensated for his injuries, but his day in court could be delayed even further because fewer cases will settle and, correspondingly, more cases will need to be tried. The problem will only get worse in the future as the bulk of baby boomers turn 65.

b. There Will Be Lost Opportunities to Recover Conditional Payments

Fewer tort lawsuits filed by Medicare beneficiaries mean less opportunity for Medicare to seek reimbursement of their conditional payments from a potential

tortfeasor who would be a primary payer under the MSPA statutes. Accordingly the end result of Medicare's full reimbursement rule is in direct contrast to the intent and over-arching statutory purpose of the 2003 and 2007 Medicare statutes, which is to reduce Medicare costs.

Medicare costs are going up, therefore it must institute policies that will reduce costs, not exacerbate them.

c. There May Be Unforeseen Societal Consequences

The concomitant result of fewer lawsuits being filed by Medicare beneficiaries is that tortfeasors will not be made to redress the harms they cause and, as a result, they will not invest the proper amount in preventing harm. Whether one supports corrective justice or a deterrence rational for tort, and whether one focuses on procedural fairness for each individual claimant, or on efficiency in the overall process, the goal of any tort regime should be, in part, to reduce the rate of negligent conduct. *See* Swedloff, *supra,* at p. 603 & fn. 191.

IV. The MSPA Does Not Forbid Honoring Allocations Arising Out of Settlements

a. The Department of Health and Human Services Recognizes Allocation of Liability Payments to Nonmedical Losses Where There Is a Court Order, and/or Adjudication as to the Merits of an Individual Settlement and Other Limited Circumstances

While Medicare recognizes allocations of liability payments to nonmedical losses when payment is based on a court order on the merits of the case, no such deference is afforded to Medicare beneficiaries where meritorious tort claims are resolved through settlement. When a settlement compensates a Medicare beneficiary for less than their total damages, HHS nevertheless requires full payment of its expenditures (minus its portion of attorney fees and costs) without consideration of the allocation of damages set forth in the settlement agreement. *See* 42 C.F.R. §411.24(c); 42 C.F.R. §411.37; Medicare Secondary Payer Manual, CMS Pub. 110-5, ch. 7, §50.4.4 (2008).

With respect to recovery of payments from settlements, HHS states it will pursue recovery "without regard to how the settlement agreement stipulates disbursement should be made," and includes situations "in which the settlements do not expressly include damages for medical expenses." Medicare Secondary Payer Manual, CMS Pub. 110-5, ch. 7, § 50.4.4 (2008). The proffered justification for this seeming contradiction is that "[s]ince liability payments are *usually* based on the injured or deceased person's medical expenses, liability payments *are considered to* have been made 'with respect to' medical services related to the injury even when the settlement does not expressly include an amount for medical expenses." *Id.* (emphasis added).

Medicare's simplistic justification that payments made to settle tort lawsuits

"usually" includes 100% of the injury related medical expenses is not supported by any authority and does not reflect the reality of how tort lawsuits are settled prior to trial. Whereas we concede that some settlements of cases with Medicare beneficiary plaintiffs may reflect a payment that is close to 100% of the injury related medical expenses, all settlements reflect some degree of compromise of the total value of the case, including each of the components of the claimed damages, to reflect the financial savings the party incurs by avoiding a jury trial. Thus, there are a myriad of reasons of why a settlement will not reflect even close to 100% of the injury related medical expenses.

One reason is the existence of valid tort defenses including plaintiff's comparative fault. Notwithstanding an accident that causes serious physical injuries and that requires extensive medical treatment, an assessment by that plaintiff and his attorney that their theory of liability will only succeed two to three times out of ten at trial will result in a discounted settlement that will reflect a payment of 20% to 30% of the injury related medical expenses. Mr. Hadden's circumstances reflect that precise situation.

