No. 11-1197

In the Supreme Court of the United States

VERNON HADDEN, PETITIONER

v.

UNITED STATES OF AMERICA

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF FOR THE UNITED STATES IN OPPOSITION

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QUESTION PRESENTED

When a Medicare beneficiary receives payment from another source for medical items or services for which Medicare had paid, the beneficiary must reimburse the government. 42 U.S.C. 1395y(b)(2)(B)(ii). Petitioner, a Medicare beneficiary and the victim of a traffic accident, settled his claims against the only identified tortfeasor for a lump sum amount in excess of the costs incurred by Medicare on his behalf. The question presented is:

Whether petitioner may limit his Medicare repayment obligation to a fraction of the costs incurred because he allegedly has additional potential claims against an unidentified motorist.

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OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-21a) is reported at 661 F.3d 298. The opinion of the district court (Pet. App. 22a-37a) is not published in the *Federal Supplement* but is available at 2009 WL 2423114.

JURISDICTION

The judgment of the court of appeals was entered on November 21, 2011. The petition for rehearing was denied on January 4, 2012 (Pet. App. 38a-39a). The petition for a writ of certiorari was filed on March 30, 2012. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

1. The Medicare Secondary Payer (MSP) provisions, 42 U.S.C. 1395y(b)(2), were first enacted in 1980 to re-

duce the Medicare program's rising costs. H.R. Rep. No. 1167, 96th Cong., 2d Sess. 352 (1980); *Zinman* v. *Shalala*, 67 F.3d 841, 845 (9th Cir. 1995). The MSP provisions make the Medicare program secondary to insurance plans that cover the costs Medicare would otherwise absorb. *Stalley* v. *Methodist Healthcare*, 517 F.3d 911, 915 (6th Cir. 2008), cert. denied, 555 U.S. 1137 (2009). They were designed to lower overall federal Medicare disbursements by requiring Medicare beneficiaries to exhaust all available insurance coverage before resorting to their Medicare coverage. *United States* v. *Rhode Island Insurers' Insolvency Fund*, 80 F.3d 616, 618 (1st Cir. 1996); see *Evanston Hosp.* v. *Hauck*, 1 F.3d 540, 544 (7th Cir. 1993) (MSP provisions are "intended to keep the government from paying a medical bill where it is clear an insurance company will pay instead."), cert. denied, 510 U.S. 1091 (1994).

Toward that end, the MSP provisions prohibit Medicare from paying for a beneficiary's medical expenses when payment has been made, or can reasonably be expected to be made promptly, by a liability insurance policy or plan. 42 U.S.C. 1395y(b)(2)(A)(ii). In order to accommodate beneficiaries, however, Congress authorized Medicare to make such payments if a "primary plan" cannot reasonably be expected to make a payment or to pay promptly. 42 U.S.C. 1395y(b)(2)(B)(i)-(ii); *Cochran* v. *United States Health Care Fin. Admin.*, 291 F.3d 775, 777 (11th Cir. 2002). (As relevant here, a "primary plan" includes "an automobile or liability insurance policy or plan (including a self-insured plan) or no fault insurance." 42 U.S.C. 1395y(b)(2)(A).) In those circumstances, the Medicare payments are conditional only and must be reimbursed if it turns out that a primary plan is respon-

sible for paying for those medical expenses. 42 U.S.C. 1395y(b)(2)(B)(i)-(ii). Under the MSP provisions as amended in 2003, a primary plan's responsibility is demonstrated through "a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means." 42 U.S.C. 1395y(b)(2)(B)(ii); see 42 C.F.R. 411.22. Once a primary plan's responsibility has been established, any "entity that receives payment from [the] primary plan" is also required to reimburse Medicare. 42 U.S.C. 1395y(b)(2)(B)(ii).

