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The Department of Health and Human Services vs. Attorneys: Will the Federal Courts Tame an Agency Run Amuck

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INTRODUCTION

Medicare is America’s single largest health insurance program. In 2010, Medicare spending constituted 15 percent of federal spending and is projected to represent 17 percent of federal spending by 2020. There is legitimate concern that federal revenue may become insufficient at some point to fund Medicare outlay. The Board of Trustees of the Federal Hospital Insurance and the Federal Supplementary Medical Insurance Trust Funds project that, by 2030, there will only be 2.4 workers in the United States per Medicare beneficiary. This is compared to 4 workers per beneficiary in 2000. The National Commission on Fiscal Responsibility and Reform projects that, by 2025, federal revenue, given current growth rates among Medicare beneficiaries as a percentage of the general population, would only cover Medicare, Medicaid, Social Security and interest on the national debt.

Hence, under the current system, either the Medicare program fails or many other programs lose funding. The political arena is rife with Medicare overhaul solutions to this problem that may or may not receive Congressional approval. In the meantime, the Department of Health and Human Services (“DHHS”), the agency charged with administration of the

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3 Potetz, supra, at 1 citing CONG. BUDGET OFFICE, MONTHLY BUDGET REVIEW (October 2010); U.S. DEP’T. OF TREASURY, FINAL MONTHLY TREASURY STATEMENT FOR FISCAL YEAR 2010 (September 2010).


5 KAISER COMMISSION ON MEDICAID AND THE UNINSURED, supra, at 37.


Medicare program, has decided to compensate for Medicare shortfalls by suing insurance companies, Medicare beneficiaries\textsuperscript{8}, corporate tortfeasors, and attorneys for not reimbursing Medicare what it is allegedly owed and failing to protect Medicare’s status as a secondary payer. This practice, particularly actions aimed at beneficiaries and attorneys, is like casting a giant net of government resources and catching one baby endangered fish. It is not worth the troubling consequences. The purpose of the Medicare Secondary Payer Act (“MSP”) is to make primary payers like insurance companies, and not Medicare, cover medical treatment for which they are responsible. Suing attorneys is ethically problematic and inconsistent with the MSP’s purpose, and suing beneficiaries is rather fruitless.\textsuperscript{9}

This article, in Part One, discusses the history of Medicare’s secondary payer status and the current process required of beneficiaries and attorneys to protect this status. Part Two primarily discusses how DHHS uses the Medicare Secondary Payer Act (“MSP”) to successfully sue attorneys whose clients did not protect Medicare’s secondary payer status. In Part Three, the article discusses one federal court’s narrow attempt to curb these DHHS actions. Then, in part Four, the article elaborates on problems inherent in DHHS actions against attorneys. Last, Part Five discusses the real and possible impact of the federal court’s actions and what to expect from Congress and DHHS in the future.

\textsuperscript{8} The hot topic in suits against Medicare beneficiaries is whether DHHS can retain full recovery of conditional payments up to the amount of settlement as opposed to recovery apportioned according to ideas of comparative fault since no one accepts liability and often it is shared in a settled case. There is a circuit split on this issue likely headed to the Supreme Court. The Sixth Circuit supports the DHHS’ right to full recovery. \textit{Hadden v. U.S.}, 661 F.3d 298 (6th Cir. 2011). The Eleventh Circuit, on the other hand, supports apportioned recovery, finding that in a case that settled for 2% of what it was worth, DHHS should only recover 2% of its conditional payment lien. \textit{Bradley v. Sebelius}, 621 F.3d 1330 (11th Cir. 2010). These decisions, of course, also impact beneficiary attorneys so long as attorneys remain exposed to DHHS collection actions.

I. THE HISTORY OF MEDICARE AND ITS SECONDARY PAYER STATUS

Congress established the Medicare system in 1965 and tasked DHHS with its administration. Medical care was a component of President Johnson’s “Great Society” legislation aimed to improve the quality of life of Americans and fight against poverty. The original Medicare legislation established Medicare as a primary payer for covered medical treatment provided to Medicare beneficiaries, except when a workers’ compensation carrier covered a beneficiary’s claim. In other words, if a Medicare beneficiary had additional private health insurance coverage and underwent treatment technically covered by both Medicare and the private policy, Medicare typically paid for the treatment. The private insurance policies, for the most part, only paid when Medicare did not cover treatment, and insurance carriers even wrote policies for Medicare beneficiaries limited to filling gaps where Medicare did not cover certain treatment. Medicare retained its primary payer status for fifteen years, but as the class of Medicare beneficiaries expanded and the cost of treatment increased, Congress took steps to limit Medicare expenditure.

First, DHHS created the Health Care Financing Administration (“HCFA”) that is now called the Center for Medicare and Medicaid Services (“CMS”) to sub-administer the program.

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14 Blue Cross and Blue Shield Ass’n, 794 F. Supp. at 1168.
Congress promulgated the Medicare Secondary Payer Act ("MSP") in 1980. The clear goal of the Act and Medicare’s transition from primary to secondary payer status was to decrease health care costs and save the Medicare system. The Act defined Medicare as a secondary payer and private insurance carriers, including automobile, liability and workers’ compensation insurers, as primary payers. Medicare was no longer responsible for a beneficiary’s medical treatment if that responsibility could be transferred to another payer. And, in the event Medicare issued payment for a beneficiary’s medical treatment covered primarily by another plan, the payment was conditioned on reimbursement by the primary payer to the appropriate Medicare Trust Fund. However, the 1980 Act contained no effective enforcement provision for DHHS to collect reimbursement for conditional payments from primary payers.

Congress gave the MSP “teeth” in 1984 by subrogating the United States to any rights of reimbursement retained by an entity or individual and creating a cause of action for the United States via the DHHS to seek reimbursement from a primary plan. Under the revised MSP, the United States could bring a cause of action against “any entity” responsible for payment for medical services, like an insurance company, and “any entity (including any physician or provider) which has been paid” for treatment covered by an entity like an insurance company.

