

MEDICARE AND THE SETTLING TORT DEFENDANT

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Every tort defendant's nightmare is a settlement that promptly spawns another lawsuit filed by a different plaintiff. But far more nightmarish is a settlement that leads not only to a second case, but to one seeking double damages, plus interest, with virtually no defense. Welcome to the world of Medicare Secondary Payer liability.

Medicare originally paid for its beneficiaries' necessary medical items and services, regardless of any private coverage apart from workers' compensation.¹ Over time, advances in medical technology yielded increasingly expensive benefits. Fearing that the program would swallow the national budget, Congress sought to rein it in by passing the Medicare Secondary Payer Act of 1980 (the "MSP").

The MSP converted Medicare from a first responder to a backstop. It bars Medicare from paying for any benefit where "payment has been made or can reasonably be expected to be made" by any "primary plan"—defined as "a group health plan or large group health plan, . . . a workmen's compensation law or plan, an automobile



or liability insurance policy or plan (including a self-insured plan) or no fault insurance.”² To ensure timely care and treatment, the MSP permits “conditional payments” through the Centers for Medicare and Medicaid Services (“CMS”), with the “condition” being that CMS *must* seek reimbursement.³ The MSP facilitates that condition by giving the government subrogation rights⁴ or an alternative double-damages remedy against any entity that would be responsible for payment, as well as “any entity that has received payment from a primary plan or from the proceeds of a primary plan’s payment to any entity” (e.g., a plaintiff or plaintiff’s counsel receiving settlement or judgment payments).⁵

If this were simply a matter of determining primacy among multiple layers of insurance, there would be little cause for concern. But what started as a largely noncontroversial effort to shield Medicare benefits with private insurance contracts has moved far beyond that. As the media reported huge tort settlements and verdicts in the 1980s and 1990s, the government took notice. Seeking a share of those settlements and verdicts, the government argued in a series of cases that the term “self-insured” in the MSP’s definition of “primary plan” included settling product liability defendants that had not purchased outside insurance policies to protect themselves in the event of injuries due to product defects.⁶

After a number of courts rejected that argument, Congress amended the MSP in 2003 to “clarify” that “[a]n entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.”⁷ Congress further “clarified” that:

[a] primary plan’s responsibility . . . may be demonstrated by a judgment, a payment conditioned upon the recipient’s compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan’s insured, or by other means.⁸

The 2003 amendments effectively eliminated tort defenses as a barrier to Medicare reimbursement. Once “responsibility” is “demonstrated” through a settlement with or a release given by a Medicare beneficiary, the only issues are when and how much the settling defendant must pay—or must

ensure that the plaintiff and the plaintiff’s attorney pay to CMS. Emboldened by these “clarifications,” the government recently sued a number of plaintiffs’ lawyers and settling companies for more than \$135 million in the aftermath of an Alabama toxic tort settlement.⁹

When conditional payments equal or exceed the consideration for a settlement, CMS may claim the entire settlement amount, even if the defendant settled on a cost-of-litigation basis and even if medical expenses represented only a small fraction of the total damages alleged. CMS refuses to recognize any private effort to differentiate medical expenses from other alleged damages in a settlement agreement.¹⁰ Several courts have deferred to CMS’s view that “[t]he only situation in which Medicare recognizes allocations of liability payments to nonmedical losses is when payment is based on a court order *on the merits of the case*.”¹¹

Things got even worse in 2007, when Congress enacted Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007.¹² Obscured and largely unpublicized at the time, that legislation mandated reports of settlements and bolstered what had been a toothless reporting regulation (42 C.F.R. § 411.25) with statutory fines of up to \$1,000 *per day* for even inadvertent failure to report a settlement.¹³ In response, CMS has designed a complicated, internet-based reporting system that stands to increase reimbursement demands exponentially when it takes effect for “self-insureds” in January 2012.¹⁴

Logically (and fairly), CMS should pursue the plaintiff, not the defendant, for expenditures resulting from the injury alleged, as CMS’s regulations acknowledge.¹⁵ The MSP does not require that, however. Moreover, CMS has made it plain that only a beneficiary/plaintiff may contest preliminary and final CMS determinations of claims for reimbursement.¹⁶ A settling defendant has no standing to participate in any way in CMS’s elaborate five-tier administrative hearing process.¹⁷ If the plaintiff is insolvent or otherwise fails to pay what CMS demands, the defendant may be held liable for twice the amount of the claim at issue, even though the defendant has not admitted, and no court has adjudicated, that the defendant’s acts or omissions caused the plaintiff’s injuries, and even though the defendant has had no opportunity to challenge CMS’s calculation of the amount subject

to reimbursement. It seems inconceivable that such a system could pass constitutional muster.

