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Huntington M. Willis

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INTRODUCTION

The principle of subrogation¹ of Medicare payments from its beneficiaries is not new, nor is it terribly complex on its face. A brief but common fact situation can be used to illustrate the circumstances to which this Comment attempts to speak. Betty, a sixty-seven-year-old retiree, is driving through an intersection when a large truck runs a stop light and collides with her vehicle. She is immediately taken to the hospital for severe injuries. Over the course of several months, she undergoes the litany of medical treatment that is associated with such trauma. Betty hires an attorney to represent her injury claim against the negligent driver on a standard contingency fee basis. The attorney proceeds to negotiate a settlement, but the extent of Betty's injuries is not yet known, and thus the value of her claim is yet to be determined. In the meantime, she needs care. Because she is an eligible beneficiary, Medicare will pay for her treatment,² and let us assume that she successfully recovers from the liability³ insurance provider. This Comment will not simply highlight Medicare's right to recover its payments when Betty recovers from the liability carrier. Rather, it is the process of that recovery and its evolving impact on the litigation of tortious injuries that calls for comment.

1. Throughout this Comment, the term "subrogation" will be used as a general reference to any right of reimbursement or repayment sought by Medicare or the U.S. Government of its conditional payments to a beneficiary of the Medicare program. The general use of the term should not be construed as to undermine the complex and expansive nature of issues and theory that involve both the legal and equitable principles of subrogation. This Comment focuses narrowly on the topic of Medicare subrogation only. For a general illustration of the theory of subrogation in various contractual relationships, see RESTATEMENT (SECOND) OF CONTRACTS § 310 (2008).

2. We assume, for purposes of this example, no care is administered that would be precluded from coverage pursuant to 42 U.S.C. § 1395y (2006).

3. This Comment uses the term "liability insurance" often to illustrate a standard recovery source from a tortious injury in which a plaintiff recovers from the party at fault. However, this term should not be seen as limiting Medicare's subrogation rights to only liability insurance. 42 U.S.C. § 1395y(b) provides that no-fault insurance, as well as workers' compensation plans, may be just as applicable if they provide the source of recovery.

What responsibilities—whether implied by virtue of representation or by *law*—do plaintiffs’ attorneys have when Medicare wants its money back? What responsibilities do the liability insurance carriers have in such situations? What about the insurance defense counsel? The plaintiff herself? This Comment is canalized towards the steps that Medicare may take to recover what it considers the *conditional*⁴ payments of Betty’s treatment and the developing legal consequences involved in what the author suggests is an inconsistent, if not underdeveloped, realm of law. It will also attempt to showcase examples of subrogation techniques that take the government’s statutory authority to recover payments beyond what was likely intended by Congress. The preceding questions and others will help set the framework for a practical analysis of today’s concept of Medicare subrogation.

I. THE RECOVERY PROCESS—WHO IS VULNERABLE?

Before an analysis of the subrogation process can be made, it is important to identify the contemporary political context of this topic. Since its inception in 1965,⁵ Medicare has been a politically charged issue.⁶ Add to the program’s history the fact that contemporary political debates heavily involve the current amount of debt the United States carries and the potential for default if not contained,⁷ and you have a perfect political storm for pinching the pennies of government. The political environment of the day has thus put Medicare squarely in the crosshairs of spending reductions. What once might have been described as a rather informal recovery process might now seem like an unpredictable obstacle.

A. *What does the current process look like?*

The Centers for Medicare and Medicaid⁸ Services (CMS) and the Department of Health and Human Services (DHHS) have promulgated an

4. Under 42 U.S.C. § 1395y(b)(2)(B)(i), Medicare will make payments for treatment on a conditional basis when it expects reimbursement from what the statute identifies as “primary” plans, as discussed *infra* in greater detail.

5. Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (codified as amended in scattered sections of 42 U.S.C.).

6. See, e.g., THEODORE R. MARMOR, *THE POLITICS OF MEDICARE* (2d ed. 2000).

7. *The Debt Alarm is Heard*, N.Y. TIMES (Jul. 14, 2011), <http://www.nytimes.com/2011/07/15/opinion/15fri1.html>.

8. The Medicare and Medicaid programs are not entirely interchangeable; however, they are close enough to lend to each other a similar analysis with regard to the subrogation process. See *Zurich Am. Ins. Co. v. O’Hara*, 604 F.3d 1232 (11th Cir. 2010). The scope of

enormity of administrative law under Title 42 of the Code of Federal Regulations.⁹ After sifting through the code, a plaintiff's attorney learns how a Medicare-eligible client may dramatically change the process of the injury claim. As soon as he has identified his client as a Medicare beneficiary, the attorney should have alerted the Medicare Coordination of Benefits Contractor (COBC) and the Medicare Secondary Payer Recovery Contractor (MSPRC).¹⁰ CMS is now intimately involved in the progression of the plaintiff's personal injury recovery, well before any form of settlement or judgment has been reached. While the plaintiff undergoes medical treatment and her attorney negotiates with the liability carrier, the federal government—or, in this case, its contractor—is calculating,¹¹ by methods largely unknown,¹² a potential subrogation lien against the plaintiff's recovery.

