Jose Ramirez, Table for Four (Used With Permission)

The Medicare Subrogation Dinner Party: Who's Invited and Who's Not?

By Mark Jones

For the personal injury attorney, understanding medical subrogation claims[1] against a client's settlement is an integral part of competent representation. In any case, there may be multiple subrogation claimants seeking reimbursement from a client's liability, uninsured/underinsured motorist settlement, and medical payments coverage for health benefits paid out by the subrogation claimant. This article focuses on subrogation claims involving: (1) Medicare; (2) Medicare Advantage Organizations (MAOs); and (3) Medicare Prescription Drug Plans ("PDPs") and seeks to give the practitioner a general understanding of these subrogation claims.

An analogy will assist us in analyzing these subrogation claims. The client's settlement is much like a dinner party at the client's house. Certain subrogation claimants are invited to the dinner party and have a place at the table. Others are not invited—although they may claim they are. Based on the current case law, traditional Medicare almost always has an invitation to your client's dinner party, but they may have to share their food. Conversely, outside of the Third Circuit, MAOs and PDPs likely do not have an invitation to the dinner party in states, like Georgia,[2] that do not permit subrogation as a matter of state law.

1. Medicare's Superlien – Medicare Always Has a Place at the Table, but Has to Share and Sometimes Must Take a Smaller Serving.

It is the day of your client's dinner party. Your client hears a knock at her door: an agent from Medicare is at the door. He demands that he be seated at the head of your client's dinner table for the party. His dinner must be made in a very particular way; the plate must be certified, china dinnerware; the silverware, he insists, must be set in a certain spot at a certain distance from the dinner plate; the napkin must be folded in the shape of a swan and placed on his plate before he will sit to be served. He requires a coaster for his drink. Food must be prepared at an exact temperature. His drink needs a certain number of ice cubes and so forth.

Must your client let the agent from Medicare in for the dinner party? Must he meet his various ridiculous demands in serving him dinner? Generally, yes. In fact, your client must, indeed, seat the Medicare

agent at the head of the dinner table and must comply with his very precise instructions on serving him.

Under the Medicare Secondary Payer Act[3] ("MSP"), Medicare has a first-priority lien on essentially any conceivable insurance policy that covers damages for injuries inflicted by a third-party against a Medicare beneficiary.[4] This lien also extends to settlements involving self-insured entities, such as Wal-Mart.[5] Self-insurance, liability insurance, uninsured/underinsured motorist insurance, and no-fault insurance are all known as "primary plans" under the MSP because Medicare pays "second" to these plans. However, since liability settlements generally involve lump sums paid many months or years after a given injury, Medicare will make payments before a settlement *on condition* that Medicare be reimbursed from any tort settlement with the primary plan.[6]

Medicare's lien is often colloquially referred to as a "superlien," and Medicare is quite forceful in demanding reimbursement for benefits paid out.

If Medicare is not reimbursed from the settlement funds, Medicare may pursue payment from anyone who touches the settlement money: the insurance company, the client, and the attorneys.[7] This superlien makes Medicare the closest thing to the "IRS" of personal injury practice. Their liens strike fear in the hearts of all involved in the settlement process—particularly the insurance adjuster.

Medicare has very specific procedures it employs that the practitioner must comply with in order to obtain Medicare's final lien amount. Specific compliance with those procedures is outside the scope of this article. However, generally speaking, Medicare's procedure for obtaining their final lien amount involves:

(1) notification of the injury and your representation (the sooner in the representation, the better);

(2) awaiting a "conditional lien amount," which is a preliminary lien amount itemizing what payments Medicare has made that it *thinks* are related to the injuries the client received;

(3) notification of settlement by the attorney, including notice to Medicare of procurement costs and the amount of attorneys fees;

(4) receipt of the final lien amount demanded by Medicare; and

(5) payment of the Medicare lien within 60 days to avoid an interest penalty. Medicare has been more efficient lately by setting up a website wherein lawyers and their staff can track the progress of a lien online through the "Medicare Secondary Payer Portal."[8]

The short of it is this: generally speaking, Medicare must be paid back from your client's personal injury settlement for

any related medical care for which Medicare issued payments.

