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# Can't Settle, Can't Sue: How Congress Stole Tort Remedies From Medicare Beneficiaries

Rick Swedloff

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## CAN'T SETTLE, CAN'T SUE: HOW CONGRESS STOLE TORT REMEDIES FROM MEDICARE BENEFICIARIES

*Rick Swedloff\**

I. Introduction .....	557
II. The History of the Medicare Secondary Payer Act.....	563
A. The Push for Government-Sponsored Health Insurance: the Progressives, the New Deal, the Fair Deal, and the Medicare Compromise.....	564
B. Medicare As a Secondary Payer: An Insurance Based Approach To Fiscal Change.....	571
C. The Government Wants More: The Secretary Takes on Mass Tort Settlements.....	579
D. Congress Amends the Medicare Secondary Payer Act.....	582
III. Suing and Settling Under the MSP: Individual Tort Lawsuits and Mass Tort Litigation.....	588
A. An Economic Model of Individual Tort Settlements..	588
B. The Structural, Ethical, and Practical Barriers To Settling Mass Torts .....	593
C. Can't Settle, Can't Sue.....	599
IV. An Inefficient Life Without Mass Torts .....	603
V. Balancing the Equation.....	605

### I. INTRODUCTION

On June 9, 1993, Bernice Loftin, a 68 year-old woman and

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Medicare beneficiary, underwent hip replacement surgery. One week after her surgery, Ms. Loftin dislocated her surgically repaired hip. X-rays subsequently revealed that the hip prosthesis was displaced and pressing against her sciatic nerve. On June 19, 1993, Ms. Loftin underwent a second surgery, which led to a serious infection. Her doctors fought the infection with extensive medical procedures including radical debridement, the insertion of cement antibiotic beads, and prolonged physical therapy. At the time of these surgeries, Medicare was Ms. Loftin's primary medical insurer, and it paid \$143,881.82 for Ms. Loftin's surgeries and subsequent medical care.<sup>1</sup>

Ms. Loftin, represented by Stephen Goetzmann, a personal injury lawyer, filed suit against the manufacturer of the hip prosthesis alleging defective design of the hip prosthesis.<sup>2</sup> Before trial Ms. Loftin settled with the manufacturer, although it never admitted liability. The manufacturer paid the full settlement amount of \$256,000 to Mr. Goetzmann, who, after deducting his 40% contingency fee, distributed the balance of \$153,600 to Ms. Loftin. The manufacturer paid all of the settlement; no part came from its liability insurance.<sup>3</sup>

In October 2000, after Ms. Loftin received her settlement, the Secretary of Health and Human Services ("Secretary")<sup>4</sup> filed suit against Ms. Loftin; her attorney, Mr. Goetzmann; and the manufacturer under the Medicare Secondary Payer Act ("MSP").<sup>5</sup> Under the MSP the

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1. *Thompson v. Goetzmann*, 337 F.3d 489, 493-94 (5th Cir. 2003); *Thompson v. Goetzmann*, No. 3:00-CV-2174-M, 2001 U.S. Dist. LEXIS 9258, at \*2-3 (N.D. Tex. July 3, 2001); Complaint at ¶¶ 17, 28, *Thompson v. Goetzmann*, 337 F.3d 489 (5th Cir. 2003) (No. 3:00-CV-2174-M).

2. *Goetzmann*, 337 F.3d at 493. The Fifth Circuit stated that "Loftin's claims [in the complaint] included the medical expenses paid for by Medicare." *Id.* This characterization does not paint an accurate picture. Texas pleading rules allow plaintiffs to sue for the amount billed by the hospital rather than the amount paid by the plaintiff. It is common for defendants to chip away at the amount claimed by arguing that the plaintiff did not pay the amount billed by the health care provider. Mr. Goetzmann, representing Ms. Loftin, never believed that he was bringing a claim or settling a claim on behalf of Medicare. Telephone Interview with Stephen R. Goetzmann (Mar. 12, 2007).

3. *Goetzmann*, 337 F.3d at 493-94.

4. Medicare is presently administered by an agency known as Centers for Medicare and Medicaid Services ("CMS"). Prior to being administered by the CMS, Medicare was administered by the Health Care Financing Administration ("HCFA"). Both agencies were organized under the authority of the United States Department of Health and Human Services. Throughout this paper, I will refer to the Secretary of the Department of Health and Human Services as the decision maker on behalf of Medicare.

5. *Goetzmann*, 337 F.3d at 493; Complaint, *supra* note 1, at ¶¶ 4-6, 11.

