The Impact of the Medicare Secondary Payer Statute on Settling Mass Tort Claims

By Thomas M. Connor

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Recent changes to the Medicare secondary payer requirements have put a spotlight on the need to reimburse Medicare proactively with settlement funds when settling with Medicare beneficiaries. In the mass tort context, the obligations are extensive, the penalties are painful, and in some areas, the guidance on how to comply is almost completely absent.

Mass tort litigators are generally aware that Medicare may have a lien against settlement funds. A common approach to addressing this possibility in mass tort cases has been for defense counsel to include an indemnification provision in the settlement agreement and then not worry too much more about it. Plaintiff's counsel then may—or may not—have seen to it that the plaintiff settled up with Medicare as necessary.

For reasons explored in this article, however, this approach is inadequate and exposes counsel, the parties, and their liability insurers (if any) to ongoing and potentially severe risks. Litigants may no longer simply address Medicare reimbursement issues as an afterthought at settlement but must make this a priority from the outset of the litigation. The parties must also recognize that Medicare's right to reimbursement may fundamentally alter the settlement calculus for the parties, making it imperative that they get an early read on the scope of Medicare's interests in a potential settlement.

The Medicare Secondary Payer Statute

When first established in 1965, Medicare was the primary payer of medical expenses for its beneficiaries. This meant that Medicare would pay the medical expenses of its beneficiaries regardless of whether another source of funds was potentially available to cover the costs. In 1980, as part of the Omnibus Budget Reconciliation Act, Congress enacted the Medicare secondary payer (MSP) statute[1] in an effort to reduce Medicare costs by shifting primary responsibility for covering beneficiary medical expenses to other available "primary payers."

The rationale for the MSP statute is straightforward: Medicare doesn't want to pay for injury-related expenses that someone else is responsible for. To this end, the MSP statute places affirmative obligations on settling parties to protect Medicare's interests.

The Centers for Medicare & Medicaid Services (CMS) is the agency responsible for the enforcement and oversight of the Medicare secondary payer provisions. The exact scope of CMS's recovery rights can be uncertain, and courts have often struggled to interpret the MSP statute, which has been described as "convoluted and complex" and a "model of un-clarity."[2] As a consequence, courts will often defer to CMS's interpretation of the statute. CMS's position is further strengthened in reimbursement actions because "the United States' right of reimbursement is paramount to any other claim."[3]

The MSP statute raises significant issues in the settlement of mass tort cases in which the plaintiff is a Medicare beneficiary. First, the parties may be required to reimburse Medicare for past payments made on behalf of a beneficiary. Second, the MSP statute may require that settlement funds be set aside to pay for future medical expenses. Last, recent amendments to the MSP statute create an obligation to report detailed information about judgments and settlements with Medicare beneficiaries. With this information, CMS will more easily identify potential recovery actions where settlements fail to protect Medicare's interest.

Past Expenses and Conditional Payments

The MSP statute provides that Medicare will not pay for medical expenses where payment "can reasonably be expected to be made under a workmen's compensation law or plan . . . or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance."[4] To avoid a lapse in coverage for a beneficiary, however, Medicare may continue making "conditional" payments for medical care even if a different payer may ultimately be responsible.[5]

Such payments are "conditional" because Medicare has a statutory right to be reimbursed if and when a different payer is determined to have had responsibility for the medical care. A defendant need not expressly accept liability for the liability insurer to be found responsible as a primary payer. Rather, responsibility for reimbursing Medicare can be demonstrated merely because a defendant enters into a settlement agreement that releases the defendant from future liability relating to the injury in question.[6]

In mass tort litigation, all involved may have a reasonable expectation that the self-insured defendants or liability insurers will ultimately cover at least some of the plaintiff's medical expenses. Regardless, no defendant or insurer will willingly pay for any such care unless and until the time of a settlement or adverse judgment. If Medicare has been paying for the beneficiary's injury-related care, it will expect reimbursement if the plaintiff receives compensation.

Upon judgment or settlement, a

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beneficiary (plaintiff) is automatically obligated to reimburse Medicare for conditional payments within 60 days.[7] If the beneficiary does not, the primary payer is obligated to reimburse Medicare "even though it has already reimbursed the beneficiary."[8] If neither party reimburses Medicare, the United States has substantial flexibility in selecting whom to pursue for reimbursement.