The implementing regulations provide that if a Medicare beneficiary receives a favorable judgment or settlement, and the Medicare payments are less than that judgment or settlement amount, Medicare is entitled to reimbursement of the conditional payments made minus an allowance for the costs of procuring the judgment or settlement. See 42 C.F.R. 411.37(c); see also 42 C.F.R. 411.24(c) (providing that Medicare is entitled to recover "the lesser of * * * [t]he amount of the Medicare primary payment" or "[t]he full primary payment amount that the primary payer is obligated to pay"). The Secretary of Health and Human Services (Secretary) has long interpreted the statute and regulations to provide that, in the context of a settlement that resolves both medical-expense claims and other claims (*e.g.*, pain and suffering), the entire settlement amount is available to reimburse Medicare for its conditional outlays. See Centers for Medicare & Medicaid Services, Medicare Secondary Payer Manual (MSP Manual), ch. 7, § 50.4.4 (2003) (Pet. App. 46a); see also MSP Manual, ch. 7, § 50.1 (2005)

("[R]egardless of how amounts may be designated in a liability award or settlement, e.g., loss of consortium, special damages or pain and suffering, Medicare is entitled to be reimbursed for its payments from the proceeds of the award or settlement."). If, however, a court order "on the merits of the case" awards one amount for medical expenses and a separate amount for other losses, Medicare will limit its claim for reimbursement to the amount designated for medical expenses. See MSP Manual, ch. 7, § 50.4.4 (2003). The Secretary may also waive recovery (in full or in part) if the beneficiary is without fault and recovery would defeat the statutory purposes or be against equity and good conscience. See 42 U.S.C. 1395gg(c); 42 C.F.R. 405.358.

2. Petitioner, a Medicare beneficiary, was injured when he was struck by a public utility truck while standing near a traffic circle. Medicare conditionally paid $82,036.17 in medical expenses arising out of the accident. Petitioner later sued the public utility company, seeking compensation for all of his medical expenses, as well as other damages, and the parties reached a settlement. In exchange for a payment of $125,000, petitioner released all claims against the utility company and its liability carrier. See Pet. App. 2a. Pursuant to the settlement agreement, petitioner placed $62,000 in escrow "for the specific purpose of reimbursing Medicare," *id.* at 3a, and agreed to take responsibility for any obligation to Medicare exceeding that amount and to indemnify the utility company and its insurer for any claims asserted by Medicare. Administrative Record 39-40 (A.R.). Medicare ultimately determined that petitioner owed it $62,338.07—the $82,036.17 in medical expenses conditionally paid by Medicare minus an allocable share of attorneys' fees. Pet. App. 2a-3a.

3. Petitioner paid under protest and sought administrative review. He contended that Medicare was entitled to recover only ten percent of the medical expenses paid (approximately $8000). According to petitioner, the accident was primarily the fault of an unidentified motorist who ran a stop sign and caused the public utility truck to swerve and hit him. Petitioner asserted that, applying state comparative-fault principles, the public utility company was liable only for ten percent of his damages, whereas the unidentified motorist was responsible for the other 90 percent. Under petitioner's reasoning, only approximately $8000 of the settlement proceeds should be regarded as covering his medical expenses, and the remaining $117,000 should be regarded as compensating him for other damages (such as pain and suffering). Pet. App. 3a.

In an initial ruling and on remand, the Medicare Appeals Council concluded that Medicare was entitled to full reimbursement of its conditional payments minus procurement costs. See Pet. App. 25a-26a; Supp. A.R. 3-17. The Appeals Council explained that a beneficiary may not limit his reimbursement obligations by unilaterally asserting that only a portion of a negotiated settlement reflected medical costs. Supp. A.R. 12 (citing MSP Manual, ch. 7, § 50.4.4 (2003)). It noted that "the allocation of liability in this case is speculative" and that, in fact, "the terms of the settlement agreement specifically prohibit any admission of fault or liability on the part of either party." *Ibid.* The Appeals Council also rejected petitioner's contention that Medicare should waive its right to reimbursement for equitable reasons under the Medicare statute and regulations. *Id.* at 14-17.

On a petition for review, the district court agreed that "any allocation of liability proposed by [petitioner]

would be purely speculative," Pet. App. 35a; that "[c]urrent regulations and law" supported the Secretary's decision, *id.* at 36a; and that petitioner "offered no evidence demonstrating that recovery is against equity and good conscience," *id.* at 35a.

