Too Many Teeth: Understanding the Medicare Secondary Payer Act and its Threat to Businesses

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ABSTRACT

The Medicare Secondary Payer Act ("MSP"), first enacted in 1980, has undergone several changes over the past three decades in an effort by the government to recoup some of its losses from conditional payments it makes on behalf of Medicare beneficiaries. In light of Congress’s many cost-cutting exploits of late, more attention should be drawn towards recent amendments to the MSP in an effort to find a healthy balance between the government’s interest in recouping its losses and private businesses’ interest in staying in business.

Congress reacted to increasing Medicare costs in 2003 by inserting in the Medicare Modernization Act of 2003 a new definition of “self-insured plan” under the MSP. The amendment effectively brought into the MSP’s grasp tortfeasors who provide their own liability insurance and pay injured claimants through a settlement or judgment. While this change might seem minor, the ramifications for businesses have been dramatic. Products liability cases, especially, can force companies out of business where a company committed a tort and settles with hundreds or thousands of claimants. This comment explores these ramifications and recommends how Congress should further amend the MSP to find an appropriate balance between government and business interests.
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I. INTRODUCTION

Amidst the health care overhaul and ever-increasing discussions of cuts on government spending in the United States, the possibility of Medicare recouping some of its losses has sounded all too enticing to Congress over the past decade. But in its effort to cut losses, Congress has overshot its goals and harmed private businesses in ways that it did not foresee with its amendments to the Medicare Secondary Payer Act (“MSP”).

In 1980, Congress enacted the first provision that made Medicare the secondary payer to certain primary plans with the passage of the MSP. The idea behind this legislation was to allow Medicare to recoup some of its losses by requiring that private resources, when available, become the primary sources of payment for medical expenses for Medicare beneficiaries. In 2003, again amidst skyrocketing healthcare costs, President


2 See MSP Manual, supra note 1, § 10.
George W. Bush signed into law the Medicare Prescription Drug, Improvement and Modernization Act of 2003 ("MMA") after it narrowly passed in Congress.\footnote{See CCH Health Law Group Editorial Staff, Medicare Prescription Drug, Improvement, and Modernization Act of 2003: Law and Explanation 1 (2nd ed. 2004) (explaining that the most provisions in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 ("MMA") were the prescription drug benefit plan and the private fee-for-service coverage, which allowed insurance companies to provide health care to Medicare beneficiaries).} The MMA largely overhauled the Medicare program with the Medicare Part D program.\footnote{See \textit{id.} (indicating that the MMA was created the option of subsidized prescription drug benefits for seniors, which served as a foundation for the passage of the legislation).} Tucked away in the bill beneath the hot-button issues surrounding the Medicare Part D prescription drug coverage plan was an amendment to the MSP that provided a definition for the term "self-insured," the previous ambiguity of which had created much uncertainty with regard to Medicare Secondary Payer reimbursement.\footnote{See, \textit{e.g.}, United States v. Baxter Int'l, Inc., 345 F.3d 866 (11th Cir. 2003) (disagreeing with the Fifth Circuit about}
ambiguity by broadly defining the term “self-insured” in the statute, the MMA enabled the Centers for Medicare and Medicaid Services (“CMS”) to recover from tortfeasors under the MSP when the injured party received reimbursement for care and treatment of injuries related to the tort.\(^6\)

This comment first discusses in Part II the background of the MSP and CMS’ role in MSP reimbursement. Next, Part III analyzes the effects the MSP had on businesses involved in a tort claim before the 2003 MMA amendments, as well as after the MMA, comparing and contrasting various courts’ handling of the MSP and its ambiguities. This analysis reveals the negative

\(^6\) See Pub. L. No. 108-173, § 301(b)(1) (explaining that a business, trade, or professional entity that carries its own risk (i.e. does not take out an insurance plan through a third party) is a “self-insured plan”).
effects the MMA amendments have had on businesses under the MSP after 2003. Part IV of this comment discusses Congress’ recent attempts at reforming the MSP to address the problems associated with the MMA amendments, namely the Medicare, Medicaid SCHIP Extension Act of 2007 ("MMSEA"), and the proposed Strengthening Medicare and Reimbursing Taxpayers ("SMART") Act. Part IV also includes recommendations and suggestions for how Congress should react. Part V provides some concluding thoughts on the current and future state of the MSP.

II. THE MEDICARE SECONDARY PAYER STATUTE

A. THE MEDICARE PROGRAM AND CMS

Before discussing the state of the MSP before and after the 2003 MMA amendments, a brief explanation of the Medicare program and CMS is necessary. Enacted in 1965, Medicare is a social insurance program administered by the United States government that provides health insurance coverage to citizens sixty-five years of age or over, those under sixty-five who are permanently disabled or have a congenital physical disability, or those who meet other special criteria such as end stage renal disease.\(^7\) The

\(^7\) See Steven Jonas, et al., Introduction to the U.S. Health Care System 135 (6th ed. 2007) (explaining that Medicare was the first national social insurance program to finance medical care in the United States and originally provided payment for some
program was created in light of increasing numbers of senior citizens who were facing heightened medical costs but did not have health insurance coverage. Medicare Part A is funded primarily from Social Security taxes, whereas two-thirds of Part B is funded from general revenues. Premiums mostly fund Part D health services for persons sixty-five years of age and older, and that Medicare’s coverage was broadened in 1973 to include permanently disabled workers and their dependents who were eligible for old age and disability insurance, as well as persons with end-stage renal disease.).

8 See id. (explaining that CMS’ administrative costs are remarkably low compared to those of the private health insurance sector).

9 See id. (stating that Medicare consists of hospital insurance (Part A), which also covers skilled nursing facility care and hospice and home health care); id. (further explaining that Medicare Part B includes supplementary medical insurance, which covers physician and certain other health professional services); id. (indicating that Medicare Part C, known as Medicare+Choice, permits Medicare beneficiaries to enroll in MCOs); id. (stating that CMS the designed Medicare Part D, or Medicare Prescription Drug Coverage, to lower the costs of prescription medication for Medicare beneficiaries.).
Medicare prescription drug coverage. Medicare reimburses physicians on a "fee-for-service" basis, while hospitals are reimbursed on an "episode-of-care" basis.

CMS is a federal agency within the Department of Health and Human Services ("DHHS"). It operates the Medicare program and works in partnership with state governments in administering Medicaid, the State Children’s Health Insurance Program ("SCHIP"), and health insurance portability standards. CMS, through the Medicare Secondary Payer Recovery Contractor

10 Id.
11 See id. at 136, 146 (explaining that for Medicare reimbursement, the beneficiary pays a deductible and the hospital or physician bills Medicare for reimbursement for the portion of the services that Medicare covers).
12 See id. at 182 (stating that CMS was known as the Health Care Financing Administration ("HCFA") until 2001).
13 See id. (explaining that because Medicare and Medicaid make up so much of the source of health costs in the United States, CMS has significant ability to influence the quality of care throughout the country’s healthcare system).
(“MSPRC”), is responsible for ensuring that the MSP receives reimbursement from primary payers.  

B. THE MEDICARE SECONDARY PAYER ACT

Under the Medicare law as originally enacted in 1965, Medicare was the primary payer for services other than those covered by workers’ compensation programs. Congress enacted the MSP with a primary goal of seeking fiscal integrity within the Medicare program by shifting costs from Medicare to private insurers.

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14 CMS Manual, supra note 1, § 10 (providing guidelines for MSP compliance, as established by CMS).

15 See id. (explaining beginning in 1980, Congress enacted provisions that made Medicare the secondary payer to primary payers); see also Social Security Act, 42 U.S.C. § 1862b (2011) (establishing the Social Security program, under which Congress had initially enacted the Medicare program in 1965).

16 See CMS Manual, supra note 1, § 10 (explaining that the MSP thus made Medicare the secondary payer to certain primary plans); see also Zinman v. Shalala, 67 F.3d 841, 845 (9th Cir. 1995) (“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.”); Tamela J. White, The Medicare Secondary Payer Act and Section
The MSP prohibits Medicare from making payment if payment has been made or can reasonably be expected to be made by any of the following primary plans: group health plans, workers’ compensation plans, liability insurance, or no-fault insurance. If a primary plan has not paid or CMS cannot reasonably expect


17 See 42 U.S.C. § 41.24(h) (2011) (providing, in pertinent part, that CMS requires reimbursement of a conditional payment when a defendant or its insurance company “is, or should be, aware that Medicare has made a conditional payment.”); see also 42 U.S.C. § 1395y(b)(2)(A)(i)-(b)(2)(A)(ii) (“[P]ayment may not be made with respect to any item or service to the extent that (i) payment has been made, or can reasonably be expected to be made, with respect to the item or service as required under paragraph (1)[.]”); CMS Manual, supra note 1, § 20 (defining “primary payer” as any entity that is or was required or responsible to make payment with respect to an item or service (or any portion thereof) under a primary plan).
the primary plan to pay, then Medicare may make a “conditional payment.” CMS makes conditional payments to providers as a protective measure for the Medicare beneficiary because a beneficiary or provider often does not know whether a primary payer exists. The entire amount of the “conditional payment” is subject to reimbursement when the primary plan makes payment.

