NEWSSTAND

The Medicare Secondary Payor Act and Insurance Bad Faith Liability

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Eric B. Hermanson

Over the past few years, liability insurers settling claims on behalf of policyholders have increasingly found themselves grappling with Medicare Secondary Payor obligations. These Medicare requirements are technical and complex, and noncompliance may carry significant penalties: an insurer that settles directly with a tort claimant, without taking account of Medicare's right to recover conditional payments under the Secondary Payor Act, may be liable to Medicare for up to twice the lien amount, plus interest and attorneys' fees.

A recent decision of the U.S. District Court for the Middle District of Florida highlights another potential problem: that an insurer, attempting to protect itself from Medicare Secondary Payor liabilities, may provide plaintiffs with the basis to allege bad faith claim handling under state law. Although this issue is just beginning to emerge, it has the potential to become a real concern for insurers, particularly in jurisdictions like Florida, where plaintiffs' lawyers are adept in the art of the "bad faith setup."

Background

The Medicare Secondary Payor Act

Medicare is a federal program that provides medical benefits for approximately 47 million people in the United States. Initially established in 1965 to provide medical care for individuals age 65 and over, it has since expanded to encompass various other diseases, and now covers approximately 8 million individuals under the age of 65.

In the mid-1970s, concerns began to emerge about the Medicare program's long-term fiscal stability. In 1980, as a response to those concerns, Congress enacted the Medicare Secondary Payor (MSP) Act (42 USC 1395y(b)(2)). The purpose of the Act was to ensure that the federal Medicare Program was a "secondary payor," which was not called upon to make payments for individuals' medical expenses when a "primary plan" – defined as a liability insurance policy, workers compensation policy, auto insurance policy, or group health plan – was available to cover the same expenses. 42 U.S.C. § 1395y(b)(2)(A)(ii).

Medicare Modernization Act of 2003

For some years after enactment of the Medicare Secondary Payor Act, enforcement of these provisions was lax. The Centers for Medicare and Medicaid Services (CMS), which administer the Medicare Program, did not consistently seek recovery of Medicare expenditures after settlements of bodily injury claims. And when CMS did try to recoup Medicare expenditures from settling parties, courts often rejected those efforts on various grounds.

For example, in *Thompson v. Goetzmann*, 315 F. 3d 457 (5th Cir. 2002), *amended and modified en banc*, 337 F.3d 459 (2003), the plaintiff, a Medicare beneficiary, was injured by an allegedly defective prosthesis. After a lawsuit, she settled with the manufacturer for $256,000. Medicare learned of the settlement and filed suit to recover a portion of the settlement amount. The Fifth Circuit denied Medicare's right of recovery on grounds that: [1] the Medicare Secondary Payor Act, as then drafted, only permitted recovery from primary payors who paid "promptly at the time medical services were provided" -- not from third parties who settled after medical services were complete; and [2] a self-insured defendant was not a "primary plan" within the meaning of the

Act. The court also noted in passing that the Medicare Secondary Payor Act had no provision requiring payback by the claimant or the claimant's attorney.

In 2003, in response to *Goetzman* and similar cases, Congress enacted the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, H.R. 1, Title III, § 301(b)(2)A. The Act expanded the definition of "primary plan" to include self-insured entities (as well as insurers and group health plans), and it changed the way Medicare reimbursement rights were treated in litigation settlements. Among other things, the Act gave Medicare what some have described as a "super-lien," with priority rights over other parties in tort settlements.

After the 2003 amendments, the Secondary Payor Act read as follows:

[a] primary plan, and an entity that receives payment from a primary plan, *shall reimburse* [Medicare] for any payment made by [Medicare] ...with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service (emphasis added)...

A primary plan's responsibility for such payment may be demonstrated by 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's insured, or by other means...

In order to recover payment made under this subchapter for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, 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.

Medicare's Rights As Secondary Payor

After the 2003 Act, it was clear that all payments made by the Government under the Medicare program were "conditional," and were subject to recoupment out of a tort settlement if a self-insured defendant, or a defendant's insurer, later agreed to pay for the recipient's medical care. In such cases, the Government was given a "direct right of recovery for the entire amount conditionally paid," plus interest. *Cox v. Shalala*, 112 F.3d 151, 154 (4th Cir. 1997).

Moreover, it became clear that the Government could pursue recovery from a primary payor even if the primary payor had already paid the settlement amount to the plaintiff as part of the settlement. As HHS stated, in its implementing regulations:

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 payor must reimburse Medicare even though it has already reimbursed the beneficiary or other party*.