On its face, this is fairly straightforward. We do not want taxpayers to be responsible for medical bills caused by a negligent driver, nor do we expect an injured plaintiff to receive a windfall from an unfortunate event. However, this creates a problem for the plaintiff's attorney: How does he manage his client's recovery and provide adequate counsel on a net settlement or judgment amount if there is a subrogation lien by Medicare that is floating somewhere in the periphery of the case's resolution?¹³

this Comment is narrowly tailored toward the Medicare program for the sake of specificity and brevity, but the author does include examples of Medicaid subrogation, either by case law or statute, that are relevant to the framework of issues addressed by this Comment.

9. See 42 C.F.R. § 411.24 (2012).

10. For a flow chart provided by MSPRC portraying the standard recovery process, see *Overview of the Recovery Process*, MSPRC, 1 (Nov. 11, 2010), <http://www.msprc.info/processes/nghp%20flowchart.pdf>.

11. See 42 C.F.R. § 411.24(c).

12. 42 C.F.R. § 411.37(c) purports to codify the actual formula used by CMS to calculate the amount of its final demand for reimbursement. This formula, however, fails to show what conditional payments CMS takes into account when making the final determination. See 42 C.F.R. § 411.37(c). The current regulations require the complete disclosure of a settlement or judgment amount to CMS, along with disclosure of the attorney fees and an *itemized* costs list (labeled “procurement costs”). *Id.* However, the beneficiary and her attorney are never given the opportunity to review values that CMS uses to calculate its demand, such as which conditional payments for treatment were attributed to the injury that is covered by the “primary” policy, and which were not. This determination is crucial, because it often speaks to the fundamental proximate cause legal argument that juries take up in injury litigation—that is, whether the defendant's acts (i.e. negligent driving) are attributed to the particular injury.

13. For a concise overview of governmental subrogation liens on personal injury claims, including Medicare, see Erik V. Larson & Diana L. Panian, *Successfully Discharging Medical Liens in Personal Injury Cases*, 32 CUMB. L. REV. 349 (2002).

Unfortunately, one answer may lie in the client hiring more attorneys. One attorney may have to limit representation to resolving the personal injury claim, while the client is forced to hire additional counsel¹⁴ to protect against an action by the federal government to recover any conditional payments. One obvious reason for this may be the standard contingency fee arrangement used in so many injury claims. The resolution of a subrogation lien does not likely lend itself to contingency fee: it “feels” more like an hourly billing matter because the final outcome of the case is not the source of payment for the attorney. A firm that operates exclusively on contingency arrangements would thus be forced to burden the client with hiring additional counsel for the lien resolution.

B. Not Just the Plaintiff's Problem

Examples and circumstances described thus far have largely spoken to problems encountered by the plaintiff or her attorney in dealing with Medicare subrogation claims. However, a close reading of the applicable regulations reveals that CMS may opt to recover its conditional payment not from the beneficiary or his attorney at all.¹⁵ 42 C.F.R. § 411.24(i) provides in part as follows:

(i) Special rules.

(1) In the case of liability insurance settlements and disputed claims under employer group health plans, workers' compensation insurance or plan, and no-fault insurance, the following rule applies: *If Medicare is not reimbursed as required by paragraph (h) of this section, the primary payer must reimburse Medicare even though it has already reimbursed the beneficiary or other party.*

(2) The provisions of paragraph (i)(1) of this section also apply if a primary payer makes its payment to an entity other than Medicare when it is, or should be, aware that Medicare has made a conditional primary payment.¹⁶

14. Law firms have been representing the insurance industry's subrogation efforts under various legal avenues for some time. See ERISA laws discussed *infra*. However, it may come as a surprise to some plaintiff's attorneys that a trending practice has become subrogation representation on behalf of the injured *plaintiff*. For an example of one such firm that touts its particular approach to such legal representation, see *Healthcare Lien Resolution*, GARRETSON RESOLUTION GRP., <http://www.garretsongroup.com/services/Pages/Healthcare-Lien-Resolution.aspx> (last visited Oct. 30, 2012) (“Attorneys’ need for a trusted healthcare lien resolution service partner is more apparent now than ever before.”).

15. See 42 C.F.R. § 411.24(i).

16. 42 C.F.R. § 411.24(i)(1)–(2) (emphasis added).