First, CMS has a direct right of action against the primary payer (the liability insurer or self-insuring defendant) and may recover double damages against the primary payer if it has been forced to pursue recovery through litigation.[9] In this unfortunate circumstance, the primary payer may need to pay up to three times the reimbursement amount—once if the beneficiary has already received the settlement funds and twice to Medicare if double damages are awarded.

In a mass tort case dealing with potentially severe or crippling injuries, this could represent an enormous penalty. Some mass torts will involve injuries that developed over an extended period, often before a cause is identified. If, for example, a pharmaceutical drug is alleged to have caused an increase in the incidence of diabetes, those settling such cases may be faced with liability for reimbursement of many years of conditional payments to a chronically ill plaintiff. The risk of severe penalties is further magnified in mass tort litigation because a typical mass tort defendant is simultaneously defending numerous similar claims. If the primary payer defendant or insurer has failed to address Medicare reimbursement properly in one case, it stands to reason that the same primary payer may have made similar oversights or errors in other similar cases.

If the United States has chosen to pursue the primary payer for reimbursement, an indemnification clause in the settlement agreement will likely be of little comfort. By the time the reimbursement action is underway, a plaintiff may easily have spent the settlement funds and thus be judgment-proof. Furthermore, to the extent that the United States seeks penalties in addition to reimbursement, the settling parties likely would need to litigate the question of whether an indemnification provision extends to such penalties.[10]

But the primary payer is not the only one who needs to worry. Medicare also has a right of action against "any entity, including a beneficiary, provider, supplier, physician, attorney, State agency or private insurer that has received a primary payment."[11] Under this provision, the United States has successfully recovered from both plaintiffs and plaintiffs' attorneys who received contingent fees but failed to reimburse Medicare as required.[12]

Because the United States has discretion in determining from whom to seek reimbursement, none of the parties to a lawsuit can know ahead of time which of them will become the target if Medicare is not reimbursed for conditional payments. Unless one party voluntarily accepts the liability, both sides must account for it in their settlement demands, therefore driving them further apart. If the parties fail to consider Medicare's interests until they sit down to memorialize a settlement agreement, they may be surprised to discover that Medicare is entitled to much, or even all, of the settlement proceeds.[13]

Another complicating factor is that mass tort settlements may often be for less than the total cost of care for an injury. This may arise where the parties have discounted the settlement to account for any weaknesses in the individual plaintiff's case, where multiple defendants are separately assuming only partial liability, or where a limited fund situation occurs, as often happens in asbestos settlements. CMS, however, will generally still require full reimbursement out of the settlement funds, making the potential Medicare liability disproportionately large as compared with the settlement total.

As a consequence, cases that should have settled may be forced to go to trial.[14] A plaintiff will need a trial to get a home-run verdict, and one that is big enough to cover Medicare's interests as well as pay the plaintiff. A mass tort defendant faced with a plaintiff's large settlement demands will be even less likely to settle demands that are driven even higher by the need to repay Medicare. Because most mass tort settlements have precedential significance to the settlement negotiations in subsequent cases, a defendant may simply be unwilling to set a high precedent that is artificially inflated by the need to reimburse Medicare. In mass tort litigation involving dozens, hundreds, or thousands of Medicare beneficiaries, this inability to settle could dramatically raise the litigation costs for both sides.

Where the parties are able to reach a settlement agreement, counsel should strive to ensure that Medicare is involved early in the litigation and is reimbursed by the plaintiff before concluding the settlement. The first issue will be determining the amount owed to Medicare. Generally, this process can be initiated by contacting the CMS Coordination of Benefits Contractor and supplying certain identifying information about the beneficiary. To accomplish this, the defendant must focus on MSP issues early in discovery or even earlier, in preparing plaintiff questionnaires, to ensure that the plaintiff's Medicare beneficiary status is probed and the information necessary for making a request to CMS is collected.