In addition, and particularly relevant to Medicare beneficiary plaintiffs, is the medical causation defense. Given the fact that many Medicare beneficiary plaintiffs may have significant preexisting injuries and illnesses, the existence of a valid medical causation defense may mean that the at fault tortfeasor is not the

legal cause of the injuries that the plaintiff alleges arose from the accident. It is very common that even when there is no dispute as to liability, there may be a vigorous defense as to the issue of whether the accident caused the alleged injuries. The settlement of a tort lawsuit where a valid medical causation defense exists will reflect a deeply discounted payment for the injury related medical expenses. Unfortunately, the text of the manual makes clear HHS simply makes the assumption that liability payments are *usually* based on the injured or deceased person's medical expenses, without conducting investigation into the actual merits of this assumption as applicable to the individual matter. As such, Medicare beneficiaries with meritorious tort claims who choose to, or are unable to, pursue their claim to verdict, are denied the opportunity to establish a proper allocation between payments for medical services and for losses other than medical services, such as pain and suffering.

HHS's interpretation of their right to recovery in the context of settlement simply ignores the reality that in settling a tort claim, a Medicare beneficiary must account for the strength of the opposing party's position. Medicare implicitly recognizes this fact in the context of court order, and can articulate no compelling justification not to apply the same deference in the context of settlement.

Indeed, the anticipated argument for applying such contradictory recovery positions is that the Government must seek full reimbursement to avoid the risk of

"settlement manipulation." However, the United States Supreme Court in the context of a similar argument pertaining to a Medicaid settlement addressed and rejected the Government's position that full reimbursement is generally required to avoid the risk of "settlement manipulation." "[T]he risk that the parties to a tort suit will allocate away the State's interest can be avoided either by obtaining the State's advance agreement to an allocation or, if necessary, by submitting the matter to a court for decision. For just as there are risks in underestimating the value of readily calculable damages in settlement negotiations, so also is there a countervailing concern that a rule of absolute priority might preclude settlement in a large number of cases, and be unfair to the recipient in others." *Arkansas Department of Health & Human Services v. Ahlborn,* 547 U.S. 268, 288 (2006).

Notably, HHS's apparent distrust of settlements is not embodied in statute or regulation, but rather in its internal Medicare Secondary Payer Manual and should thus be given little deference. *See* Medicare Secondary Payer Manual, CMS Pub. 110-5, ch. 7, §50.4.4 (2008).

b. The Practice of Denying Allocation to Medicare Beneficiaries Who Engage in Settlement Conflicts with the Purposes and Policies Underlying the Medicare Program

i. The Use of the Phrase "Item Or Service" in the MSPA Specifically Limits Medicare's Right to Reimbursement

42 U.S.C. §§1395y(b)(2)(B)(i) and (b)(2)(B)(ii) sets forth that Medicare shall recover expenditures for an "item or service" where a primary plan is deemed responsible for said expenditures. Where a Medicare beneficiary settles a meritorious tort claim, a portion of such a settlement is properly attributable to items and services the Medicare beneficiary has received from Medicare. However, pursuant to the statute, Medicare should only be entitled to that portion of the settlement that is attributable to items or services for which Medicare paid. Indeed, that Congress specifically refers to an "item or service" indicates that Congress intended to limit Medicare's right to reimbursement to the extent that a Medicare beneficiary's settlement actually covers the items or services for which Medicare seeks reimbursement.

In *Ahlborn* the United States Supreme Court held that the state Medicaid agency was entitled only to a proportionate share of a settlement between a Medicaid beneficiary and a third-party tortfeasor. *Ahlborn, supra,* at 282. In *Ahlborn,* the United States Supreme Court rejected the State's argument that similar statutory language allowed the State to recover up to the amount it paid out on the recipients behalf, and was not limited by the third-party tortfeasor's particular liability for medical expenses, noting:

> [b]ut that reading ignores the rest of the provision, which makes clear that the State must be assigned 'the rights of [the recipient] to payment by any other party *for such health care items or services.'* §1396a(a)(25)(H) (emphasis added). Again, the statute does not

> sanction an assignment of rights to payment for anything other than medical expenses—not lost wages, not pain and suffering, not an inheritance."

Id. at 281 (emphasis original).

Thus, the United States Supreme Court has recognized that health care "items and services" allows the Government to recover only that portion of a settlement attributable to medical expenses.