4. The court of appeals affirmed. See Pet. App. 1a-21a. On appeal, the parties agreed that petitioner was obligated to reimburse Medicare as a result of the $125,000 lump sum settlement payment. The only dispute was whether petitioner owed Medicare approximately $80,000 (minus an allowance for procurement costs)—the amount Medicare conditionally paid to cover petitioner's medical expenses—or approximately $8000—the portion of the settlement petitioner alleged should be considered compensation for those medical expenses.

a. The court of appeals agreed with the Secretary and the district court that petitioner was obligated to fully reimburse Medicare from the settlement proceeds for conditional payments made to cover his medical expenses. Pet. App. 4a-11a. The court explained that the MSP provisions make petitioner's repayment obligation identical to the primary plan's (*i.e.*, the public utility company's liability carrier) "responsibility" to make payment for petitioner's medical expenses. *Id.* at 5a (quoting 42 U.S.C. 1395y(b)(2)(B)(ii)). The court explained further that, pursuant to 2003 amendments to the MSP provisions, the primary plan's "responsibility" to make payment for those expenses had been demonstrated because petitioner had made a "claim against" the primary plan for the full amount of his medical expenses and because the primary plan had made a "payment" in return for a "release" of that claim. See *id.* at 7a (quoting 42 U.S.C. 1395y(b)(2)(B)(ii)). The MSP pro-

visions, the court continued, do not allow a beneficiary to "tell a third party that it is responsible for all of his medical expenses, on the one hand, and later tell Medicare that the same party was responsible for only 10% of them, on the other." *Ibid.* Because the primary plan had made a payment conditioned on petitioner's release of all claims, including medical expenses, the court concluded that the primary plan was "responsib[le]" for the full amount owed to Medicare, and so too was petitioner once he received the settlement proceeds. *Ibid.*[1]

The court of appeals rejected petitioner's reliance on other statutory schemes that address reimbursement for medical expenses, because "the words that Congress used in the Medicare statute are materially different from the words it used in the other statutes that [petitioner] cites." Pet. App. 7a-10a. The court also rejected petitioner's suggestion that the Secretary is limited to a right of subrogation under Section 1395y(b)(2)(B)(iv). *Id.* at 10a. Rather, the court explained, the Secretary has an independent right to seek reimbursement under Section 1395y(b)(2)(B)(iii) that is "'separate and distinct' from its rights of subrogation under clause (iv)." *Ibid.* (quoting *Zinman*, 67 F.3d at 845). Finally, the court concluded that the Secretary was not required to waive

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[1] The court of appeals noted that the Ninth Circuit had reached a similar conclusion in *Zinman*. See Pet. App. 5a-6a. In that case, the Ninth Circuit had relied on the Secretary's "interpretation of the statute, under which Medicare was 'entitled to full reimbursement of conditional Medicare payments when a beneficiary receives a discounted settlement from a third party,'" and "easily found [that] interpretation to be reasonable." *Ibid.* (quoting *Zinman*, 67 F.3d at 846). The court of appeals here did not question that holding, but instead focused on the language of the 2003 amendments which postdated *Zinman*.

petitioner's reimbursement obligation for equitable reasons. *Id.* at 11a.

b. Judge White dissented, concluding that the 2003 amendments to the MSP provisions do not "address[] the amount of reimbursement due," Pet. App. 15a-16a, and that the Secretary's interpretation is not entitled to deference, *id.* at 16a-21a.[2] The dissent recognized that "Medicare regulations interpret 42 U.S.C. § 1395y(b)(2)(B)(ii) to allow [the agency] to obtain full reimbursement of conditional payments from a judgment or settlement obtained by the beneficiary against his or her tortfeasor(s)," *id.* at 17a; that the Ninth Circuit had upheld those regulations as a "rational construction of the statute," *ibid.* (citing *Zinman*, *supra*); and that "[t]here is undoubtedly a risk that settling parties in tort claims that involve medical expenses paid by Medicare could manipulate the proportions of each category of damages and leave Medicare with the smallest slice of the pie," *id.* at 18a-19a. The dissent nevertheless focused on the Secretary's "policy [of] apply[ing] principles of equitable allocation only in cases where the beneficiary's claim for damages is adjudicated on the merits," *id.* at 17a, and concluded that the arguments set forth in support of that policy were unpersuasive, *id.* at 18a-21a.

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[2] Contrary to petitioner's contention, the dissent did not conclude that "the government's construction of the Act to require full reimbursement 'is in violation of the express terms of the statute.'" Pet. 6 (quoting Pet. App. 13a). Instead, the dissent suggested that if the majority's interpretation of the statutory text were correct, then the Secretary's allowance of allocated recoveries following a court order on the merits would be "in violation of the express terms of the statute." Pet. App. 13a. That is incorrect for the reasons set forth at page 14, *infra*.

