

Deluding the Unwary

The Revised Medicare Secondary Payer Act

by Thomas C. Regan and Seamus M. Morley

**What are fears but voices airy?
Whispering harm where harm is not.
And deluding the unwary
Till the fatal bolt is shot!**

William Wordsworth

Congress formed the Medicare system through a series of amendments to the Social Security Act of 1965 in order to provide a primary means for payment of medical and hospital expenses for citizens over the age of 65. Even as the system was formed, however, it was designed to be secondary to certain payments. In 1980, Congress enacted the Medicare Secondary Payer Act ("MSP") in an effort to reduce the costs associated with the Medicare system. Nearly 20 years later, the government began seeking recovery of Medicare liens from defendant product manufacturers who settled cases with injured plaintiffs. The government's position was consistently rejected by the courts until the Eleventh Circuit permitted such a recovery under the MSP stemming from the set-

tlement of a breast implant class action in *United States v. Baxter Int'l*, 345 F.3d 866 (11th Cir. 2003). The now-codified *Baxter* decision, which permitted the recovery of the Medicare lien from a settling defendant, creates a chilling and dangerous precedent for the unwary defense counsel.

The Medicare Second Payer Act

Under the original Medicare law, enacted as part of the Social Security Act of 1965, Medicare was the primary payer for Medicare-covered services (except for services covered by workers' compensation), regardless of whether the recipient also had private health insurance. The MSP was enacted by Congress in the 1980s to combat the rising burden of Medicare payments on the Federal Government by shifting the primary burden to private sources of payment. *See* 42 U.S.C. 1395y, *et seq.* To achieve this goal, the MSP mandates that Medicare providers, suppliers or beneficiaries must first submit claims to private health insurers, who then process the claims and make payments according to their coverage agreements. Then Medicare, as the "second payer," provides for the amounts not covered by the primary plan. In short, the MSP requires beneficiaries to exhaust all other available coverage before turning to Medicare for coverage.

If a primary health insurer does not pay the initial sum in accordance with its coverage agreement, or if that insurer is late in providing such payment, Medicare must make a timely, but reimbursable, payment to the providers. If such a conditional payment is made, the MSP allows the government to initiate an action against the private health insurer or a third party for double damages if the primary plan has failed to make payment in accordance with MSP regulations and Medicare has not been reimbursed.

Pursuant to the MSP, the Department of Health and Human Services has set forth regulations dictating when, and against whom, the government may bring the private action to recoup the conditional payment. *See* 42 C.F.R. §411.24. These regulations were designed as a tool to prevent plaintiffs from procuring double recovery for their medical expenses. First, the government may initiate a direct action against third parties responsible for making primary payments, such as private health insurers. Second, in the event that an individual beneficiary or provider receives payment from a third party, such as a private health insurer, they must reimburse Medicare within 60 days. Under the "received payment" provision of the MSP, those recipients of Medicare payments from third parties who do not reimburse Medicare within 60 days, including individual beneficiaries, health care providers, physicians and private insurers can be compelled to reimburse Medicare for the conditional payments. Finally, the MSP also gives the government the right to obtain reimbursement from a third party that should have paid Medicare, but pays a tort victim instead. In the case of liability insurance settlements, if the individual beneficiary or provider receiving the payment for medical expenses from the settlement does not reimburse Medicare within 60 days, the government may initiate an action against the third-party payer, including a defendant tortfeasor, *even though it has already compensated the beneficiary*. This final avenue to recovery is the one solidified by *Baxter* and is the one most dangerous to defendants.



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Leading up to *Baxter*

For nearly 20 years after the MSP's inception in the early 1980s, the federal government did not challenge the proposition that alleged tortfeasors were beyond the grasp