Because CMS is a federal agency, its actions obviously fall within the ambit of the Fifth Amendment. Equally clear is that a deprivation of money falls within the category of “property” protected by the Due Process Clause.¹⁸ It follows that CMS cannot deprive any defendant of dollars demanded as Medicare reimbursement without affording due process.

The Supreme Court “consistently has held that some form of hearing is required before an individual is finally deprived of a property interest.”¹⁹ “The constitutional right to be heard is a basic aspect of the duty of government to follow a fair process of decisionmaking when it acts to deprive a person of his possessions.”²⁰ Although the opportunity to be heard in defense does not always have to precede deprivation, it generally should, absent “extraordinary situations,” which should only rarely arise in connection with MSP demands.²¹ Regardless of timing, the opportunity to be heard “must provide a real test[,]” “aimed at establishing the validity, or at least the probable validity, of the underlying claim” on which the deprivation is to be founded.²²

In holding in *Goldberg v. Kelly*, 397 U.S. 254 (1970), that due process requires a pre-termination hearing before the government can suspend welfare payments to an eligible recipient, the Court dismissed arguments similar to those CMS likely would assert—that “governmental interests in conserving fiscal and administrative resources” outweigh competing property interests.²³ The Court explained that “[w]hile the problem of additional expense must be kept in mind, it does not justify denying a hearing meeting the ordinary standards of due process.”²⁴ “The fundamental requisite of due process of law is the opportunity to be heard. The hearing must be at a meaningful time and in a meaningful manner.”²⁵ As a result, “[i]n almost every setting where important decisions turn on questions of fact, due process requires an opportunity to confront and cross-examine adverse witnesses.”²⁶

Goldberg does not stand alone. Just to highlight two more examples among many, the Court also has held that due process requires the state to conduct a hearing before enacting a wage garnishment²⁷ or before the sheriff seizes personal property.²⁸ If, as *Goldberg* holds, recipients of benefits provided under government largesse have a property interest in

the continuation of their benefit payments sufficient to trigger due process requirements, it must be the case that a hearing is required when the government seeks to take property already in a person’s lawful possession. And if, as the other examples show, due process requires a hearing before the state imposes a temporary deprivation of personal property where two private parties dispute who has the stronger interest, then surely the state cannot forgo such a hearing in a situation distinguished only by the substitution of the government for one of the private parties claiming rightful ownership. The only hearing provided in a double-damages action arguably falls far short of constitutional requirements because the defendant cannot raise a defense; thus, the proceedings assure a settling defendant neither a meaningful “opportunity to speak up in his own defense”²⁹ nor a meaningful opportunity “to confront and cross-examine” the persons whose knowledge underlies and determines the amount at issue.³⁰

If CMS were to exercise its subrogation rights and litigate the plaintiff’s claim, it would have to make a prima facie case, against which the defendant could defend itself and as to which it could reach a definitive compromise. Subrogation also would permit an equitable apportionment that would recognize the plaintiff’s other elements of damage and scale down the defendant’s potential Medicare liability accordingly.³¹ But the MSP allows the government to sit out the original litigation and then to sweep in after settlement to take money from the defendant, armed with a presumption of liability—on the thin basis that the defendant chose to settle with the plaintiff—yet provides no process for the rebuttal of that presumption. That is fundamentally unfair.

ADDRESSING AND MINIMIZING RISKS

In short, there is good reason to question the MSP’s constitutionality insofar as it would impose liability upon a settling defendant that admits no fault.³² That said, standing, ripeness, and sovereign-immunity principles may very well prevent a defendant from mounting a constitutional attack until CMS files suit and the defendant faces the risk of liability head-on. This makes due process arguments something of a last-ditch defense. To address and hopefully minimize the risks upfront, there are a number of measures to consider.