18 See CMS Manual, supra note 1, § 20 (defining “conditional payment” as “a Medicare payment, conditioned upon reimbursement to Medicare, for services for which another insurer is primary payer,” and further explaining that Medicare “conditionally” pays for the medical costs of every Medicare-eligible individual and later seeks reimbursement if it determines that the medical costs were actually the responsibility of another under the MSP).

19 See White, supra note 16, at 183 (indicating that Medicare beneficiaries, upon enrollment in Medicare, must agree that Medicare can recover money that it has spent, as with conditional payments, which prevents the beneficiary from unlawfully profiting off of the Medicare); see also 42 U.S.C. § 411.24(1)(2)(i) (2011) (explaining that Medicare beneficiaries, as a condition of participation in the Medicare program, must disclose any actual or potential alternative sources of payment other than Medicare; 42 U.S.C. § 1395y(b)(2)(B)(i) (stating that
a Medicare beneficiary’s failure to disclose such knowledge introduces the possibility of exclusion from the Medicare program).

20 See CMS Manual, supra note 1, § 10 (explaining that in other circumstances, when a private primary payer is available and Medicare is thus the secondary payer, the provider or beneficiary submits a claim to the primary payer before CMS makes a payment); see also Kenneth Paradis, How Will New Legislation Affect You? New Requirements for Medicare Set-Aside Arrangements, 18 J. Workers Comp. 32, 38 (2009), http://www.cpscmsa.com/uploads/article_jwc.pdf (providing that these payments are conditional regardless of whether CMS knows of another entity that should be the primary payer; however, the Medicare, Medicaid, and SCHIP Extension Act of 2007 (“MMSEA”) will require covered entities to report to CMS any claim involving a Medicare-eligible beneficiary, regardless of whether Medicare actually made any conditional payments on the claim). But see Hadden v. United States, 661 F.3d 298, 305 (6th Cir. 2011) (White, J., dissenting) (raising the question of whether Medicare actually has an automatic right to recover the full amount of the conditional payment in tort claims settlements, or whether the amount should be something less, as in a percentage
For many years, the MSP regulations were poorly understood and greatly under-enforced.\textsuperscript{21} Before 2003 CMS could only track beneficiaries and seek reimbursement through primary plans and not through tortfeasors themselves.\textsuperscript{22} CMS often tried to recover of the settlement that reflects the damages for medical expenses).

\textsuperscript{21} See Paradis, supra note 20, at 35-36 (explaining that even in cases where insurers or counsel successfully obtain information from Medicare, they must still submit the settlement documentation to CMS, a final step that insurers and attorneys often overlook); see also Roy A. Franco et al., Mission Impossible: Resolution of a Case with a Medicare Claimant?, For the Defense 10 (May 2009), available at https://www.google.com/search?ix=heb&sourceid=chrome&ie=UTF-8&q=Roy+A.+Franco++Resolution+of+a+Case+with+a+Medicare+Claimant%3F (follow the first search result hyperlink from “www.dri.org”; then open the PDF document that automatically downloads) (indicating that the MSP was rarely followed by insurance carriers and self-insured entities and was not enforced by CMS until around 2001, which prompted the MMA amendments to the Act).

\textsuperscript{22} See, e.g., Thompson v. Goetzmann, 337 F.3d 489 (5th Cir. 2003) (holding that CMS could not collect reimbursement from the self-
payments from tortfeasors by claiming that tortfeasors fell under the MSP’s scope through the term “self-insurer”, even though the statute never actually defined the term.\textsuperscript{23} CMS argued this under the theory that tortfeasors were the “primary payers” in tort liability claims in which they pay a settlement or judgment to an injured Medicare beneficiary.\textsuperscript{24} Courts generally rejected this argument, finding that the statute’s plain meaning insured prosthetic hip manufacturer because the settlement agreement did not transform the defendant company into a “self-insured” entity for MSP purposes); Mason v. Am. Tobacco Co., 346 F.3d 36 (2d Cir. 2003) (finding that tobacco companies were not “self-insured” plans and thus could not be held liable to CMS under the MSP for payments made by Medicare to treat the beneficiaries’ illnesses).

\textsuperscript{23} See, e.g., Goetzmann, 337 F.3d at 495 (explaining that the government argues that Zimmer is liable for reimbursement because Zimmer was “required or responsible” to make payments to Loftin).

\textsuperscript{24} See, e.g., Mason, 346 F.3d at 40 (“Plaintiffs argue that each defendant in this action ‘is a self-insured plan as a matter of law because the corporate structure through which each conducts its business has the purpose and legal effect, in part, to assume legal liability for injury.’”).
meant that the MSP applied only to various types of insurance plans and not to tortfeasors generally.\textsuperscript{25}

In 2003, Congress amended the MSP in an attempt to resolve the ambiguity in the MSP surrounding the lack of definition for “self-insured.”\textsuperscript{26} The amendment, or the MMA, established that CMS could collect not only from the “primary plan,” but also “an entity that receives payment from a primary plan” (emphasis added).\textsuperscript{27} These statutory changes meant that “self-insured” entities now included what CMS argued for many years: any entity that pays its own settlement or judgment without going through insurance is subject to liability.\textsuperscript{28} Because of the possibility

\textsuperscript{25} See \textit{Goetzmann}, 337 F.3d at 502 (explaining that the plain meaning of the MSP supports this interpretation).

\textsuperscript{26} See 42 U.S.C. § 1395y(b)(2)(A)(ii) (2011) (“An 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.”).

\textsuperscript{27} \textit{Id.} at 1395y(b)(2)(B)(ii).

\textsuperscript{28} See \textit{id.} (indicating that if a self-insured entity pays a Medicare beneficiary a settlement or judgment with retained funds, that entity would now be subject to liability to CMS under the MSP); \textit{see also Goetzmann}, 337 F.3d at 493 (“The
of a tortfeasor being subject to liability to CMS even years after a settlement (or judgment), it is in the parties’ interest to know what amount the tortfeasor could potentially owe CMS.\textsuperscript{29} The current law has no mechanism for CMS to provide this estimate.\textsuperscript{30} This creates disincentives for parties involved in government alleged that Zimmer was “self-insured for its liability to Loftin,” which, as a putative tortfeasor settling Loftin’s products-liability action against it, had paid Loftin a substantial sum of money.”).\textsuperscript{29} See \textit{The Strengthening Medicare and Repaying Taxpayers (SMART) Act – S. 1718/H.R. 1063}, Medicare Advocacy Recovery Coalition, http://www.marccoalition.com/PDF/the-smart-act-legislative-one-pager-h.r.-1063-0005.pdf (last visited Mar. 4, 2012) [hereinafter SMART Act Explanation] (explaining through a hypothetical the disincentives to settle that the MSP provides parties to a tort claim involving a Medicare beneficiary).\textsuperscript{30} See \textit{The Strengthening Medicare and Repaying Taxpayers (SMART) Act: How Will the SMART Act Improve Efficiency in the Medicare Secondary Payer (MSP) System?}, Medicare Advocacy Recovery Coalition, http://www.marccoalition.com/PDF/the-smart-act-section-by-section-legislative-summary-h.r.-1063-0006.pdf (last visited Mar. 4, 2012) [hereinafter SMART Act Fact Sheet] (explaining that Medicare has no pathway to provide an amount
tort cases to settle claims, thus leading to judicial inefficiency because of an influx of cases continuing with litigation.\textsuperscript{31}

\textbf{i. What Kinds of Tortfeasors Can Face Liability to CMS?}

The CMS Manual defines “liability insurance” as insurance that provides payment based on the policyholder’s alleged legal liability for injury or illness or damage to property.\textsuperscript{32} An entity that engages in a business, trade, or profession is considered a self-insured entity for liability purposes to the extent that it has not purchased liability insurance.\textsuperscript{33}

The statute stipulates that CMS may make a “conditional payment” if the tortfeasor or liability insurer will either not due to CMS to the parties before settlement for conditional payments).\textsuperscript{31}

\textsuperscript{31} See \textit{id.} (indicating that claims involving Medicare beneficiaries today cannot settle because the parties cannot determine their respective obligations to reimburse CMS).