of the MSP. When the Department of Justice eventually did make the argument that the MSP's reach extended to tort defendants, it was met with judicial scorn. In 2000, one court admonished the government's claim and stated that such an argument would "perhaps have some merit" in the "former Soviet Union." *In re Dow Corning*, 250 B.R. 298, 339 (Bankr. E.D. Mich. 2000). In fact, as originally drafted, the only insurance programs subject to obligations under the MSP were "primary plans," defined as group health plans, liability insurance policies or plans and "self-insured plans." Self-insured plans were not defined by the MSP, but regulations promulgated under the MSP defined a self-insured plan as an "arrangement, oral or written...to provide health benefits or medical care or [to] assume liability for injury or illness" under which an entity "carries its own risk instead of taking out insurance with a carrier." *Mason v. American Tobacco Co.*, 346 F.3d 36, 39 (2d Cir. 2003) (citing 42 C.F.R. §§411.21, 411.50(b)). This definition was consistently held by the Courts of Appeal not to include tort defendants. See *United States v. Rhode Island Insurers' Insolvency Fund*, 80 F.3d 616, 620-22 (1st Cir. 1996) (stating that MSP specifically relates to the business of insurance and recovery under MSP is limited to entities within the insurance industry). Indeed, before *Baxter*, every court to consider the issue of whether the MSP permitted recovery from alleged tortfeasors rejected the government's argument and held that reimbursement under the MSP was limited to formal insurance entities.

In re Dow Corning Corp.

In *Dow Corning*, the government failed in an attempt to use the MSP as a basis to file claims against the bankruptcy estate of a silicone breast implant manufacturer. The United States Bankruptcy Court for the Eastern District of Michigan directly addressed the question of the entities against which the government may recover pursuant to the MSP. Citing the statute, the court stated that the United States is limited to pursuing reimbursement from two types of entities: a "primary plan" or an entity that has received payment from a primary plan. Therefore, the court held that unless a tort defendant qualifies as a primary plan or received payment from a primary plan,

the MSP does not grant the United States the right to initiate a direct action against it. The court noted that "the primary plan's responsibility rests upon contract principles and the question of tort liability is not part of the equation."

Mason v. American Tobacco Co.

In an opinion decided just weeks after *Baxter*, but before denial of certiorari and amendment of the MSP, the Second Circuit reasserted the overwhelming majority of legal precedent by stating that a compa-

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ny's status as an alleged tortfeasor does not render it liable under the MSP. In deciding the question of whether the MSP reaches alleged tortfeasors, the court noted that with the exception of the Eleventh Circuit in its decision in *Baxter Int'l*, courts have rejected all efforts to apply the statute's heavy remedy of double damages to the context of tort litigation.

After citing to the litany of jurisprudence rejecting the government's argument over the last decade, the court found that the plaintiffs had not offered any compelling reason why the MSP should apply to tort litigation. The court's language highlighted the government's illogical argument.

The plaintiffs question 'why is it "harsh" to impose double damages on a corporate tortfeasor who has chosen to self-insure (and who actually caused the victim's harm), but it is not "harsh" to impose double damages on the corporate tortfeasor who has bought insurance, or, even worse, on the insurance company who has actually done nothing wrong?' Plaintiffs' Brief at 53. But the answer to this is simply that it is harsh to impose MSP liability against alleged tortfeasors, but it is not harsh to impose such liability against entities who renege upon a pre-existing contractual arrangement to provide healthcare coverage. That is, it is not harsh to use the statute to serve the purpose for which it was enacted. In sum, the defendants are clearly correct when they assert that 'the trigger for bringing a MSP

claim is not the pendency of a disputed tort claim, but the established obligation to pay medical costs pursuant to a pre-existing arrangement to provide insurance benefits.'

The court noted that the case before it was distinguishable from the *Baxter* decision. Whereas the *Baxter* defendants had assumed an obligation to pay for the medical costs of plaintiffs through the establishment of a settlement fund, the defendants in *Mason* had taken no steps to pay medical costs of any potential plaintiffs.

The Baxter Decision

In *Baxter*, the United States filed an intervention complaint against manufacturer-defendants in a silicone breast implant product liability class action. In pertinent part for the discussion in this article, the intervenor was filed to recoup monies paid out by Medicare from the payers of a \$4.2 billion settlement involving 400,000 potential claimants. The complaint alleged that Medicare had made conditional payments, within the meaning of the MSP, to some or all of the class action plaintiffs and, as such, was entitled to reimbursement under the Act. Furthermore, because the product liability defendants qualified as "self-insured," Medicare was entitled to double the payments back.