ARGUMENT

The court of appeals' decision is correct and does not conflict with any decision of this Court or any other court of appeals. Further review is not warranted.

1. The court of appeals' decision is correct. Medicare paid more than $80,000 to cover the medical expenses petitioner incurred as a result of injuries sustained when he was struck by a public utility truck. Under the MSP provisions, those payments were conditional only and were to be reimbursed if another party was ultimately deemed responsible for those same expenses.

Section 1395y(b)(2)(B)(ii) provides that a "primary plan * * * shall reimburse" Medicare "for any payment made by the Secretary * * * with respect to an item or service" if the primary plan has a "responsibility to make payment with respect to such item or service." 42 U.S.C. 1395y(b)(2)(B)(ii). The Secretary made payments for "item[s] or service[s]" totaling approximately $80,000. Petitioner does not dispute that the primary plan has a responsibility to make payment with respect to some of those items or services. The only question is whether the primary plan has a responsibility to make payment with respect to all of those items or services.

As the court of appeals explained (Pet. App. 5a-7a), the 2003 amendments to the MSP provisions answer that question. A primary plan's "responsibility" is demonstrated by, among other things, "a payment conditioned upon" a "release (whether or not there is a determination or admission of liability) of payment for items or services" that were "included in a claim against the primary plan." 42 U.S.C. 1395y(b)(2)(B)(ii). Petitioner filed suit against the public utility company and included a claim for all of the items or services paid for by

Medicare. As part of the settlement, the utility company's liability carrier made a $125,000 payment to petitioner that was "conditioned upon" petitioner's "release" of all of his claims, including the claim for medical expenses. See *Mathis* v. *Leavitt*, 554 F.3d 731, 733 (8th Cir. 2009) ("[T]he settlement, which settled all claims brought, necessarily resolved the claim for medical expenses."). Thus, under the plain terms of the statute, the "primary plan" "had a responsibility to make payment with respect to" the approximately $80,000 in "item[s] or service[s]" for which Medicare conditionally paid. Because petitioner qualifies as "an entity that [has] receive[d] payment from a primary plan," he too is obligated to reimburse Medicare for that same amount. 42 U.S.C. 1395y(b)(2)(B)(ii).

The Secretary's longstanding interpretation of the MSP provisions in the context of a negotiated settlement (before and after the 2003 amendments) is consistent with the court of appeals' decision. As the dissent recognized, the Medicare regulations "interpret 42 U.S.C. § 1395y(b)(2)(B)(ii) to allow [the Secretary] to obtain full reimbursement of conditional payments from a judgment or settlement obtained by the beneficiary against his or her tortfeasor(s)." Pet. App. 17a (citing 42 C.F.R. 411.24(c), 411.37(c)); *Zinman* v. *Shalala*, 67 F.3d 841, 845 (9th Cir. 1995) (explaining that the Secretary interpreted the pre-2003 MSP provisions "to allow full reimbursement of conditional Medicare payments even though a beneficiary receives a discounted settlement from a third party"). And the MSP Manual provides that "Medicare policy [generally] requires recovering payments from liability awards or settlements * * * without regard to how the settlement agreement stipulates disbursement should be made," and that "[t]he

only situation in which Medicare recognizes allocations of liability payments to nonmedical losses is when payment is based on a court order on the merits of the case." MSP Manual, ch. 7, § 50.4.4 (2003); see *id.* § 50.1 (2005).

As the Ninth Circuit held in *Zinman,* that interpretation is eminently reasonable. "The transformation of Medicare from the primary payer to the secondary payer with a right of reimbursement reflects the overarching statutory purpose of reducing Medicare costs." *Zinman*, 67 F.3d at 845. The "system is set up [so that] the beneficiary gets the health care she needs, but Medicare is entitled to reimbursement if and when the primary payer pays her." *Cochran* v. *United States Health Care Fin. Admin.*, 291 F.3d 775, 777 (11th Cir. 2002). Mandating "[a]pportionment of Medicare's recovery in tort" settlements would contravene those purposes and increase costs, because it "would either require a factfinding process to determine actual damages or would place Medicare at the mercy of a victim's or personal injury attorney's estimate of damages." *Zinman*, 67 F.3d at 846.