Consider what the above regulation provides under our opening example. If Betty recovers the policy limits of the liability plan that insured the defendant in her claim, and fails to reimburse Medicare for her treatment as provided by regulation, Medicare may recover its conditional payments from the insurance company that has already paid out on its claim. The potential for the liability carrier to sustain this type of “double loss” may trigger unwelcome defensive posturing by insurance companies when processing settlements. Consider an example: defense counsel mails the settlement proceeds to plaintiff’s attorney, but the check is made out to the plaintiff, the plaintiff’s attorney, and *Medicare*. By doing this, defense counsel is probably preventing Medicare from returning in the future to claim their right of reimbursement because defense counsel can now point to the fact that his payment included Medicare on the check. The insurance company is, understandably, seeking to create a safety net. However, this type of defensive posturing is disproportionately detrimental to the injured claimant and her attorney. Practically speaking, where does one find someone within the Medicare machine to endorse the check so that proceeds may be disbursed? Does accepting such a check mean that the plaintiff has assured any future subrogation efforts will be directed at her? Such a defensive method of settling claims would likely have the effect of shifting the risk of future subrogation action to the plaintiff’s attorney, rendering 42 C.F.R. § 411.24(i) ineffective as a governmental enforcement tool. Further, as one author suggests,¹⁷ it may even have the effect of plaintiffs’ attorneys declining to represent injured Medicare beneficiaries because of that risk.

Additionally, the plaintiff’s attorney is not the only party to this process with an interest in her client’s Medicare eligibility from the beginning. The failure of the “primary” plan—the defendant’s liability insurance carrier in our example—from reporting and disclosing certain mandatory information as required by statute¹⁸ will carry with it a substantial penalty.¹⁹ At a glance, it would seem as if the statute were

17. Rick Swedloff, *Can’t Settle, Can’t Sue: How Congress Stole Tort Remedies From Medicare Beneficiaries*, 41 AKRON L. REV. 557, 599 (2008).

18. 42 U.S.C. § 1395y(b)(8) (2006).

19. See Medicare, Medicaid, and SCHIP Extension Act of 2007, Pub. L. No. 110-173, § 111, 121 Stat. 2492 (codified as amended at 42 U.S.C. § 1395y(b)(8)(B) (2006)) (requiring disclosure of “the identity of the claimant for which the determination under subparagraph (A) was made; and . . . such other information as the Secretary shall specify in order to enable the Secretary to make an appropriate determination concerning coordination of benefits, including any applicable recovery claim”). Failure to comply with this reporting

written to balance the consequences of non-disclosure between the injured beneficiary and the primary policyholder. Further review, however, shows that this balancing attempt actually shifts the greatest weight to the back of the plaintiff in the form of an inability to settle her claim with the liability carrier.²⁰

II. ACTIONS FOR SUBROGATION—A REVIEW OF MODERN CASE LAW

A. ERISA Subrogation Distinguished

Attorneys practicing in personal injury and similar tort litigation will likely state with confidence their understanding of the concept of the subrogation of liability proceeds by non-governmental, secondary insurance policies, due to the decades of litigation surrounding rights first codified under the Employee Retirement Income Security Act (ERISA) of 1974.²¹ Dual-wielding the swords of the federal taxing power²² and the Commerce Clause,²³ Congress enacted sweeping reforms and regulation to employee benefits plans. Among the relevant reforms was a right of enforcement vested in, among other entities, a plan fiduciary to bring an action for subrogation to enforce the plan's right to recoup payments if a beneficiary recovers the cost of her medical bills from a third party.²⁴ For an easy example, let us make a few modifications to our original plaintiff. Suppose we change her age to thirty-five and use the same facts surrounding her injury, but instead of Medicare providing interim coverage until she recovers, a private health insurer provides coverage. If the private health insurer is considered a plan governed by ERISA, they will have, as a fiduciary to the plan, a right to recover their payments when the plaintiff recovers from the liability carrier.²⁵

requirement imposes a \$1,000 per day fine on the insurance carrier. 42 U.S.C. § 1395y(b)(8)(E).

20. Swedloff, *supra* note 17, at 588–92 (discussing with detailed formulae the economic incentives for settlement on either side of the adversarial system when a Medicare lien is asserted).

21. Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, 88 Stat. 829 (codified as amended at 29 U.S.C. §§ 1001–1461 (2006)).

22. U.S. CONST. art. I, § 8, cl. 1.

23. U.S. CONST. art. I, § 8, cl. 3.

24. 29 U.S.C. § 1132(a)(3) (2006); *see also* Martin H. Drake, *Zurich Am. Ins. Co. v. O'Hara: Application of the Federal Common Law "Make-Whole Doctrine" to Preclude the Effect of Reimbursement and Subrogation Provisions in Health Benefit Plans*, 34 AM. J. TRIAL ADVOC. 227, 227 (2010).

25. *See* 29 U.S.C. § 1132(a)(3).