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17 Omnibus Reconciliation Act of 1980, supra, at 2647.
18 Omnibus Reconciliation Act of 1980, supra, at 2647.
20 Deficit Reduction Act of 1984, supra at 1095-1096.
In 1986, Congress amended the MSP to provide a private cause of action (with the possibility to recover double damages) to encourage Medicare beneficiaries to recover from primary payers on Medicare’s behalf. The amendment provided a list of primary payers limited to group health plans, workers’ compensation plans, automobile and liability insurance plans, and no-fault insurance. The 1986 version of the MSP provided the United States with a cause of action for double damages against entities required to pay for medical treatment, primary payers, and any entity that received payment for treatment.

To enhance and define its enforcement power, the DHHS promulgated 42 C.F.R. §411.24 in 1989. This regulation explained DHHS’ right to recover conditional payment reimbursement from the entities required to pay for medical treatment, primary payers, and entities that receive payment for treatment. Specifically, “CMS has a right of action to recover its payments from any entity, including a beneficiary, provider, supplier, physician, attorney, State agency or private insurer that has received a primary payment.”

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24 Medicare as Secondary Payer and Medicare Recovery Against Third Parties, 54 Fed. Reg. 41716, 41738 (October 11, 1989)(codified at 42 C.F.R. §411.24). Of interest in this discussion of the final rule is DHHS’s summary of the 1984 Deficit Reduction Act that does not mention attorney as a type of entity, stating “DHHS has a right to recover from “[a]ny entity (such as a beneficiary, provider, physician or State agency) that has received payment from a third party that is required to pay before Medicare.”” Id. at 41716.


II. PROTECTING MEDICARE’S SECONDARY PAYER STATUS

To protect Medicare’s secondary payer status, CMS requires beneficiaries and attorneys involved in a law suit to (1) determine whether Medicare issued conditional payments related to that law suit and (2) reimburse Medicare from settlement proceeds as appropriate. Though this sounds simple, the process of obtaining this information is not.

Sub-administration of Medicare falls under the large umbrella of DHHS. More specifically, CMS administers Medicare. Under the CMS umbrella falls the Coordination of Benefits Contractor (COBC) and the Medicare Secondary Payer Contractor (MSPRC).\(^\text{27}\) COBC handles reporting of claims involving Medicare beneficiaries.\(^\text{28}\) MSPRC handles the initial collection of conditional payments.\(^\text{29}\) The two bodies under CMS identify beneficiaries and gather evidence for DHHS to take up its enforcement activities to protect Medicare’s secondary payer status.

Hence, the conditional payment search process begins by reporting the involvement of a beneficiary in a workers’ compensation, liability, and/or group health plan claim to the COBC.\(^\text{30}\) Reporting a beneficiary’s status and involvement of a primary payer in his or her life generates a

\(^{27}\) Originally, the COBC and MSPRC were entities served by separate contractors hired by CMS. Douglas L. Shaw, CMS Issues and RFP for MSPIC Services, MEDIVEST BLOG.COM (December 29, 2011), http://www.medivest.com/wordpress/?p=464. In December 2011, CMS hired one contractor temporarily to run both the COBC and the MSPRC called the Medicare Secondary Payer Integration Contractor (MSPIC). Id. Eventually, there will be one long-term contractor functioning as the MSPIC to perform the jobs of the COBC and MSPRC discussed herein. Id.


Medicare Secondary Payer Rights and Responsibilities letter to the beneficiary by the MSPRC with a supplemental Medicare Secondary Payer Recovery Contractor Brochure.\textsuperscript{31} Within 65 days from the date of this Rights and Responsibilities letter, MSPRC promises to release a Conditional Payment Letter (CPL).\textsuperscript{32} The CPL lists payments made by Medicare for medical treatment that MSPRC believes should have been the responsibility of a primary payer.\textsuperscript{33} MSPRC generates this letter by searching for all treatment provided to the beneficiary by Medicare. MSPRC uses diagnostic codes submitted by the health care providers and the timing of treatment to determine whether there is a causal connection between the treatment and the beneficiary’s litigated injury.

MSPRC provides an example CPL on-line.\textsuperscript{34} The example shows an estimated $467.80 in conditional payments owed that the beneficiary, upon reviewing the CPL, reduced to $93.53 based solely on causation issues.\textsuperscript{35} This is a typical reduction from a CPL based on causation. MSPRC’s methods for the creation of a lien are far from perfect, as they rely primarily on providers to code treatment correctly. This practice shifts the burden to the parties to sort out unrelated treatment, as demonstrated in MSPRC’s example. MSPRC advises that the CPL is not

\begin{footnotesize}

\textsuperscript{32} MSPRC, RIGHT AND RESPONSIBILITIES LETTER, supra, at 3. In practice, this promise is not always fulfilled and there is no “safe harbor” provision in the MSP or DHHS regulations. Hence, an attorney can request a CPL repeatedly with no response from MSPRC, even more than 120 days out from settlement and still be allegedly responsible for reimbursing the Medicare Trust Fund in the event conditional payments were made.

\textsuperscript{33} MSPRC, RIGHT AND RESPONSIBILITIES LETTER, supra, at 3.

\textsuperscript{34} MSPRC, OPTION TO SELF-CALCULATE YOUR FINAL CONDITIONAL PAYMENT AMOUNT PRIOR TO SETTLEMENT, 9, http://www.msprc.info/forms/SelfCalculatedFinalCP.pdf.

\textsuperscript{35} MSPRC, OPTION TO SELF-CALCULATE YOUR FINAL CONDITIONAL PAYMENT AMOUNT PRIOR TO SETTLEMENT, supra, 9.
\end{footnotesize}
a final document.\footnote{MSPRC, \textbf{RIGHT AND RESPONSIBILITIES BROCHURE}, \textit{supra}, at 1.} It continually updates the conditional payment information as the claimant or plaintiff incurs additional treatment and/or MSPRC locates other treatment received in the past but not previously included on the CPL.