Secretary is allowed to seek reimbursement from a primary insurer<sup>6</sup> for payments made by Medicare to a Medicare beneficiary that the primary insurer should have paid or from any person that receives a payment from a primary insurer.<sup>7</sup> The Secretary argued that by making its own payment to Ms. Loftin, the manufacturer was self-insuring against any risk and was thus a primary insurer subject to the MSP statute.<sup>8</sup> Further, as allowed under the statute, the Secretary sought reimbursement from Ms. Loftin and Mr. Goetzmann out of the payments received from the manufacturer and, under a provision that allows the Secretary to seek double damages from a primary insurer,<sup>9</sup> the Secretary sought double damages from the manufacturer.<sup>10</sup> Had the Secretary won this lawsuit, Medicare could have taken almost all of Ms. Loftin's payment, leaving her less than \$10,000 to compensate her for her pain and suffering. Alternatively, Medicare could have claimed double damages from the manufacturer, thus increasing the manufacturer's total payment to \$543,763.64<sup>11</sup> even though it never admitted liability for Ms. Loftin's injury. Under these circumstances, Ms. Loftin and the manufacturer had no incentive to settle their dispute. And, had Mr. Goetzmann known of this liability before bringing the claim on behalf of Ms. Loftin, he likely would not have agreed to the representation, because his best chance of recovering a fee would have been a long and costly trial.

The Northern District of Texas,<sup>12</sup> the United States Court of Appeals for the Fifth Circuit,<sup>13</sup> and almost every court in every jurisdiction to consider the Secretary's unprecedented argument rejected

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6. A primary insurer is one "who is contractually committed to settling a claim up to the applicable policy limit before any other insurer becomes liable for any part of the same claim" whereas a secondary or excess insurer "is liable for settling any part of a claim not covered by an insured's primary insurer." BLACK'S LAW DICTIONARY 823 (8th ed. 2004); *see also* Douglas L. Grundmeyer, *Insurance*, 64 LOY. L. REV. 31, 94 (2000) ("Primary' insurance coverage attaches immediately upon the occurrence that gives rise to liability, whereas an 'excess' policy covers liability above the limits of the exhausted primary insurance.").

7. 42 U.S.C. § 1395y(b)(2)(B)(ii) (2002) (current version at 42 U.S.C. § 1395y(b)(2)(B)(iii) (2006)).

8. *Goetzmann*, 337 F.3d at 493; *Goetzmann*, 2001 U.S. Dist. LEXIS 9258 at \*4-5; Complaint, *supra* note 1, at ¶ 45.

9. 42 U.S.C. § 1395y(b)(2)(B)(ii) (2002) (current version at 42 U.S.C. § 1395y(b)(2)(B)(iii) (2006)) (allowing the Secretary to seek "double damages against [a primary plan]" which the government has to sue to recover its conditional outlays on behalf of a Medicare beneficiary).

10. *Goetzmann*, 337 F.3d at 493-94; Complaint, *supra* note 1, at ¶ 57.

11. This amount is equal to the total payment to Ms. Loftin plus double the amount of Medicare's conditional payments.

12. *Goetzmann*, 2001 U.S. Dist. LEXIS 9258, at \*5-9.

13. *Goetzmann*, 337 F.3d at 500-01.

it.<sup>14</sup> And these courts did so with good reason: the Secretary's position had no basis in the text of the statute or the legislative history<sup>15</sup> and, as is clear from Ms. Loftin's case, the Secretary's position makes it difficult to settle tort lawsuits.

Nonetheless, in 2003, as a small part of the Medicare Modernization Act of 2003 ("MMA"), Congress amended the MSP to reflect the Secretary's litigation position.<sup>16</sup> The MMA is best known for adding a prescription drug benefit for Medicare beneficiaries. The new drug benefit captured the national spotlight and occupied the bulk of Congressional debate over the MMA. Congress spent little, if any, time discussing the amendments to the MSP or the implications of the amendment.

Yet, this amendment significantly affects the ability of Medicare beneficiaries to bring or settle individual tort claims, the incentives for attorneys to represent Medicare beneficiaries in individual and mass tort litigation,<sup>17</sup> and the tort system generally. Because of this – and despite

14. See *Mason v. Am. Tobacco Co.*, 346 F.3d 36, 43 (2nd Cir. 2003); *In re Orthopedic Bone Screw Prods. Liab. Litig.*, 202 F.R.D. 154, 165 (E.D. Pa. 2001); *Brown v. Am. Home Prods. Corp.*, Nos. MDL 1203, 99-20593, 2001 WL 283163, at \*10 (E.D. Pa. Mar. 21, 2001); *United States v. Phillip Morris, Inc.*, 116 F. Supp. 2d 131, 145-46 (D.D.C. 2000); *In re Dow Corning Corp.*, 250 B.R. 298, 349 (Bankr. E.D. Mich. 2000); but see *United States v. Baxter Int'l Inc.*, 345 F.3d 866, 886 (11th Cir. 2003); *Brown v. Thompson*, 252 F. Supp. 2d 312, 319-20 (E.D. Va. 2003), *aff'd* 374 F.3d 262 (4th Cir. 2004).