As the American Journal of Trial Advocacy notes in a recent article,²⁶ the leading case upholding such an action to subrogate on behalf of a plan fiduciary is *Zurich American Insurance Company v. O'Hara*.²⁷ In *Zurich*, a catastrophically injured plaintiff (O'Hara) recovered a substantial monetary amount from a defendant driver's liability insurance carrier.²⁸ Following the recovery, the plaintiff's ERISA-governed group health plan brought an action to recover its payments for its beneficiary's medical care.²⁹ Although the case turns largely on an application of the "make-whole" doctrine to an ERISA-governed plan's right to subrogate,³⁰ the holding brings into focus a distinction between ERISA subrogation and the current process used by CMS—that is, each independent ERISA plan's right to seek reimbursement is governed by its own language.³¹ Although ERISA gives plan providers the authority to compel reimbursement, it is contractual obligations that provide for the process.³² While this may provide for an unfair outcome, or at least one "sympathetic" to the plaintiff with regard to recovery,³³ the plan itself will at least provide controlling language that allows the plaintiff's attorney (and the liability carrier, for that matter) to posture accordingly during settlement negotiations.

B. Ahlborn: A Model Example of Subrogation Issues From Settlement Proceeds

In 2006, the Supreme Court of the United States brought the contemporary concerns of various subrogation tactics to national attention with its decision in *Arkansas Department of Health and Human Services v. Ahlborn*.³⁴ In *Ahlborn*, a nineteen-year-old college student suffered permanent brain damage and other catastrophic injuries from an automobile collision.³⁵ While her attorney pursued a recovery from potential tortfeasors, her financial status made her eligible for the state's applicable

26. See Drake, *supra* note 24.

27. *Zurich Am. Ins. Co. v. O'Hara*, 604 F.3d 1232 (11th Cir. 2010).

28. *Id.* at 1234.

29. *Id.* at 1235.

30. See *id.* at 1236.

31. See *id.* at 1237.

32. *Id.*

33. See *id.* at 1237–38 (noting that, while finding a measure of sympathy for the plaintiff, the enforcement of reimbursement language in ERISA-backed plans produces a cost-benefit for all beneficiaries).

34. *Ark. Dep't of Health & Human Servs. v. Ahlborn*, 547 U.S. 268 (2006).

35. *Id.* at 272–73.

Medicaid plan,³⁶ which began to pay for substantial medical treatment during her recovery.³⁷ Ultimately, Ahlborn's attorneys reached a gross settlement agreement totaling \$550,000.³⁸ However, unlike jury verdicts, in which an allocation of damages is likely to solve the issue (i.e., the jury attributes X amount of the total damages award to pain and suffering, Y amount of the total damages award to medical bills, etc.), a gross settlement figure is simply one number. Thus the court asks—when the Arkansas Department of Health and Human Services (ADHS), the state agency that administered the applicable Medicaid program, comes looking to recoup payment for its \$215,000 worth of medical bills, is it permitted to a full recoupment from a gross settlement that did not distinguish as to what amount of that settlement was attributed to Ms. Ahlborn's damages from medical bills? In a unanimous decision, the Court said “no.”³⁹

As a matter of judicial economy, cost effectiveness, and an emotional amelioration on clients, settlement is often preferred to a complete judicial resolution on the merits of any given claim.⁴⁰ In light of that principle, it becomes clear why Ms. Ahlborn and others may be so substantially burdened by these subrogation techniques. Justice Stevens, writing for the Court, states it eloquently: “For just as there are risks in underestimating the value of readily calculable damages in settlement negotiations, so also is there a countervailing concern that *a rule of absolute priority* might preclude settlement in a large number of cases, and be unfair to the recipient in others.”⁴¹ Thus, in interpreting federal Medicaid law authorizing the ADHS to recoup its conditional payments, the Court limited that recovery to the proportion of the value of Ms. Ahlborn's claim that could be attributed to medical costs, not a *cart blanche* subrogation of her gross settlement.⁴²

While *Ahlborn* involves a Medicaid subrogation claim, the holding is instructive because it highlights the very same problem that CMS and MSPRC have created in Medicare liens regarding the settlement process.

36. While it is true that Medicaid is supported by federal *and* state funds and administered by state agencies, where Medicare, by contrast, is a federal program administered by a federal agency, *Hadden v. United States*, No. 1:08-CV-10, 2009 U.S. Dist. LEXIS 69383, at *9–10 (W.D. Ky. Aug. 6, 2009), plaintiffs' advocates have still argued *Ahlborn* in the Medicare context. *See, e.g., id.*

37. *Ahlborn*, 547 U.S. at 273.

38. *Id.* at 274.

39. *Id.* at 275, 292.

40. *See, e.g., Bradley v. Sebelius*, 621 F.3d 1330, 1339 (11th Cir. 2010).