The product liability defendants filed a motion to dismiss the complaint pursuant to F.R.C.P. 12(b)(6), arguing that the government failed to state a claim upon which relief could be granted. The district court dismissed the complaint, finding that: (1) the government improperly failed to particularly identify the Medicare beneficiaries, the services provided and the amounts owed; and (2) the product manufacturers did not qualify as a "self-insured plan" under the MSP. Both of these arguments were rejected and reversed by the Eleventh Circuit, and the case was remanded by that court for further findings on certain issues. The defendants' Petition for Writ of Certiorari to the United States Supreme Court was denied in June 2004.

The failure to identify the Medicare beneficiaries will generally only arise in the context of a class action or similar litigation. It is really only in that situation where the complaint would be filed without particularity as to the identity of the beneficiary and the

scope of the payments. However, those who have practiced for long enough (or in the right arena) are familiar with the difficulties in dealing with Medicare in terms of gathering information about a specific claimant, sometimes waiting up to a year for the information, if not longer.

The second decision listed above, *i.e.*, that the product manufacturers qualified as a self-insured plan under the MSP, has a far more sweeping and dangerous effect. As noted earlier, the MSP was designed by Congress to place Medicare in the position of being a secondary payer. Medicare is required to make first payment only: (1) when there is no alternative means of procuring payment for the beneficiary; or (2) when no payment from a “primary plan” has been made and none is expected. The *Baxter* decision specifically stated that payments from third parties in litigation are payments that are not “reasonably expected to be made” within the 120 day framework of the conditional payment requirements.

Any payments made under the second part of this framework are considered conditioned on reimbursement once payment is made by the primary plan.

The *Baxter* court refused to address the issue of whether or not the government is required to first pursue the beneficiary for reimbursement before targeting the primary plan because the issue was not fully briefed on appeal. Experience dictates, however, that such a requirement is unlikely. As a general matter, when the government is seeking reimbursement of payments it is owed, the courts have been reluctant to establish an order in which the government must pursue the potential obligees.

Where *Baxter* split from other courts that had previously addressed the issue was by its inclusion of product liability defendants in the definition of self-insured plans. As outlined previously, every other court that has dealt with the subject rejected the government’s position that a settling product liability defendant should be held account-

able for the Medicare lien as a “primary plan” under the MSP.

Although the government conceded that the defendants’ settlement arrangement was not a self-insured plan according to the plain language of the MSP, the *Baxter* court latched onto the very broad and inclusive definition of “self-insured plan” promulgated by the Department of Health and Human Services in the MSP implementing regulations. The court held this broad definition to include a combination of deductibles or payments from the defendants and the purchase of insurance policies. Thus, because the defendants had made some payments themselves through an arrangement to self-insure up to the amount of their policies’ deductibles, instead of completely relying on purchased insurance, the Eleventh Circuit deemed the defendants a self-insured plan. Accordingly, the defendant could be subject to a claim for recoupment under the self-insured plan provision of the MSP.

The Eleventh Circuit set forth another dangerous proposition in holding that if defendants had either actual or constructive knowledge that some recipients of the funds they were paying out had received Medicare payments, then defendants would be liable to reimburse the government pursuant to the MSP statute. The court stated that the defendants were in the best position to ascertain whether Medicare had made payments on behalf of a particular claimant, despite the existence of 400,000 registered potential claimants in this class action.

Keeping in mind that the *Baxter* decision was an appeal from a motion to dismiss, Medicare is not required (at least in the Eleventh Circuit) to identify the beneficiaries, services or payments made with particularity in the context of a class action complaint. The court noted that the identity of the potential claimants who might have received Medicare benefits was within the control of the defendants. Medicare could generate a list of all its beneficiaries who had received benefits or treatment related to silicone breast implants, perhaps, but such a list would almost certainly include people who had not filed claims, people who had opted out, or people who had their implants removed for reasons other than those for which they could receive payment. As a consequence, the court reasoned, the Department of Justice's Rule 11 obligation to file a complaint in good faith precluded the filing of such a list.

As a practical matter for situations not involving a class action, however, Medicare is notorious for refusing to speak to litigants or their counsel, ignoring letters and other requests for information, and generally frustrating attempts to gather the information required to avoid running afoul of the tenets of the MSP. In fact, this author's personal experience has included a Medicare employee stating that Medicare will not furnish the amount or details of the lien until the case settles. While that incident is almost certainly anecdotal and unusual, it calls into question the Eleventh Circuit's assumption that the product liability defendant is in a better position to know that the payment has been duplicated. This holding requires defendants to not only defend against plaintiff's claims, but also unduly burdens the defendant with the task of ascertaining the existence of any Medicare payments made,

no matter how voluminous the number of claimants or the lack of assistance from Medicare.