15. *Orthopedic*, 202 F.R.D. at 165; *In re Diet Drugs Prods. Liab. Litig.*, Nos. MDL 1203, 99-20593, 2001 WL 283163, at \*10 (E.D. Pa. Mar. 21, 2001); *Phillip Morris*, 116 F. Supp. 2d at 146, n.22; *Dow Corning*, 250 B.R. at 340.

16. 42 U.S.C. § 1395y(b)(2)(B)(iii), amended by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 [hereinafter MMA], Pub. L. No. 108-173, § 301, 117 Stat. 2066, 2222 (2003).

17. There is no universal definition of "mass torts." However, one commonly accepted definition is found in the MANUAL FOR COMPLEX LITIGATION, which states that:

Mass torts litigation "emerges when an event or series of related events injure a large number of people or damage their property." A mass tort is defined by both the nature and number of claims; the claims must arise out of an identifiable event or product, affecting a very large number of people and causing a large number of lawsuits asserting personal injury or property damage to be filed.

MANUAL FOR COMPLEX LITIGATION (FOURTH) § 22.1, at 343 (2004) (quoting Advisory Comm. on Civil Rules & Working Group on Mass Torts, Report on Mass Tort Litigation 10 (Feb. 15, 1999), reprinted without appendices in 187 F.R.D. 293, 300 (1999)). This definition covers at least two distinct types of tort claims: mass accidents and dispersed mass torts. See *id.* at 343-44; see also L. Elizabeth Chamblee, *Unsettling Efficiency: When Non-Class Aggregation of Mass Torts Creates Second-Class Settlements*, 65 LA. L. REV. 157, 165 (2004) (adding property damage mass torts and economic loss torts to the list). Mass accidents, or single event mass torts, "usually involve one catastrophic event that causes harm to a readily identifiable group of putative plaintiffs." *Id.* at 166. "[P]laintiffs in a single event mass tort share the common characteristics of time, place, and cause of

the fact that courts<sup>18</sup> and academics<sup>19</sup> have largely ignored this amendment – attorneys from around the country have sounded alarm bells since the government first took the litigation position now reflected in the MSP. Lawyers have raised serious concerns about their ability to bring and settle individual and mass tort litigation under the MSP's harsh liability rules.<sup>20</sup>

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injury.” Working Group on Mass Torts, *supra*, at 10. These torts are typified by airplane crashes, environmental hazards such as oil spills or chemical leaks, and fires. Dispersed mass torts, in contrast, “typically arise from widespread use of, or exposures to, widely distributed products or substances. . . .” MANUAL FOR COMPLEX LITIGATION, *supra*, at 344. Dispersed mass torts generally arise in one of two ways: exposure to a pharmaceutical drug or device that is removed from the market or exposure to a substance over a prolonged period of time. *Id.*; see Chamblee, *supra*, at 168. In the former category, the injured parties know that they were exposed to a particular substance over a relatively short period of time. Examples of these cases are the anti-cholesterol drug, Baycol; the diet drug, Phen Fen; and the anti-arthritis drug, Vioxx. See MANUAL FOR COMPLEX LITIGATION, *supra*, at 344. In the latter category, parties may have latent injuries that take years or even decades to develop. See *id.* Examples of latent injury claims include those related to asbestos, silicone gel breast implants, and radiation exposure. *Id.* at 344-45. This dichotomy is only somewhat helpful as mass accidents, like dispersed mass torts, can result in multi-jurisdictional, multi-party disputes. Thus, it is best to think of these cases as arising on a continuum from cases that can easily be aggregated and litigated as one case to cases that are simply too diverse in terms of injury, operative law, and remedy to be aggregated with ease.

18. With the exception of Judge Weinstein in *In re Zyprexa Products Liability Litigation*, 451 F. Supp. 2d 458, 470 (E.D.N.Y. 2006), no court has addressed the settlement implications of the MSP. This is not entirely unexpected. Courts will rarely write about the true impact of the MSP because it generally affects the incentives for bringing or settling tort lawsuits – two areas in which the courts rarely write opinions. See generally David A. Hoffman et al., *Docketology, District Courts, and Doctrine*, 85 WASH. U. L. REV. (forthcoming 2008).

19. A review of the search results for “medicare /5 secondary” in the Westlaw JLR database yields only one academic article that addresses the topic. See David B. Torrey, *Compromise Settlements Under State Workers’ Compensation Acts: Law, Policy, Practice, and Ten Years of the Pennsylvania Experience*, 16 WIDENER L. J. 199, 389-98 (2007) (addressing the implications of enforcement of the MSP act in the context of state worker’s compensation “compromise and release agreements”).