With this said, there are two glimmers of hope under federal law for practitioners seeking to limit Medicare's portion of the settlement proceeds.

First, Medicare will automatically reduce its final lien amount by sharing pro-rata in your attorney's fee and also taking into account any out-of-pocket expenses in obtaining the settlement.[9] Medicare refers to these as "procurement costs." This is essentially a codification of the equitable common fund doctrine.[10]

Secondly, at least in the Eleventh Circuit, it is possible to reduce Medicare's superlien using equitable allocation principles, but the stars must align properly. Such was the case in *Bradley v. Sebelius*, 621 F.3d 1330 (11th Cir. 2010). There, the Court flatly rejected Medicare's claim that it was entitled to full reimbursement from a de minimus wrongful death settlement. Due to insufficient insurance coverage, the settlement in the *Bradley* case was for far less than what the claims of the estate and the surviving children were worth as per the finding of the probate court allocating the settlement.[11] Under Florida law, the surviving children's claim for the proceeds from the wrongful death settlement was separate and apart from the estate; the estate possessed the claim for the decedent's medical expenses.[12]

In *Bradley*, Medicare sought over $38,000.00 in reimbursement from a $52,500.00 settlement. The decedent's personal representative and the surviving children petitioned the probate court for an allocation of the settlement funds. The Secretary of Health and Human Services declined to attend the probate court hearing, despite notice, and the court allocated $787.50 to Medicare as its proportional share of the limited settlement funds[13] Medicare thumbed its nose at the probate court, calling the court's decision "advisory" and citing its own manual as authority to ignore a court's allocation of settlement funds. Medicare demanded full reimbursement from the settlement, and the family and children appealed Medicare's decision all the way to the Eleventh Circuit Court of Appeals, exhausting all administrative remedies.

In a harshly worded opinion, the *Bradley* Court gave *no deference* to Medicare's *Medicare Secondary Payer Manual*, which states Medicare is always entitled to full reimbursement, unless there is an allocation after an adjudication on the merits. The *Bradley* Court thus affirmed the probate court's allocation of $787.50 to Medicare as full satisfaction of its lien, despite no adjudication on the merits.

Reading the case broadly, the *Bradley* decision stands for the following propositions: (1) Medicare is not entitled to full reimbursement from a settlement where doing so would work an injustice; and (2) Medicare is subject to equitable allocation principles in pre-litigation settlements. Reading the decision narrowly, Medicare is not entitled to full reimbursement only

where there is: (1) a claim that inherently involves some form of apportionment like the wrongful death claim in *Bradley*; (2) actual apportionment by a court with Medicare receiving notice; and (3) insufficient coverage.

Bradley is the only decision that has not held that Medicare is entitled to full reimbursement of its lien. The leading decision holding the opposite is *Hadden v. United States*, 661 F.3d 298 (6th Cir. 2011). In *Hadden*, a Medicare beneficiary was struck by a corporate truck that swerved to avoid colliding with a John Doe motorist that ran a stop sign. A panel of the Sixth Circuit rejected a beneficiary's argument that Medicare was entitled to only 10% of its lien amount due to the John Doe motorist being 90% responsible for the wreck that injured Plaintiff. The *Hadden* settlement was with the remaining corporate tortfeasor that the Plaintiff claimed was only 10% responsible for his loss. Medicare refused to reduce its $82,000.00 lien on a $125,000.00 settlement.

The Sixth Circuit held that Medicare was entitled to full reimbursement and deferred to Medicare's *Medicare Secondary Payer Manual*.[14] A vigorous dissent by Judge Hellene N. White pointed out the elephant in the room: that a policy of full reimbursement without considering fault allocation would lead to absurd results – thereby precluding any recovery at all since beneficiaries (and their attorneys) will fear that Medicare will devour the entire settlement if there is a large lien.[15] Ultimately, the issue of whether equitable reductions/apportionment applies to Medicare will have to be resolved by the Supreme Court, but for now, the Supreme Court has declined to get involved.[16]

PRACTICE POINTER: It is better to deal with a Medicare reduction issue concerning unrelated conditional payments *before* notification of the *settlement* to Medicare.