In effect, then, an insurer that settles a contested tort action without taking appropriate steps to protect Medicare's interests risks having to pay twice for the plaintiff's medical care – once to the plaintiff and a second time to the Government. To the extent the Government is required to initiate litigation to recover these amounts, the insurer risks having to pay double the amount, plus interest, under 42 U.S.C. § 1395y(b)(2)(B)(iii). The insurer cannot escape its reimbursement obligation simply by paying the plaintiff, on behalf of its insured, and assuming that the plaintiff (or his counsel) will repay the Government from those proceeds.

Risks to Settling Insurers

The risks are real to settling insurers who fail to comply with these Medicare provisions. Over the last several years, the Government has displayed an increasing willingness to prosecute claims and seek penalties from settling parties.

For example, in the recent (and highly publicized) case of *U.S. v. Stricker*, No. 09-KOB-2423-E (N.D. Ala.), the defendants included a group of insurance companies – Travelers, AIG, National Union, Lexington, American Home, the Insurance Company of the State of Pennsylvania; a group of self-insured defendants; and a group of plaintiffs' law firms that collectively negotiated a $300 million settlement of a class action liability lawsuit (the "Abernathy Settlement"). The settlement was allegedly entered into without any party determining whether any of the class members were Medicare beneficiaries, or notifying the Government under 42 CFR §411.25, or taking steps to reimburse Medicare conditional payments.

Some years later, the Government sued for repayment from the settling insurers and other parties. It alleged that the Abernathy Settlement included 907 Medicare beneficiaries, who received conditional Medicare payments totaling $67.1 million. It demanded that the settling parties reimburse the $67.1 million directly, plus double damages and interest: a total of roughly $150 million.

The District Court ultimately dismissed the Government's case in *Stricker* on statute of limitations grounds. But the message was clear. *Stricker* was clearly intended as a warning to insurers (and others) to exercise caution when settling claims involving Medicare beneficiaries. Given the penalties associated with the statute, it is not the kind of warning an insurer can easily ignore.

Measures to Avoid Medicare Statutory Liability

Unfortunately, in practice, the protection of Medicare's statutory interests is easier said than done. The calculation of what the Government has spent on a particular plaintiff's care, and which aspects of that care were related to a particular incident, may be difficult. The process is even more complicated in cases where a plaintiff has ongoing medical expenses – meaning that Medicare may face expenses in the future arising out of the plaintiff's injury. In some cases, the process of resolving a Medicare lien can take six months or longer.

In most cases, insurers rely on plaintiffs' counsel to resolve these issues with Medicare. Generally, in the settlement documents, an insurer will make the plaintiff's satisfaction of the lien a condition precedent to any settlement payment. While the plaintiff's counsel is negotiating the lien, the insurer will either withhold payment, or will issue a check with Medicare as a payee, so that the plaintiff cannot cash the check and access the funds without Medicare's express approval.

Some insurers -- though not all -- will agree to make a partial payment to the plaintiff while the lien remains outstanding, so long as the plaintiff's law firm agrees to indemnify the insurer for any Medicare liability that could arise if liens are not satisfactorily resolved. On the other hand, this practice bears some risks, and some state court ethics rulings have suggested that it is problematic. See, e.g., Tennessee Formal Op. 2010-F-154 (2010); see also Wisconsin Formal Opinion E-87-11 (barring defense lawyers from proposing, demanding, or entering into an indemnification agreement for medical liens).

The Bad Faith Setup

Finally, what if a plaintiff's law firm is unwilling to await the outcome of this complex process and demands payment from an insurer up front without satisfactorily addressing Medicare's conditional payments? This was the situation in a recent decision from the Middle District of Florida, *Tomlinson v. Landers*, No. 07-CV-1180-J-TEM (April 27, 2009). The holding of that case is somewhat troubling from an insurer's perspective.

Tomlinson, a Medicare recipient, was seriously injured in a head-on auto accident with another individual (Landers). On June 20, 2007, his counsel wrote to Landers' insurance carrier, Millers Classified Insurance Co.

("MCIC"), demanding that the insurer tender policy limits of $100,000 to settle Tomlinson's bodily injury claim. Discussions between Tomlinson and MCIC did not succeed in resolving the claim.

On November 14, 2007, Tomlinson's counsel again wrote MCIC, stating that Tomlinson "will consider MCIC to be in bad faith unless your limits of $100,000 are paid within ten (10) days of the date of this letter." On November 20, 2007, MCIC accepted the plaintiffs' demand and tendered a check in the amount of $100,000, made payable to Tomlinson, his attorney, *and to Medicare*, which had a lien against the settlement proceeds.