\textsuperscript{32} See CMS Manual, \textit{supra} note 1, § 20 (stating that liability insurance also includes payments under state “wrongful death” statutes that provide payment for medical damages).

\textsuperscript{33} \textit{Id.} § 10.6.
pay or not pay promptly. CMS conditions these payments on reimbursement if the tortfeasor has a demonstrated responsibility to make the primary payment. The MSP enforces this provision by allowing the Secretary of DHHS to file suit against the beneficiary or a third party, such as the defendant or the plaintiff’s and defendant’s counsels, for double damages if the primary plan fails to make a payment. CMS may seek

34 Id. § 10.7 (stipulating that CMS may not make payment if liability insurance or the like is the proper primary payer and makes payment.); see 42 U.S.C. § 1395y(b)(2)(A)(i)-(b)(2)(A)(ii) (2011) (explaining when payment from a primary payer can reasonably be expected to be made).

35 See 42 U.S.C. § 1395y(b)(2)(B)(ii) (explaining that responsibility can be demonstrated through a judgment, a settlement payment, a waiver, or a release of payment for items or services included in a claim against the primary payer or the payer’s insured, or by other means).

36 See CMS Manual, supra note 1, §§ 10.6, 40.1 (stating that CMS has a right to recover from these private entities that is “superior to other entities including Medicaid because Medicare’s direct right of recovery is explicitly proscribed in Federal law and other entities’ recovery rights are based on either State law or subrogation rights”).

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reimbursement from the entire settlement amount less attorneys’ fees.\textsuperscript{37}

The problems with the expanded definition of “self-insured” entities in the MSP and MMA amendments can be illustrated through a hypothetical. Suppose a new drug manufacturer, PharmInc., has developed a drug to treat patients with hypertension. The Food and Drug Administration approved the drug for sale. PharmInc. sells the drug to thousands of patients, who at first seemed to handle the drug well with no serious side-effects. Several years after the drug was on the market, however, patients began having heart attacks with increasing frequency. The lawsuits began to reign in with plaintiffs alleging that PharmInc. improperly manufactured drug and caused the drug users’ injuries. After a few more years, a court consolidates the claims into a single products liability case in federal court. PharmInc. had to weigh the costs of settling against the costs of pursuing litigation and potentially losing more money with litigation costs and a larger judgment against them. PharmInc. decides to settle in the class action suit, so

\textsuperscript{37} 42 C.F.R. § 1395y(b)(2)(B)(ii) (stating that if the primary payer does not reimburse Medicare within sixty days of the date of notice of reimbursement, CMS may charge interest on the amount of reimbursement until the primary payer pays).
it sets up a settlement fund through which it compensates the plaintiffs from the case without going through liability insurance. The total settlement is $30 million.

About fifty-five of those who claimed injuries from the drug were Medicare beneficiaries who received conditional payments from Medicare for treatment of their injuries. Because PharmInc. chose to settle, it is now liable to CMS for reimbursement of any conditional payments CMS made to the injured beneficiaries for treatment of their injuries related to PharmInc.’s alleged tortious conduct. PharmInc., however, has no idea how much it could potentially owe CMS; the current MSP does not require CMS to give any sort of estimate. PharmInc. therefore has a disincentive to settle with these fifty-five beneficiaries because of its potential future liability to CMS, preferring to litigate in the hopes of winning a judgment in its favor. For purposes of this hypothetical, however, assume that PharmInc. decides to settle despite the disincentives.

III. THE MSP BEFORE AND AFTER THE 2003 MMA AMENDMENTS

A. THE MSP BEFORE THE 2003 MMA AMENDMENTS

Before the 2003 MMA amendments, most courts would not consider PharmInc. a “self-insured” entity under the MSP. Most courts rejected CMS’ arguments that the term “self-insured” included tortfeasors, finding that the MSP applied only to various types of insurance plans and not to alleged
tortfeasors.\textsuperscript{38} Consequently, before the 2003 MMA amendments, PharmInc. would likely seek settlement with the beneficiary because of CMS’ unlikelihood of succeeding on a claim against the company for reimbursement.\textsuperscript{39}

In this pre-MMA amendments scenario, the hypothetical parties agreed to settle for $45 million. If CMS asserted a claim for reimbursement from PharmInc. and the beneficiaries under the theory that the company was “self-insured” under the pre-2003 statute, a court would have likely dismissed its claim.\textsuperscript{40} The MSP would protect PharmInc. against CMS’ ability to

\textsuperscript{38} See, e.g., Thompson v. Goetzmann, 337 F.3d 489 (5th Cir. 2003) (holding that alleged tortfeasors that do not have liability insurance from a third-party insurer and who settle with plaintiffs and pay out of pocket are not “self-insured plans” within the meaning of the MSP).

\textsuperscript{39} See SMART Act Explanation, supra note 29, (explaining that MSP laws and regulations were poorly understood and rarely enforced for many years).

\textsuperscript{40} See, e.g., In re Diet Drugs Products Liab. Litig., 2001 WL 283163 (E.D. Pa. Mar. 21, 2001) (rejecting the government’s argument that an entity that enters a liability settlement and that assumes risk for its own liability is a self-insured plan under the statute); see also 42 U.S.C. § 1395y(b)(2)(A)(ii)
recover.\textsuperscript{41} Case law from before 2003 demonstrates the tendency of courts to reject the government’s argument that companies like PharmInc. become “self-insured” plans for MSP purposes when they settle with plaintiffs.

\textbf{i. The Ambiguity of a “Self-Insured” Entity}

In \textit{Thomas v. Goetzmann}, a pre-MMA amendment case, the Fifth Circuit refused to read into the MSP that a tortfeaso was “self-insured”.\textsuperscript{42} In this case, a woman received a hip (defining a “self-insured plan” as a plan that “carries its own risk (whether by failure to obtain insurance, or otherwise) in whole or in part.”).

\textsuperscript{41} See \textit{In re Diet Drugs Products Liab. Litig.}, 2001 WL 283163 (citing United States v. Phillip Morris, Inc., 116 F.Supp.2d 131, 135 (D.D.C. 2000)) (“Congress did not intend MSP to be used as an across the board procedural vehicle for suing tortfeasors.”).

\textsuperscript{42} See generally Thompson v. Goetzmann, 337 F.3d 489 (5th Cir. 2003) (affirming the Court of Appeals findings that an “(1) alleged tortfeaso that settles a Medicare recipient’s tort claim against it is not, ipso facto, a ‘self-insurer’ under the MSP statute, such that settlement proceeds are not subject to government’s right of reimbursement; and (2) by collecting settlement funds, Medicare recipient and her attorney did not
replacement manufactured by Zimmer, Inc. After suffering complications with the prosthetic hip, the patient sued Zimmer, Inc. alleging defective design. Zimmer, Inc. settled with the injured party for $256,000. Years later, CMS filed suit against the original plaintiff, her attorney, and Zimmer, Inc. to recover the amount it had paid to the injured party for her medical expenses. CMS argued that Zimmer, Inc. was liable as a

thereby receive money under any 'self-insurance plan,' as required to support government's reimbursement claims against them.”)

43 Id. at 493.

44 See id. (explaining that after post-surgery complications arose that required Loftin to undergo a second surgery, Medicare had paid $143,881.82 for the two surgeries and subsequent medical treatment).

45 See id. (explaining that Zimmer, Inc. paid Loftin a lump sum of $256,000 out of pocket without insurance paying any part, and Zimmer, Inc. never admitted liability).

46 See id. (indicating that the government filed suit under the MSP statute, which authorizes the government to obtain reimbursement from a firm or entity that has a “self-insurance plan”).
“self-insured” entity because it had paid, via the settlement proceeds, for the injured party’s medical expenses.\textsuperscript{47}

The Fifth Circuit ultimately held that a tortfeasor is not liable to CMS for reimbursement of Medicare expenses a tortfeasor is not an insurance plan.\textsuperscript{48} Because Zimmer, Inc. was not an insurance plan, the company was not liable to CMS.\textsuperscript{49}

\begin{footnotes}
\item[47] See \textit{id.} at 495 (stating the government’s argument as citing the legislative history of the MSP as reflecting Congressional intent to reduce Medicare expenditures and that the MSP provides a right of recovery to the government in seeking reimbursement from self-insurance plans); see also 42 U.S.C. 1395y(b)(2)(A)(ii) (providing a definition of a “self-insured plan”).
\item[48] See \textit{Goetzmann}, 337 F.3d at 497 (explaining that the plain meaning of the term “self-insured plan” and its application clearly do not indicate that it applies to alleged tortfeasors who settle with plaintiffs).
\item[49] See \textit{id.} (“The term ‘primary plan’ is pivotal to the applicability of the MSP statute-its reimbursement provisions are not triggered unless a Medicare recipient's source of recovery meets the definition of ‘primary plan,’ regardless of whether that source is a group healthcare plan, workman's compensation, liability insurance, or a self-insurance plan.”).
\end{footnotes}
Nevertheless, the court decided that it could not compel Zimmer Inc. to reimburse Medicare without satisfying the definition of “self-insured plan.”