This is because Medicare's attitude has consistently been that it is entitled to full reimbursement for all related payments made regardless of comparative fault issues, shaky liability scenarios, or very limited policy amounts—all of which, in the reality of personal injury practice, play significant roles in settling a case.

Therefore, the prudent practitioner will dispute any unrelated charges immediately after receipt of the conditional lien and will refrain from notifying Medicare of any settlement until after an updated conditional lien is received that removes the unrelated charges.

In this author's experience, disputing Medicare's conditional lien amount on the front end leads to a far higher success rate in significantly reducing Medicare liens.

In sum, Medicare's lien must be satisfied from your client's settlement, i.e., they always have a place at the table at your client's dinner party. However, Medicare *does* have to share some of its food with you as the claimant's attorney since Medicare reduces its reimbursement claim pro-rata to share in any attorney's fees and out-of-pocket costs. Furthermore, at least in the

Eleventh Circuit pursuant to the *Bradley* decision, there is an argument that Medicare has to reduce its dinner portion based on equitable principles.

2. Medicare Advantage Plans and Medicare Part D Prescription Drug Plans Are Likely Not Invited to the Dinner Party in States Where Subrogation is Not Allowed.

PRACTICE POINTER: In their zeal to protect Medicare's "superlien," sometimes the insurance adjuster will want to include Medicare on the settlement check even after a settlement amount is agreed upon.

This is not required by federal law.[17] A primary plan has no authority to act as Medicare's debt collector.[18] At best, this practice is horribly inefficient;[19] at worst, it is bad faith[20] and tortious interference with your contractual relations with your client. The real issue is the potential for the primary plan to have to pay the lien twice—i.e., the plan's own liability rather than any "requirement" under federal law.

The practitioner should make clear in any settlement demand how the check should be made payable and that any check with co-payees on it will be considered a counteroffer to avoid any confusion or delay on this issue.

This is particularly important once Medicare is notified of the settlement, since Medicare requires payment – from whatever source – within 60 days of the date of its final demand letter.

Continuing with our analogy, let us assume that your client hears another knock at the door. This time it is the Medicare agent's little brothers at the door. They heard about your dinner party and are elbowing to get a place at the table. The little brothers represent Medicare Advantage Organizations ("MAOs") under Medicare Part C, and Medicare Part D, involving prescription benefits ("PDPs").

The Code of Federal Regulations provides that subrogation claims for PDPs are identical to MAOs.[21] Therefore, the analysis under the law is the same concerning these two subrogation claimants. However, the case law deals primarily with MAOs.

Whether MAOs/PDPs have a valid right of subrogation is not settled by the current case law. The short answer is that, they may have a valid private cause of action under federal law for reimbursement against a primary plan such as a self-insured tortfeasor or an insurance company; however, MAOs/PDPs may, but likely do not, have a valid right of subrogation for medical payments made against a plan *beneficiary* so long as: (a) the state where the beneficiary resides does not permit subrogation; and (b) there is no diversity jurisdiction where the MAOs/PDPs could sue the beneficiary in federal court.

A bit of background is necessary to understand why these entities are probably not invited to share in your client's dinner.

MAOs "replace" traditional Medicare. Congress created the MAOs through the Balanced Budget Act of 1997[22] and revamped them in 2003 under the Medicare Modernization Act.[23] MAOs were created to provide "private efficiency" to Medicare.[24] The Medicare Modernization Act created Medicare Part D, which provides prescription drug benefits to Medicare beneficiaries.[25]

The case law concerning subrogation claims of MAOs focuses on a *jurisdictional* analysis regarding whether Congress intended to grant MAOs a private cause of action to enforce reimbursement claims in federal court.

While this is an unsettled area of the law, the leading cases on the subrogation rights of MAOs are:

- *Humana v. Reale*, 2011 U.S. Dist. LEXIS 8909, 2011 *WL* 335341(S.D. Fla.);
- *Parra v. PacifiCare of Arizona, Inc*., 2011 WL 1119736, (D. Ariz.); and
- *In re Avandia Marketing*, 685 F.3d 353 (3rd Cir. 2012).