This, of course, assumes that CMS and/or its contractors can accurately determine what medical care is related to the injuries at issue in the case. For example, a hypothetical asthmatic plaintiff alleging breathing problems as a result of formaldehyde exposure in a FEMA trailer is likely to have required medical care for respiratory ailments both before and after the alleged exposure. The odds that CMS will accurately isolate the plaintiff's respiratory treatments related only to the allegations in such a case seems remote at best, potentially leading to time-consuming administrative appeals for resolution. It is, therefore, imperative that the parties get an early read on what CMS thinks the reimbursement amount will be so there is time to challenge the determination if needed.

Medicare Secondary Payer Reporting

Those who may be tempted to think "Hey, I haven't been doing any of this and everything has worked out fine" are in for a rude awakening. In the past, Medicare had limited visibility to even the existence of mass tort settlements. Soon, however, Medicare will have all the knowledge it needs to find and pursue opportunities for reimbursement. This is a result of the most recent addition to the MSP statutory scheme: the requirement to report detailed information about settlements and judgments involving Medicare beneficiaries to the Center for Medicate & Medicaid Services (CMS).

The reporting requirement arises under the Medicare, Medicaid and SCHIP Extension Act of 2007, and went into effect on July 1, 2009, although CMS extended the deadline to submit the reports for liability insurance, no-fault insurance, and workers' compensation until the second quarter of 2010.[i] Once implemented, this reporting will give CMS tremendous ability to spot potential reimbursement claims. Indeed, CMS states that "[t]his information will be used to ensure that Medicare makes payment in the proper order and/or takes necessary recovery actions."[ii]

In the mass tort context, the reporting obligation generally rests with the provider of the liability insurance plan that is responsible for paying the settlement or judgment amount to the plaintiff. To the extent that a defendant pays such compensation directly, it will be considered its own insurer subject to the reporting requirements. To report a settlement, the reporting entity must first determine the Medicare beneficiary status of the plaintiff. Fortunately, this may be done simply by submitting the plaintiff's Social Security number, name, birth date, and gender on a CMS webpage.[iii] The online system will search the Medicare records and report back whether the submitted individual is a beneficiary. Because mass tort litigation often involves numerous plaintiffs, however, the defense will need to ensure that it has a methodical procedure in place to collect the necessary information from plaintiffs, to verify the information, and to periodically recheck plaintiffs' beneficiary status throughout the litigation.

CMS has specified in great detail in a published User Guide what will need to be reported, although CMS has repeatedly stated that it is working on refining the requirements for mass tort claims.[iv] The penalty for failure to comply with the reporting requirements is $1,000 per day of violation for each claimant, in addition to any penalties that may be separately enforced for ignoring Medicare's reimbursement rights.[v] To bring this into focus, if a mass tort settlement involves just 10 Medicare beneficiaries and the liability insurer is just 30 days late meeting its reporting obligations, the aggregate civil penalty is $300,000.

Endnotes

i. 42 U.S.C. § 1395y(b)(8); CMS, Revised Implementation Timeline, May 12, 2009.

ii. Supporting Statement for the Medicare Secondary Payer (MSP) Mandatory Insurer Reporting Requirements of Section 111 of The Medicare Medicaid, and SCHIP Extension Act of 2007, Aug. 1, 2008.

iii. https://www.section111.cms.hhs.gov/MRA/LoginWarning.action

iv. MMSEA Section 111 Medicare Secondary Payer Mandatory Reporting Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Workers' Compensation User Guide Version 2.0, July 31, 2009. Transcripts of the CMS town hall teleconferences are available at www.cms.hhs.gov/MandatoryInsRep/07_NGHP_Transcripts.asp#TopOfPage.

v. 42 U.S.C. § 1395y(b)(8)(E).

Once the parties have determined the reimbursement amount, both the primary payer and plaintiff's counsel have an incentive to avoid facing liability themselves by ensuring that Medicare is actually reimbursed out of settlement funds. If the parties were unable to negotiate a timely resolution, defense counsel may wish to consider having Medicare named as a second payee on the settlement check or simply withhold payment until Medicare is reimbursed.[15] By forcing a resolution of the reimbursement issues, the settling primary payer can avoid the unsettling prospect of lingering exposure to a Medicare reimbursement claim.