The basic facts of the hypothetical are similar to those of Goetzmann. In both cases, a tortfeasor reached a settlement with an injured party (or parties, in the case of the hypothetical) in the absence of “a detailed formulation of a program of action,” according to the Fifth Circuit’s definition of “plan.”

Though this definition becomes more complicated when applied to the hypothetical because PharmInc. set up a formal settlement fund, the Fifth Circuit would seem to agree that PharmInc. is not a “self-insurance plan” for purposes of the pre-2003 MSP.

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50 See id. at 503 (expressing frustration with the government for continuing to ask courts to read into the MSP beyond its plain meaning despite the fact that six federal district courts and one bankruptcy court at the time had rejected the argument).

51 See id. 497.

52 See id. at 498 (explaining that to be a self-insured primary plan under the MSP, the plan must set aside funds for itself before any alleged tort has occurred as a source of funds for payment of liabilities and it must have a set of procedures for disbursement of the funds when claims are made against the company). But see In re Diet Drugs Products Liab. Litig., 2001
Similarly, in Mason v. Am. Tobacco Co., the Second Circuit held that tortfeasors were not “self-insured plans” when private plaintiffs filed a suit against tobacco companies to recover medical expenses on the theory that the tobacco companies were “self-insurance plans” within the meaning of the MSP statute. The plaintiffs argued that the tobacco companies, as corporations whose structures were designed to protect against individual stockholder liability, became self-insured plans for MSP purposes. The court rejected this argument, however, claiming that accepting the plaintiffs’ argument would turn


See Mason v. Am. Tobacco Co., 346 F.3d 36, 38 (2d Cir. 2003) (citing Mason v. Am. Tobacco Co., 212 F.Supp.2d 88, 90 (E.D.N.Y. 2002)) (stating that the plaintiffs in this class-action suit are individuals who have or are receiving health care treatment, which Medicare has paid for, for injuries related to tobacco-use).

See id. at 40 (explaining that the plaintiffs argued that the corporate structure is a means of self-insurance because it allows individual directors and shareholders to shift liability from themselves to the corporation, thereby assuming legal liability for injury).
every corporation into an insurance company subject to suit under the MSP.\textsuperscript{55}

If one of the injured hypothetical parties filed a claim for declaratory judgment making PharmInc. liable to CMS for reimbursement of the conditional payment, that plaintiff would have been unlikely to succeed before 2003.\textsuperscript{56} A plaintiff would have argued that PharmInc., as a corporation whose corporate structure is designed to limit individual stockholder liability, became a “self-insured plan” under the MSP. The Second Circuit would have rejected this argument, however, because of its sweeping implications for corporations in terms of their liability to CMS.

\textsuperscript{55} See \textit{id.} (explaining that even though the plaintiffs tried to limit their argument by having it apply to only “publicly-traded corporations,” accepting this argument would effectively turn every corporation into a self-insured entity subject to suit under the MSP, which could not have been the intention of Congress).

\textsuperscript{56} See \textit{id.} at 36 (standing for the proposition that a corporation’s status as an alleged tortfeasor does not render it liable under the MSP).
ii. The MSP Applied to Mass Tort Litigation Before the MMA

Amendments to the MSP

In In re Diet Drugs Prods. Liab. Litig., a case more similar to the hypothetical than the previous two cases discussed, CMS could not recover under the MSP from a mass tort settlement fund because the government’s “MSP cause of action arises when the ‘primary plan’ is obligated to pay for the primary care at issue under a contract of insurance, not when the payment obligation arises out of tort litigation” (emphasis added).\(^{57}\) Although the defendant in Diet Drugs established a settlement fund with its own monies, the court of the Eastern District of Pennsylvania found that a tortfeasor is not a primary plan for purposes of the MSP liability merely because it set up a tort settlement fund.\(^ {58}\)

\(^ {57}\) In re Diet Drugs, 2001 WL 283163, at *12 (finding that the American Home Products Corporation (“AHP”) must disburse settlement funds through its Settlement Trust to commence distribution of proceeds and to set aside $7 million in a reserve fund).

\(^ {58}\) See id. (explaining that to hold otherwise would lead to the conclusion that Congress authorized double damages against alleged tortfeasors merely for contesting liability).
The Eleventh Circuit held the exact opposite in a nearly identical case in *United States v. Baxter Int’l, Inc.*\(^59\) This case involved five silicone breast implant manufacturers that established a settlement fund through which the defendants assumed obligations to pay for the medical costs of plaintiffs.\(^60\) The companies set aside approximately $1 billion in a fund under the settlement agreement to cover the past and future claims related to injuries from defective silicone breast implants.\(^61\) The Eleventh Circuit held that the mere setting aside of funds to cover future liabilities is insufficient by itself to

\(^{59}\) See generally *United States v. Baxter Int’l, Inc.*, 345 F.3d 866 (11th Cir. 2003) (finding that the defendant corporation was a “self-insured plan” within the meaning of the MSP).

\(^{60}\) See *id.* at 872, 899 (holding that defendant corporations had in fact self-insured “against the risk [. . .] of claims” for injuries related to their silicone breast implants, indicating that the arrangement existed before the claims did, thereby satisfying the requirement of an ex ante arrangement to assume legal liability).

\(^{61}\) See *id.* at 874 (explaining that over 400,000 women, who are all eligible to receive settlement proceeds, had registered as plaintiffs in the case).
constitute a self-insurance plan within the meaning of the MSP.\footnote{62}{See id. at 893 (explaining that the court disagrees with the district court that type of formal arrangement by which funds are set aside and accessed to cover future liabilities, by itself, creates a "self-insured plan"); see also id. at 896-97 ("[A]n absolute requirement that funds be set aside is plainly inconsistent with the thrust of the regulations: that a self-insurance plan encompasses any arrangement, even an oral one, to assume such risks [. . .] and that it encompasses the combination of deductibles and insurance policies discussed above, which in common experience often do not include a set-aside of funds."); 42 C.F.R. § 1395y(b)(2)(A)(ii) (2011) (defining "self-insured plan" as a plan to carry one's own risk instead of taking out insurance, a definition requiring only a "plan" and no other formalities).}

On the other hand, establishing a formal settlement fund through which a tortfeasor pays out its liabilities to injured parties, according to the court and as happened in this case, is sufficient to be considered a "self-insurance plan."\footnote{63}{See id. at 898 (explicitly disagreeing with the Goetzmann court about the proposition that there cannot be a self-insured plan without setting aside funds and formal procedures); see}
the hypothetical also involved the defendant business creating a formal settlement fund through which to pay the plaintiffs’ settlement proceeds, the Eleventh Circuit would have likely considered PharmInc. a self-insured entity before the passage of the MMA.

Notably, however, courts disagreed as to whether the setting up of a formal settlement fund would convert a tortfeasor into a “self-insured” entity for purposes of the MSP. Because PharmInc. set up a settlement fund, whether it would have been considered a “self-insured” entity would have


64 See, e.g., Estate of Urso v. Thompson, 309 F.Supp.2d 253, 256-59 (D.Conn. 2004) (standing for the proposition that the MSP gives the government the right to recover its share of an individual Medicare beneficiary’s tort settlement); Brown v. Thompson, 252 F.Supp.2d 312 (D.Va. 2003) (standing for the proposition that the MSP confers on the government the right to reimbursement from beneficiary’s medical malpractice settlement for Medicare payments received for services related to the malpractice), aff’d, 374 F.3d 253, 256 (4th Cir. 2004).
depended on the circuit in which the case was argued. It was because of this ambiguity in the statute and the splits in the circuits that Congress decided to step in to clear up the disagreement in 2003 with the MMA amendments.