In *Reale*, Humana paid $19,155.41 in medical benefits for a plan beneficiary, Reale, who was injured in a slip and fall at a hotel. The plan beneficiary went on to settle her case with the hotel for an amount in excess of the $19,155.41. Reale did not reimburse Humana, and Humana sued Reale in federal court. Humana contended that the MSP, specifically 42 USC § 1395y(b)(2)(B)(i),[26] provided it a private right of action for reimbursement against a plan beneficiary.

In essence, Humana argued that it stepped into the shoes of the Secretary of Health and Human Services pursuant to 42 C.F.R. § 422.108(f), which provides: "the [MAOs] will exercise the same rights to recover from a primary plan, entity, or individual that the Secretary exercises under the MSP regulations […]."

Reale moved to dismiss the action for lack of federal jurisdiction, arguing that the MSP did not provide MAOs with a private cause of action under federal law, and there was no diversity jurisdiction.

The Court held that exclusive authority to bring a federal collection action for reimbursement against a beneficiary under the MSP rested with the *United States* pursuant to 42 U.S.C. §1395y(b)(2)(B)(iii).[27] To the Court, stepping into the shoes of the Secretary did Humana no good because only the United States itself could bring a collection action against a beneficiary for reimbursement of payments made by Medicare. *Id.* (Although not discussed by the *Reale* Court, the Department of Justice brings the claim on behalf of the United States under the Federal Claims Collection Act.[28])

In Parra, the procedural posture was identical to *Reale*. The MAO initiated a private action in federal court for reimbursement against a plan beneficiary; the beneficiary moved to dismiss for lack of

federal jurisdiction. The *Parra* Court exhaustively catalogued the various statutory mechanisms that MAOs have used to attempt to bring a private cause of action in federal court. The Court rejected each one of them stating:

> The Medicare statutes at issue, here, do no more than create a federal right. They stop short of creating a federal private right of action to enforce that right and do not contain any jurisdictional provision granting the federal courts exclusive jurisdiction …

Conversely, in *In re Avandia Marketing*, supra, the Court found that the MSP provided a private cause of action by MAOs against a self-insured tortfeasor, GlaxoSmithKline ("GSK")

A careful reading of the *Avandia* decision shows that its holding was actually quite limited and does not hold that MAOs have a private right of action against *the beneficiary*. Instead, the *Avandia* Court held that the 42 U.S.C. § 1395y(b)(3)(A) provided Humana with a private cause of action against GSK—*the self-insured, defendant tortfeasor and "primary plan*." 42 U.S.C. § 1395y(b)(3)(A) provides:

> There is established a private cause of action for damages (which shall be in an amount double the amount otherwise provided) in the case of a primary plan which fails to provide for primary payment […].

Reading this language broadly and applying *Chevron* deference to the *Medicare Secondary Payer Manual*, the *Avandia* Court held that the "plain language" of this section permitted Humana to seek reimbursement against *GSK* through a private action in federal court.[29] But the "plain language" of this section nowhere mentions bringing an action against a *plan beneficiary* and instead is couched in terms of a "primary plan." Thus, in the Third Circuit, practically speaking, the MAOs have snuck in through the back door to your client's dinner party since they have a private cause of action against the primary plan. This means the insurance adjuster will want the MAOs' claim for reimbursement addressed from the settlement proceeds.

The only arguable holding of *Avandia* that provides MAOs with a private right of action against a plan *beneficiary* is the application of *Chevron* deference to the *Medicare Secondary Payer Manual*, CMS regulations, and unsigned memoranda[30] stating, without substantive explication, that MAOs have the same enforcement rights as Medicare.