Additionally, the court held that because the *Baxter* defendants received payment from their liability carriers, they could be held to have "received payment" from a primary plan and thus sued under the MSP for reimbursement under that separate theory. As stated above, the MSP as originally drafted provided for a cause of action for reimbursement against entities which received Medicare payments from third

A self-insured plan need not consist of a formal set-aside.

parties, and specifically named physicians and providers. Before *Baxter*, all courts to decide this issue had determined the statute referred to the ultimate recipients, such as beneficiaries, physicians and health care providers, not entities that merely handle the money as intermediaries. The Eleventh Circuit, however, again looked to the regulations, rather than the text of the statute, and determined that the entities liable as recipients included, "a beneficiary, provider supplier, physician, attorney, State agency, or private insurer." (Emphasis added). After noting that the MSP treats self-insureds as insurers, the court stated that the defendants could be subject to a claim for receiving reimbursements from their excess carriers. The court held that because the defendants had contributed to a settlement fund from their retained earnings and then submitted claims to liability insurers for reimbursement, it could be proved that defendants had "received payment" of Medicare benefits through a third party. The court reversed and remanded to allow the government to marshal evidence showing defendants did in fact receive such funds.

2003 Amendments to the MSP

On December 8, 2003, after the panel issued its decision in *Baxter*, the President signed the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 into law, Pub. L. No. 108-173, 117 Stat. 2066 ("MMA"). Section 301 of the MMA largely codifies the regulations of the Department

of Health and Human Services relied upon by the Eleventh Circuit in *Baxter*. The MMA states that the amendments to the MSP are effective as if originally part of MSP statute as enacted in 1980.

The relevant portions of the MMA include a definition of the term "self-insured plan." The amendment states "[a]n entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part." This provision establishes that a self-insured plan need not consist of a formal set-aside and that an entity may be considered self-insured for *any* amount for which the entity carries its own risk, notwithstanding the fact that it has procured liability insurance.

The MMA also amends the "received payment" provision of the MSP statute. The MMA states that "the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity." The amendment essentially codifies the Eleventh Circuit's assertion that defendant tortfeasors that are deemed "self-insured plans" are subject to a cause of action for reimbursement to the extent that they are found to have received payment from a primary plan, including traditional liability insurance plans.

The Road from *Baxter*

The decision in *Baxter*, and its expanded codification by the MMA, creates a new environment in which defendants must settle their cases. The decision by the Supreme Court in *Baxter* to refuse to grant the defendants' writ of certiorari is more than likely a function of the fact that Congress has weighed in on the issue and changed the MSP to conform to the *Baxter* decision. Like it or not, the sweeping language of the MMA, which creates an even broader definition of self-insured plan than the Eleventh Circuit did, imperils all defendants settling cases in which Medicare has paid any portion of the plaintiff's medical expenses. In fact, it could be argued that no defendant is safe from the reach of the revised MSP.

The self-insured definition makes no effort to require that the portion of the risk carried by the settling defendant be the first

part of the risk. As a consequence, an *underinsured* defendant may not only be required to pay a portion of a settlement for a badly injured plaintiff, (thereby assuming the risk in part) but also double the Medicare lien if it is not paid by the settling plaintiff. A defendant who maintains a \$500 deductible is technically on the risk in part and, as such, is subject to the collection provisions of the MSP. Finally, because neither the Eleventh Circuit nor Congress dealt with the issue of the order in which the government must seek reimbursement, there is nothing to require the Department of Justice to seek reimbursement from the Medicare beneficiary first. In effect, *Baxter* and the MMA mandate that defendant tortfeasors are better served paying increased insurance premiums to private liability insurance providers in order to place the risk completely on that provider, rather than assuming any of the risk by setting aside their retained earnings to prepare themselves for potential litigation.

Avoiding the Trap

As was noted by Benjamin Franklin, an ounce of prevention is worth a pound of cure. When litigating and settling your case, awareness of the issues raised in this article may help to avoid painful consequences for your client (and for you when your client asks why it was not made aware of the risk).