B. THE 2003 MMA AMENDMENTS TO THE MSP

Before the 2003 MMA amendments, PharmInc. would have a greater chance of escaping liability. After 2003, however, the MSP would no longer shield PharmInc. from liability to CMS. The MMA amended the MSP in two major ways. First, the MMA provided

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65 Compare United States v. Baxter Int'l, Inc., 345 F.3d 866, 899 (11th Cir. 2003) (ruling that setting aside funds to cover future liabilities in a formalized manner with formalized procedures is enough to make a tortfeasor a "self-insured" entity), with Thompson v. Goetzmann, 337 F.3d 489, 498 (5th Cir. 2003) (standing for the proposition that simply because a tortfeasor pays an injured party settlement proceeds, it does not then become a "self-insured" entity).

a broader definition of a “self-insured” entity, defining it as an entity that “engages in a business, trade or profession...[which] carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.”67 This means that PharmInc. would be liable to CMS because of its settlement payments to the injured party, even if reimbursement to CMS occurred through its own settlement fund.68 Second, the MMA expanded the scope of persons subject to reimbursement, including a Medicare beneficiary who receives a settlement or award, and delineated a timeline for “responsibility” of reimbursement.69 The MMA added the “demonstrated responsibility” piece to the definition of a self-insured entity that could be to recover payment from primary payers under the MSP “would be clarified” as a result of the amendments in the MMA).


68 See id. § 1395y(b)(2)(A)(ii).

69 See id. § 1395y(b)(2)(B)(ii) (“If reimbursement is not made to the appropriate Trust Fund before the expiration of the 60-day period that begins on the date notice of, or information related to, a primary plan’s responsibility for such payment or other information is received, the Secretary may charge interest [. . . .] on the amount of the reimbursement until reimbursement is made.”).
liable to CMS for reimbursement. An entity, such as a tortfeasor, has a “demonstrated responsibility” when there exists a judgment or a settlement through which it paid proceeds to the injured party in exchange for waiving their rights to further payment or services. Furthermore, any entity that

70 See id. (in pertinent part) (“A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this subchapter 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. 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 [. . .] of payment for items or services included in a claim against the primary plan or the primary plan’s insured, or by other means.”).

71 CMS Manual, supra note 1, § 20; see Reimbursement Obligations of Primary Payers and Entities that Received Payment from Primary Payers, 42 C.F.R. § 411.22(b)(2) (2011) (indicating that tortfeasors can demonstrate responsibility through “payments conditioned upon the recipient’s compromise, waiver, or release . . . of payment for items or services included in a
receives payment from a primary plan would now be liable to CMS for reimbursement.\textsuperscript{72} Much of the case law after the MMA amendments has focused on the “demonstrated responsibility” component of the provision.\textsuperscript{73}

This section looks at four cases applying the MSP after the MMA amendments to various tort liability cases, which demonstrates how courts would now consider PharmInc. a “self-insured” entity for MSP purposes and subject it to liability to CMS. In interpreting the MSP after the MMA amendments, the Eastern District of New York in \textit{In re Zyprexa Prods. Liab.}

\begin{quote}
claim against the primary payer or the primary payer’s insured,” regardless of a determination of liability).
\end{quote}

\textsuperscript{72} \textit{See id.}

\textsuperscript{73} \textit{See, e.g., In re Zyprexa Products Liab. Litig., 451 F.Supp.2d 458, 466 (E.D.N.Y. 2006) (holding that a tortfeasor who paid claimants through a settlement fund was a “self-insured” entity after looking at the legislative history of the MMA, citing that its purpose was to disallow tortfeasors in products liability cases from escaping liability to CMS by taking advantage of an ambiguous phrase in the original MSP) judgment entered sub nom. In re Zyprexa Products, 04-MD-1596 (JBW), 2006 WL 2739721 (E.D.N.Y. Sept. 25, 2006) and \textit{opinion clarified}, 04 MD 1596 (JBW), 2006 WL 2792767 (E.D.N.Y. Sept. 28, 2006).}
Litig. found that the tortfeasors who set up a fund with its own money to pay out plaintiffs in settlement of their claims are the exact types of entities Congress sought to bring within the scope of MSP liability with the amendments. The Fourth Circuit in Brown v. Thompson found that the MMA amendments even applied retroactively to tortfeasors who committed an alleged tort before 2003 and established a settlement fund. The Eleventh Circuit, however, found a limiting principle in the MSP in Glover v. Ligget Group, Inc. with a “demonstrated responsibility” requirement that tortfeasors must meet before CMS can consider them a “self-insured” entity. On the other hand, the Sixth Circuit recently limited the Glover “demonstrated responsibility” requirement by claiming that it is

74 See id. (explaining that the MMA amendments removed the two elements of the MSP that had resulted in conflicting interpretations among different courts).

75 See Brown, 374 F.3d at 258 (finding the alleged tortfeasor was a “self-insured plan” within the meaning of the MSP).

76 See Glover v. Ligget Group, Inc., 459 F.3d 1304, 1306 (11th Cir. 2006) (holding that a private plaintiff cannot bring a cause of action under the MSP against alleged tortfeasor corporations for failure to reimburse Medicare before there exists a demonstrated responsibility to do so).
unnecessary for courts to find a demonstrated responsibility when a private plaintiff (i.e. not CMS) brings a claim against a tortfeasor.\footnote{77 Bio-Med. Applications of Tennessee, Inc. v. Cent. States Se. & Sw. Areas Health & Welfare Fund, 656 F.3d 277, 279, 293 (6th Cir. 2011) (disagreeing with the expansion of \textit{Glover}, which had led to courts interpreting the holding to mean that the “demonstrated responsibility” provision applies in the traditional insurance context, rather than only to lawsuits against alleged tortfeasors, as a means to prevent lawsuits by healthcare providers against private insurers).} These cases demonstrate how after the enactment of the MMA amendments, PharmInc. would be reluctant to settle with the beneficiary because of the possibility of CMS coming after them later and the uncertainty over the potential amount of future liability to CMS.\footnote{78 See SMART Act Explanation, supra note 29 (explaining through a hypothetical that parties involved in a tort claim are reluctant to settle without determining exactly how much they owe CMS because there is no mechanism under current law for CMS to provide this information before settlement, and even if the parties could determine the amount on their own, they could not pay CMS at the time of settlement).}
i. Tortfeasors Have More Difficulty Escaping Liability to CMS

After the MMA Amendments

The United States District Court of the Eastern District of New York explicitly noted in *Zyprexa* that cases like *Diet Drugs* would come out differently today because of the MMA amendments.\(^79\) *Zyprexa* involved a products liability claim where the manufacturer of a prescription drug used for treating schizophrenia paid out over 8,000 plaintiffs through a settlement fund.\(^80\) The court cited the legislative history of the MMA to support its assertion that one of the purposes of the MMA amendments was to provide courts a statutory basis for considering tortfeasors like the manufacturers of *Zyprexa* involved in products liability cases a “self-insured” entity


\(^80\) See *id.* at 462 (explaining that the settlement funds would be disbursed to plaintiffs according to claims processing procedure set forth in the master settlement agreement).
under the MSP.\textsuperscript{81} The court therefore found the defendant liable to CMS for reimbursement.\textsuperscript{82} Similarly, PharmInc. set up a settlement fund and therefore has a demonstrated responsibility to reimburse CMS for any of the plaintiffs’ conditional Medicare payments.\textsuperscript{83} The broader, yet more precise, definition of a “self-insured” ensures PharmInc. is liable to CMS for reimbursement.\textsuperscript{84}

\textsuperscript{81} See id. at 466 (citing H.R. Rep. No. 108-178(II) at 189-90) (stating that one reason for the amendments was to remedy the effects of recent court decisions that would allow firms that self-insure for product liability to avoid liability for reimbursement).

\textsuperscript{82} See id. at 480 (holding that the drug manufacturer shall continue to pay plaintiffs who received Medicare).

\textsuperscript{83} See id. at 466 (quoting Brown v. Thompson, 374 F.3d 253, 258 (4th Cir. 2004)) (“As amended, the MSP ‘plainly entitles Medicare to reimbursement of any payment it makes for medical services if a primary plan later pays for those medical services as part of a settlement agreement.’”).

\textsuperscript{84} See 42 U.S.C. § 1395y(b)(2)(A)(ii) (2011) (defining a “self-insured plan” as “an entity that engages in a business, trade, or profession” that “carries its own risk [. . . ] in whole or in part”).
Expanding upon the *Zyprexa* holding, the Fourth Circuit in *Brown* found that the MSP even applies retroactively to claims involving alleged torts that took place before the MMA amendments. The court noted that the MSP, as amended by the MMA, “plainly entitles Medicare to reimbursement of any payment it makes for medical services if a primary plan later pays for those medical services as part of a settlement agreement.”

*Brown* concerned the retroactivity aspect of the MMA amendments. Relying on the clear language of the statute the court held for the government and found that CMS could collect from the plaintiffs even though the tort took place before the 2003 MMA amendments. While this case was about a plaintiff seeking declaratory judgment against liability for reimbursement of

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85 See *Brown v. Thompson*, 374 F.3d 253, 258 (4th Cir. 2004) (explaining that the MMA removed the two elements of the MSP that had resulted in courts’ conflicting interpretations of the law).