41. *Ahlborn*, 547 U.S. at 288 (emphasis added).

42. *Id.* at 292.

Defense counsel is not likely to offer an “itemized” settlement, and plaintiff’s counsel is not likely to accept one, because it may cause substantial issues regarding the plaintiff’s release.⁴³

Trial courts, however, have been hesitant to find *Ahlborn*’s holding directly applicable to Medicare claims.⁴⁴ In fact, some courts have construed *Ahlborn* narrowly even in the Medicaid context, as a United States District Court demonstrated in *Tristani v. Richman*.⁴⁵ There, the trial judge permitted a state subrogation provision to allocate the settlement provisions of a claim that was *not* allocated by the parties,⁴⁶ effectively superseding the more equitable approach to non-allocated settlements exemplified by *Ahlborn*.⁴⁷

C. *Subrogation Tactics and the Search for a Trend—The Courts of Appeals Weigh In*

Two leading United States Court of Appeals cases demonstrate the government’s aggressively evolving approach to subrogation of Medicare payments. In *Thompson v. Goetzmann*,⁴⁸ the Fifth Circuit, in the first federal appellate review of the government’s subrogation action against a Medicare beneficiary,⁴⁹ prevented what would likely have been a harsh, if not erroneous, interpretation of the Medicare Secondary Payer (MSP) provisions regarding “self-insured” plans. In *Thompson*, a Medicare beneficiary had settled a products liability claim with the manufacturer of a hip prosthetic.⁵⁰ In an “all of the above” approach, DHHS brought an action against the Medicare beneficiary, her attorney, *and* the manufacturer

43. Defense counsel will protect his client’s future exposure by requiring plaintiff to sign a “release of all claims.” Thus, any type of itemized settlement agreement would still make future claims against defendant possible if the injury had not been discovered at the time of settlement.

44. See, e.g., *Hadden v. United States*, No. 1:08-CV-10, 2009 U.S. Dist. LEXIS 69383, at *9–10 (W.D. Ky. Aug. 6, 2009).

45. *Tristani v. Richman*, 609 F. Supp. 2d 423 (W.D. Pa. 2009), *aff’d in part, vacated in part*, *Tristani ex rel. Karnes v. Richman*, 652 F.3d 360 (3d Cir. 2011).

46. *Id.* at 464–66.

47. See *id.* at 465–66. Pennsylvania law also precluded the settling-plaintiff from later making a showing that such a settlement did not fully compensate, or “make whole,” the plaintiff, or that her injuries were worth more than the settlement amount. *Id.*

48. *Thompson v. Goetzmann*, 337 F.3d 489 (5th Cir. 2003).

49. *Id.* at 494 (“We are the first appellate court to address the issue of an alleged tortfeasor’s reimbursement liability under the MSP [Medicare Secondary Payer] statute.”).

50. *Id.* at 493.

of the prosthetic that paid the settlement.⁵¹ As noted above, the MSP statute authorizes the government to recover any conditional payment from what it deems “self-insured” plans, as well as general liability policy coverage.⁵² However, in *Thompson*, the government asked the court to take that provision to its extreme, effectively applying a right of subrogation against *any* settlement or judgment simply by identifying the manufacturer of the hip prosthetic as a self-insured entity.⁵³ Because the designation of a self-insured entity “does not exist in a vacuum within the MSP statute,”⁵⁴ the court notes that the statute is clear on its face—a self-insured entity is one that would constitute a primary plan as defined by the statute’s language,⁵⁵ and a Medicare beneficiary’s settlement with a tortfeasor does not vest in the government a sweeping, unchecked power to subrogate.⁵⁶

As the *Thompson* court states, the relevant MSP rights of recovery are narrowly tailored to plans, not to a broad category of “tortfeasors.”⁵⁷ If Plaintiff A, a Medicare beneficiary, sues and recovers a settlement or judgment from Defendants B and C for her injuries, all parties to this litigation would become potential defendants to the government’s action under a theory that Defendant B and C’s failure to insure themselves still designates them as self-insured. But it is Plaintiff A who suffers the most, because it is, after all, her compensation that is at stake. Her status as a Medicare beneficiary alone, and not the fact that the defendant tortfeasors were covered by a primary plan, would have exposed her recovery to the government’s subrogation efforts. This “full house” approach to naming any and all parties to the initial tort litigation as defendants may again obfuscate the injured plaintiff’s chances of settlement, because all tortfeasors of Medicare beneficiaries would now have a second lawsuit waiting for them in the wings.

Seven years after *Thompson*, the Eleventh Circuit decided *Bradley v. Sebelius*.⁵⁸ In *Bradley*, the plaintiffs were the survivors of a deceased Medicare beneficiary who died in the care of a negligent nursing home.⁵⁹

51. *Id.* at 493–94.