Future Expenses and Medicare Set-Asides

The parties' obligations to Medicare do not necessarily end with reimbursing Medicare for past conditional payments, because the parties may also be required to protect Medicare from paying for medical care in the future. In the personal injury and mass tort context, this is by far the most unclear and unsettled area of MSP law. Whereas the conditional payment provisions of the MSP are clear about the obligation of various parties to reimburse Medicare for past conditional payments, the statute itself does not expressly require parties to ensure that the settlement funds are used as the primary source of ongoing payments for related medical care.

For several years, however, CMS has required just that in the workers' compensation context. CMS announced its intention to address future expenses in workers' compensation cases in 2001, when it issued a memorandum first requiring the use of "administrative mechanisms," such as Medicare set-asides (MSAs), to cover future medical expenses out of settlement funds.[16] CMS later extended this requirement to situations where the beneficiary is not covered by Medicare at the time of settlement but where there is a reasonable expectation[17] of becoming a beneficiary in the next 30 months.

There is no formal definition of an MSA, but it generally refers to a method of quantifying and then segregating a portion of available funds to pay for future expenses where Medicare is a secondary payer.[18] While the use of MSAs is routine for workers' compensation settlements, the applicability of the MSA requirements to mass torts is much less certain. Although the MSP statute makes Medicare a secondary payer to liability insurers, the 2001 CMS memorandum discussing MSAs deals

exclusively with workers' compensation claims and primarily relies on a workers' compensation regulation dealing with lump-sum payments as support.[19] Liability settlements are not mentioned in this, or in subsequent guidance memorandums. Thus, the legal authority for requiring workers' compensation MSAs may not even apply to liability cases.[20]

Not all practitioners agree, however, that the MSA requirement is inapplicable to personal injury liability cases because, regardless of what guidance has been published, the core statutory requirements to protect Medicare apply equally to workers' compensation and personal injury cases.[21] Some practitioners are also reporting that CMS has informally advised that the concept of addressing future medical expenses applies to liability cases, even if no formal guidance has yet been published.

Because CMS has not provided guidance on how or whether a personal injury liability MSA should be handled, the guidance for workers' compensation MSAs must be the starting point, although the comparison is imperfect. One author notes

> The math may prove to be the challenge in liability settlements. Unlike workers' comp, which covers a worker's lifetime injury-related care, liability insurance policies generally have caps, and the doctrines of comparative fault and contributory negligence inherent in personal injury cases work to offset the damages to an amount less than full value. Currently, CMS's calculation methodologies are geared toward the full-value, "no fault" nature of workers' comp statutes.[22]

Where a workers' compensation MSA is required, CMS will review it for preapproval before the settlement is finalized.[23] Unfortunately, there is little reason to expect that CMS has either the desire or the ability to handle such prescreening for liability cases, leaving the parties to hope that CMS would not take issue with the methodologies and calculations employed after the settlement.

Because a life care plan will usually be prepared in mass tort cases, it could be used as a justifiable basis for quantifying the amount to be set aside for future expenses in the absence of contrary guidance from CMS. Toxic torts will likely produce the most challenging issues, because the injuries being litigated may merge with preexisting health issues of the plaintiff. If, for example, a plaintiff with an extensive smoking history and a variety of pulmonary diseases suffers further lung injury from long-term exposure to a toxin in the workplace, what percentage of his future respiratory medical care is related to the injury (and thus to be covered by settlement funds) and what percentage is unrelated (and still Medicare's responsibility)? More than likely, this question will be resolved on a best-guess reconciliation of the various expert opinions obtained by the parties in the course of the litigation. Where the parties seek to settle even before incurring the cost of experts, the challenge is even greater.

Given the debate over whether mass tort litigants are required to set aside settlement funds for future medical expenses, litigants will simply need to evaluate their risk tolerance and potential exposure to determine whether it makes sense in a particular case to implement an MSA or other similar device. If an MSA seems advisable, a mass tort litigator's workers' compensation colleagues will likely be the best resources for navigating the process, given their years of experience dealing with MSAs. A litigator may also consider involving one of numerous specialized firms that can manage MSA setup and administration.