This case demonstrates the soundness of the Secretary's interpretation. Petitioner seeks to limit Medicare's recovery to ten percent of the amount Medicare paid to cover his medical expenses. The proposed ten-percent reimbursement is based on petitioner's unilateral (and speculative) assessment that the public utility company is at fault for ten percent of his losses, and an unidentified motorist is responsible for the remainder. Based on that unproven premise, petitioner asserts that Medicare is entitled to recover only approximately $8000 of the more than $80,000 paid on condition of reimbursement, and petitioner is entitled to retain the remaining

$117,000 of the settlement proceeds (which, under petitioner's theory, presumably represent ten percent of the total amount due for other (nonmedical) losses).

Petitioner asserts that the government "never disputed that [his] settlement was for only ten percent of his damages." Pet. 25 n.13 (citing Gov't C.A. Br. 20-21 & n.3). In fact, the government's brief on appeal noted the "anomaly" of petitioner's proposed allocation of damages given that "the third party is unknown and the allocation of fault unascertainable." Gov't C.A. Br. 20-21. The cited footnote in the government's brief stated: "Although [petitioner] now characterizes the 10-percent allocation as 'undisputed,' this figure, as his attorney acknowledged in a hearing before the agency, is an 'allegation' based on his estimate of the total damages in the case that would need to be tested by a 'fact finder.'" *Id.* at 21 n.3 (internal citation omitted). And both the Medicare Appeals Council and the district court characterized petitioner's fault allocation as "speculative." See Supp. A.R. 12; Pet. App. 35a. The Secretary has quite reasonably sought full reimbursement in circumstances where, as here, a lump sum settlement resolves a beneficiary's claim for medical expenses for which Medicare conditionally paid.

2. Petitioner's arguments to the contrary are without merit.

a. Petitioner first contends that the court of appeals rewrote the statute by "replac[ing] the term 'responsibility' with 'full responsibility'" and by ignoring the phrase "item[s] or service[s]." Pet. 13 (second and third brackets in original). Petitioner misconstrues the court of appeals' analysis and the statutory text.

As explained above, Section 1395y(b)(2)(B)(ii) sets forth when a "primary plan" is required to reimburse

Medicare for "any payment made by the Secretary * * * with respect to an item or service." 42 U.S.C. 1395y(b)(2)(B)(ii). A primary plan is required to reimburse the Secretary for "such payment" (*i.e.*, "any payment made by the Secretary * * * with respect to an item or service") if the primary plan has "a responsibility to make payment with respect to such item or service" (*i.e.*, an item or service for which the Secretary has paid). *Ibid.* Under the Medicare statute, a primary plan is responsible for making "such payment" (*i.e.*, payment for an item or service for which the Secretary has paid) when, *inter alia*, the primary plan makes a payment "conditioned upon" the "release" of "payment for items or services included in a claim against the primary plan." *Ibid.* The primary plan therefore bears "responsibility" for reimbursing all of the medical expenses paid by Medicare not because the statute speaks of "full responsibility," but because it defines the payment due in terms of "any payment made by the Secretary" for an "item or service," and because it defines "responsibility" in terms of what "items or services" were "included in a claim against the primary plan."

Petitioner also contends (Pet. 17-19) that the court of appeals' interpretation leads to absurd results because, according to petitioner, it allows Medicare to recover the full amount of payments made even if they exceed the settlement proceeds. Petitioner's premise is flawed. Longstanding Medicare regulations establish that, "[i]f Medicare payments equal or exceed the judgment or settlement amount, the recovery amount is the total judgment or settlement payment minus the total procurement costs." 42 C.F.R. 411.37(d). Petitioner does not purport to challenge that regulation and, in any

event, the settlement proceeds in this case were of course more than sufficient to fully reimburse Medicare.