52. 42 U.S.C. § 1395y(b)(2)(A)(ii) (2006).

53. *Thompson*, 337 F.3d at 495.

54. *Id.* at 497.

55. *See, e.g.*, 42 U.S.C. § 1395y(b)(2)(A)(ii) (specifying workers’ compensation plans, automobile or other liability insurance policies (including self-insured plans), and no-fault insurance policies).

56. *See Thompson*, 337 F.3d at 498, 503–04.

57. *Id.* at 499.

58. *Bradley v. Sebelius*, 621 F.3d 1330 (11th Cir. 2010).

59. *Id.* at 1332.

The decedent's survivors settled with the defendant nursing home for the liability policy limits.⁶⁰ As a precautionary measure, the survivors asked the local probate court to determine what, if any, amount it owed Medicare from the settlement.⁶¹ Medicare asserted a subrogation lien against the survivor's recovery under a strict interpretation of administrative field manuals.⁶² A fundamental issue the *Bradley* court points to is the fact that the government is attempting to recoup payments from survivors who are entitled to damages by law that consist of, among other things, mental pain and suffering and emotional loss.⁶³ The beneficiary's decedents were collecting from a liability insurance policy that compensated them for the negligent loss of their father under state wrongful death law, not for medical bills or other special damages.⁶⁴ As the court explains: "Nowhere in the definition of primary plan are listed 'surviving children with tort property beneficiary rights.'"⁶⁵

In pursuing this lien, CMS and DHHS again seem to insist that no allocation of settlement funds would be adhered to unless the survivors pursued a case to judgment.⁶⁶ Again, the court invokes a concern all too parallel to that of Justice Stevens' opinion in *Ahlborn*⁶⁷ when it notes: "The Secretary's position would have a chilling effect on settlement. The Secretary's position compels plaintiffs to force their tort claims to trial, burdening the court system. It is a financial disincentive to accept otherwise reasonable settlement offers. It would allow tortfeasors to escape responsibility."⁶⁸ It is substantial in itself that a beneficiary must exhaust all available administrative remedies before challenging an action by CMS to subrogate in federal court.⁶⁹ A holding for the government in *Bradley*

60. *Id.*

61. *Id.* at 1337–38.

62. *Id.* at 1338. The government asserted that Medicare field manuals should be given the authority and force of law. *Id.* The court rejected these manuals as controlling authority, citing substantial case law holding to the contrary. *Id.* (citing *United States ex rel. Walker v. R & F Props. of Lake Cnty., Inc.*, 433 F.3d 1349, 1357 (11th Cir. 2005)).

63. *See Bradley*, 621 F.3d at 1337; FLA. STAT. §§ 768.16–768.23 (2003).

64. *Bradley*, 621 F.3d at 1337.

65. *Id.*

66. *See id.* at 1339.

67. *Ark. Dep't of Health & Human Servs. v. Ahlborn*, 547 U.S. 268, 288 (2006).

68. *Bradley*, 621 F.3d at 1339.

69. *See Braucher v. Swagat Grp., LLC*, No. 07-CV-3253, 2011 U.S. Dist. LEXIS 21190, at *6 (C.D. Ill. Mar. 3, 2011) (dismissing plaintiff's action to adjudicate a Medicare lien because the court lacked jurisdiction "to review MSPRC's claim for part of the Fund except through judicial review of the final administrative decision").

would move the starting line for a Medicare beneficiary's challenge miles yet down the road.

D. The Front Lines—How Trial Courts are Shaping Medicare Subrogation

As Supreme Court Justice Antonin Scalia once said in a prominent constitutional debate with Justice Stephen Breyer, a trial judge can often resolve a case with a discretion that no other level of the judiciary enjoys.⁷⁰ And thus, with so little appellate authority—like *Thompson* and *Bradley*—to draw on, the district courts are largely breaking ground on the emerging issues regarding the government's actions to recover Medicare payments. A sampling of recent district court opinions will showcase the need for more authority on this subject.

As previously noted, the *Ahlborn* case sought review of similar subrogation issues involving the Medicaid program.⁷¹ One district court ruling involving Medicare, giving perhaps much credence to Justice Scalia's conclusion above, refused to find any such similarity.⁷² In *Hadden v. United States*, the injured plaintiff argued the equitable language of *Ahlborn* as persuasive precedent after Medicare asserted a lien of almost one-half of his settlement.⁷³ The Court dismissed the *Ahlborn* comparison without applying any principles of special damages allocation.⁷⁴ In fact, it appears the ruling was inconsistent with at least some of the language in *Bradley* only one year later.⁷⁵

Consider how one district court dealt with what might be described as the most typical piece of ammunition used in motions for summary judgment at trial—the statute of limitations. A close reading of 42 U.S.C. § 1395 *et seq.* will show that Congress, whether intentionally or not, failed to

70. The Federalist Society for Law and Public Policy Studies, *A Conversation on the Constitution—Part 1*, YOUTUBE (Oct. 23, 2009), http://www.youtube.com/watch?v=-oIBM02Lw7w&feature=list_related&playnext=1&list=SPDA5818F20281BBB2.

