

HADDEN CASE BRINGS INTERPRETATION OF MEDICARE SECONDARY PAYER ACT

The United States Court of Appeals for the Sixth Circuit published its ruling in *Vernon Hadden v. United States of America*, No. 09-6072, 2011 U.S. App. LEXIS 23289, on November 21, 2011. The long-awaited decision regarding the extent of Medicare's reimbursement rights to conditional payments made on behalf of an injured beneficiary was eagerly anticipated. For the Medicare compliance industry, tort litigants and beneficiaries, the Hadden case brings to light at least one court's interpretation of the Medicare Secondary Payer Act and the seeming incongruity between Medicare's broad right of recovery and the reality of tort settlements and awards.

Hadden, injured in 2004 when he was struck by a vehicle, argued that he had recovered only 10% of the total damages in his case (the remaining 90% were the fault of an unidentified motorist). Of the \$125,000.00 settlement paid by the insured tortfeasor, Medicare claimed a reimbursement right to \$62,338.07. Hadden took the position that Medicare's reimbursement rights should be reduced as a result of his failure to recover the lion's share of the damages that resulted from the accident.

HADDEN ARGUED FOUR POINTS

Hadden essentially argued four points on appeal from the United States District Court for the Western District of Kentucky at Bowling Green. First, he said his obligation to reimburse Medicare should be limited to a pro rata share of

the portion of his recovery that represented medical expenses. Second, he argued that Medicare reimbursement cases should be handled pursuant to other federal and state statutes, including the Medical Care Recovery Act, 42 U.S.C. § 2651(a) and the Medicaid statute. He cited the Supreme Court's decision in *Arkansas Department of Health and Human Services v. Ahlborn*, 547 U.S. 282 (2006) as authority. Third, he argued that, technically, Medicare's right to reimbursement as set forth in 42 U.S.C. 1395y(b)(2)(B) was only enforceable pursuant to § iv of the statute when an action was specifically brought. Accordingly, principles of subrogation would preclude action against Mr. Hadden directly. Last, Hadden said that Medicare should have waived the reimbursement obligation in his case as their recovery was "against equity and good conscience."


COURT'S FINDINGS

The court in affirming the District Court's order denying the relief Mr. Hadden sought, addressed each argument in turn.

With regard to the position that Medicare should have waived the lien based upon the circumstances of the claim and the amount of settlement, the court found that the Appeals Council and the Administrative Law Judge

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that reviewed the case had “little to no evidence” that the reimbursement amount would have caused a hardship to the plaintiff. Specifically, Mr. Hadden retained almost \$44,000.00 after reimbursing Medicare.

As to the argument that the Medicare Secondary Payer Act can only be enforced by bringing action under 42 U.S.C. 1395y(b)(2)(B)(iv), the court reasoned that 42 U.S.C. 1395y(b)(2)(B)(iii) allows the United States to recover against any entity that receives payment from a primary plan, which would include Mr. Hadden. Thus, the Medicare Secondary Payer Act is broad enough to include all parties to a settlement, judgment or award.

The more significant findings were made regarding Hadden’s first two arguments. As to the position taken by the plaintiff that the Medicare Secondary Payer Act and Medicare’s reimbursement rights should specifically recognize the extent to which tort recoveries are reduced by facts, including failure to recover the full measure of damages, the court was unsympathetic (unlike the state Medicaid decision in *Ahlborn*, which limits recovery to the extent that there is legal liability to pay for care). Attempting to attach the same type of standard whereby the parties’ legal obligations (wherein proportionate fault is analyzed as in a Medicaid reimbursement case) under the Medicare Secondary Payer Act is simply not contemplated by 42 U.S.C. 1395y(b)(2).

Perhaps most importantly, the court found that Medicare’s reimbursement rights, as set out in 42 U.S.C. 1395y(b)(2)(B)(ii), includes the “responsibility” to reimburse Medicare from both the beneficiary and a primary plan. Citing the portion of the statute that establishes Medicare’s right to reimbursement despite a determination or admission of liability, the court found that when a beneficiary demands medical expenses from a primary plan to their full extent, he cannot then argue that Medicare should receive only 10% of the total. In short, the court determined that the scope of the responsibility to reimburse Medicare is determined by what has been requested of the third party. Here, because Mr. Hadden’s arguments were not restricted to a pro rata share of the medical expenses incurred, the court determined that he is then bound by the position taken at the time of the settlement.

DISSENTING OPINION

A dissenting opinion was also filed by one of the judges calling into question the majority’s definition of “responsibility” and arguing that, in reality, the majority’s reading of the Medicare Secondary Payer Act is both too broad and impractical in the world of tort litigation.

SUMMARY/CONCLUSION

For the Medicare compliance industry and Medicare beneficiary tort litigants, the *Hadden* case seems to suggest that Medicare will not be inclined to consider arguments including a reduced tort award as a means to compromise conditional payment liens. However, the case also appears to suggest that compromise and waiver arguments are still considered viable avenues to reduce Medicare’s ultimate recovery, if properly presented. Whether the case triggers any internal policy or procedural change within Medicare should be known shortly.

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