Upon reaching a settlement between a beneficiary and an implicated primary payer,\footnote{One cannot obtain a final demand letter prior to or without settlement. \textit{See generally} MSPRC, http://www.msprc.info/ (last visited April 4, 2012). Leaving one to wonder how to protect Medicare’s status and reimburse conditional payment in circumstances outside of settlement.} the parties must advise MSPRC of the gross settlement amount along with attorney fees and costs to protect Medicare’s secondary payer status under the MSP and avoid DHHS enforcement action.\footnote{If notice of final settlement is the first notice MSPRC receives of the beneficiary’s involvement in a claim, it will release a Conditional Payment Notice (CPN) instead of a CPL. MSPRC, \textit{NEW CONDITIONAL PAYMENT NOTICE}, 2, http://www.msprc.info/forms/cpn.pdf \footnote{This gives the parties involved 30 days to dispute conditional payments before MSPRC releases a Final Demand. Id. at 5-6. Like the CPL, the amount on the CPN is not a final amount. Id. at 7.}.\footnote{MSPRC, \textbf{RIGHT AND RESPONSIBILITIES BROCHURE}, \textit{supra}, at 1.} In response, MSPRC issues a “Final Demand Letter” to all listed parties to a liability, no-fault insurance or workers’ compensation settlement, that takes into account attorney fees and costs consistent with DHHS regulations.\footnote{Social Security Act, 42 U.S.C. §1395ff(b)(2)(C)(iv)(2012).} This is the amount to be paid from the settlement proceeds.

At this point, the plaintiff beneficiary has the option to administratively appeal the final demand amount under 42 U.S.C. §1395ff(b).\footnote{Haro v. Sebelius, 789 F. Supp. 2d 1179,1193 (D. Ariz. 2011).} However, an attorney has no independent appeal right under the MSP.\footnote{Social Security Act, 42 U.S.C. §1395ff(b)(2)(C)(iv)(2012); Haro, 789 F. Supp. 2d at 1182.} The appeal process is very slow, and interest accrues during the process at a rate typically over 11\%.\footnote{Until recently, DHHS tried to collect disputed conditional}
payments pending review. Additionally, appeals were not particularly effective, because the amount of evidence and paperwork required to contest a conditional payment demand typically outweighs the beneficial results of appeal, in practice.

MSPRC recently offered some flexibility in this process for low-value liability settlements. On September 6, 2011, MSPRC announced that beneficiaries with liability settlements under $300, under a very limited set of circumstances, can escape MSPRC seeking reimbursement duties. As of November 7, 2011, beneficiaries settling liability claims at $5,000 or less can reimburse the Medicare Trust Fund 25% of the gross settlement proceeds instead of calculating conditional payments owed. Assume a beneficiary settles an automobile accident case. If he or she is represented, the attorney takes at least 25% of the gross proceeds. Medicare takes 25%, leaving the beneficiary with 50% of the remaining proceeds to cover outstanding medical bills not covered by Medicare, wage loss, pain and suffering, etc.

Most recently, as of February 21, 2012, a beneficiary involved in a liability case can “self-calculate” a final conditional payment amount. To qualify for this option, the settlement or award must be for a physical trauma based injury unrelated to ingestion, exposure or medical implant, $25,000 or less, for a date of incident at least 6-months prior to the submission of the self-calculated payment, and the beneficiary must submit proof from a physician that he or she

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43 Haro, 789 F. Supp. 2d at 1182.


46 MSPRC, OPTION TO SELF-CALCULATE YOUR FINAL CONDITIONAL PAYMENT AMOUNT PRIOR TO SETTLEMENT, http://www.msprc.info/forms/SelfCalculatedFinalCP.pdf.
requires no further treatment related to the incident and has had no treatment in the past 90 days.\textsuperscript{47} By self-calculating the conditional payment amount, the beneficiary waives the right to appeal the final demand amount from MSPRC.\textsuperscript{48}

III. DHHS SUES CORPORATIONS AND ATTORNEYS OF BENEFICIARIES

In the 1990s and early 2000s, DHHS began to use its enforcement power under the MSP and 42 C.F.R. §411.24 to sue businesses that settled mass tort claims without the aid of insurance to recoup Medicare conditional payments and damages. Additionally, DHHS filed suits against attorneys who represented Medicare beneficiaries for reimbursement of conditional payments. DHHS even sued attorneys who attempted to comply with the conditional payment reimbursement process.\textsuperscript{49}

DHHS had little success in claims against corporate tortfeasors that settled claims directly with plaintiffs.\textsuperscript{50} DHHS interpreted the Department’s enforcement power broadly, asserting these businesses fit the definition of a primary payer or entity responsible for payment under the MSP as “self-insured plans”.\textsuperscript{51} Federal Courts did not agree with DHHS’s interpretation and held the MSP did not require corporate tortfeasors to reimburse the Medicare Trust Fund because the MSP gave the United States a cause of action against primary payer insurers but not

\textsuperscript{47} Option to Self-Calculate Your Final Conditional Payment Amount Prior to Settlement, \textit{supra}, at 2.

\textsuperscript{48} Option to Self-Calculate Your Final Conditional Payment Amount Prior to Settlement, \textit{supra}, at 2.


\textsuperscript{51} Thompson, 337 F.3d at 495; In re Dow Corning Corp, 250 B.R. at 338.
expressly against tortfeasors. In *Thompson v. Goetzman*, the Fifth Circuit held that corporations were not self-insured plans as intended by the MSP. The Fifth Circuit decided *Thompson* on July 7, 2003.

After little change to the secondary payer provisions since the late 1980s, Congress amended the MSP on December 8, 2003 with a piece of legislation entitled the Medicare Prescription Drug-Improvement and Modernization Act. Most of the attention ascribed to this bill came from its introduction of the Medicare prescription benefit under Part D. However, the new law included a definition of “self-insured plan” specifically intended by Congress to encompass corporate tortfeasors and enhance DHHS’s enforcement power against those entities.

On the other hand, DHHS, without the help of Congress, successfully sued attorneys who represented Medicare beneficiaries for reimbursement, primarily because the attorneys did not challenge DHHS’s right to do this under the MSP. In *Sosnowski v. United States*, a Medicare beneficiary sustained injuries in an automobile accident and sued the driver of the other vehicle

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52 *In re Orthopedic Bone Screw Prods. Liab. Litig.*, 202 F.R.D. at 164; *Thompson*, 337 F.3d at 497.