71. See *Ahlborn*, 547 U.S. 268.

72. *Hadden v. United States*, No. 1:08-CV-10, 2009 U.S. Dist. LEXIS 69383, at *9–10 (W.D. Ky. Aug. 6, 2009).

73. *Id.*

74. *Id.* Notably, the court distinguishes Medicare from Medicaid by contrasting the agencies that run the programs as “federal” and “state,” yet acknowledges that Medicaid is still governed “within the confines of federal parameters.” *Id.*

75. Contrary to the *Bradley* court's deference to the judicially economic process of settlement, the court in *Hadden* states, “had plaintiff wanted equitable allocation and subrogation principles to apply in this case, then he should have proceeded to trial on the merits of his tort claim in state court.” *Id.* at *18.

include a statute of limitations for the government's subrogation actions pursuant to the MSP's grant of authority.⁷⁶ It was precisely this problem the court faced in *United States v. Stricker*.⁷⁷ *Stricker* arose out of the government's action to recoup payments stemming from a massive class action settlement against defendant chemical companies that yielded some \$300 million worth of payments to at least some alleged Medicare beneficiaries.⁷⁸ Perhaps because the class action involved thousands of plaintiffs, the government named only the plaintiffs' attorney and the chemical companies as defendants when it brought its action to subrogate.⁷⁹ Because of a complete absence of an applicable statute of limitations within 42 U.S.C. § 1395, the court applied provisions of the Federal Claims Collection Act (FCCA),⁸⁰ and for the first time distinguished between the government's actions against an attorney and those against a corporate third-party tortfeasor.⁸¹ Subsequent holdings have yet to disagree with *Stricker's* conclusions regarding the applicable statute of limitations pertaining to subrogation actions under the MSP.

A very recent district court case regarding Medicare subrogation tactics may showcase an escalation of the government's approach to the issue. As recently as May 2011, the United States District Court for the District of Arizona, in *Haro v. Sebelius*,⁸² dismissed the government's cause of action pending the plaintiff's appeal to CMS, even noting the use of what plaintiff's counsel deemed questionable tactics by the government to expedite recovery of its payments.⁸³ The plaintiffs in *Haro* sought an administrative appeal of Medicare's demand amount under CMS's own appeals policy⁸⁴ as prescribed in Title 42 of the Code of Federal

76. See 42 U.S.C. §§ 1395 to 1395b-10 (2006).

77. *United States v. Stricker*, No. CV 09-BE-2423-E, 2010 WL 6599489 (N.D. Ala. Sept. 30, 2010).

78. *Id.* at *2.

79. See *id.* at *2-3.

80. 28 U.S.C. § 2415 (2006).

81. *Stricker*, 2010 WL 6599489, at *6-12. An action to subrogate against a beneficiary's attorney will attach to a six-year statute of limitations. *Id.* at *9. An attorney's contractual relationship with his injured client is what gives rise to his involvement in a potential subrogation action by the government, and the relevant portions of the FCCA apply a six-year statute to those actions sounding in contract. *Id.* at *9. Conversely, as to a corporate tortfeasor, because it is that defendant's alleged tort on the beneficiary that gives rise to his status as a potential defendant in the subrogation action, the relevant FCCA tort statute of limitations of three years is applied. *Id.* at *8.

82. *Haro v. Sebelius*, 789 F. Supp. 2d 1179 (D. Ariz. 2011).

83. *Id.* at 1182.

84. *Id.* at 1180.

Regulations.⁸⁵ CMS sought to collect, however, before plaintiffs had exhausted their rights to appeal the demand, and even employed what plaintiffs' counsel described as "the use of scare tactics accompanying its pre-decisional reimbursement demands, such as: imposition of exorbitant interest on unpaid claims; threats of cessation of the beneficiary's Social Security or Railroad Retirement payments, and collection referrals to several federal law enforcement agencies."⁸⁶

Further, the government demanded that the beneficiary "must" satisfy the lien before any settlement disbursements would be made.⁸⁷ The court also points out that the government confused beneficiaries when it implied that they had no recourse to challenge the lien.⁸⁸ It is unclear why the government would alter standard demand language⁸⁹ by implying that a beneficiary had no recourse but to comply with Medicare's demand. This case demonstrates both confusion and inconsistency within the agency. CMS's actions against its beneficiaries ought to present uniformity and fairness.