If the parties decide against a full-blown MSA, they may want to at least consider enhancing the language of the settlement agreement to expressly state what portion of the settlement funds are to be designated and used only for paying future medical costs for which Medicare is a secondary payer.[24]

Although it is uncertain whether these steps would be found to comply with the obligation to protect Medicare's secondary payer status, at least the parties could demonstrate that they made a good faith effort to set aside a defensible sum for future medical expenses. In all cases, the litigants should know the risks, investigate their options, and make a conscious choice on how to proceed rather than simply ignoring Medicare's interests.

Conclusion

The Medicare secondary payer statute creates a number of obligations on parties to a mass tort settlement and can leave the parties exposed to significant liability for failing to take Medicare's rights into account during settlement. Because of the new reporting requirements, it is sensible to expect renewed enforcement of these provisions in the coming years, especially if Medicare becomes increasingly unstable financially. Given the sheer numbers of plaintiffs involved in mass tort litigation, it is crucial that mass tort lawyers be familiar with their obligations and make it a priority to address them in an organized, systematic manner early in the litigation process. ■

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Endnotes

1. 42 U.S.C. § 1395y. The statute and its supporting regulations at 42 C.F.R. § 411.20 et seq. and 42 C.F.R. § 411.40 et seq. are sometimes collectively referenced as "the MSP statute."
2. Estate of Urso v. Thompson, 309 F. Supp. 2d 253, 259 (D. Conn. 2004).
3. United States v. Geier, 816 F. Supp. 1332, 1337 (W.D. Wis. 1993).
4. 42 U.S.C. § 1395y(b)(2)(A)(ii).
5. 42 U.S.C. § 1395y(b)(2)(B)(i).
6. 42 U.S.C. § 1395y(b)(2)(B)(ii).
7. 42 C.F.R. § 411.24(h).
8. 42 C.F.R. § 411.24(i).
9. 42 C.F.R. § 411.24(e); 42 C.F.R. § 411.24(c)(2).
10. Robert Trusiak, The Medicare Secondary Payer Statute and the Medicare, Medicaid and SCHIP Extension

Act: Impact on Litigating Personal Injury Claims, DRI live web cast, Aug. 26, 2009.

11. 42 C.F.R. § 411.24(g).

12. *See e.g.,* United States v. Sosnowski, 822 F. Supp. 570 (W.D. Wis. 1993); United States v. Harris, 2009 WL 891931 (N.D. W. Va. Mar. 26, 2009).

13. *E.g.,* Hadden v. United States, 2009 U.S. Dist. Lexis 69383 (W.D. Ky. Aug. 6, 2009).

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

15. Roy Franco, Jeffrey Signor & Thomas Thornton III, *Resolution of a Case with a Medicare Claimant?,* For the Defense 11 (May 2009).

16. CMS, Parashar Patel, Worker's Compensation: Commutation of Future Benefits (July 23, 2001) (widely referred to as "the Patel Memorandum").

17. CMS, Medicare Secondary Payer—Workers' Compensation (WC) Additional Frequently Asked Questions, Apr. 22, 2003.

18. Sagrillo, Kohnlein & Dauby, Medicare Set-Aside Guidebook 8 (Dec. 2005).

19. 42 C.F.R. § 411.46.

20. *See, e.g.,* Patty Meifert & Robert Lewis, *Considering Medicare's Interests in Liability Cases: Will the Real Expert Please Stand Up,* 3–4 (Aug. 2005), *available at* www. nuquestbridgepointe.com/services/med_res/nq_liability_article.pdf; Norma Schmidt, Note, *The King Kong Contingent: Should the Medicare Secondary Payer Statute Reach to Future Medical Expenses in Personal Injury Settlements?,* 68 U. Pitt. L. Rev. 469, 480–481, 489 (2006).

21. Matthew L. Garretson, *Making Sense of Medicare Set-Asides,* Trial 4 (May 2006); *See also* Robert Sagrillo, *Medicare's Role in Third-Party Liability Cases: Medicare Modernization Act and Medicare Set-Asides,* 51 (2005), *available at* www.protocolsllc.com/documents/Medicares_Role.pdf.

22. Garretson, *supra* note 21, at 4–5.

23. Sagrillo, Kohnlein & Dauby, *supra* note 18, 14–18.

24. *See, e.g.,* Meifert & Lewis, *supra* note 20, at 5.

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