20. Before the MMA, practitioners were concerned about their potential liability if the courts accepted the Secretary’s litigation position. See e.g., Wesley S. Caldwell III, et al., *The Medicare Secondary Payer Program and Its Implications for Personal Injury Clients*, 47 SOC. SEC. REP. SERV. 807, 807 (1995) (warning that “[a]ttorneys should realize that Medicare may be lying in wait, poised to recapture prior medical payments from awards that were considered by the client to be safe and secure”); Thomas J. Nyzio, *Medicare Recovery in Liability Cases*, S. C. LAW., May-June 1996, at 20, 23 (warning that “[i]n the event that Medicare’s interest is not repaid, anyone who could have protected Medicare’s interest may be liable for repayment,” and that “this even includes lawyers whose fees are paid from settlement proceeds”); H. Kennard Bennett, *Settlement Issues in Nursing Home Cases: Medicare Liens, Medicaid and Other Complications*, 2 NO. 11 ANDREWS NURSING HOME LITIG. REP. 11 (2000) (noting the “chilling effect” of Medicare liens on plaintiffs’ ability to bring lawsuits); Glenn E. Bradford & Melinda M. Ward, *The Medicare “Super Lien” Revisited*, 56 J. MO. B. 44, 44-45 (2000) (warning that “attorneys should proceed with caution” in the area of the Medicare “super lien” to protect against “later MSP collection efforts by the

In this article, I show that, as amended, the MSP will likely have unforeseen consequences to the tort system. I start by reviewing the history of Medicare and the forces that led Congress to enact and amend the MSP.<sup>21</sup> With illustration from the classic economic model of litigation, I then show that, not surprisingly, the MSP – as written – makes it more difficult for Medicare beneficiaries to bring and settle individual tort claims.<sup>22</sup> What may be less obvious is that this amendment may have a profound impact in the area of mass tort litigation. If individual parties to a mass tort cannot settle, plaintiffs’ attorneys, who make the litigation decisions in mass torts, may determine that it is not lucrative to include Medicare beneficiaries in mass tort litigation or to bring mass tort litigation at all. This could have several consequences. First, and most obviously, if certain plaintiffs

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government”); See Charles F. Preuss, Alan J. Lazarus & Krista L. Cosner, *The Keys to Successfully Resolving Multi-District Litigation: The Problem of Federal Medical Liens* (2004) (warning practitioners about the possibility of a Medicare lien and double damages).

After the amendment, although resigned to the inevitability of their difficulties, practitioners continued to sound the alarm. See, e.g., John L. Tate & Demetrius O. Holloway, *Medicare Liens: A Stumbling Block to Settlement*, 24 NO. 2 LJN’S PROD. LIAB. L. & STRATEGY 8, 8 (Aug. 2005) (“In cases involving catastrophic injury, . . . staggering [Medicare] liens often control the feasibility of reaching an acceptable [settlement] agreement.”); Thomas C. Regan & Seamus M. Morley, *Deluding the Unwary: The Revised Medicare Secondary Payer Act*, 47 NO. 1 DRI FOR DEF. 47 (2005) (warning practitioners that “[i]t is imperative that you make yourself aware of the new provisions [of the MSP]” because “a relatively modest settlement can become an extremely expensive one in the blink of an eye”); Matthew L. Garretson, *Making Sense of Medicare Set-Asides: As Medicare’s Role in Workers’ Compensation and Liability Settlements Evolves, a Lack of Clear Guidance has Left Many Lawyers Perplexed*, TRIAL, May 2006, at 64 (noting the frustration attorneys face deciphering their potential obligations to Medicare, and advising them to take a conservative approach); Frank Verderame, *Medicare Reimbursement Claims*, 1 ATLA ANN. CONVENTION REFERENCE MATERIALS 921 (2005) (calling the amended MSP “awful,” and warning lawyers to “[b]eware” of the changes); William E. Pipkin, Jr. & Conley W. Knott, *In Plain Language: Medicare and the Secondary Payer Statute*, 48 No. 3 DRI FOR DEF. 44 (Mar. 2006) (noting that the “MSP program fails to sufficiently account for” settlements where the merits of the underlying claim are in dispute); Robert S. Dampf, *Mediations & Settlements: Applicability of the Medicare Secondary Payer Act*, 54 LA. B. J. 173 (Oct.-Nov. 2006) (warning practitioners that if Medicare’s interests are ignored the government has a right to collect damages or, potentially, double damages); Walter C. Morrison, NAT’L BUS. INST., *Settle Medical Negligence Cases Efficiently and Successfully* 55, 60 (2006) (warning practitioners that it is “imperative” to know whether there is a possibility of Medicare recovery and the degree of liability when filing a lawsuit); Jules B. Olsman, *Medicare Liens in Personal Injury Litigation*, 2 ATLA ANN. CONVENTION REFERENCE MATERIALS 1811 (2006) (advising practitioners that “[t]here is no specific solution to this vexing problem” of Medicare liens); Patty L. Wisecup, *Minding Medicare’s Interests: It May Preserve Your Fiscal Health*, 64 BENCH & B. MINN. 25 (Feb. 2007) (warning practitioners of the potential repercussions of ignoring potential Medicare liability).

