WHEN IT COMES TO MEDICARE, MORE CAN BE BETTER

Stephen E. Geduldig and Ryan C. Blazure Thomas, Thomas and Hafer LLP

Counsel rarely need to be told to include 'more' when they write. Indeed, it is often the woe of many a reviewing court that counsel are too wordy. However, when it comes to Medicare and its concomitant reporting and repayment obligations, a seemingly 'small' trial court decision from Allegheny County, Pennsylvania (Pittsburgh), serves to inform counsel across the nation that when it comes to protecting both their clients and themselves from Medicare liability, "more" may be better.

Heightened awareness of potential liability to Medicare for reimbursement of Medicare expenses rushed to the forefront in a 2009 case, *United States of America v. Stricker*, 1:2009-CV-2423, brought before the U.S. District Court of the Northern District of Alabama. In *Stricker*, the U.S. government filed suit against almost all involved in the $300 million *Abernathy v. Monsanto* class action settlement. The government's position was clear and incredibly broad since it sued the original companies, their insurers and even participating attorneys, alleging that in the course of the original settlement's distribution, counsel improperly failed to account for Medicare's interests. In its suit, the government sought reimbursement for payments it made for the benefit of the settling plaintiffs. The government continued, arguing that the defendants were liable to Medicare for up to double the amount of medical expenses indemnified by Medicare, claiming authority under the Medicare Secondary Payer statute, 42 U.S.C. §1395y(b). Under this statute, tortfeasors and, by extension, their insurers (as well as plaintiffs) are "primarily responsible" for payment of the items and services for which Medicare (the "secondary payer") typically makes payment. As such, if Medicare subsequently determines that it has paid for covered items or services, these "primary payers" can be held financially responsible by direct action against them by Medicare in the event it was not reimbursed.

While the *Stricker* litigation was eventually dismissed based on a statute of limitations defense, and remains on appeal, its wake is clear. Since that litigation, parties, their insurers and their counsel have attempted various ways to protect not only their clients, but themselves, from running afoul of the Medicare and the Secondary Payer Statute. One of the 'easiest' ways devised to seek insulation from liability to Medicare was the relatively simple "two check" or "two payee" approach. Indeed, many self-insureds and carriers insist on putting Medicare on the settlement check or receiving a no-lien letter before issuing payment upon a settlement. Plaintiffs generally take issue with this approach because it can substantially delay receipt of their money.

While not a federal decision, the

Pennsylvania Superior Court provided guidance on how it views insurers and others attempting to protect themselves in this manner. In *Zaleppa v. Seiwell*, 9 A.3d 632 (Pa. Super. 2010), a jury rendered judgment and an award in favor of the plaintiff, a Medicare beneficiary. The defendant sought to condition payment of that judgment by adding Medicare as a payee on the check or by holding the money in court until Medicare's interest could be determined, both of which options the plaintiff refused. The *Zaleppa* court noted that a defendant was not authorized to act "on behalf of" Medicare and, thus, ordered that the defendant make payment as called for by the jury in its award. Although *Zaleppa* involved a judgment, many believe that were the case appealed on the same issue, but involving a settlement, the outcome would be the same.

However, in 2012, what could have been dismissed as a 'mere' trial court opinion, provides sound guidance for insurers, clients and counsel seeking to protect themselves against Medicare liability, by conditioning the **settlement itself** on the issuance of a final lien letter or placement of Medicare on the settlement draft.

In the case of *Wimberly and Dawson v. Katruska*, AR-11-004777957 (Allegheny County, Pennsylvania, May 23, 2012), Judge R. Stanton Wettick was faced with determining when and whether a defendant may condition a settlement payment upon plaintiff providing a no-lien letter from Medicare – a daily, almost universal dilemma in civil litigation. While it was undisputed that the parties agreed upon the amount of the settlement and, essentially, that the case was settled, when it came time for payment, the defendant insisted on verification that Medicare was not involved in the matter. Possibly recognizing the length of time such a letter would take to obtain, Plaintiff responded by filing a motion to enforce the settlement.

Judge Wettick began his analysis by noting what is at stake when Medicare is involved in third-party litigation, describing, of course, the Secondary Payer statute. The court recognized that in an attempt to avoid potential Medicare exposure, the defendant's insurer in *Wimberly* sought an affirmative statement that Medicare did not have an interest in the matter – a "no lien letter." The defendant argued that it merely sought to avoid double liability. As the matter remained within the Commonwealth of Pennsylvania, the court rejected this argument under *Zaleppa*. However, the defendant also argued (in the alternative) that **prior to settlement** the parties agreed to condition payment of any settlement proceeds upon determination of Medicare's interest. Not surprisingly, plaintiff denied that any such arrangement existed. In considering this argument, Judge Wettick relied on standard principles of contract law, recognizing the parties' common interest in reaching a settlement and achieving finality. Indeed, in personal injury litigation, a plaintiff desires financial payment and the defendant desires an end to its liability. Clearly, both of these desires were before the court. Accordingly, Judge Wettick issued a rule upon the defendant to show cause why the settlement should not be enforced and ordered that, at the hearing upon that rule, it would be defendant's burden to establish that payment of the settlement was conditioned upon determination of Medicare's interest.

We suggest that it would be a good practice for defendants and their insurers to clearly include their intention to determine Medicare's interest at the time they communicate any and all offers of settlement.

The "take away" here is clear. We suggest that it would be a good practice for defendants and their insurers to clearly include their intention to determine Medicare's interest at the time they communicate any and all offers of settlement. Language akin to the following should be included in any settlement offer:

> *"To the extent that your client is a Medicare beneficiary, as part of the conditions of settlement, a Final Demand Letter will be necessary before any settlement draft is issued. Acceptance of a settlement offer in this matter shall constitute an express understanding that no settlement funds will be distributed to plaintiff or plaintiff's counsel until a Final Demand Letter is received. We reserve the right to place Medicare's name on any settlement draft or to issue separate payment to Medicare based upon the Final Demand Letter."*

Although the specific issue has yet to be determined by a reviewing court, it appears to the authors that such an approach would be most beneficial. The interposition of conditions, such as Medicare's provision of a final lien letter and/or placement of Medicare as a payee on the settlement check, as **material terms** of the settlement negotiated by the parties may serve to protect the defense's interest in informing Medicare, determining reimbursement obligations and, most important, staying clear of Medicare scrutiny.

Any questions regarding this case can be directed to USLAW members, Stephen E. Geduldig (717-237-7119, sgeduldig@tthlaw.com) or Ryan C. Blazure (570-820-0240, rblazure@tthlaw.com) of Thomas, Thomas and Hafer LLP, Harrisburg, Pennsylvania.

Steve Geduldig is a partner at Thomas, Thomas & Hafer LLP, in Harrisburg, Pennsylvania, with over 25 years of courtroom experience, having first-chaired more than 100 jury trials. His practice is primarily devoted to the defense of claims against the transportation industry. He is Chair of the Firm's Transportation Group, and Vice Chair of USLAW's Transportation Practice Group. He is (AV) rated by Martindale-Hubbell.

Ryan C. Blazure, is a graduate of Wilkes University and the Syracuse University College of Law. He is a partner with the firm of Thomas, Thomas & Hafer LLP, practicing in all manner of civil litigation and workers' compensation. He personally represents individuals, national retailers, commercial and utility interests.