53 *Thompson*, 337 F.3d at 497.

54 *Thompson*, 337 F.3d at 498.

55 *Thompson*, 337 F.3d at 489.


and his insurance company, Home Mutual.\textsuperscript{59} Medicare paid for some of the beneficiary’s treatment for injuries sustained in the automobile accident.\textsuperscript{60} The parties agreed to a judgment in favor of the beneficiary at Home Mutual’s policy limit of $25,000 in exchange for a release of liability.\textsuperscript{61} Home Mutual paid $25,000 to the beneficiary and his attorney in satisfaction of the judgment.\textsuperscript{62} No one reimbursed the Medicare Trust Fund for the treatment covered by Medicare as required by 42 U.S.C. § 1395y(b)(2) of the MSP.\textsuperscript{63}

DHHS sued the beneficiary and his attorney for conditional payment reimbursement plus double damages.\textsuperscript{64} DHHS based its suit on 42 U.S.C. §1395y(b)(2)(B)(ii) that allowed the United States to file a cause of action to recover conditional payments plus double damages from an entity responsible for payment and/or an entity who received payment from the responsible entity.\textsuperscript{65} DHHS also relied on 42 C.F.R. §411.24(g) that defined entity as a term inclusive of a Medicare beneficiary and an attorney.\textsuperscript{66}

The court adopted DHHS’s argument, and the beneficiary and his attorney did not refute DHHS’s ability to sue them under the above provisions.\textsuperscript{67} Instead, the plaintiffs made an interesting argument that DHHS was equitably estopped from collecting the money in this

\textsuperscript{59} Sosnowski, 822 F. Supp. at 572.
\textsuperscript{60} Id.
\textsuperscript{61} Id.
\textsuperscript{62} Id.
\textsuperscript{63} Id.
\textsuperscript{64} Id.
\textsuperscript{65} Id.
\textsuperscript{66} Id.
\textsuperscript{67} Id. at 573.
fashion, because it had notice of the automobile accident case and did nothing prior to the entry of judgment.\textsuperscript{68} The court rejected this argument and other less persuasive arguments made by the plaintiffs and ruled in favor of DHHS.\textsuperscript{69}

In \textit{United States v. Weinberg}, DHHS sued the attorney of a Medicare beneficiary injured in an automobile accident.\textsuperscript{70} After the accident, the beneficiary suffered a possibly unrelated stroke.\textsuperscript{71} Medicare paid almost $188,867.27 for the beneficiary’s treatment. The attorney asserted that some of this treatment was for the stroke and not the automobile accident.\textsuperscript{72} The attorney’s causation argument was particularly strange, because he argued in the automobile accident case that the stroke was related.\textsuperscript{73} The court did not estop him from arguing to the contrary in this case against DHHS but advised DHHS could use his previous arguments against him.\textsuperscript{74} The attorney also contested many of MSPRC’s claims for reimbursement as being time-barred and argued only $6,242.27 of the $188,867.27 lien asserted by MSPRC was owed to the Trust Fund.\textsuperscript{75} The attorney settled the automobile accident case for $750,000 and paid the Medicare Trust Fund the undisputed amount of $6,242.27 in 1999, after a protracted fight with MSPRC over the lien amount.\textsuperscript{76}

\textsuperscript{68} \textit{Id.} at 574.

\textsuperscript{69} \textit{Id.}

\textsuperscript{70} \textit{Weinberg}, 2002 WL 32356399, at *1.

\textsuperscript{71} \textit{Id.}

\textsuperscript{72} \textit{Id.}

\textsuperscript{73} \textit{Id.} at *6.

\textsuperscript{74} \textit{Id.}

\textsuperscript{75} \textit{Id.}

\textsuperscript{76} \textit{Id.}
In 2001, DHHS sued the attorney for reimbursement of the full lien amount under 42 U.S.C. §1395y(b)(2)(B)(ii) and 42 C.F.R. §411.24(g). Instead of refuting the United States’ right to sue attorneys under this statute, the attorney defended himself with a statute of limitations argument, asserting DHHS based its 2001 claim on payments for medical treatment provided primarily in 1995. The attorney also raised accord and satisfaction because he paid the undisputed part of the MSPRC claim. Last, he raised causation, asserting DHHS failed to prove the stroke treatment was related to the automobile accident claim. The court rejected the attorney’s statute of limitations and accord and satisfaction arguments and remanded the causation issue and the determination of what was owed to the Medicare Trust Fund to a bench trial, holding the attorney responsible for paying the amount determined once a final decision was reached.

More recently, in United States v. Harris, a Medicare beneficiary sustained injuries from a fall from a ladder. Medicare paid approximately $22,549.67 for treatment for the beneficiary and asserted a conditional payment lien of approximately $10,253.59. The beneficiary hired an attorney to represent him in a suit against the ladder retailer. The matter settled for $25,000.

77 Id. at *2.
78 Id. at **2-6.
79 Id. at *7.
80 Harris, 2009 WL 891931, at *1.
81 Id. The reduced amount reflected subtraction of Harris’ attorney fees and costs incurred in reaching the settlement consistent with DHHS regulations. Id.
82 Id.
83 Id.
The beneficiary did not appeal the Medicare lien amount and neither the attorney nor his client reimbursed the Medicare Trust Fund from the settlement proceeds.84

DHHS sued the attorney for the lien amount plus interest under the same statutory framework discussed above.85 DHHS asserted the attorney waived the right to contest the lien amount by not appealing the lien.86 The attorney did not contest the United States’ right to sue under 42 U.S.C. §1395y(b)(2)(B)(ii).87 Instead, he requested time for discovery to explore issues of liability, causation and estoppel, similar to arguments raised by the attorney in Weinberg.88

The court ruled in favor of DHHS, supporting its argument that the attorney waived his right to contest the lien by failing to appeal it.89 The court ordered the attorney to pay $11,367.78 plus additional interest accrued during litigation.90 The court’s finding is rather shocking given no attorney has an independent right to appeal a conditional payment lien under the MSP, as discussed in Part II.