In discovery, it is imperative that you make every effort to determine whether or not the plaintiff was eligible for Medicare, and whether or not Medicare has made any payments. Remember that for litigation purposes under the new MSP, any payment made by Medicare should be considered a contingent payment unless your client maintains none of the risk of liability. (It appears from the revised MSP that no risk means no deductible *and* fully insured for the potential value of the claim.) The most prudent action where the plaintiff was eligible for Medicare is to determine from Medicare if it has made any payments. This can be a long and difficult process, so involving Medicare's Coordination of Benefits Department as early in the litigation as possible is absolutely required. If the plaintiff's attorney is already involved with Medicare, you should not be reluctant to ask him or her exactly what steps

are being taken to insure that the entire lien is being accounted for. It is suggested that you make your requests, and receive your responses, in writing. For more information, the Department of Health and Human Services offers a website specifically to explain the coordination of benefits at <http://www.cms.hhs.gov>.

When coordinating your client's settlement, you must keep in mind that the perspective following *Baxter* is that Medicare must be reimbursed for its payments, regardless of fault or reason for payment. As a consequence, you must counsel your client to avoid the inclusion of any language that is designed to circumvent that effort. In recent years, many plaintiffs' attorneys have started to request that language be included in the release and/or settlement agreement that indicates that the settlement is made for pain and suffering only. You must be aware that this approach is designed solely to circumvent the Medicare lien, and it is now placing your client at risk for the reimbursement or double the settlement. Furthermore, the language insulates the settling plaintiff from a third-party action to recover the reimbursement made by your client. After all, if your client has drafted or approved a document that says the settlement is for pain and suffering only, how could a subsequent action against that plaintiff to recover payment of the Medicare lien possibly succeed?

Another suggestion for settlements is to include language that the plaintiff is responsible for payment of all outstanding medical liens, including reimbursement of Medicare. The language seems innocuous and almost redundant, but the language can be important to the eventual protection of your client. If possible, it may be prudent to specify the amount of the Medicare reimbursement included in the settlement proceeds, or even to hold back that amount and make the payment directly to Medicare. Since it is most likely the plaintiff who has standing to challenge the amount of the lien, it is better to join the plaintiff's interests with those of your client. If plaintiff feels that the amount being withheld from the payment is inaccurate, then the plaintiff can challenge the amount of the lien without dealing with the issue of standing.

A final possibility would be to include indemnification language in the settlement

agreement so that your client is protected from unreimbursed payment of the Medicare lien. This tactic is a last resort. It is very likely that such language will be met with stiff resistance from the plaintiff's attorney in your case. Furthermore, it is probably not in your client's best interest to guarantee not one but two additional litigations in order to resolve the first one, particularly since the final litigation, *i.e.*, your client's attempt to recover the Medicare lien from the original injured plaintiff, would probably not have a great success rate. A jury would probably not look kindly on a corporate defendant seeking reimbursement from a plaintiff it injured. Further, the plaintiff may be insolvent or difficult to find once the Medicare lien is finally paid. Finally, since the Medicare lien sought may be doubled under the MSP, the reimbursement of Medicare may actually be more expensive to your client than the original settlement. Thus, while inclusion of the indemnification language is certainly better than nothing, it may ultimately be as effective as shutting the barn door after the horse has escaped.

The government can institute an action against the defendant tortfeasor for double the amount of the Medicare lien, without regard to: (1) the fact that the defendant has already compensated the beneficiary once for the value of the medical expenses through settlement; and (2) whether Medicare has first sought reimbursement from the beneficiary—essentially resulting in a triple payment of the lien (and double recovery by the injured plaintiff). The only defense to this unfair and potentially catastrophic result is vigilance by defense counsel.

Conclusion

The newly revised Medicare Secondary Payer Act creates a different environment in which certain bodily injury cases must be litigated and settled. It is imperative that you make yourself aware of the new provisions and guide your clients accordingly. Since the Act does not differentiate between the source of the reimbursement or the amount paid in the settlement, a relatively modest settlement can become an extremely expensive one in the blink of an eye. Caution is required to insure that your client is not the target of the next *Baxter* decision.