Medicare's Lien on Recovery from a Settlement Limited to the Amount Apportioned to Medical Expenses

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Assume an accident victim was taken to the hospital, where he later died. As a result of the incident, Medicare paid $50,000 in medical bills for him. The estate had its claim for medical bills, but his wife and children also suffered their own losses by his death. The tortfeasor then offered to settle all claims by the estate, the widow, and the children for $50,000, the limit of the tortfeasor's liability insurance policy. The tortfeasor has no other assets to support a judgment. Medicare has a right to reimbursement, but the question is, Does Medicare get fully reimbursed the entire $50,000 or is it limited to the portion that represents medical expenses?

In this hypothetical scenario, the importance of the question is immediately evident: if Medicare is fully reimbursed, the family's or the estate's recovery may not be worth pursuing. In this scenario, the victim's family is effectively denied any recovery for their injuries and the estate, too, is no better off after the settlement. With better facts—smaller medical bills, more assets subject to judgment, or both—the outcome would be only marginally less harsh.

The 11th Circuit recently encountered such a situation in *Bradley v. Sebelius*.[4] It held Medicare's reimbursement was limited to the portion of the settlement representing medical expenses.[5]

In *Bradley*, Charles Burke, the decedent, lived in a nursing home for about 18 months before being moved to a hospital. He stayed in the hospital until his death, approximately three months later. During his hospital stay, Medicare paid $38,875.08 in medical expenses on his behalf. Carvondella Bradley, Burke's daughter who served as the personal representative of his estate, sent a demand letter to the nursing home and its liability insurance carrier on behalf of the estate and Burke's ten surviving children, asserting abuse and neglect. The nursing home settled all claims for $52,500—the policy limit of its liability insurance.

Bradley notified the Secretary for Health and Human Services of the settlement and related costs. The Secretary refused to recognize the medical expense claim had been settled for less than full value, however. Bradley then filed an application to adjudicate the rights of the estate and the children regarding the settlement in probate court. Though Medicare was given notice of the suit and its interests were adverse to the children, the Secretary declined to participate. The probate court found that each of the ten children had claims worth $250,000. The claims of each of the ten children plus the estate's claim for medical expenses resulted in the case's valuation at $2,538,875.08. The probate court determined $787.50 of the settlement was attributable to medical expenses.

The Secretary took the position that the probate court's determination was advisory or superceded by federal law and consequently refused to accept the court's decision. Bradley paid Medicare under protest, exhausted administrative appeals and remedies, then appealed to district

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[4] *Bradley v. Sebelius*, 621 F.3d 1330 (11th Cir. 2010).
[5] *Id.* at 1340.

court. The district court, adopting the recommendation of the magistrate judge, decided in favor of the Secretary. Bradley appealed to the 11th Circuit.

The Secretary maintained her position that Medicare was entitled to full reimbursement, relying on provisions in the Medical Secondary Payer (MSP) statute and a statement from one of the Medicare field manuals to support her position. Under the MSP statute, Medicare is a secondary payer of medical expenses, not the primary payer.[6] When Medicare pays medical expenses, it has a right to reimbursement if a primary payer later pays or is found to be responsible for payment.[7] According to the Medicare field manual, allocations between medical expenses and non-medical damages are recognized only if the allocation is based on a court order issued on the merits.[8] And the Secretary maintained that an out-of-court settlement is not an allocation made on the merits, even when a Florida probate court made the allocation. According to her view, the children were required to "chip in" the settlement of their claims until Medicare was fully reimbursed.[9]

Unlike the district court, which relied heavily on the Medicare field manual, the court of appeals declined to defer to the manual in interpreting the MSP statute. Agency interpretations in field manuals are not entitled to the force of law.[10] Without even appearing before the probate court, the Secretary relied on the Medicare field manual to defy the court's decision, "citing no statutory authority, no regulatory authority, and no case law authority . . . ."[11]

After interpreting the MSP statute itself, the court of appeals held Medicare's reimbursement was limited to the apportionment for medical expenses.[12] Under Florida law the claims of the decedent's estate and those of surviving children are separate and distinct.[13] The medical expenses are a claim of the estate; each child's loss of parental companionship claim belongs solely to that child. As the estate has no claim on the settlement for the children's damages, Medicare also has no claim—only the estate's allocated share of the proceeds is subject to the authority of the Secretary.