Assess the plaintiff’s Medicare status at the outset if it is not obvious. Ask opposing counsel about this at the first

preliminary case management or Federal Rule of Civil Procedure 26(f) conference. To avoid wasting valuable interrogatories or document requests limited by local rules, it may be advisable to cover Medicare disclosures in case management orders or “Lone Pine” questionnaires. Otherwise, consult CMS’s MSP Mandatory Reporting GHP User Guide³³ to determine the data that will satisfy CMS’s reporting requirements for settlements and adverse judgments. Gather that and any Medicare-related correspondence through discovery requests, and follow up in depositions. While opposing counsel may object to items aimed at Section 111 reporting and potential MSP liability, at least one reported decision permits discovery along these lines.³⁴

Think twice before trying to discover facts that might induce CMS to waive its claim. Such facts may include, for example, the adequacy of the plaintiff’s financial resources to meet the plaintiff’s normal needs, any undue hardship the plaintiff might experience if required to reimburse Medicare for conditional payments, whether the plaintiff’s ordinary monthly expenses equaled or exceeded the plaintiff’s monthly income from all sources, and other considerations suggesting that reimbursement would not comport with equity and good conscience. This may prove counterproductive. For example, in *Roland v. Sebelius*, answers to one defendant’s interrogatories on such matters were introduced by CMS in administrative proceedings, resulting in denial of a requested waiver.³⁵

Consider that defensive terms in settlement agreements may offer only incomplete protection against potential MSP liability. Some plaintiffs’ counsel may resist including MSP provisions altogether. Others may insist on prompt disbursement of settlement funds before final resolution of CMS claims, leaving the defendant open to the risk of the plaintiff’s future inability to pay those claims upon demand. Because CMS will give at most preliminary estimates of its claims before a settlement is reached (and then only to the plaintiff or the plaintiff’s attorney), the defendant may be forced to evaluate a settlement on the basis of substantially incomplete information.³⁶ When drafting a settlement agreement, consider representations as to Medicare benefits received or the lack thereof, requirements to report or determine initial and final claims (a potentially time-consuming process), commitments by both the plaintiff and the plaintiff’s counsel to pay reimbursement claims when due, related indemnity and hold-harmless clauses, cooperation clauses, hold-back

requirements for future medical expenses, waivers of any rights of action for double damages, and explicit references to Medicare in releases and covenants not to sue. Although forms developed for these matters often refer to “Medicare liens,” that terminology has been held to be inaccurate and could pose difficulties.³⁷

Specify each defendant’s contribution separately. If multiple defendants are covered by the same settlement agreement, specify each defendant’s contribution separately to preempt any argument that the total settlement amount determines a defendant’s individual obligation. It may be best to require a separate release/settlement document for each defendant.

Aggregate lump-sum settlements in mass tort cases pose particular problems. Some have proposed carving out Medicare beneficiaries and treating them separately.³⁸ Plaintiffs’ lawyers may balk at this approach, because it has the potential to create conflicts between their Medicare and non-Medicare clients that could require separate counsel (with a resulting requirement to share contingent fees). It may be possible to negotiate separate terms for the Medicare-eligible group only after all plaintiffs have accepted and undertaken a neutral allocation proceeding. To avoid triggering a premature reporting obligation, a mass tort settlement should not take effect until the lump sum is allocated and each plaintiff has agreed to the allocation by signing a release accepting the allocated sum as settlement consideration.³⁹ Conditions precedent expressed in preliminary agreements with plaintiffs’ counsel should make that delayed effect explicit.

Some courts have held that CMS cannot lay claim to amounts clearly due to settling parties who are not Medicare beneficiaries or to damages clearly meant to compensate for something besides medical expenses.⁴⁰ These holdings have prompted efforts to define away the problem by specifying the medical component as a mere fraction of the total settlement proceeds. As noted above, CMS takes a dim view of contractual allocations and has persuaded judges to sweep aside a number of these attempts. Still, a few courts have sympathized with such efforts, especially regarding future medical expenses, because CMS steadfastly has refused to devise procedures for advance review of future “set-asides” outside the workers’ compensation context, making it very difficult to determine whether honestly estimated

hold-backs will satisfy subsequent CMS demands.⁴¹ In some cases, settling parties have obtained court orders purporting both to determine the amount due to Medicare and to absolve the parties from any further MSP liability upon payment of the specified sum, despite the fact that CMS did not take part in the proceedings.

A recent Eleventh Circuit decision adds fuel to the fire. In *Bradley v. Sebelius*, the parties settled a wrongful death claim before any suit was filed.⁴² After CMS demanded payment of medical expenses in full, which would have left the claimants with little to divide among themselves, the claimants petitioned a probate court to apportion the settlement. Although notified, CMS declined to participate.⁴³ The probate court reduced the medical-expense component to a mere \$787,50.⁴⁴ When CMS refused to accept the probate court's apportionment, the claimants' representative paid the full claim and sued the Secretary of HHS for a refund, which the district court denied.⁴⁵ On appeal, the Eleventh Circuit reversed that ruling. Reasoning that CMS's position "would have a chilling effect on settlement" that would force tort claims to trial, it reinstated the probate-court decision.⁴⁶ This suggests that courts' patience with the MSP's procedural deficiencies may be wearing thin.