86 See id. (indicating that the plaintiff argued that the MMA constituted a substantive change in the law and, therefore, retroactively applying the MSP to her would violate her due process rights).

87 See id. at 262 (finding that the alleged tortfeasor maintained an ex ante arrangement to pay for liability claims).
medical expenses, its principle could equally apply to tortfeasors.  
Consequently, in the hypothetical, even if the tort took place before 2003, a court could still apply the MMA amendments retroactively to find PharmInc. liable for reimbursement to CMS.

Courts clarified the MSP after the 2003 amendments to provide at least some, though limited, protection for tortfeasors through the “demonstrated responsibility” provisions of the MSP. To take this “demonstrated responsibility” route, parties must reach a settlement before a plaintiff can seek declaratory judgment making a tortfeasor liable to CMS. In Glover, plaintiffs sued cigarette manufacturers Philip Morris USA and Liggett Group, Inc. seeking to recover the cost of Medicare payments for certain health care treatment related to illnesses from cigarette smoking, which a prior court held the defendant cigarette manufacturers had caused. The plaintiffs

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88 See id. (standing for the proposition that the MSP even applies to claims where the alleged tort took place before 2003, thus illustrative of the far-reaching aspects of CMS’s ability to recover on conditional payments because of the MMA amendments to the MSP).

89 See Glover v. Liggett Group, Inc., 459 F.3d 1304, 1306 (11th Cir. 2006) (dismissing the plaintiffs’ claim because the MSP
sought a private cause of action against the defendants to order the defendants to reimburse the government rather than have the plaintiffs repay CMS. Because the parties never reached a settlement, however, the Eleventh Circuit held for the defendants. Consequently, the plaintiffs could not assert their

does not create a cause of action against an alleged tortfeasor that has no demonstrated responsibility to pay medical costs); see also 42 U.S.C. § 1395y(b)(3)(A) (establishing a private cause of action for Medicare beneficiaries to file suit against the primary payer to recover conditional payments).

90 See id. at 1308 (explaining that the plaintiffs argued that the defendants’ responsibility to pay a Medicare beneficiary’s health care expenses can be demonstrated by litigating a tort claim during the MSP private cause of action for failure to reimburse Medicare).

91 See id. at 1309 (holding for the defendants for three primary reasons: (1) finding for the plaintiffs would drastically expand federal court jurisdiction by creating a federal forum to litigate any state tort claim in which a business entity allegedly injured a Medicare beneficiary; (2) an alleged tortfeasor could otherwise not contest liability without risking the double damages penalty; and (3) the plaintiffs’ interpretation would “allow individuals acting as private
private cause of action until a court found the defendants’ conduct tortious or until a settlement.\textsuperscript{92} While \textit{Glover} does not necessarily apply specifically to the hypothetical, it is significant for many businesses because provides at least some protection for businesses from liability to CMS.\textsuperscript{93}

Plaintiffs can, however, assert a private cause of action against defendant businesses for reimbursement of medical expenses for Medicare if the defendant has a “demonstrated responsibility” to do so, as through a judgment or settlement.\textsuperscript{94}

\begin{quote}
attorney generals to litigate the state tort liability of a defendant towards thousands of Medicare beneficiaries” without complying with class action requirements).
\end{quote}

\textsuperscript{92} See id. (explaining that the defendant’s responsibility was not demonstrated when the plaintiffs filed their MSP claim).

\textsuperscript{93} See generally \textit{Glover}, 459 F.3d 1304 (standing for the proposition that if there has been no settlement or judgment in favor of a plaintiff in a tort case, a plaintiff cannot assert a private cause of action against the tortfeasor in a separate action seeking a declaratory judgment to make the tortfeasor liable to CMS for the plaintiff’s medical expenses).

\textsuperscript{94} See 42 U.S.C. § 1395y(b)(2)(B)(ii) (2011) (stating that a primary plan can have a demonstrated responsibility to reimburse
The United States District Court in the Western District of Missouri dismissed a plaintiff’s suit seeking reimbursement for Medicare’s conditional payments under the MSP. Fisher, the plaintiff in Fisher v. Clarendon Nat. Ins. Co. was injured in an accident while operating a long-haul truck for defendant company Clarendon and asserted a right to workers compensation, which Clarendon was fighting in a different court proceeding. Fisher argued that she could show the defendant business’s responsibility “by other means,” as by the fact that Clarendon had paid for Fisher’s health care costs through its insurance policy. The court in Glover stated that “Section Medicare if it has a judgment or settlement, “or by other means”).

See Fisher v. Clarendon Nat. Ins. Co., 2008 WL 191813, at *3 (W.D. Mo. Jan. 18, 2008) (finding that the plaintiff failed to show that the defendant company had a demonstrated responsibility under the MSP to make payment for an item or service).

Id. at *1.

See id. (explaining that Clarendon’s responsibility could be demonstrated “by other means” in this case because Clarendon agreed to pay her health care costs through its health insurance policy).
1395y(b)(2)(B)(ii), as amended by the MMA, requires a primary plan to reimburse Medicare ‘if it is demonstrated’ that the primary plan ‘has or had a responsibility’ to make payment for an item or service.”

Because a workers compensation claim was pending in another jurisdiction, the court could not rule until Clarendon’s responsibility had been demonstrated in the other jurisdiction.

In a more recent case, however, in Bio-Medical Applications of Tennessee, Inc. v. Central States Southeast and Southwest Areas Health and Welfare Fund, the Sixth Circuit interpreted the MSP’s “demonstrated responsibility” provision to be a precondition to an MSP suit only if CMS itself files suit.


99 See id. at *3 (explaining that it did not have jurisdiction to resolve the employment compensation claim and therefore could not determine whether Clarendon had a demonstrated responsibility to reimburse Medicare).

100 Bio-Med. Applications of Tennessee, Inc. v. Cent. States Se. & Sw. Areas Health & Welfare Fund, 656 F.3d 277, 279 (6th Cir. 2011) (holding that the demonstrated responsibility provision does not apply to this case because the provision only applies...
“Demonstrated responsibility” is not a precondition to private MSP “lawsuits against traditional insurers.” Rather, it is only a precondition to a suit that Medicare brings against a tortfeasor. This provides yet another limitation that aims to protect tortfeasors from CMS’ ability to recover. Consequently, PharmInc. would have to have a “demonstrated responsibility” to CMS to be liable. Because PharmInc. reached a settlement, it satisfies the demonstrated responsibility provision of the MSP.

What is significant about each of these cases is that they all point towards an almost certain judgment against PharmInc.

101 See id. at 294 (explaining that the demonstrated responsibility provision of the MSP does not apply to lawsuits brought by private parties under the MSP’s private cause of action; rather, the provision applies only to lawsuits brought by Medicare for reimbursement).

As the Fourth Circuit in Brown notes, the “MSP now states unequivocally that ‘[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.’”\textsuperscript{103} PharmInc. therefore has no chance of escaping liability to CMS. The millions of dollars of medical costs for which it is liable to reimburse CMS would gravely harm its ability to continue operating.

Assume, however, that PharmInc. has not yet settled, but rather is deciding whether to settle or proceed with litigation. Another problem with the MSP is that it provides tortfeasors no estimate of future liability on which to base its decision to proceed with litigation or settle.\textsuperscript{104} In this situation, the tortfeasor is much more likely to forgo settlement and proceed with litigation in hopes of winning a judgment in its favor (and

\textsuperscript{103} Brown v. Thompson, 374 F.3d 253, 258 (4th Cir. 2004) (citing 42 U.S.C. § 1395y(b)(2)(B)(ii)).

\textsuperscript{104} See SMART Act Explanation, supra note 29 (explaining through a hypothetical the problem of not knowing the reimbursement amount before settlement).
to not be liable to CMS at all).\textsuperscript{105} Because of this problem, Congress has passed yet another amendment to the MSP that has created even more ambiguity with the statute, although it has not yet been fully enacted.\textsuperscript{106}

\textsuperscript{105} See Protecting Medicare with Improvements to the Secondary Payer Regime: Hearing before the Subcomm. on Oversight and Investigations of the H. Comm. on Energy and Commerce, 112th Cong. (2011) (statement of Cliff Stearns, Chairman, Subcomm. on Oversight and Investigations) (explaining that parties cannot settle in a timely or conclusive manner because there is currently no requirement for CMS to provide the parties with amounts due or the amount they should set aside to cover future payments before settlement so that the parties can resolve Medicare obligations during settlement negotiations).