Where a Medicare beneficiary with a meritorious tort claim settles for less than the full value of the injuries and damages, then all components of their damages claims are reduced proportionally, including damages for pain and suffering and medical expenditures among others. Medicare will accept this fact where the merits of an action are subject to a court order, but not for a settlement. Such distinctions from the perspective of Medicare beneficiaries with meritorious tort claims are irrelevant.

A Medicare beneficiary shares Medicare's goal of full reimbursement for all injuries caused through tort. However, as discussed *supra*, it is often not in the Medicare beneficiary's control whether to litigate a case to verdict given financial restraints and potential difficulty obtaining competent legal representation. Medicare beneficiaries with meritorious tort claims should not be penalized where for a multitude of reasons, their counsel determines the case should objectively settle rather than proceed to trial. Moreover, should Medicare beneficiaries with

meritorious tort claims be forced to pursue their claim to trial rather than settle, many of them may fail to recover at all, despite that they may have recovered some portion of their claim in settlement.

ii. The Purposes and Policies Underlying the Medicare Program Should Not Be Subordinate to the Government's Interest in Protecting the Federal Fisc

Medicare was designed "to protect individuals 65 years of age and over from the high cost and the hardship of illness." *See Martinez v. Richardson,* 472 F.2d 1121, 1123 (10th Cir. 1973). In short, while the purposes of 42 U.S.C. §1395y(b)—to obtain federal budget savings—are proper and desirable, such noble ends should not be sought on the backs of the very Americans that Medicare was enacted to protect.

Mr. Hadden, like many Medicare beneficiaries with tort claims against third parties apparently held no fault for the incident that caused his injuries. If Mr. Hadden had successfully tried his case to verdict, Medicare would accept a proportional recovery. That Mr. Hadden, with the assistance of competent counsel, determined that all parties, including Medicare, would be best served through settlement does not diminish Mr. Hadden's claims for pain and suffering associated with this tort.

Medicare may waive recovery where a Medicare beneficiary with a

meritorious tort claim was not at fault and recovery would "defeat the purposes" of the Medicare Act or be "against equity and good conscience." 42 U.S.C. §1395gg(c); 42 C.F.R. § 405.358. In the context of a Medicare beneficiary who settles a tort claim for personal injury, it is against equity and good conscience for Medicare to seek recovery for more than the portion of the settlement attributable to medical items and services.

Mr. Hadden's case throws into stark relief the problems associated with the HHS's narrow interpretation of the equity and good conscience clause. To passively allow a Medicare beneficiary to expend considerable time and resources to develop a case to the point he or she may receive some partial payment for their injuries, only to demand full recovery of its claim with no offset for fault allocation, is simply inequitable. HHS must conduct an individualized investigation into the individual merits of a claim to properly determine if Medicare's recovery would be against equity and good conscience.

Medicare should not receive a "super-right" that puts its interests above even Mr. Hadden. To allow such a system will only result in reduced revenue for Medicare and additional suffering for Medicare beneficiaries, as Medicare beneficiaries with meritorious tort claims will be unable to obtain the assistance of competent counsel for claims that, for a variety of reasons, are not appropriate to pursue through trial. Such a result is a perversion of the noble goals the Medicare

system was designed to achieve, and should not be permitted. Where a Medicare beneficiary with a meritorious tort claim with the assistance of competent counsel settles their claim for less than their total damages, Medicare should recover proportionally to the amount recovered by the Medicare beneficiary.

Respectfully submitted,

Dated: December 17, 2009

/s/
Paul Caleo

Dated: December 17, 2009

/s/
Kevin M. Larson

Dated: December 17, 2009

/s/
John Tate

CERTIFICATE OF COMPLIANCE

The undersigned certifies that this brief complies with the type-volume limitation provided in Fed. R. App. P. 32(a)(7) and 29(d). The foregoing brief contains 6,397 words of Times New Roman (14 point) proportional type excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(b)(iii). The word processing software used to prepare this brief was Microsoft Word 2007.

/s/
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On this 17th day of December 2009, the foregoing Amicus Brief was filed with the Court's ECF system and served by email upon:

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