Interpleader is an obvious answer for defendants faced with conflicting demands by plaintiffs and CMS. Unfortunately, the government routinely removes state interpleader actions and, wherever sued, typically asserts sovereign immunity as an argument for dismissal.⁴⁷ Yet the government sometimes proves willing to participate in the interpleader action.⁴⁸ Accordingly, interpleader may be worthwhile in an appropriate case.

When the time comes to cut a settlement check, should Medicare be named as a payee? Plaintiffs may fear this will tie up funds unnecessarily and indefinitely, but defendants naturally will prefer it, because it would ensure CMS reimbursement and eliminate the risk of a double-damages action. In *Wall v. Leavitt*, a federal magistrate considered naming Medicare as a payee to be a "practical necessity" even though the MSP does not expressly require that.⁴⁹ In *Tomlinson v. Landers*, however, a different magistrate rejected an argument to that effect and held that disagreement over how to make out the settlement check showed that the parties' minds had never met on settlement.⁵⁰ And in *Zaleppa v. Seiwel*, a Pennsylvania judge found

that adding Medicare as payee on a check issued to pay a judgment violated state law.⁵¹

All of this illustrates that there's no fail-safe answer to MSP liability. In some cases, the inability to address MSP concerns with any finality may prevent the parties from settling.⁵² Practice standards are still evolving. The steady flow of new decisions in this area may suggest better ways to address this serious problem, and Congress may yet weigh in.⁵³ Stay tuned. ■

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¹ See, e.g., Peter A. Corning, "The Evolution of Medicare . . . *From Idea to Law*," ch. 4, *The Fourth Round—1957 to 1965* (1969), available at <http://www.ssa.gov/history/corningchap4.html> (all web sites herein last visited Apr. 4, 2011); see also *Health Ins. Ass'n of Am. v. Shalala*, 23 F.3d 412, 414 (D.C. Cir. 1994).

² 42 U.S.C. § 1395y(b)(2)(A).

³ See *id.* § 1395y(b)(2)(B)(i). The MSP confers rights and responsibilities upon the Secretary of the Department of Health and Human Services ("HHS"), who in turn has delegated authority over Medicare to CMS. For simplicity, this article uses "CMS" at some points to refer to that agency alone and at others to refer to the Secretary and/or HHS. References to "the government" encompass all three, as well as responsible officials in the Department of Justice and appropriate Offices of United States Attorneys.

⁴ *Id.* § 1395y(b)(2)(B)(iv).

⁵ *Id.* § 1395y(b)(2)(B)(iii).

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⁶ See, e.g., *Thompson v. Goetzmann*, 337 F.3d 489 (5th Cir. 2003); *Mason v. Am. Tobacco Co.*, 212 F. Supp. 2d 88 (E.D.N.Y. 2002); *In re Silicone Gel Breast Implants Prods. Liab. Litig.*, 174 F. Supp. 2d 1242 (N.D. Ala. 2001); *United States v. Philip Morris, Inc.*, 156 F. Supp. 2d 1 (D.D.C. 2001); *In re Orthopedic Bone Screw Prods. Liab. Litig.*, 202 F.R.D. 154 (E.D. Pa. 2001); *In re Diet Drugs*, MDL No. 1203, Civ. A. 99-20593, 2001 WL 283163 (E.D. Pa. Mar. 21, 2001); *United States v. Philip Morris, Inc.*, 116 F. Supp. 2d 131 (D.D.C. 2000); *In re Dow Corning Corp.*, 250 B.R. 298 (Bankr. E.D. Mich. 2000).

⁷ See Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173 § 301(b), codified at 42 U.S.C. § 1395y(b)(2)(A).

⁸ *Id.* § 301(c), codified at 42 U.S.C. § 1395y(b)(2)(B)(ii).

⁹ See Complaint, *United States v. Stricker*, No. 1:09cv2423 (N.D. Ala. Dec. 1, 2009).

¹⁰ See Centers for Medicare & Medicaid Services, *Medicare Secondary Payer Manual*, ch. 7, § 50.4.4 (2011), available at <https://www.cms.gov/Manuals/OM/itemdetail.asp?filterType=none&filterByDID=99&sortByDID=1&sortOrder=ascending&itemID=CMS019017> ("MSP Manual").