\textsuperscript{106} See John J. Campbell, New Medicare Secondary Payer Reporting Requirements, Law Offices of John J. Campbell, P.C. (Feb. 10, 2008), http://www.jjcelderlaw.com/MMSEAMSABull.htm (explaining that the MMSEA imposes on liability insurance plans, including self-insured plans, reporting requirements for tort claims impose a $1,000 per day per claim fine for failure to comply; however, they do not specify how soon after a judgment, settlement, or award the tortfeasor must submit required information to CMS regarding the claim).
IV. FURTHER AMENDMENTS TO THE MSP

A. SUBSEQUENT LEGISLATION: THE MMSEA AND THE SMART ACT

After the enactment of the MMA amendments to the MSP, CMS found it financially and administratively infeasible to pursue reimbursement from many tortfeasors involved in claims with Medicare beneficiaries.\footnote{Paradis, supra note 20, at 32 (explaining that legislation lacked a strong enforcement mechanism because plaintiffs and tortfeasors could gamble as to whether CMS would actually find out about their settlement).} Congress then enacted the Medicare, Medicaid, and SCHIP Extension Act of 2007 ("MMSEA") to put the onus on businesses and insurers to report to CMS any claim involving a Medicare beneficiary.\footnote{42 U.S.C. 1395y(b)(8)(E)(i) (2011) (providing that a plan that fails to comply with the reporting requirements will be subject to a civil monetary penalty of $1,000 for each day of noncompliance for each claim).} While this amendment aims to provide CMS with greater enforcement power, it overshoots its goals and actually places too large of a burden on businesses to comply with the MSP. The MMSEA provides that if self-insured entities do not report claims of Medicare-eligible claimants or plaintiffs to CMS, the tortfeasor receives a $1,000 daily fine.
plus “double damages” for failure to comply.\textsuperscript{109} The mandatory reporting requirement is supposed to provide greater clarity and enforcement power to the MSP provisions, increasing CMS’ ability

\textsuperscript{109} See id.; see also Robert G. Trusiak, The Medicare Secondary Payer Statute: Medicare’s Recovery Rights in Relation to Liability and No-Fault Insurance, \textit{48 B. Ass’n of Erie County Bull.} 1, 21-22 (Oct. 2008), available at http://www.baec.affiniscape.com/associations/10677/files/bulletin_october_2008.pdf (contending that this approach to MSP reimbursement creates cooperation among the Medicare beneficiary, her attorney, and the primary plan that limits expenses of federal court litigation, limits the primary payer’s risk of incurring double damages, and preserves judicial resources); see also Revised Implementation Timeline for Certain Liability Insurance (Including Self-Insurance) Total Payment Obligation to the Claimant (TPOC) Settlements, Judgments, Awards, or Other Payments, Centers for Medicare and Medicaid Services (Sept. 30, 2011), http://www.cms.gov/MandatoryInsRep/Downloads/RevNGHPTimelineTPOC.pdf (indicating that CMS begins to phase the MMSEA reporting requirements into effect on January 1, 2012 based on thresholds for the size of the claims, the largest of which will be phased in first).
to identify individuals who received Medicare payments. CMS hopes that through the MMSEA amendments, it will be able to recoup an estimated $1.74 billion of inappropriately paid benefits each year.\textsuperscript{111}

Despite Congress' intentions, the MMSEA will likely impede settlements and impose a risk of future liability against all parties involved in a given claim.\textsuperscript{112} The MMSEA requires Responsible Reporting Entities (“RRE”), including liability insurance plans, Group Health Plans, no fault insurance plans, and workers' compensation plans, to directly report potentially

\textsuperscript{110} See Paradis, supra note 20, at 32 (explaining that Congress passed the MMSEA with the goal of improving enforcement under the MSP).

\textsuperscript{111} See Medicare Secondary Payer Act (MSP): What is it? And What Impact Will it Have?, \textit{Rumberger, Kirk, & Caldwell} (June 8, 2009), http://www.rumberger.com/?t=40&an=872&format=xml#_edn6 (indicating that Medicare hopes to recoup an estimated $1.74 billion of funds per year with the enactment of the MMSEA).

\textsuperscript{112} See Franco, supra note 21, at 11 (explaining that because there are no safe harbor provisions present in the MMSEA amendments and limited guidance from CMS on how to comply with the reporting requirements, the MSP exposes businesses to liability to CMS).
eligible claimants and plaintiffs to CMS.\footnote{See 42 U.S.C. § 1395y(b)(8)(A)(i)-(ii) (2011) (providing that self-insured entities must submit information regarding a claimant that is a Medicare beneficiary to CMS).} Even if no determination of liability is made, an RRE must still report to CMS or face a $1,000 per day penalty.\footnote{42 U.S.C. 1395y(b)(8)(E)(i); see also ALERT for Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Workers’ Compensation, \textit{Centers for Medicare and Medicaid Services} (Mar. 20, 2009), http://www.cms.hhs.gov/MandatoryInsRep/Downloads/Allert_UserGuid eSupp_NGHP.pdf (explaining that an RRE must register electronically with CMS to initiate the reporting process).} If CMS is required to take legal action to secure recovery, CMS is entitled to recover “double damages”, i.e. twice the amount of the payments made on behalf of the beneficiary.\footnote{See 42 U.S.C. § 1395y(b)(2)(B)(iii) (stating that the United States may collect double damages against an entity against which it brings an action to collect reimbursement funds and a court finds the entity had a demonstrated responsibility to reimburse Medicare).}

Under the MMSEA, RREs must also obtain private information about claimants for reporting requirements, such as social
security numbers and Health Insurance Claim Numbers, RREs are required to retain their MSP records for ten years.\textsuperscript{116}

The complexities and ambiguities of the reporting and reimbursement obligations have tipped the problems associated with the MMA in the opposite direction. The possibility of Medicare’s post-settlement involvement is too large of a threat.\textsuperscript{117} Returning to the hypothetical, PharmInc. would be

\textsuperscript{116} \textit{See} Franco, \textit{supra} note 21, at 9-10 (explaining that RREs must submit the Social Security number, name, date of birth, and gender of the injured party for each request, after which CMS then determines the beneficiary’s status within fourteen days); \textit{see also} SMART Act Fact Sheet, \textit{supra} note 30 (indicating beneficiaries are resistant to providing their Health Insurance Claims Numbers and social security numbers, and companies do not want to bear the burden of collecting and maintaining this information).

\textsuperscript{117} \textit{See} Jeffrey J. Signor, \textit{A Look Behind the Federal Government’s New Efforts to Track and Recover Medicare Liens}, 48 \textit{B. Ass’n of Erie County B. Bull.}, 1, 19-20 (Dec. 2008), \textit{available at} http://www.baec.affiniscape.com/associations/10677/files/bulletin_december_2008.pdf (explaining how, upon settlement or a judgment in the plaintiff’s favor, even claims with a single plaintiff can expose the defendant business and the attorneys
unsure of the amount for which it would be liable to CMS in the event of a settlement or judgment in the beneficiaries’ favor because CMS is not required to provide a repayment amount until after the parties have settled or after a judgment. The disincentive to settle that was so problematic with the MMA amendments is still present with the MMSEA. The fact that parties have disincentives to settle means that more cases are going to trial. The more cases that go to trial means that more alleged tortfeasors achieve judgments in their favor that would otherwise have settled and enabled CMS to recover from these settlement proceeds. In other words, the fewer cases that settle means that Medicare is recovering fewer funds, which is the goal for both attorneys for both sides to double damages for not reimbursing Medicare within sixty days).

But see Option to Self-Calculate Your Final Conditional Payment Amount, Medicare Secondary Payer Recovery Contractor, http://msprc.info/forms/SelfCalculatedFinalCP.pdf (last visited Mar. 4, 2012) (indicating that on February 21, 2012, Medicare implemented an option to self-calculate a claimant’s final conditional payment amount prior to settlement, though this option is only available to settlements of $25,000 or less where the beneficiary has completed treatment for a physical trauma based injury, in addition to several other restrictions).
of the MSP statute and the MMSEA amendments in the first place.\textsuperscript{119} Furthermore, there is no appeal process for RREs after CMS notifies them of a penalty for failure to comply. Finally, critics of the MMSEA point to privacy issues associated with the collection and storage of the private health information that RREs are required to provide to CMS. It is because of these issues that the enactment of the MMSEA has been pushed back several times.\textsuperscript{120}

\textsuperscript{119} Protecting Medicare with Improvements to the Secondary Payer Regime: Hearing before the Subcomm. on Oversight and Investigations of the H. Comm. on Energy and Commerce, 112th Cong. (2011) (statement of Jason Matzus, Partner, Raizman Frischman & Matzus, P.C.) (explaining that the fact that more cases go to trial instead of being settled results necessarily means that less money will be recovered by Medicare, which is contrary to the primary goal to the MSP system).