IV. FEDERAL DISTRICT COURT OF ARIZONA GIVES NARROW RELIEF TO ATTORNEYS

On May 9, 2011, the United States District Court of Arizona issued Haro v. Sebelius.91

In this class action suit brought by a group of Medicare beneficiaries and an attorney

84 Id.
85 Id. at **1-2.
86 Id. at *2.
87 Id. at *3.
88 Id.
89 Id. at *4.
90 Id. at *5.
representing beneficiaries, the plaintiffs raised two major problems with the DHHS’s collection process for conditional payments made by Medicare. First, the plaintiffs challenged DHHS’s practice of seeking reimbursement of challenged conditional payments still pending administrative appeal. Second, the plaintiffs challenged DHHS’s asserted right to sue plaintiff attorneys directly for conditional payment reimbursement.

The class of Medicare beneficiaries in *Haro* were injured, received medical treatment conditionally paid by Medicare instead of a primary payer, settled their respective personal injury claims and then received settlement proceeds from a primary payer. Each beneficiary received a demand letter from MSPRC setting forth an amount owed to the Medicare Trust Fund for reimbursement of alleged conditional payments. Plaintiffs disputed the amount owed in their respective demand letters. Despite the plaintiffs’ administrative appeal of the conditional payment amount, MSPRC demanded reimbursement in full within sixty (60) days or interest would accrue at a significant rate of 11.375%. MSPRC sent a separate letter to the beneficiary’s attorney involved in *Haro* setting forth the same 60-day notice and also advising

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92 *Id.* at 1180.

93 *Id.*

94 *Id.*

95 *Id.* at 1182.

96 *Id.*

97 *Id.* This decision to dispute a demand letter is not an uncommon process. Most of these demands are blanket requests that deem almost every payment made by DHHS for treatment of an individual as conditional payment as opposed to a payment unrelated to the plaintiff’s case that Medicare should cover as a primary payer. See MSPRC, *OPTION TO SELF-CALCULATE YOUR FINAL CONDITIONAL PAYMENT AMOUNT PRIOR TO SETTLEMENT*, 9, http://www.msprc.info/forms/SelfCalculatedFinalCP.pdf.

98 *Id.*
that Medicare must be paid in full before the attorney distributed any settlement proceeds to his or her client.99

To address the propriety of MSPRC collection activities against beneficiaries with disputed conditional payments, the court looked to the MSP, particularly 42 U.S.C. § 1395y(b)(2)(B)(ii).100 Subsection (ii) of this part of the MSP, entitled “Primary Plans”, instructs a primary plan and “any entity that receives payment from a primary plan” to reimburse the Medicare Trust Fund for conditional payments made by Medicare if it is demonstrated that the primary plan is responsible for the treatment given the beneficiary.101 A court judgment or settlement demonstrates the primary payer’s responsibility.102 The payer has 60 days from receiving notice of responsibility to reimburse the Trust Fund or face interest and possibly a lawsuit filed by the United States to recover double damages under 42 U.S.C. §1395y(b)(2)(B)(iii).103 The United States can recover payment from any primary plan and any entity that receives payment from a primary plan, as discussed.”104 By regulation, DHHS defines an entity to include attorneys, beneficiaries and private insurers.105

The Haro court determined the Congressional intent behind the MSP, particularly given the 2003 amendments, is to give the United States a right to recover Medicare payouts from insurance companies and self-insured corporate tortfeasors settling claims with Medicare

99 Id.
100 Id. at 1183.
beneficiaries. The MSP includes kinder provisions for beneficiaries not available to these primary payers with deeper pockets. For example, a beneficiary can request and obtain a waiver of the conditional payment reimbursement requirement. Additionally, the beneficiary has administrative appeal rights to use to dispute Medicare conditional payments claims. Therefore, the court reasoned that holding a beneficiary with a disputed claim to the 60-day reimbursement requirement is “neither rational nor consistent with the statutory scheme providing for waiver and appeal rights.” The court explained DHHS has plenty of weapons in the “arsenal”, including collection of double damages against primary payers, to protect the Trust Fund and should basically leave the small category of beneficiaries with disputed conditional payments issues alone until the end of the appeal process.

To address the propriety of DHHS and MSPRC collection activities against attorneys of beneficiaries with disputed conditional payments, the court looked again to 42 U.S.C. §1395y(b)(2)(B)(ii) and (iii). DHHS argued that these provisions and the DHHS definition of entity under 42 C.F.R. §411.24(g) that includes “attorney” allow it to do three things. First, she can prevent an attorney from distributing all settlement proceeds to a client until the final

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106 Haro, 789 F. Supp. 2d at 1187-1188.
107 Id. at 1188.
110 Haro, 789 F. Supp. 2d at 1190.
111 Id. at 1190-1191.
112 Id. at 1191.
113 Id.
resolution of all Medicare-related issues.\textsuperscript{114} Second, DHHS can require the attorney to pay the Trust Fund within sixty days, despite the disputed nature of a conditional payment claim, or accrue interest.\textsuperscript{115} Third, DHHS can recover conditional payment reimbursement from an attorney directly when his or her client fails to reimburse the Trust Fund, even if the attorney retains no settlement proceeds.\textsuperscript{116}

\textit{Haro} came to the rescue of attorneys, sort of. The court first noted that Congress never included “attorneys” in the “entity” language in the MSP.\textsuperscript{117} The legislative history indicates Congress intended to cover primarily insurers, self-insurers and physicians/health-care providers with this language.\textsuperscript{118} The court also found “no statutory support, either expressly or in the legislative history, to support DHHS’s assertion that she has a direct cause of action, pursuant to 42 U.S.C. §1395y(b)(2)(B)(ii), to recover a reimbursement claim from an attorney that has received payment from a primary plan and has passed it along to the beneficiary.”\textsuperscript{119}