Petitioner next asserts (Pet. 21-22) that the court of appeals' decision cannot be reconciled with the Secretary's willingness to accept a court's designation of medical expenses after an adjudication on the merits. See MSP Manual, ch. 7, § 50.4.4 (2003). There is, however, a significant difference between a lump sum payment made pursuant to a negotiated settlement and a payment made pursuant to an adjudication on the merits where there has been a judicial determination of the extent to which the primary plan is responsible for medical expenses. Indeed, Section 1395y(b)(2)(B)(ii) identifies a "judgment" as one means of demonstrating "responsibility," and a settlement as another. 42 U.S.C. 1395y(b)(2)(B)(ii); see 42 C.F.R. 411.22(b)(1) and (2). In the settlement context, the primary plan is deemed responsible for medical items or services for which Medicare has paid that are "included in a claim against the primary plan." 42 U.S.C. 1395y(b)(2)(B)(ii). The court of appeals' decision says nothing about the circumstances in which a primary plan's responsibility can be separately "demonstrated by a judgment." *Ibid.*[3]

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[3] Petitioner also compares a tort settlement to the settlement of a workers' compensation claim, and argues that the distinction the Secretary has drawn between the two is "arbitrary" (Pet. 22). Petitioner failed to present that argument to the agency, to the district court, or to the court of appeals. In any case, the distinction drawn by the Secretary is reasonable because "[w]orkers' compensation schemes generally determine recovery on the basis of a rigid formula" and, thus, "[a]pportionment" generally "involves a relatively simple" calculation, whereas, in a tort settlement, "a victim's damages are not determined by an established formula" and apportionment would be both speculative and costly. *Zinman*, 67 F.3d at 846.

b. Petitioner points to the availability of apportionment and partial reimbursement under other statutory schemes, Pet. 23-26, but the court of appeals correctly rejected that argument, Pet. App. 7a-10a.

The Medicaid provisions at issue in *Arkansas Department of Health & Human Services* v. *Ahlborn*, 547 U.S. 268 (2006), require Medicaid beneficiaries to "assign the State any rights * * * to payment for medical care from any third party," 42 U.S.C. 1396k(a)(1)(A), and require the State to "seek reimbursement for [medical] assistance to the extent of" "the legal liability of third parties * * * to pay for care and services available under the plan," 42 U.S.C. 1396a(a)(25)(A) and (B). See also 42 U.S.C. 1396a(a)(25)(H) (requiring States to have laws in effect "under which * * * the State is considered to have acquired the rights of such individual to payment by any other party for such health care items or services"). Under Medicaid's statutory scheme, a third party's "legal liability" is determined as a matter of state law. In contrast, under the Medicare statute, a primary plan's "responsibility" for reimbursing Medicare is exclusively a matter of federal law pursuant to the MSP provisions.[4]

Similarly, the Federal Medical Care Recovery Act, 42 U.S.C. 2651(a), sets forth the government's right to reimbursement in different terms. It grants the United States "a right to recover * * * from [a third person

[4] The Court's decision in *Ahlborn* is also distinguishable in other respects. The Court, for example, held that the Medicaid statute did not *mandate* the State's enforcement scheme (which automatically imposed a lien on all tort settlement proceeds equal to Medicaid's costs), *Ahlborn*, 547 U.S. at 282, and ultimately invalidated the state law based on an independent anti-lien provision in the Medicaid statute that has no relevance here, *id.* at 283-286.

who is liable in tort] the reasonable value of the care and treatment," and provides that "this right [shall] be subrogated to any right or claim" that the injured person has against the tortfeasor "to the extent of the reasonable value of the care and treatment." 42 U.S.C. 2651(a). Under that statute, a third party's liability is defined by state tort law. In contrast, the MSP provisions require reimbursement whenever another plan of insurance or self insurance is primary, regardless of whether the Medicare beneficiary has alleged or established the existence of a tort.

Petitioner's appeal to generalized considerations favoring settlement of disputes, Pet. 26-29, is also unpersuasive. Petitioner's primary argument has always been that Medicare is entitled only to ten-percent reimbursement because the settling party (the public utility company) bears ten percent of the fault under comparative-fault principles, not that the public utility company settled the claims for less than the ten percent it purportedly owed. And even if truly "discounted" tort settlements were apportioned in the way petitioner suggests, that would not extinguish Medicare's right to reimbursement for *all* of the conditional payments made on a beneficiary's behalf under the MSP provisions.[5] See 42 C.F.R. 411.24(i); *Health Ins. Ass'n of Am., Inc.* v. *Shalala*, 23 F.3d 412, 417-418 (D.C. Cir. 1994), cert. denied, 513 U.S. 1147 (1995).