21. See *infra* Part II.

22. See *infra* Part III.

cannot bring claims, they will not be appropriately compensated for their harms. Moreover, if tortfeasors are not made to pay for their tortious conduct, they will not internalize the harms caused and will not take the proper amount of precaution to protect against future harms. Further, if there are no mass tort actions, the Secretary will not have access to the discovery done by private litigation against these mass tort defendants. As such, the Secretary may have a harder time collecting Medicare's conditional outlays from truly tortious parties. Lastly, I offer a simple means to rectify this complex problem: force the Secretary to use the clear statutory right of subrogation against tortfeasors.<sup>23</sup> Subrogation will not fundamentally change Medicare's ability to recover its costs from an alleged tortfeasor, but will alleviate the disincentives to settlement in the tort setting.

## II. THE HISTORY OF THE MEDICARE SECONDARY PAYER ACT

Medicare began as and remains a government-sponsored insurance program.<sup>24</sup> The legislation only gained popular and legislative support when its architects made clear that Medicare would not create a government handout. Rather, as constructed by its architects and as it exists today, Medicare provides health insurance to a select set of the working population. It is paid for by the working population and is meant to solve a gap in coverage created by the free market.

In this section, I first trace the roots of the Medicare bill to show that Congress intended the program to be a social insurance program, not a welfare entitlement. This is important because, as originally enacted, the MSP made sense specifically because Medicare functioned as an insurance program. But, by amending the MSP as part of the Medicare Modernization Act of 2003, Congress granted the Secretary the right to recover from Medicare beneficiaries and alleged tortfeasors, which is at odds with the history of Medicare generally and the secondary payer provisions specifically. Further, Congress created a remedy that is unknown in contract, tort, or insurance law.

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23. See *infra* Part V.

24. See *infra* Part II.A.

A. *The Push for Government-Sponsored Health Insurance: the Progressives, the New Deal, the Fair Deal, and the Medicare Compromise*

As with most legislation, the Medicare story begins with idealistic notions and ends with fierce lobbying and politically expedient compromises. By the time Congress passed Medicare as Title XVIII of the Social Security Amendments of 1965,<sup>25</sup> this country had already rejected three attempts to pass some form of universal healthcare insurance – at the turn of the twentieth century, as a part of the New Deal, and as part of the Fair Deal.<sup>26</sup> These proposals shared a unifying theme: the idea that healthcare costs would be paid through a social insurance scheme, not as a direct health benefit. That is, the intended beneficiaries (whether industrial workers, all workers, or all citizens) would insure against identifiable risks to individual beneficiaries by contributing to a fund large enough to guarantee benefits if the covered risk occurs.<sup>27</sup>

The first push in the United States for government-sponsored health insurance derived from a nineteenth-century movement in Europe for compulsory healthcare for industrial workers. In 1883, Germany, under Chancellor Otto von Bismark, embraced the “social insurance” philosophy by enacting the German Sickness Insurance Act, which created a redistributive model for the provision of medical care for industrial workers.<sup>28</sup> Between 1883 and 1913, ten other European countries adopted some form of compulsory healthcare insurance for their workers.<sup>29</sup> The United States, which at that time “was peculiarly

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25. Social Security Act Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286, 291-343 (1965).

26. See JONATHAN OBERLANDER, *THE POLITICAL LIFE OF MEDICARE* 18 (2003) (“Medicare represented the fourth wave in the campaign for national health insurance in the United States.”).

27. Public health insurance, like private health insurance, “covers individuals against the costs of unpredictable illness and disability by sharing individual financial risks across a large population.” NATIONAL ACADEMY OF SOCIAL INSURANCE, *MEDICARE AND THE AMERICAN SOCIAL CONTRACT* 31 (1999), [www.nasi.org/usr\\_doc/med\\_report\\_soc\\_contract.pdf](http://www.nasi.org/usr_doc/med_report_soc_contract.pdf). Common risks dealt with under social insurance are old age, ill health or injury, and unemployment. See *id.*

28. OBERLANDER, *supra* note 26, at 18; SUE A. BLEVINS, *MEDICARE’S MIDLIFE CRISIS* 25 (2001).

29. The following European countries introduced some form of compulsory medical care at the turn of the twentieth century: Austria (1888), Hungary (1891), Denmark (1892), Luxembourg (1901), Norway (1909), Serbia (1910), Great Britain (1911), Russia (1912), Romania (1912), and the Netherlands (1913). *Id.* By 1940, every western European country had some form of government health insurance program for at least its lowest-income workers. THEODORE MARMOR, *POLITICS OF MEDICARE* 7 (1973).