The court discussed why DHHS suits against attorneys are problematic.\textsuperscript{120} First, the practice is inconsistent with the DHHS regulation that allows a reduction in reimbursement claims for attorney fees and costs incurred to reach settlement.\textsuperscript{121} Second, the attorney is not an

\begin{footnotesize}
\textsuperscript{114} \textit{Id.} at 1191-1192.
\textsuperscript{115} \textit{Id.} at 1191.
\textsuperscript{116} \textit{Id.}
\textsuperscript{117} \textit{Id.} at 1192.
\textsuperscript{118} \textit{Id.}
\textsuperscript{119} \textit{Id.} at 1195.
\textsuperscript{120} \textit{Id.} at 1192.
\textsuperscript{121} \textit{Id.} at 1192 citing Medicare Secondary Payer Act, 42 C.F.R. §411.37(a)(1)(2012).
\end{footnotesize}
“end-point” recipient of settlement proceeds.\textsuperscript{122} DHHS would thus be suing the attorney for property that does not belong to him or her but to the beneficiary client.\textsuperscript{123} Third, DHHS offers no appeal right to attorneys for conditional payment claims.\textsuperscript{124} Fourth, filing a cause of action against a beneficiary attorney raises ethical concerns.\textsuperscript{125} For example, a lawyer should not be a witness in the client’s case. But, an attorney becomes a witness when forced to testify in the client’s case as to why DHHS is not entitled to reimbursement for various payments made or why the beneficiary should have a waiver to defend himself or herself against a possible DHHS action.\textsuperscript{126}

The court also examined the problems raised by the plaintiffs in \textit{Haro} with DHHS collecting disputed claims from beneficiary attorneys and preventing attorneys from distributing undisputed proceeds to the beneficiary clients.\textsuperscript{127} The DHHS cause of action option under the above circumstances creates a clear conflict of interest between an attorney who must protect herself from a cause of action with interest accrual from DHHS but must also protect the client from paying money to DHHS that is not owed, as this is not in the client’s best interest.\textsuperscript{128}

\textsuperscript{122} \textit{Id.} at 1192.

\textsuperscript{123} \textit{Id.}

\textsuperscript{124} \textit{Id.} at 1193.

\textsuperscript{125} \textit{Id.} at 1193-1194.

\textsuperscript{126} \textit{Id.} See also \textsc{Model Rules of Prof’l Conduct R. 3.7} (2012)( Rule does not completely exclude an attorney from being a witness in a client’s trial but does not advocate the practice).

\textsuperscript{127} \textit{Id.} at 1195.

\textsuperscript{128} \textit{Id.} at 1194. See also \textsc{Model Rules of Prof’l Conduct R. 1.3}(2012)( Requires an attorney to act with “reasonable diligence and promptness in representing a client.”) Further, an attorney should pursue matters for a client “…despite opposition, obstruction or personal inconvenience to the lawyer, and take whatever lawful and ethical measures are required to vindicate a client’s cause or endeavor.” \textsc{Model Rules of Prof’l Conduct R. 1.3 cmt. 1} (2012). It is difficult for an attorney to dedicate herself to her own preservation and the client’s best interests under these circumstances.
Additionally, Arizona Rule of Professional Conduct 1.5, similar to the widely adopted ABA Model Rule 1.15, requires a lawyer to “promptly distribute all portions of the property as to which the interests are not in dispute.” Therefore, the DHHS’s position that the lawyer cannot distribute proceeds at all until Medicare’s interests are paid puts the attorney in an ethical quandary.

The court narrowly held DHHS cannot collect conditional payments or charge interest pending appeal. Additionally, DHHS cannot prevent a lawyer from distributing undisputed proceeds. However, the court made no ruling on DHHS’s right to sue attorneys directly. In dicta, the court suggested that this is not supported by the MSP and inconsistent with the rules of professional conduct.

V. PROCEDURAL AND ETHICAL PROBLEMS INHERENT IN DHHS LAWSUITS AGAINST ATTORNEYS: A HARIO ELABORATION

Arizona and most states follow Model Rule of Professional Conduct 1.3 that requires an attorney to act with “reasonable diligence and promptness in representing a client.” Comment 1 for Rule 1.3 further explains that a lawyer should pursue matters for a client “...despite opposition, obstruction or personal inconvenience to the lawyer, and take whatever
lawful and ethical measures are required to vindicate a client’s cause or endeavor.” 134 With a DHHS option to sue attorneys for the actions of their beneficiaries, several conflicts arise from this diligence requirement.

First, a conflict comes from the appeal rights established by the MSP. 42 U.S.C. §1395ff gives beneficiaries the right to challenge conditional payment claims but attorneys have no direct right. Therefore, an attorney may find herself needing to counsel a beneficiary uninterested in appeal to pursue appeal to protect the attorney from an unfair DHHS collection claim. Additionally, as of February 21, 2012, a beneficiary involved in a liability case can “self-calculate” a final conditional payment amount under limited circumstances discussed in Part Two. 135 By self-calculating the conditional payment amount, the beneficiary waives the right to appeal the final demand amount from MSPRC. 136 Here, the attorney is placed in a position to unethically counsel against self-calculation in all cases to prevent losing the beneficiary’s appeal right, again to protect the attorney from unfair collections.

Second, as demonstrated in Weinberg, a conflict often arises with causation arguments. In the suit against the tortfeasor and auto insurance carrier, the attorney diligently argued, on behalf of the beneficiary in his automobile accident lawsuit, that the beneficiary’s stroke suffered soon after the automobile accident was related to the accident and injuries sustained therein. 137 Once the lawsuit settled and DHHS sued the attorney, he contested the conditional lien amount

136 MSPRC, Option to Self-Calculate Your Final Conditional Payment Amount Prior to Settlement, supra.
asserted by DHHS, in part, on the grounds that DHHS failed to prove the stroke related to the accident.\textsuperscript{138} Though the court found no problem with the attorney making this argument, it stated DHHS could use the attorney’s assertions made in the automobile accident case against him in the DHHS cause of action.\textsuperscript{139} Hence, diligent representation of his client in the automobile accident claim basically ensured the attorney’s liability in the DHHS action.