¹¹ *Id.* (emphasis added); see *Zinman v. Shalala*, 67 F.3d 841 (9th Cir. 1995); *Hadden v. United States*, No. 1:08-CV-10, 2009 WL 2423114 (W.D. Ky. Aug. 6, 2009) (appeal pending); *accord Denekas v. Shalala*, 943 F. Supp. 1073, 1081 (S.D. Iowa 1996).

¹² Pub. L. No. 110-173.

¹³ See 42 U.S.C. § 1395y(b)(7) (requiring submission of information by group health plans); *id.* § 1395y(b)(8) (requiring submission of information by liability insurers, including "self-insurers").

¹⁴ See Jennifer C. Jordan, "Medicare Secondary Payer Enforcement: Shifting the Burden of Medicare to the Private Sector," 39 *The Brief* 1, 14 (2009), available at <http://www.medval.com/wordpress/wp-content/uploads/2010/07/Jordan-Jennifer-Medicare-Secondary-Payer-as-published.pdf>. The risk of reimbursement liability and related statutory penalties will not necessarily be confined to cases involving traditional negligence and "personal injury" claims but could apply as well to any case in which a plaintiff gives a general release after incurring medical expenses conditionally paid by Medicare. See Transcript of Town Hall Teleconference on Section 111 of the Medicare, Medicaid, & SCHIP Extension Act of 2007, 42 U.S.C. § 1395y(b)(8), at 26 (Oct. 14, 2010), available at <https://www.cms.gov/Mandatory/Insrep/Downloads/Oct242010NGHPTscript.pdf>.

¹⁵ 42 C.F.R. § 411.24(h)-(i).

¹⁶ See MSP Manual, ch. 7, § 50.8.2.

¹⁷ See *id.*; see also, generally, Woody R. Clermont, *Introduction to Medicare and the Office of Medicare Hearings and Appeals* (2009).

¹⁸ See *Bd. of Regents of State Coll. v. Roth*, 408 U.S. 564, 576-78 (1972).

¹⁹ *Mathews v. Eldridge*, 424 U.S. 319, 333 (1976).

²⁰ *Fuentes v. Shevin*, 407 U.S. 67, 80 (1972).

²¹ *Id.* at 90 (quoting *Boddie v. Conn.*, 401 U.S. 371, 379 (1971)).

²² *Id.* at 97 (quoting *Sniadach v. Family Finance Corp. of Bay View*, 395 U.S. 337, 343 (1969) (Harlan, J., concurring)).

²³ 397 U.S. at 265.

²⁴ *Id.* at 261 (quoting *Kelly v. Wyman*, 294 F. Supp. 893, 901 (S.D.N.Y. 1968)).

²⁵ *Id.* at 267 (internal quotation marks and citations omitted).

²⁶ *Id.* at 269.

²⁷ See *Sniadach*, 395 U.S. at 342.

²⁸ See *Fuentes*, 407 U.S. at 96.

²⁹ *Id.* at 81.

³⁰ *Goldberg*, 397 U.S. at 269.

³¹ See MSP Manual, ch. 7, § 50.4.4 ("The only situation in which Medicare recognizes allocations of liability payments to nonmedical losses is when payment is based on a court order on the merits of the case.").

³² A federal district court recently rejected a due process challenge to the MSP under different circumstances. See *Benson v. Sebelius*, --- F. Supp. 2d ---, No. 09-1931 (RMU), 2011 WL 1087254 (D.D.C. Mar. 24, 2011). In that case, the court affirmed that CMS may collect from the proceeds of a wrongful death settlement obtained by an heir of the decedent where the underlying suit sought to recover, among other damages, medical costs that had been paid by Medicare. The court rejected the argument that CMS violated the heir's due process rights by threatening to seek interest payments if he delayed payment or that HHS did so by hearing his challenge to the calculation of the amount due only after the deadline for payment. Either of these is a weaker due process argument than those potentially available to a settling defendant from which CMS seeks to collect without providing any opportunity for a hearing at all.

³³ Centers for Medicare & Medicaid Services, *GHP User Guide* (2010), available at <https://www.cms.gov/MandatoryInsRep/Downloads/GHPUserGuideV31.pdf>.

³⁴ See *Seeger v. Tank Connection, LLC*, No. 8:08CV75, 2010 WL 1665253, at *4-6 (D. Neb. Apr. 22, 2010).

³⁵ No. 3:08-CV-2084-K, 2010 WL 70855, at *1, *4 (N.D. Tex. Jan. 6, 2010).

³⁶ See MSP Manual, ch. 7, § 50.4.2.