Still, not all trial courts are as deferential to the beneficiary's cause as *Haro* and others have been. In *Benson v. Sebelius*,⁹⁰ decided only two months prior to *Haro*, the court upheld a Medicare lien of some \$40,000 worth of payments against a \$90,000 wrongful death settlement.⁹¹ The *Benson* court distinguished *Bradley* from the facts before it by assuming that because the plaintiff signed a release that included medical liens against the defendant, this language somehow affirmatively demonstrated the plaintiff did in fact recover medical damages.⁹² The court presumes to know what the parties "contemplated" during settlement negotiations simply by reading a sentence from the release documents.⁹³ Again, this

85. See 42 C.F.R. § 405.942(a) (2012).

86. *Haro*, 789 F. Supp. 2d at 1182.

87. *Id.*

88. *Id.* at 1183.

89. *Id.* This was evinced when the court points out that DHHS "changed the demand for immediate payment from 'must pay' to 'should pay' . . . and fails to include language explaining that filing an appeal or waiver will suspend collection activities until agency review results in a final determination." *Id.*

90. *Benson v. Sebelius*, 771 F. Supp. 2d 68 (D.D.C. 2011).

91. *Id.* at 69–70.

92. *Id.* at 75.

93. *Id.* Indeed, it is difficult to imagine a release that defense counsel would approve that did not release her client from exposure to potential medical liens, regardless of the source.

type of subjective standard is not consistent, nor could it be said to benefit either party's efforts during settlement negotiations.

Even in those trial court decisions where the Medicare beneficiary has “lost,” the seemingly inequitable result placed on the injured beneficiary is not lost on the courts. Judge Russell's sympathetic tone for the plaintiff in *Hadden* is demonstrative:

Nonetheless, the Court is not unsympathetic to the dilemma facing Plaintiff and his counsel. . . . While CMS essentially receives free representation for the collection of its claim and no offset for a fault allocation, Plaintiff must pay attorney's fees and costs for a settlement he perceived to be based on an exposure or fault allocation by the settling defendant.⁹⁴

CONCLUSION

It does not take much stretch of the imagination to understand why a Medicare beneficiary should pay the government back when a primary policy covers her medical costs flowing from a tortious injury. In an effort to redress taxpayer grievances by minimizing excessive government expenditures and to contemporaneously prevent a beneficiary from receiving a “windfall” from her Medicare eligibility status, Congress, in good faith, enacted the relevant recovery portions of the Medicare Secondary Payer Act. However, in doing so, it may have created a “windfall” of its own. As the court noted in *Hadden*, an injured Medicare beneficiary negotiates a settlement for two parties now—herself and the government.⁹⁵ The government receives essentially free representation by the injured beneficiary's attorney, while at the same time eyes that very beneficiary and her attorney as potential defendants, should the government bring suit. Meanwhile, despite the Supreme Court's holding in *Ahlborn*, principles of equitable allocation seem to be rejected by both CMS and the courts. Medicare will claim to reduce its lien when considering the beneficiary's case costs and attorney fees, but is less forthcoming about how it calculates that lien in the first place with regard to each particular medical treatment.

CMS's current subrogation efforts can and do burden the settlement process for injured Medicare beneficiaries, and may burden the court system with unneeded adjudication for approval of reimbursement demands, as well as claims that would have otherwise settled. Medicare

94. *Hadden v. United States*, No. 1:08-CV-10, 2009 U.S. Dist. LEXIS 69383, at *19–20 (W.D. Ky. Aug. 6, 2009).

95. *Id.*

plaintiffs are in the dark as to net settlement amounts before disbursement because of the inability of CMS to provide demands for reimbursement timely or predictably.

Plaintiffs and defendants in tort litigation are turning to the court system to fill the holes of an administrative effort that lacks uniformity, resulting in sporadic and sometimes even misguided applications of the government's subrogation authority. The concerns highlighted herein appear to be getting at least some attention. On June 22, 2011, the House Energy and Commerce Committee held a hearing on precisely these issues, noting in its opening statement the inefficiency of the current process.⁹⁶ It appears that, to at least some extent, these concerns are being discussed in Washington.⁹⁷ But without much needed clarification by Congress, the equitable rights of Medicare beneficiaries will remain the subject of many disputes between governmental agencies, insurance companies, and plaintiffs' attorneys alike. And without more predictability and stability in recovery actions by the Medicare Secondary Payer Recovery Contractor, the courts will continue to be forced to resolve subrogation disputes by filling in the gaps left by Congress.

Huntington M. Willis

96. *Protecting Medicare with Improvements to the Secondary Payer Regime: Hearing Before the Subcomm. on Oversight and Investigations of the H. Comm. on Energy & Commerce*, 112th Cong. 1–3 (2011) (statement of Rep. Stearns, Chairman, S. Comm. on Oversight and Investigations).

97. *See id.*