Some opinions go the other way, and the opposing view is worth some consideration. One contrary case is *Zinman v. Shalala*.[14] Under the MSP statute, Medicare has the ability to take direct action to recover in addition to reimbursement when the beneficiary receives a settlement or collects a judgment.[15] In the *Zinman* court's view, the nature of that direct action determines whether Medicare's recovery is subject to apportionment. The court was too charitable in its Chevron deference, but also found that Medicare's independent right of recovery was not subject to the equitable principle of apportionment and limiting Medicare's subrogation right alone would render the independent right superfluous.[16]

In re Dow Corning[17] examined the reasoning in *Zinman* and found it wanting. The direct action right is subrogatory in nature, and thus subject to equitable principles, including apportionment.[18] The

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[6] 42 U.S.C.A. § 1395y(b)(2).
[7] *Id.* § 1395y(b)(2)(B).
[8] MSP Manual (CMS Pub. 100-05) Chapter 7 Section 50.4.4.
[9] *Bradley*, 621 F.3d at 1333 n.5.
[10] *Id.* at 1338 (quoting United States v. R & F Properties of Lake County, Inc., 433 F.3d 1349, 1357 (11th Cir. 2005) (citing Christensen v. Harris County, 529 U.S. 576, 587 (2000)); citing Shalala v. Guernsey Mem'l Hosp., 514 U.S. 87, 99 (1995)).
[11] *Id.*
[12] *Id.*
[13] *Id.* at 1335.
[14] *Zinman v. Shalala*, 67 F.3d 841 (9th Cir. 1995).
[15] In re Dow Corning Corp., 250 B.R. 298, 342 (Bankr. E.D. Mich. 2000).
[16] Zinman, 67 F.3d at 845.
[17] In re Dow Corning Corp., 250 B.R. 298 (Bankr. E.D. Mich. 2000).
[18] *Id.* at 342.

MSP statute provides the government with a statutory right of recovery, but does not provide a specific cause of action for the government to use in this recovery.[19] If the government has an independent claim, its recovery must therefore come from another source. But no contract or tort cause of action exists that the government may use to recover in this situation because the government is not a party to any contract between victim and tortfeasor nor is the government a victim of the tortious act. Therefore the government's recovery cannot arise from its own independent claim, but instead relies solely on the rights of the beneficiary—Medicare would have to prove everything that the beneficiary would be required to prove under state law in order to recover. In bringing an action itself, Medicare is still stepping into the shoes of the beneficiary. This conclusion is in-line with the Fifth Circuit's decision in *Waters v. Farmers Texas County Mutual Insurance*, in which the court stated that under the subrogation provision or the independent recovery provision, Medicare stood to recover only the beneficiary's share.[20]

The Supreme Court addressed a situation similar to *Bradley* in *Arkansas Department of Health and Human Services v. Ahlborn*.[21] In that case, Heidi Ahlborn suffered brain damage in a car accident and was therefore unable to complete her college education. The Arkansas Department of Health and Human Services (ADHS) paid $215,645.30 of Ahlborn's medical expenses through the state's Medicaid plan. When Ahlborn sued the tortfeasors, ADHS intervened and asserted a lien on the proceeds of any recovery Ahlborn might obtain. Ahlborn and the tortfeasors settled all claims for $550,000.

Ahlborn filed a declaration action in federal district court against ADHS, asserting that the lien violated Medicaid law by depleting her settlement. The parties stipulated the value of all of Ahlborn's claims against the tortfeasors was $3,040,708.12 and that the settlement amount was reasonable. The parties also agreed that if Ahlborn's view of the law applied, then ADHS's portion of the settlement for reimbursement of the medical expenses it paid under Medicaid would be $35,581.47.

The issue was assignment. ADHS argued that Under Arkansas law, Ahlborn automatically assigned her recovery to AHDS for the full amount of the medical expenses paid on her behalf as a condition for eligibility. Based on the Arkansas Supreme Court's ruling in *Arkansas Department of Human Services v. Ferrel*,[22] ADHS believed it had a right to recover not only the amount of a judgment or settlement allocation for medical expenses, but all the medical expenses it paid the recipient.