open to foreign models and imported ideas,” considered following suit.<sup>30</sup> In this country, two lobbying organizations led the charge to create a healthcare entitlement: the American Association for Labor Legislation (“AALL”), a political group of academics, lawyers, and other progressives, and the American Medical Association (“AMA”), led by urban, academically minded doctors.<sup>31</sup> In 1912, influenced, in part, by the progressive stance of the AALL and the AMA, Theodore Roosevelt included compulsory health insurance for industrial workers as part of his platform for president. Although Roosevelt lost the 1912 election, the AALL and the AMA continued to push for a governmental solution to the issue of healthcare.<sup>32</sup>

These lobbying efforts did not go unchecked. The insurance industry, pharmaceutical companies, and organized labor united to oppose nationalized health care. In particular, Samuel Gompers, the president of the American Federation of Labor, claimed that any form of compulsory health care would be a means for the government to control industrial workers.<sup>33</sup> The insurance and pharmaceutical industry opposed compulsory healthcare for business reasons, claiming that compulsory governmental healthcare would eliminate the need for private insurance and stifle the development of the pharmaceutical industry.

This first push for compulsory healthcare ended by the time the United States entered World War I. After 1917, those who opposed universal healthcare poisoned the debate by arguing that nationalized

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30. DANIEL T. RODGERS, *ATLANTIC CROSSINGS: SOCIAL POLITICS IN A PROGRESSIVE AGE* 4 (1998) (arguing, in part, that after the end of the American Civil War, but before the United States took its place as a super power after World War II, the United States was more open to the influences of European countries than ever before or since). American politicians were particularly influenced by Great Britain’s insertion of a program for health insurance for low-income workers into a more general social security program that provided pensions, unemployment compensation, and sickness benefits. See MARMOR, *supra* note 29, at 7; BLEVINS, *supra* note 28, at 26.

31. See OBERLANDER, *supra* note 26, at 18; MARMOR, *supra* note 29, at 7.

32. See OBERLANDER, *supra* note 26, at 18.

33. OBERLANDER, *supra* note 26, at 20, MARMOR, *supra* note 29, at 7. In part Gompers feared that any form social insurance would draw workers closer to the state at the expense of the unions. See generally DANIEL S. HIRSHFIELD, *THE LOST REFORM: THE CAMPAIGN FOR COMPULSORY HEALTH INSURANCE IN THE UNITED STATES FROM 1932 TO 1943* 20 (1970).

healthcare was a foothold to socialism and Bolshevism.<sup>34</sup> By 1920, the AMA withdrew its support as rural and private doctors took control of the organization's message from the urban, academic doctors. Rural and private doctors were influenced both by the comparison to socialism and by a concern that compulsory health insurance would negatively impact their income and social status.<sup>35</sup> Without support and without a strategy to combat the smear campaign, the first movement toward compulsory healthcare ended.

The second push for compulsory healthcare began with Franklin Roosevelt and the New Deal.<sup>36</sup> During the Great Depression, the unemployment and poverty rates among the elderly grew at drastic rates.<sup>37</sup> Although approximately thirty States had some form of old-age pension by 1935, only 3% of the elderly received benefits and the average benefit was only \$0.65 per day.<sup>38</sup> Three significant reasons prevented the elderly from receiving benefits under these State plans: a) significant social stigma and objection to being on the government dole; b) complicated eligibility requirements that precluded many seniors from receiving these benefits, and c) although States adopted the legislation, individual counties failed to put the welfare plans into action.<sup>39</sup> Thus, the efficacy of State welfare programs suffered significantly.

In 1934, Roosevelt created the advisory Committee on Economic Security ("CES") to seek a method to provide minimum income for the aged, unemployed, blind, and the widowed.<sup>40</sup> The CES based the proposed Social Security bill on the social insurance model, and paid out retirement benefits based on contributions paid into the fund through

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34. BLEVINS, *supra* note 28, at 27:

Before World War I, American reformers looked to Europe for policy models and argued that the United States had fallen behind its European counterparts . . . . [After 1917], that strategy had backfired. 'The very explicitness of the American borrowings . . . all became potential liabilities after 1917.

OBERLANDER, *supra* note 26, at 20 (quoting RODGERS, *supra* note 30, at 257).

35. See BLEVINS, *supra* note 28, at 27 ("The links with Germany and Russia created a postwar reaction to progressivism that dampened enthusiasm for social insurance in the United States.").