Petitioner also fails to explain why parties would suddenly abandon a cost-effective way of resolving litigation based on Medicare's longstanding position that it is entitled to full reimbursement from settlement proceeds.

[5] That this case does not appear to present a discounted settlement in the relevant sense further demonstrates that it is not a suitable candidate for further review.

Indeed, in this case, the parties were certainly aware that Medicare would seek full reimbursement: petitioner placed $62,000 in escrow (nearly identical to the amount owed) and the public utility company's liability carrier insisted on a full release of, and indemnification against, any additional Medicare obligations. In addition, while petitioner focuses on the general policy in favor of settlement, competing policy concerns specifically animated Congress's enactment of the MSP provisions: namely, the need to stem Medicare's rising costs. See *Zinman*, 67 F.3d at 845. And, consistent with Medicare's well-established position on this issue, Congress amended the MSP provisions in 2003 to further protect the viability of the Medicare Trust Fund.

Finally, petitioner argues (Pet. 29-30) that the MSP Manual is not entitled to deference. Petitioner does not address the Medicare regulations (see 42 C.F.R. 411.24(c), 411.37(c)), to which the Ninth Circuit deferred in *Zinman*. See 67 F.3d at 843, 845-846. Nor does petitioner explain why the agency's interpretation is not entitled to any weight *if* the court of appeals was wrong to conclude that the MSP provisions speak directly to the issue of allocation. Instead, petitioner simply restates his argument that the manual provisions "exceed[] Medicare's authority *under the court of appeals' reading of the statute*." Pet. 30 (emphasis added); see p. 14, *supra* (explaining why that is incorrect). Petitioner, however, contends that the court of appeals' reading of the statute is incorrect, and he does not argue that the MSP provisions compel his interpretation. See Pet. 29 (arguing that "[n]owhere does the MSP [provision] speak to equitable allocation"). If the statute is silent, as petitioner suggests, then the agency's inter-

pretation (as expressed in regulations and in the MSP Manual) is entitled to deference.

3. Contrary to petitioner's contention (Pet. 7-13), there is no circuit conflict. Petitioner cites only two other court of appeals' decisions in the last two decades that have purportedly addressed the question presented. The Ninth Circuit's decision in *Zinman* predated the 2003 amendments and is fully consistent with the decision below. And the Eleventh Circuit's decision in *Bradley* v. *Sebelius*, 621 F.3d 1330 (2010), is inapposite. Further review is not warranted.

Petitioner contends (Pet. 7-13) that the decision below conflicts with the Eleventh Circuit's decision in *Bradley*. That case, however, involved unusual facts and a fundamentally different type of settlement. In *Bradley*, the personal representative of a Medicare beneficiary's estate settled, in a single agreement, both the Medicare beneficiary's claims and separate claims brought by the beneficiary's survivors that did not include medical expenses. See 621 F.3d at 1337 ("The settlement involved the medical expenses and costs recovered by the estate (and subject to the MSP statute), *along with* the non-medical, tort [and] property claims of the surviving [] children for lost parental companionship, etc., under state law[] (*and not subject to the MSP statute)*."). A state probate court had apportioned the undifferentiated settlement between the estate's claims (which included medical expenses) and the children's claims (which did not). *Id.* at 1333-1334, 1337-1338. The Eleventh Circuit ultimately concluded, in light of the state probate court's decision, that the claims of the Medicare beneficiary's survivors were not the property of the estate and, therefore, were not subject to the MSP provisions at all. *Id.* at 1335, 1337.

Contrary to petitioner's suggestion (Pet. 8 & n.3, 12), neither the majority nor the dissent in *Bradley* engaged in any discussion of the pertinent statutory language—let alone "ruled" that the statute was silent with respect to the separate question presented here. *Bradley* is a recent decision and no court has applied its reasoning to a single-party settlement of a claim that includes medical expenses.[6] Indeed, although petitioner relied on *Bradley* in the court of appeals, even the dissent did not cite it. There accordingly is no circuit conflict warranting this Court's review.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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JULY 2012

[6] Although petitioner's wife was also a party to the settlement, petitioner has not identified any state law governing how the proceeds of the settlement are to be divided between them—let alone a court order limiting his wife's recovery to nonmedical losses.