However, *Chevron* deference is insufficient to resolve the issue because *Chevron* deference does not address the *Reale* Court's argument that only the United States may bring a collection action against the plan beneficiary. One might go so far as to say to the *Avandia* Court to "get real." As

to subrogation against plan beneficiaries, the *Reale* Court has the stronger "plain language" argument concerning the statutory interpretation of the MSP since the statute says in 42 U.S.C. §1395y(b)(2)(B)(iii) that only the *United States* may recover reimbursement for conditional payments against a beneficiary.

Nor does the *Avandia* Court address the *Bradley* Court's arguments that an agency manual, such as the *Medicare Secondary Payer Manual*, is not entitled to *Chevron* deference.[31] To paraphrase Judge White's dissent in the *Hadden* case, *Chevron* deference is not the answer to every issue concerning the MSP.[32]

So where does the case law leave the practitioner confronted with MAOs/PDPs demanding reimbursement from a client's settlement and a place at the dinner table?

Practitioners in the Third Circuit should: (1) avoid having the personal injury client sign any indemnity language in the release, since *Avandia* is arguably limited to private causes of action against primary payers such as insurance companies and self-insured defendants; or (2) confront the issue head on and negotiate a reduction of the MAO's subrogation claim.

A few points may assist those practicing in the Third Circuit in negotiating with MAOs/PDPs. First, even the *Avandia* Court would admit that MAOs/PDPs should receive rights no greater than what Medicare itself has.[33] Therefore, MAOs/PDPs should be subject, just as Medicare is, to sharing pro rata in any attorney's fees and other procurement costs.[34] MAOs/PDPs should also permit your client to benefit from contractor enhancements that Medicare allows, such as the fixed payment option and self-calculate option.[35] Further, since the Medicare regulations and memoranda provide that MAOs/PDPs have the same rights as the Secretary of Health and Human Services,[36] at least one court has suggested that MAOs/PDPs must exhaust administrative remedies before proceeding to federal court.[37] An equitable argument based on *Bradley* may also assist the practitioner in arguing equitable allocation/reduction applies to MAOs/PDPs' subrogation claims.

For those not practicing in the Third Circuit, if the state in which the client resides does not permit subrogation of medical benefits[38] and there is no diversity jurisdiction, then there is a strong argument that forum state's subrogation law will apply to any claim for reimbursement by an MAO. This is because, presumably, the state court would apply its own anti-subrogation law to any claim arising in its own court system, which is what the *Parra* Court implied in dicta.[39] However, the practitioner must still exercise care. At least one state court has held that its anti-subrogation statute was pre-empted by federal law, and the MAOs had a right to reimbursement—even at the *state* level in an anti-subrogation state.[40]

In sum, it is debatable whether MAOs/PDPs have an invitation to your client's dinner party. They likely do not if your state: (a) bars medical benefits

***PRACTICE POINTER*:** Some practitioners disagree with paying MAOs anything from a settlement if the forum state does not permit subrogation, and there is no diversity jurisdiction.

However, keep in mind that in negotiating settlements (particularly pre-litigation settlements), the practitioner is often dealing with an insurance adjuster who is: (1) unfamiliar with the intricacies of federal jurisdiction; and (2) thinks Medicare is somehow involved and has been told that Medicare must always be reimbursed.

Therefore, it may be in the client and practitioner's best interests to attempt to negotiate the MAO's claim for reimbursement for substantially less than the MAO claims. In the author's experience, MAOs will often negotiate their claims to pennies on the dollar after pointing out the questionable basis for the claim for reimbursement.

subrogation; and (b) there is no diversity jurisdiction concerning your client's subrogation claim.

Some authority provides that MAOs have no private cause of action in federal court against a beneficiary for reimbursement, leaving state law to govern the issue of subrogation. In the *Avandia* decision, the Third Circuit recognized a private cause of action for MAOs in the context of an action against a primary plan who failed to reimburse an MAO, which, practically speaking, provides MAOs with a place at the table at your client's dinner party.