³⁷ See *Zinman v. Shalala*, 835 F. Supp. 1163, 1171 (N.D. Cal. 1993), *aff'd*, 67 F.3d 841 (9th Cir. 1995) ("The MSP statute does not state that Medicare has a lien, it articulates Medicare's right as a claim to recover from entities who, pursuant to the statute, are required to pay primary. Nor does Defendant contend that Medicare's right is a lien. The Secretary maintains that Medicare's right is superior to a lien."); see also Glenn E. Bradford and Melinda M. Ward, "The Medicare 'Super Lien' Revisited," 56 *J. Mo. Bar* 44 (2000), available at <http://www.mobar.org/journal/2000/janfeb/bradford.htm>.

³⁸ See, e.g., Tara Kelly, "New Reporting Deadlines Affect Mass Torts Settlements," 8 *Mass Torts* 1, 16 (2010), available at http://www.kslaw.com/imageserver/KSPublic/Library/publication/MassTorts-Summer2010_TaraKelly.pdf.

³⁹ See Model Rules of Prof'l Conduct R. 1.8(g) (2010).

⁴⁰ See, e.g., *Bradley v. Sebelius*, 621 F.3d 1330, 1339-40 (11th Cir. 2010); *Denekas*, 943 F. Supp. at 1081.

⁴¹ See, e.g., *Big R Towing v. Benoit*, No. 10-538, 2011 WL 43219 (W.D. La. Jan. 5, 2011); *Goetz v. Allouez Marine Supply, Inc.*, No. 09-cv-670-wmc (W.D. Wis. Dec. 21, 2010); *Finke v. Hunter's View, Ltd.*, No. 07-4267 (WRWRLE), 2009 WL 6326944 (D. Minn. Aug. 25, 2009).

⁴² *Bradley*, 621 F.3d at 1332.

⁴³ See *id.* at 1332-33.

⁴⁴ See *id.* at 1333-34.

⁴⁵ See *id.* at 1334.

⁴⁶ *Id.* at 1339.

⁴⁷ See *Coastal Rehab. Servs. v. Cooper*, 255 F. Supp. 2d 556 (D.S.C. 2003); *Hat Ranch, Inc. v. Babbitt*, 932 F. Supp. 1 (D.D.C. 1995); cf. *Portman v. Goodson*, No. 3:10CV-313-S, 2011 WL 773427 (W.D. Ky. Feb. 28, 2011); *Hicks v. Chamberlain*, No.

10-144-DLB, 2010 WL 4226698 (E.D. Ky. Oct. 22, 2010); *Lusker v. Sec'y of U.S. Dep't of Health & Human Servs.*, No. 8:09-CV-2193-T-17TBM, 2010 WL 76456 (M.D. Fla. Jan. 7, 2010).

⁴⁸ Consider *Farmers Insurance Exchange v. Forkey*, No. 2:09-cv-00462-GMN-GWF, 2010 WL 5477726 (D. Nev. Dec. 29, 2010), where the insurer moved for interpleader and paid its policy limits after an accident victim's widow and HHS both made claims under the victim's policy, and where HHS straightforwardly, and successfully, asserted its right to a share of the proceeds.

⁴⁹ Civ. No. S-05-2553 FCD GGH, 2008 WL 4737164, at *6 (E.D. Cal. Oct. 29, 2008).

⁵⁰ Case No. 3:07-cv-1180-J-TEM, 2009 WL 1117399, at *4-5 (M.D. Fla. Apr. 24, 2009).

⁵¹ 2010 PA Super. 208 (2010). *But see Haskell v. Graham*, No. 08-cv-05880 (N.D. Ill. June 10, 2010) (refusing to sanction a defendant that deposited judgment funds with the clerk of court pending resolution of Medicare issues).

⁵² See Rick Swedloff, "Can't Settle, Can't Sue: How Congress Stole Tort Remedies from Medicare Beneficiaries," 41 *Akron L. Rev.* 557, 588 (2008).

⁵³ See H.R. 1063 (The Strengthening Medicare And Repaying Taxpayers (SMART) Act of 2011), introduced in the 112th Congress, 1st Session, *available at* <http://www.gpo.gov/fdsys/pkg/BILLS-112hr1063ih/pdf/BILLS-112hr1063ih.pdf>; see also Medicare Advocacy Recovery Coalition, The Strengthening Medicare and Repaying Taxpayers (SMART) Act, *available at* http://www.marccoalition.com/MSP_Reform.html (synopsizing proposed SMART Act).