On November 29, 2007, Tomlinson's counsel returned the check to MCIC, with the demand that MCIC tender a check that did not include Medicare as a payee. Tomlinson's counsel indicated that he intended to "resolve the lien directly with Medicare, and hold [MCIC] harmless." It insisted that the insurer accept this offer as part of the settlement, under Florida's "mirror image rule." *See Montgomery v. English*, 902 So. 2d 836, 837 (Fla. 5th DCA 2005) (no contract is formed unless the acceptance of an offer is "absolute, unconditional and identical with the terms of the offer").

On December 7, 2007, MCIC advised Tomlinson's counsel that the Medicare Secondary Payor Act required the insurer to take responsibility for satisfying Medicare's lien in order to avoid a potential liability for twice the lien amount and attorneys' fees. "We simply cannot rely on a promise from the claimant to satisfy the lien because the statute and regulations provide that a settling party like [MCIC] would remain liable even after paying the money to your client … A Secondary Payor can be subject to liability for double the amount of the lien plus attorneys' fees."

MCIC then offered two alternative ways of proceeding, to accommodate Medicare's interests. The first method (which MCIC had previously offered) was to issue a check made payable jointly to Tomlinson, his law firm and Medicare. The second method was to wait until plaintiffs' counsel had secured written documentation from Medicare, stating the amount of the conditional payments for which Medicare was seeking reimbursement. MCIC would then issue separate checks to Medicare for the amount of their lien, and to Tomlinson for the remainder.

Tomlinson declined both of these options, and proceeded with a suit against MCIC's insured. One year later, on January 29, 2009, MCIC moved to enforce the settlement, arguing that there had been a valid offer and acceptance, because all essential terms of the settlement demand were accepted when MCIC agreed to pay its policy limits.

The court denied MCIC's motion. It held that no settlement had been consummated between the parties because no meeting of the minds had occurred on the steps that must be taken to resolve the Medicare lien at issue. Specifically, the court noted plaintiffs' "objection to MCIC's insistence on the inclusion of Medicare as a payee on the settlement check," and plaintiffs' desire "to resolve any Medicare liens on their own accord," subject to an agreement to hold MCIC harmless.

Based on this offer, which MCIC had rejected, the court found that "the parties were engaged in ongoing negotiations regarding the inclusion, or lack thereof, of Medicare as a payee on the settlement check, and that no meeting of the minds ever occurred regarding this point of contention between the parties."

The *Tomlinson* Dilemma

The insurer in *Tomlinson* faced a dilemma. On the one hand, the insurer could have simply complied with Tomlinson's counsel's time-limited demand for immediate payment of policy limits. This would have cut off the possibility of a claim for bad faith by Tomlinson under Florida law. But in so doing, the insurer would have left itself liable to Medicare for failing to protect Medicare's secondary-payor lien. If Medicare had then moved to seek reimbursement from the insurer directly – as in *Stricker* – the insurer might have found itself liable to pay its policy limits twice: once to Tomlinson in settlement, and once to Medicare, as reimbursement for Medicare conditional payments made on Tomlinson's behalf. (In fact, if Medicare found it necessary to initiate

litigation to recover the conditional medical payments, the insurer might have become liable to pay its policy limits three times: once to Tomlinson in settlement, and twice more to the Government under 42 U.S.C. § 1395y(b)(2)(B)).

On the other hand, the insurer could have refused to comply with Tomlinson's time-limited demand – as in fact it did – unless Tomlinson also included provisions that adequately protected the insurer from Medicare liability. This option would have cut off the possibility of double-payment and penalties under the Medicare Secondary Payor Act. However, under Florida's version of the "mirror-image rule," the refusal would have left the insurer exposed – as in fact it did – to a potential claim of bad faith under Florida law.

Finally, of course, the insurer might have valid preemption defenses to any state law claim of liability for bad faith claim handling based on the insurer's attempt to protect Medicare's statutory rights. However, these defenses have not yet been tested in the federal appellate courts.

Conclusion

The question of how to approach the *Tomlinson* dilemma will implicate difficult and subtle considerations, which may vary depending on the facts of the case, the jurisdiction, and the still-emerging law in this area. For the moment, the most that can comfortably be said is that insurers must remain sensitive to the potentially conflicting obligations imposed by the Medicare Secondary Payor Act and state common law.