The Supreme Court rejected ADHS' argument, holding that ADHS could not claim a portion of the settlement outside of the allocation for medical expenses.[23] Under Medicaid, a state may recover from a liable third party only the "legal liability" of the third party for "care and services available under the plan."[24] The liable third party in Ahlborn's case took on legal liability for only 1/6 of the total damages claimed. Of the $550,000 settlement, the share for medical expenses was $35,581.47—the only care and services provided under the plan. The assignment of rights to ADHS extended only to third party liability repayment for medical expenses, not to damages such as inheritance, lost wages, or pain and suffering. Under Medicaid law, a state is assigned "the rights of [the recipient] to payment by any other party for such health care items or services."[25] The language "amount recovered . . . under an assignment" in the statute does not refer to the entire settlement amount.[26] ADHS is assigned the settlement payments designated for medical care. ADHS has priority over the recipient only for "any

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[19] *Id.* at 346.
[20] Waters v. Farmers Tex. County Mut. Ins. Co., 9 F.3d 397, 400 (5th Cir. 1993).
[21] Arkansas Dept. of Health & Human Servs. v. Ahlborn, 547 U.S. 268 (2006).
[22] Arkansas Dept. of Human Servs. v. Ferrel, 984 S.W.2d 807, 811 (Ark. 1999).
[23] *Ahlborn*, 547 U.S. at 292.
[24] *Id.* at 280 (citing 42 U.S.C. § 1396a(a)(25)(A)).
[25] *Id.* at 281 (citing 42 U.S.C. § 1396a(a)(25)(H)).
[26] *Id.* at 282.

damages representing payments for medical care" and cannot require an assignment or place a lien on any portion of the recipient's property outside of the payments for medical care.[27]

Although *Ahlborn* involved Medicaid while *Bradley* involved Medicare, the operation and purpose of the programs are parallel. The Secretary of Health and Human Services has the authority to apply the laws of both programs.[28] Outcomes under each should therefore be comparable unless some specific consideration compels a discrepancy. The different programs are sufficient to distinguish the two fact patterns and prevent *Ahlborn* controlling in Medicare situations, but the fact *Bradley* reaches a similar conclusion under a similar program is strong indication it arrived at the correct rule.

If the holding in the 11th Circuit's opinion in *Bradley* and the Supreme Court's reasoning in the parallel situation in *Ahlborn* are not enough, consider the effect the alternate rule would imply. If Medicare's liens are not limited to the apportionment for medical expenses, then apportionment of settlements will be treated differently than apportionment on the merits, longstanding policy favoring settlement is undermined, and the ultimate cost to Medicare may actually be greater.

Nothing justifies treating settlement apportionments different than on-the-merits determinations. The language of the MSP statute doesn't—even if you disagree with *Bradley*, the court's construction of the statute is a reasonable one. The fear that parties will collude to minimize Medicare's recovery by weighing other claims more heavily doesn't—Medicare may join or intervene in actions against tortfeasors, can bring its own actions against primary payers, and can recover from third parties sums it should have been reimbursed.[29] Little separates a decision on the merits to a court apportioned settlement. Some kind of apportionment is required in these types of cases, and Medicare concedes to being limited to the apportionment for medical expenses in determinations based on the merits. "Administrative convenience and the avoidance of contrived apportionments do not allow the government to take settlement proceeds to which others are entitled."[30]

Undermining pro-settlement policy serves no purpose. Had the Secretary's view prevailed in *Bradley*, Medicare's recovery would not be limited to apportionment for medical expenses where the parties settled, but would be limited to apportionment for medical expenses where determined on the merits.[31] Thus, if an allocation or apportionment for medical expenses were based on the merits, then even if the medical expense allocation were less than the full reimbursement, Medicare would accept that allocation. But then Medicare maintains settlements are not apportionments on the merits, even when apportioned by a court. This scheme would create an incentive to risk court to recover the same, limited amount, merely to get the apportionment considered as being on the merits. This requires greater judicial resources, and for no reason. Going to trial has drawbacks, even with a solid case. Putting a decision into the hands of a jury always involves a certain amount of risk, which means the resulting award may be less than the settlement offer. It may even be no award whatsoever. If the defendant has deep pockets, it is possible the beneficiary wins big enough at trial to make the risk worth taking. But in these cases, when the possible recovery is limited by the policy limits of an insurance policy or otherwise, Medicare's policy imposes greater risk with no gain.