36. OBERLANDER, *supra* note 26, at 20-21.

37. Unemployment rates reached over twenty-five percent during the Depression and some estimates suggest that in 1934 over half of the elderly could not support themselves. Social Security Administration, *Historical Background and Developments in Social Security*, paras. 30, 40, <http://www.ssa.gov/history/briefhistory3.html> (last visited December 2006).

38. *Id.* at para. 30.

39. *Id.* at para. 31.

40. MARMOR, *supra* note 29, at 8.

compulsory payroll taxes.<sup>41</sup> This model had several significant political benefits. First, it removed some of the stigma from the notion of welfare, because individuals believed that they were receiving benefits based on what they paid in.<sup>42</sup> Second, because all workers contributed and all workers received benefits, the program received broad support across generations and classes. No one felt that another group was being given a handout.<sup>43</sup>

The proposed Social Security bill from the CES originally included a one-line proposal to authorize a study of compulsory health insurance. However, that single line motivated the AMA to oppose the entire bill.<sup>44</sup> As Edwin Witte, the chair of the Committee on Economic Security remarked: "that little line was responsible for so many telegrams to the members of Congress that the entire social security program seemed endangered until the Ways and Means Committee unanimously struck it out of the bill."<sup>45</sup> Fearing that support for the entire Social Security bill would evaporate, the Roosevelt administration withdrew its support for a national health insurance program.<sup>46</sup> The Social Security bill passed in 1935<sup>47</sup> without mention of compulsory health insurance, and with that, the second push for compulsory healthcare effectively died.<sup>48</sup>

The third push for compulsory health insurance began with Senator Robert Wagner (D., N.Y.) who in 1935 first introduced legislation to remove income as a barrier to accessing medical care.<sup>49</sup> Although he failed to gain support for this bill, Senator Wagner continued to push annually for universal healthcare. By 1943, Senator James Murray (D. Mont.) and Representative John Dingell, Sr. (D., Mich.) had joined Wagner's annual appeal for comprehensive health insurance for all

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41. See OBERLANDER, *supra* note 26, at 77-78.

42. See *id.* at 79 ("The trust fund was seen, in effect, as the public property of the individuals who had paid into it, not simply as another government program that went to help 'others.'").

43. See *id.*

44. See *id.* at 21.

45. See EUGENE FEINGOLD, *MEDICARE: POLICY AND POLITICS* 91 (1966); MARMOR, *supra* note 29, at 8.

46. See MARMOR, *supra* note 29, at 8; OBERLANDER, *supra* note 26, at 47.

47. Social Security Act, Pub. L. No. 74-271, 49 Stat. 620 (1935).

48. The AMA and other critics saw the Social Security bill as the first step toward a health care entitlement. See MARMOR, *supra* note 29, at 9. See also JAMES G. BURROW, *AMA: VOICE OF AMERICAN MEDICINE* 197 (1963). In an effort to limit government action in the health care arena, the AMA endorsed private health care insurance such as Blue Cross for hospitalization and Blue Shield for surgical and medical expenses. MARMOR, *supra* note 29, at 9. Interestingly, these programs, in turn, became the model for Medicare's Part A and Part B.

49. MARMOR, *supra* note 29, at 10.

citizens.<sup>50</sup> In 1948, Harry Truman supported the Wagner-Murray-Dingell bill in his run for the Presidency, even though he knew that the bill would never pass the Republican-controlled Congress.<sup>51</sup> After taking office in 1949, Truman again pushed for a national health insurance program as part of his Fair Deal policy for social change.<sup>52</sup> Truman, like Roosevelt, met stalwart opposition from the medical profession. The AMA launched another campaign to defeat nationalized health care, capitalizing on the red scare and linking nationalized health insurance to a fear of a Communist takeover. The AMA also warned that government insurance would ruin the quality of care by reducing the incentives for physicians to provide quality services. Together with Blue Cross, the AMA again pushed private insurance as the alternative solution.<sup>53</sup> By 1950, the AMA's campaign against government-sponsored healthcare of any kind had been credited with the defeat of at least three congressmen who had been in favor of Truman's plan.<sup>54</sup> And, with that, the third campaign for national health insurance ended.

After the collapse of the Fair Deal proposal, a small group of national health care advocates designed a new strategy to garner support for health care.<sup>55</sup> Rather than try to provide nationalized health insurance for the entire population, the new proposal had smaller aims. The architects of the new Medicare proposal intended to provide limited insurance benefits to a small, but vulnerable population so that the most vulnerable could avoid complete financial collapse. The new bill provided aid only to those over sixty-five and only to those already participating in the Social Security system. To this group, the bill provided assistance for sixty days of hospitalization, sixty days of nursing home care, and some surgical benefits.<sup>56</sup> Further, by grafting Medicare onto the Social Security program, Medicare's architects made

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50. *Id.*

51. *Id.* at 11. Proponents of the Fair Deal legislation had a greater distributive goal than earlier movements. As stated in the 1952 report of President Truman's Commission on the Health Needs of the Nation, "[a]ccess to the means of attainment and preservation of health, is a basic human right." *Id.* at 10. As Marmor observed, "New Deal-Fair Deal champions of medical care proposals did not view it primarily as a measure to further income security but as a remedy for the inequitable distribution of medical services." *Id.* at 9-10.