Third, there is no safe harbor provision to cover beneficiaries or attorneys when MSPRC fails to respond to a conditional payment search request with a CPL and/or final demand letter. Widely adopted ABA Model Rule 1.15(e)\textsuperscript{140}, requires a lawyer to “promptly distribute all portions of the property as to which the interests are not in dispute.”\textsuperscript{141} With no knowledge of a dispute, upon approval of a final settlement by the court, the attorney is ethically required to release proceeds. However, an attorney, with no response from MSPRC to a conditional lien search request, must also protect his client and himself indefinitely, given the absence of a safe harbor provision, causing another quandary not discussed by Haro. This may not be in the best interest of the client if he or she is in financial peril but could be in the best interest of the beneficiary’s attorney. This places the attorney in an untenable positon.

Facing the possibility of suit from DHHS, it is difficult for an attorney anywhere in the United States to abandon self-preservation and focus solely on the client’s best interests under these circumstances. Hence, many attorneys choose not to offer services to Medicare

\textsuperscript{138} Id.

\textsuperscript{139} Id.

\textsuperscript{140} AMERICAN BAR ASSOCIATION, CPR POLICY IMPLEMENTATION COMMITTEE, Variations of the ABA Model Rules of Professional Conduct, Rule 1.15 Safekeeping Property (July 1, 2011), http://www.americanbar.org/content/dam/aba/migrated/cpr/pic/1_15.authcheckdam.pdf .

\textsuperscript{141} MODEL RULES OF PROF’L CONDUCT R. 1.15(2012).
beneficiaries, another unfortunate consequence of DHHS actions. Preventing DHHS’s attorney lawsuits resolves these conflict issues. Though Haro was a step in the right direction, it is not enough to put these many issues to rest, and it is not a final decision. Attorneys require broader protection.

VI. POST-HARO EVENTS AND POSSIBILITIES

After the Haro decision, MSPRC revised its “Right to Recovery Letter,” found problematic in Haro, to state MSPRC would take no collection action pending appeal or processing of a waiver request by a beneficiary. MSPRC also revised the letter to remove language that demanded the beneficiary’s attorney withhold all proceeds from a client pending appeal. However, MSPRC continues to let outstanding conditional payment liens, even those properly contested and pending appeal, accrue interest. And, it seems, DHHS is uninterested in permanently ceasing its collection activities with respect to contested liens.

Despite the Arizona Federal District Court’s expressly narrow holding, DHHS appealed Haro to the Court of Appeals for the Ninth Circuit on June 30, 2011. The parties submitted briefs on January 12, 2012, and currently await a schedule for oral arguments from the Ninth

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Circuit that should occur in late spring or summer of 2012. The decision lies with the Ninth Circuit to maintain the minimal protections afforded to attorneys and beneficiaries in Haro or definitively take that protection away, making even the helpful dicta from the Arizona Federal District Court useless.

There is a surprising lack of discussion regarding this appeal in published scholarship and on-line media. Most bloggers and authors on-line turn to a blog article entitled Haro Up on Appeal Too, in which the author predicts the Ninth Circuit will affirm Haro for reasons predominantly grounded in public policy and fairness to attorneys and beneficiaries involved in the lien appeal process. The reasoning is that Haro’s narrow holding does not ultimately prevent DHHS from collecting conditional payments. This is sound reasoning. Hence, affirming Haro eases the ethical quandaries caused by DHHS suits against attorneys in a small way without causing more than minimal delay to DHHS.

However, history suggests an affirmance from the Ninth Circuit could prompt negative Congressional action, a large cost to attorneys for the minor protections of Haro. As discussed in Part III, federal courts reigned in DHHS in the 1990s and early 2000s, basically preventing DHHS from suing corporate tortfeasors for conditional payment reimbursement. The problem DHHS faced with the courts was the undefined term “self-insured” in the MSP’s list of primary

146 Medicare Set Aside Services, Haro Up on Appeal Too, THE OFFICIAL MEDICARE SET ASIDE BLOG AND INFORMATION RESOURCE, supra.

147 Medicare Set Aside Services, Haro Up on Appeal Too, THE OFFICIAL MEDICARE SET ASIDE BLOG AND INFORMATION RESOURCE, supra.

payers.\textsuperscript{149} DHHS asserted this term encompassed corporate tortfeasors, but the federal courts disagreed.\textsuperscript{150} When this occurred, DHHS turned to Congress, and Congress amended to the MSP to define “self-insured plan” to include corporate tortfeasors.\textsuperscript{151}

The problem raised by the \textit{dicta} in \textit{Haro} is the undefined term “entity” in the MSP, later defined by DHHS to include attorneys.\textsuperscript{152} Congress could take action like it did in 2003 to simply define “entity” in the MSP and include “attorney” as a responsible entity to resolve any question created by \textit{Haro} as to DHHS’s right to sue attorneys, leaving them open to the many problems inherent in DHHS lawsuits against attorneys. This, of course, can happen despite or because of the Ninth Circuit affirming the narrow \textit{Haro} decision from the Federal District Court of Arizona, an unfortunate result from the first battle fought on this issue.

On the other hand, Congress could use its power to provide attorneys with broader protection than that afforded by \textit{Haro}. Proposed legislation entitled the Strengthening Medicare and Repaying Taxpayers Act of 2011 (SMART Act) that would ease some of the problems with DHHS enforcement of the MSP collection provision. Congressmen Murphy, a Republican from Pennsylvania, and Kind, a Democrat from Wisconsin, introduced this House of Representatives version of this bill, H.R. 1063, on March 14, 2011. The bill has ninety-six co-sponsors in the House showing true bi-partisan support.\textsuperscript{153} After referral to the House Ways and Means

\begin{footnotesize}
\begin{enumerate}
\item[149] Thompson, 337 F.3d at 495; \textit{In re Dow Corning Corp}, 250 B.R. at 338.
\item[150] Thompson, 337 F.3d at 497.
\item[152] \textit{Haro}, 789 F. Supp. 2d at 1192-1195.
\end{enumerate}
\end{footnotesize}
Committee and the House Energy and Commerce Committees on March 14, 2011, the bill went to the Subcommittees on Health and Oversight and Investigation for further consideration, including a hearing held on June 22, 2011.\textsuperscript{154}

Four Senators, two Republicans and two Democrats, introduced the Senate version of the SMART Act on October 7, 2011.\textsuperscript{155} The bill now has additional bi-partisan sponsorship from ten other Senators and rests before the Senate Committee on Finance.\textsuperscript{156}