\textsuperscript{120} See, \textit{e.g.}, Revised Implementation Timeline for Certain Liability Insurance (Including Self-Insurance) Total Payment Obligation to the Claimant (TPOC) Settlements, Judgments, Awards, or Other Payments, Centers for Medicare and Medicaid Services, (Sept. 30, 2011),

http://www.cms.gov/MandatoryInsRep/Downloads/RevNGHPTimelineTPOC
In the meantime, Congress has been playing with several additional amendments to the MSP. Its latest reform effort, called the Strengthening Medicare and Repaying Taxpayers Act (“SMART Act”), is currently in the committee stage. Like the MMSEA, the SMART Act provides for a three-year statute of limitations for MSP recovery actions from the receipt of the Section 111 report and still requires mandatory reporting.\footnote{SMART Act Fact Sheet, supra note 30.} Furthermore, the SMART Act requires CMS to disclose Medicare repayment amounts to beneficiaries before entering final settlements, thus allowing parties to factor the full repayment amount into the final settlement.\footnote{See Medicare Reform – The Next Step, Crowe Paradis Services Corporation, http://www.cpscmsa.com/Docs/articles/reform.pdf (last visited Mar. 4, 2012), [hereinafter Medicare Reform – The Next Step] (explaining that after three years CMS could no longer pursue claims and that CMS cannot pursue amounts below a certain threshold because of scarcity of administrative resources).}

The SMART Act differs from the MMSEA, however, in several key respects. First, the SMART Act adjusts the communication
process between CMS and the parties to a claim.\textsuperscript{123} The SMART Act would give CMS sixty-five days after a request for a reimbursement estimate so that the parties can factor this amount into settlement.\textsuperscript{124} If CMS misses the sixty-five day window, the settling parties must send a second “cure” notice requesting information, at which point CMS has an additional thirty days.\textsuperscript{125} If CMS misses this deadline, it can avoid losing the claim by showing “exceptional circumstances,” defined as being justified as an excuse for up to one percent of the claims.\textsuperscript{126} Further, it provides for discretionary penalties

\textsuperscript{123} See SMART Act Fact Sheet, supra note 30 (explaining that the current MSP provides no process for CMS to provide a reimbursement estimate before settlement).

\textsuperscript{124} Id.

\textsuperscript{125} See id. (indicating that this provision exists to alleviate some of the administrative burden on CMS with this procedure).

rather than the mandatory $1,000 per day penalty as the law currently stands.\footnote{127} The SMART Act also allows for safe harbor provisions for meeting the mandatory requirements, such as looking for good faith efforts to identify a beneficiary.\footnote{128} As the MMSEA amendments currently stand, there is no protection afforded to businesses if a Medicare beneficiary claimant fails to disclose his Medicare status to the alleged tortfeasor.\footnote{129} Finally, where the MSPEA set a flat $5,000 threshold, below which settlements were exempt from MSP repayment and reporting, the SMART Act’s threshold will be directly related to CMS’s cost of collection to ensure that the government is not spending more than it will collect on a given claim.\footnote{130}

\footnote{127} See id.

\footnote{128} See Medicare Reform - The Next Step, supra note 122 (discussing the problems with the current MPSA law as Medicare having the ability to penalize a liability insurer who relies on the claimant’s representation that she does not receive Medicare benefits and does not expend resources pursuing a claim against someone who did not, in fact, receive Medicare benefits).

\footnote{129} See id.

\footnote{130} See MSPA Blog, supra note 126 (explaining how this provision benefits both the CMS and the parties involved in the claim).
B. HOW CONGRESS SHOULD FURTHER AMEND THE MSP

According to the MSP, CMS has a legal right to money that it pays out to beneficiaries related to injuries in a tort action in the event of a settlement or judgment in favor of the beneficiary. But the process by which CMS recoups its losses should be less burdensome to businesses and Medicare beneficiaries. The MSP should not bankrupt businesses like PharmInc. merely because of ambiguous legislation. If CMS wants to recoup its losses in tort cases involving conditional payments to Medicare beneficiaries, it needs to do so in a way that does not have the potential to put companies out of business.

The three-year statute of limitations in the MMSEA is significantly less burdensome on businesses than the six-year statute of limitations previously proscribed by courts under the

MSP, which is how the law currently stands. The statute of limitations, however, is not the only problem with the MSP. While the spirit of the MMSEA is a step in the right direction towards enabling CMS to recoup some of its losses, the unanticipated ambiguities in the statute only create further complications for businesses like PharmInc. If the MMSEA amendments to the MSP remain unchanged, PharmInc. would have to come up with its own system of reporting that it must regularly update, which costs the company additional time and money. The $1,000 per day penalty for failure to report could produce significant harm to businesses like PharmInc. and especially to smaller businesses and start-up businesses. A $250 per day penalty would still have a desired deterrence effect while not placing undue harm on small businesses. Another option is to use a penalty based on the size of the business measured by the business’ net profits, though this may be more controversial than a smaller across-the-board penalty.

Congress should also consider a safe harbor provision for failing to report.\textsuperscript{132} As the law currently stands, if a beneficiary provides false or inaccurate information concerning

\begin{footnotesize}
\textsuperscript{132} See id.; see also 42 C.F.R. § 1395y(b)(2)(B)(ii) (2011) (explaining how the United States may even file a claim against any of the attorneys in the suit for failure to report a claim).
\end{footnotesize}
her Medicare eligibility status, the attorney would still be subject to liability to CMS. The SMART Act should entail a safe harbor provision that shields attorneys and business tortfeasors from liability as long as the insurer undertook a good-faith effort to identify the beneficiary.\(^{133}\)

The SMART Act’s provisions only trigger the reporting requirement if it is financially and administratively feasible for CMS to do so.\(^{134}\) This is beneficial to both the government and to businesses as businesses need not report smaller claims, while the government saves time and money not worrying about small claims. On the other hand, products cases like the hypothetical, where larger sums of money are at issue, would still have to be reported. CMS could achieve its desired goal of recouping larger losses without wasting additional taxpayers’

\(^{133}\) See Medicare Reform – The Next Step, supra note 122; see also Christopher C. Yearout, Big Brother Is Not Just Watching, He's Suing: Medicare's Secondary Payer Statute Evolves in Aggressive Pursuit of Fiscal Integrity, 41 Cumb. L. Rev. 117, 147 (2011) (discussing the dangers of the current MSP as attorneys can never be certain whether the information they are receiving from claimants is accurate).

\(^{134}\) See SMART Act Fact Sheet, supra note 30 (indicating that CMS previously had been pursuing claims that were as low as $1.59).
dollars while also avoiding placing an undue burden on businesses for smaller claims.

Furthermore, the single, simplified system CMS would use under the SMART Act to estimate the reimbursement amount before final settlement would make the law more streamlined and easier to comply with. Businesses would have a better idea of their potential liability to CMS in deciding whether to settle. The MSP could be further amended by providing all settling parties with a right of appeal if they disagree with Medicare’s repayment request or if they believe Medicare made a mistake.

Finally, another issue that the SMART Act tried to address and that should be a piece of any further amendments to the MSP is the information businesses and attorneys collect from claimants that they report to CMS. Under the MMSEA, businesses would have to collect claimants’ entire social security number, which could lead to fraud and abuse. By requiring businesses to collect only the last four digits of a claimant’s social

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135 See SMART Act Explanation, supra note 29 (explaining how this provision enables parties to factor the estimated reimbursement amount into the settlement).

136 See SMART Act Fact Sheet, supra note 30.

137 See id. (discussing how beneficiaries are resistant toward submitting their personal information to defendant businesses).
security number, there is less risk of abuse and CMS still has the necessary information to determine whether a claimant is a beneficiary.\(^{138}\)

V. CONCLUSION

The MSP currently imposes an undue burden on businesses by making them liable to CMS as far as six years after a settlement or judgment in tort cases. The MSP further impedes parties’ incentives to settle. Though Congress amended the MSP with the MMSEA, this act has not yet fully gone into effect, and it will likely create further ambiguity for businesses attempting to comply with the MSP. Businesses, namely those susceptible to mass tort litigation and products liability claims, are especially at risk because of the lack of clarity or coherence in the current MSP. Accordingly, Congress should further amend the MMSEA. Congress needs to clarify how CMS calculates the pre-settlement amount of reimbursement and to establish a threshold-reporting amount for claims to make the process more straightforward. Finally, Congress should soften the penalty for non-compliance or make it proportional to the size of the claim or the size of the business. Only with further Congressional clarification will the MSP remove the ambiguity of the reporting requirements and overwhelming compliance penalties for

\(^{138}\) See id.
businesses. Medicare can still achieve its goal of recouping its losses from businesses in these tort cases without bankrupting businesses.