It is not clear from the *Avandia* decision whether this private cause of action may be brought against a plan *beneficiary* and points can be made on both sides of the issue, depending on how one reads *Avandia*. Regardless, even in the Third Circuit, MAOs/PDPs should: (1) be subject to a pro-rata offset for procurement costs of any settlement, just as Medicare is; and (2) comply with any beneficial options Medicare permits, such as the self-calculate or fixed payment options. Finally, MAOs/PDPs may have to exhaust administrative remedies before bringing a federal action. If all else fails, an argument still exists that MAOs/PDPs are subject to equitable allocation per *Bradley.* Otherwise, the forum state's own law should apply to govern the claims of MAOs.

3. *Conclusion: Medicare is Always Invited; Medicare Advantage Plans and Medicare Prescription Drug Plans, Probably Not.*

Medicare always has an invitation to your client's dinner party. Medicare will reduce its lien, however, to share pro-rata in your attorney's fees and expenses, and Medicare may be subject to equitable reduction and allocation principles under the *Bradley* decision.[41]

If the state where the client resides bars subrogation for medical benefits paid out by an insurer; the subrogation amount is less than $75,000.00, and/or there is no complete diversity; then MAOs/PDPs likely have no subrogation rights and no place at

the dinner table against your client's settlement.

In the Third Circuit, the MAOs/PDPs can enter into your client's dinner party through the back door since they have a private cause of action against the primary plan. An experienced adjuster/defense attorney will protect the interest of the MAOs/PDPs and will almost certainly demand that the plaintiff's attorney address any subrogation claims by the MAOs/PDPs. However, the practitioner still has a few arrows in his quiver to reduce the MAOs and PDPs' subrogation claims: (1) the common fund reduction for attorney's fees and expenses as codified at 42 CFR § 411.37; (2) the benefits of Medicare's own streamlining options; and (3) an argument that MAOs and PDPs must exhaust administrative remedies before filing a private action in federal court.

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[1]Although subrogation and liens have different legal meanings, in modern practice, the terms are used interchangeably. In this article, subrogation is used as a term representing any entity seeking to take money from a client's settlement for reimbursement.

[2] O.C.G.A. § 33-24-56.1(Georgia's anti-subrogation statute); *Davis v. Kaiser Foundation*, 271 Ga. 508, 521 S.E.2d 815 (1999).

[3] 42 U.S.C. § 1395y

[4] Id.

[5] 42 U.S.C. § 1395y(b)(2)(A)(ii).

[6] 42 U.S.C. § 195y(b)(2)(B)(i)-(ii).

[7] 42 U.S.C. § 1395y(b)(2)(B)(iii) ; *Zaleppa v. Seiwell*, 9 A.3d 632, 629 n.7 (Pa. Sup. Ct. 2010) (government may pursue personal assets of the beneficiary as well as the beneficiary's attorney and any other entity or person that acted as an intermediary); see, e.g., *United States v. Stricker*, 2010 WL 6599489 (N.D. Ala.) (attorneys and defendant sued by United States for reimbursement of conditional payments).

[8] https://www.cob.cms.hhs.gov/MSPRP/

[9] 42 CFR § 411.37.

[10] See generally, *GEICO v. Capulli*, 859 So. 2d 1115 (Ala. Civ. App. 2002)(describing common fund doctrine in depth).

[11] *Bradley v. Sebelius*, 621 F.3d 1330, 1333-1334 (11th Cir. 2010).

[12] Id.

[13] Id.

[14] See *Hadden v. United States*, 661 F.3d 298 (6th Cir. 2011).

[15] *Id.* at 308-309 (White, J., dissenting). Ironically, since Medicare generally pays health providers at significantly discounted rates, cases where there are limited settlement funds and large Medicare liens are the cases where the primary plan will usually have the greatest incentive to settle due to the presence of catastrophic injury. Further these cases are the ones where Medicare needs reimbursement the most due to having made significant expenditures on a beneficiary's behalf. They are also the most likely to require some sort of equitable apportionment/reduction due to the reality that most insurance policies are simply insufficient to cover catastrophic injuries.

[16] The Supreme Court denied certorari in the *Hadden* case. 2012 WL 1106757.