The strongest lobbying force behind the legislation is the Medicare Advocacy Recovery Coalition ("MARC").\textsuperscript{157} There are approximately eighty organizations formally endorsing the SMART Act, according to MARC, notably including the U.S. Chamber of Commerce, many prominent insurance carriers, and most of the larger players in the Medicare/MSP compliance industry.\textsuperscript{158}

The goal of the SMART Act is to simplify protection of Medicare’s Secondary Payer status.\textsuperscript{159} The Act\textsuperscript{160} addresses some of the procedural problems inherent in obtaining correct

\begin{itemize}
\item \textsuperscript{154} Bill Summary and Status, H.R. 1063, 112\textsuperscript{th} Congress (2011-2012), available at http://thomas.loc.gov/cgi-bin/bdquery/D?d112:1:./temp/~bdNg3l:@@X|/home/LegislativeData.php (last visited April 4, 2012).
\item \textsuperscript{155} Bill Summary and Status, S. 1718, 112\textsuperscript{th} Cong. (2011-2012), available at http://thomas.loc.gov/cgi-bin/bdquery/D?d112:1:./temp/~bdsy3j:@@X|/home/LegislativeData.php (last visited April 4, 2012).
\item \textsuperscript{156} Bill Summary and Status, S. 1718, 112\textsuperscript{th} Cong. (2011-2012), available at http://thomas.loc.gov/cgi-bin/bdquery/D?d112:1:./temp/~bdsy3j:@@X|/home/LegislativeData.php (last visited April 4, 2012).
\item \textsuperscript{157} MEDICARE ADVOCACY RECOVERY COALITION WEB SITE, http://www.marccoalition.com/ (last visited April 4, 2012).
\item \textsuperscript{160} The House version of the Act (H.R. 1063) is identical to the Senate version in terms of the content discussed below. H.R. 1063, 112\textsuperscript{th} Cong. (2011-2012).
\end{itemize}
and timely conditional payment lien information from MSPRC. Specifically, the Act seeks to amend 42 U.S.C. § 1395y(b)(2)(B) of the MSP to allow parties to a settlement that involves a Medicare beneficiary to request conditional payment information from DHHS 120 days before the case is reasonably expected to settle or a judgment or an award entered. Further, the amendment requires DHHS to respond within 65 days of this request with a reimbursement amount. If DHHS fails to deliver a response, the beneficiary, insurance plan or any entity that receives payment from a plan, would provide additional notice to DHHS. If DHHS fails to respond with a reimbursement amount within 30 days of receiving the additional notice, the beneficiary, insurance plan, and any entity that receives payment from a plan would not be liable to DHHS for conditional payment reimbursement. These amendments would resolve or at least ease the lack of a safe harbor concern where attorneys sit and wait for DHHS conditional payments amounts with no response despite follow up. It also speeds up the appeal process pre-settlement, relieving one of the ethical quandaries caused by an attorney having to hold onto the client’s settlement proceeds for an extended time period.

The Act also provides a right of appeal to primary plans and attorneys, agents or third-party administrators on behalf of primary plans regarding conditional payment determinations made by DHHS via the MSPRC. However, the Act does not extend an individual appeal right to attorneys.

162 S. 1718, §2, supra.
163 S. 1718, §2, supra.
164 S. 1718, §2, supra.
165 S. 1718, §2, supra.
Section 3 of the Act amends 42 U.S.C. §1395y(b)(2)(B)(ii) to create a monetary threshold limit on the United States’ right to pursue causes of action against primary plans.\textsuperscript{166} This would be a yearly threshold figure set by the Chief Actuary of CMS.\textsuperscript{167} Hence, settlements or judgments under the set amount would not be subject to collection activities. The purpose of this provision to prevent DHHS from spending more on litigation than it realizes from successful collection activities. The result would be to ease the burden and uncertainty of this process for some beneficiaries and their attorneys but certainly not all. Additionally, there are already some threshold rules in place by the DHHS.

Last, with respect to the conditional payments issue discussed herein, the Act, in Section 6, creates a 3-year statute of limitations for all MSP claims brought by the United States.\textsuperscript{168} This adds some certainty and finality to the conditional payment collection process for beneficiaries and attorneys. After all, it would have helped the attorney in \textit{Weinberg}.\textsuperscript{169}

The SMART Act has a chance of passing through Congress due to its bi-partisan support and aim to repair some of DHHS’s costly bureaucratic inefficiencies. Congress can provide broad protection to attorneys simply by amending this Act. Ideally, Congress would simply amend the MSP to define the term “entity” to specifically exclude attorneys. Alternatively, Congress should adopt an amended version of this Act that extends an individual appeal right to attorneys of Medicare beneficiaries with respect to conditional payment liens.

\textsuperscript{166} S. 1718, §3, \textit{supra.}

\textsuperscript{167} S. 1718, §3, \textit{supra.}

\textsuperscript{168} S. 1718, §6, \textit{supra.}

\textsuperscript{169} \textit{Weinberg}, 2002 WL 32356399, at *7.
CONCLUSION

DHHS lawsuits against attorneys create problems on many levels, from ethical and financial problems for attorneys, to financial problems and issues finding representation for beneficiaries. Yet, DHHS’s appeal in Haro shows its dedication to broadly pursuing reimbursement of conditional payments. Whether the Ninth Circuit affirms or reverses Haro, the court cannot fully protect attorneys. With an affirmance, the Ninth Circuit can only provide limited relief to attorneys and encourage future jurisprudential attempts to curb DHHS suits.

Congress, on the other hand, has the power to either curb or foster DHHS suits against attorneys. Amending the MSP to include “attorney” in the definition of entity causes more problems for attorneys raised in this article than it solves for DHHS. Amending the SMART Act as suggested above provides the broad protection attorneys desire from DHHS lawsuits and resulting ethical dilemmas. Instead of waiting on the Ninth Circuit, perhaps attorneys should turn their attention to Congress for more immediate relief than future jurisprudence and support legislation to reign in a DHHS run amuck.