In *Bradley*, the court of appeals noted the settlement allocation, as well as the actions by the estate, were sensible and cost-effective. The fairness of the settlement for the full value of the available insurance was never contested. The court said that the incentive to trial that would be created if the

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[27] *Id.* at 284–85.
[28] *Id.* at 275.
[29] Denekas v. Shalala, 943 F. Supp. 1073, 1080 (S.D. Iowa 1996).
[30] *Id.*
[31] *Bradley, 621 F.3d at 1334 (citing MSP Manual (CMS Pub. 100-05) Chapter 7, § 50.4.4).*

Secretary's view prevailed was contrary to public interest in expeditious resolution of lawsuits through settlement and the law's historical encouragement to settle cases.[32]

Two reasons suggest Medicare would face greater costs under the alternate rule. First, not only would the alternate rule impose greater risk to recovery with no upside, it certainly would impose greater costs in achieving the same, limited recovery. Medicare is required to pay its share of attorney's fees and costs of obtaining the funds.[33] Thus if Medicare's policy encourages a case to go to trial when it otherwise would settle, Medicare will be harmed because their award will be reduced by the fees they are required to pay under the regulations.

Second, in being reimbursed only the apportionment for medical expenses, Medicare benefits from its beneficiaries' efforts to recover without having to expend the resources pursuing its reimbursement independently. In a given case, Medicare would obviously recover more if it were not limited to the apportionment for medical expenses and could reach the entire settlement until fully reimbursed. But if Medicare were not limited to the apportionment for medical expenses, then in cases where medical expenses eclipse the tortfeasor's ability to pay, the beneficiaries know they will recover nothing short of enduring the ordeal of trial. Even when the tortfeasor's ability to pay is somewhat larger than the medical expenses Medicare paid, beneficiaries have to assert the same effort for a marginal recovery. With these prospects, beneficiaries are less likely to bother pursuing recovery at all. In these cases, Medicare is better off recovering a fraction of the available recovery than all of a recovery nobody ever pursues.[34]

Arguments on costs should not obscure Medicare's policy objectives. Perhaps few enough cases would actually not be pursued had the alternative prevailed, or perhaps Medicare has the resources to undertake direct recovery in more cases to offset reimbursement it would otherwise miss out on. The purpose in making Medicare the secondary payer was to reduce the costs of the program.[35] The amendments doing so restricted when Medicare could expend money.[36] Does this indicate Congressional intent to reduce costs by increasing reimbursement? No provision in the MSP clearly and explicitly requires full reimbursement or disallows apportionment upon a settlement of claims.[37] But the MSP does provide provisions for waiver and reduction of Medicare's medical expense reimbursement in an effort to protect that injured beneficiary.[38] In total, this suggests that cost savings were not to be gained through recovery of payouts but by limiting payouts. And full reimbursement deprives beneficiaries and their families needed compensation for their non-medical damages.[39]

In conclusion, Medicare's right to reimbursement from the proceeds of a settlement agreement is limited to the portion of the settlement compensating medical expenses. Although Medicare would like full reimbursement without regard to the apportionment of the settlement, it has no right to other claims, and its own "interpretation" that it does is without legal basis and therefore entitled to no deference. Limiting Medicare's right to reimbursement in the settlement agreement context is consistent with its right to reimbursement in an apportionment on the merits and therefore does not discourage settlement as a means to resolve cases. Limiting Medicare 's right to reimbursement might maximize Medicare's recovery in the long run.

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[32] *Id.* at 1338–39.
[33] 42 C.F.R. § 411.37(a)(1).
[34] [34] In re Zyprexa Products Liab. Litig., 451 F. Supp. 2d 458, 470 (E.D.N.Y. 2006) judgment entered sub nom. In re Zyprexa Products, 2006 WL 2739721 (E.D.N.Y. Sept. 25, 2006) and opinion clarified, 2006 WL 2792767 (E.D.N.Y. Sept. 28, 2006).
[35] *Id.* at 465.
[36] *Id.*
[37] Zinman, 67 F.3d at 845.
[38] *Id.* at 843.
[39] Zyprexa, 541 F. Supp. at 470.