[17] *Tomlinson v. Landers*, 2009 WL 1117399 (M.D. Fla.) (no meeting of the minds where insurer refused to issue check without Medicare as co-payee); *Zaleppa*, at 9 A.3d at 640 (defendant could not satisfy judgment with check including Medicare as co-payee); *Hearn v. Dollar Rent a Car, Inc.*, 315 Ga.App. 164 (726 S.E.2d 661) (Ga. App., 2012) (no authority for insurer's practice of including Medicare as a co-payee on settlement check).

[18] *Zaleppa*, 9 A.3d at 640.

[19] *Hearn*, 315 Ga. App. at 172.

[20] *Wisinski v. American Commerce Group*, 2011 WL 13744 (N.D. Pa.).

[21] 42 C.F.R. § 422.108**;** 42 CFR § 423.462.

[22] Pub.L. 105–33.

[23] Pub.L. 108–173.

[24] Some question whether the MAOs create any efficiency since they receive billions in taxpayer subsidies each year. See Families USA, *Special Report: Whose Advantage? Billions in Windfall Payments Go to Private Medicare Plans*, June 2007, available at: http://www.familiesusa.org/assets/pdfs/medicare-private-plans.pdf.

[25] Pub.L. 108–173.

[26] 42 U.S.C. § 1395y(b)(2)(B)(i) provides:

The Secretary may make payment under this subchapter with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.

[27] 42 U.S.C. § 1395y(b)(2)(B)(iii) provides in relevant part:

The United States may bring an action against any or all entities that are or were required or responsible […] to make payment […] under a primary plan. The United States may […] collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity.

[28] See, e.g., *United States v. Stricker*, 2010 WL 6599489 (N.D. Ala.).

[29] But see, *Stalley v. Catholic Health Initiatives*, 509 F.3d 517, 524-525 (8th Cir. 2007) ("Section 1395y(b)(3)(A) grants *the Medicare beneficiary* a private right of action for double damages against an insurer or other primary payer that fails to pay the amounts it owes on the insured's behalf" because " the beneficiary can be expected to be more aware than the government of whether other entities may be responsible to pay his expenses […].")(emphasis added).

[30] CMS Memo, *Medicare Secondary Payment Subrogation Rights*, December 5, 2011 http://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/downloads/21_MedicareSecondaryPayment.pdf

[31] *Bradley v. Sebelius*, 621 F.3d at 1338 (citing *Christensen v. Harris County*, 529 U.S. 576, 587 (ordinarily "policy statements, agency manuals, and enforcement guidelines, all of which lack the force of law—do not warrant *Chevron* style deference")).

[32] *Hadden*, 661 F.3d at 307.

[33] See *In re Avandia* 685 F.3d at 364 (noting, "MAOs were intended to enjoy a status parallel to that of traditional Medicare.").

[34] 42 C.F.R. § 411.37.

[35] See generally http://www.msprc.info/ for information concerning these options.

[36] 42 C.F.R. § 422.108(f).

[37] See *Parra v. PacifiCare of Arizona, Inc*., at *7-8 2011 WL 1119736, (D. Ariz.) ("Pacificare fails to recognize that recovery actions taken by the Secretary involve detailed administrative procedures, which are required to be exhausted […]. Practically speaking, this means the Secretary cannot proceed directly to federal court in circumvention of the beneficiary's rights and must issue a final decision before bringing legal action for reimbursement.").

[38] See generally, *The Made Whole Doctrine in All 50 States,* available at: http://www.mwl-law.com/CM/Resources/Made-Whole-in-All--50-States-8-31-09.pdf.

[39] See *Parra*, at *8 (“There being no jurisdiction in this Court for Pacificare’s claim, it must proceed in state court ... for what is essentially a contract claim …”); *Nott v. Aetna U.S. Healthcare, Inc*., No. 03-CV-4044 (E.D. Pa. Jan. 23, 2004)(remanding MAOs claim back to state court for lack of federal jurisdiction).

[40] *Trezza v. Trezza*, 2012 NY Slip Op 9048 (N.Y. App. Div., 2012).

[41] Note that *Bradley*-based arguments for reduction are the practitioner’s “in case of emergency break glass” argument. The author sees *Bradley* based arguments as falling on deaf ears in dealing with Medicare.