52. *Id.* at 11.

53. OBERLANDER, *supra* note 26, at 22. See MARMOR, *supra* note 29, at 12; see *supra* notes 48 and accompanying text.

54. See OBERLANDER, *supra* note 26, at 22.

55. *Id.* at 23.

56. SHERI I. DAVID, WITH DIGNITY: THE SEARCH FOR MEDICARE AND MEDICAID 3 (1985); MARMOR, *supra* note 29, at 15.

sure that the public understood that the bill provided an earned benefit, not a welfare entitlement.

As with the original push for Social Security, the focus on the elderly had both practical and sentimental appeal. On the practical side, many elderly were left with no real options for private insurance. Although labor unions made great strides in the 1950s by obtaining private health insurance for their members from employers, this insurance generally ended at the time of retirement.<sup>57</sup> Non-profit organizations like Blue Cross and Blue Shield initially provided some coverage for retirees. However, as the market moved healthy workers into private insurance, these non-profit organizations increasingly only insured high-risk individuals. As such, the non-profits had to raise premiums simply to stay in business, and by 1958, this insurance “was out of the price range of those living on a pension or Social Security checks.”<sup>58</sup> With premiums on the rise from non-profits and private insurers loath to offer health insurance to the elderly, those over sixty-five were often left with no real means to insure themselves. Further, the elderly had vast political appeal, and to the extent they were viewed as needy, they were also considered deserving. Thus, limiting the proposal to the elderly provided some political cover, while still advancing the cause of national health insurance, if only incrementally.<sup>59</sup>

As planned, Medicare gained credibility because of this connection to Social Security, which had gained widespread acceptance. As with Social Security, individuals paid in over time and received benefits upon their sixty-fifth birthday. In a country that was “traditionally skeptical of public assistance to ‘undeserving’ recipients, the notion that social welfare benefits had been earned was politically crucial.”<sup>60</sup> Thus, the Medicare proposal lacked the usual stigma associated with welfare programs.

Despite these strategies, the debate over the Medicare proposal raged throughout the Eisenhower and Kennedy (1953-63) administrations. During this time, the proposals for Medicare’s

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57. DAVID, *supra* note 56, at 4.

58. *Id.*

59. OBERLANDER, *supra* note 26, at 24; *see* MARMOR, *supra* note 29, at 16-17. Likewise, the decision to limit the scope of benefits provided was politically expedient. Because Medicare’s architects believed that large-scale change was out of the question, they aimed to protect the elderly from financial catastrophes resulting from illness. At the time, hospitalization represented the greatest threat. *See* OBERLANDER, *supra* note 26, at 25.

60. *See* OBERLANDER, *supra* note 26, at 24.

coverage changed, but the bill remained limited in scope and continued to target Social Security beneficiaries. And, as before, objections from conservatives and the AMA focused on the evils of Socialism. This time, however, new liberal lobbying efforts rebuffed the AMA's attacks.<sup>61</sup> One group in particular shouldered the lobbying burden for Medicare, a group called the National Council of Senior Citizens, which was financed by the AFL-CIO specifically to lobby for Medicare.<sup>62</sup> Thus, despite its early rejection of national health care, by the time Congress enacted Medicare, organized labor fully supported the proposal.

In 1964, Lyndon Johnson won the presidential election, swept a Democratic majority into Congress, and Medicare finally had the Congressional backing it required.<sup>63</sup> Seeing the writing on the wall, Republicans and the AMA offered different proposals to shape Medicare. Under the Republican proposal, the government would subsidize the premium payments the elderly made for private insurance. This proposal would have been financed two-thirds from the public coffers and one third from premium payments. The AMA, in turn, proposed Eldercare, a state administered program to subsidize private health insurance for the poor.<sup>64</sup>

On July 30, 1965, President Johnson signed Medicare into law as Title XVIII of the Social Security Amendments of 1965.<sup>65</sup> This bill included elements of the proposals from the Democrats, the Republicans, and the AMA: hospitalization insurance (Part A),<sup>66</sup> a voluntary outpatient medical insurance program for the aged and disabled (Part B),<sup>67</sup> and an expanded program of federal assistance for

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61. See generally MARMOR, *supra* note 29, at 23-28.

62. See *id.* at 24.

63. OBERLANDER, *supra* note 26, at 29.

64. See OBERLANDER, *supra* note 26, at 30.

65. Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (1965).

66. Part A of the Title XVIII of the Social Security Act of 1965, Publ. L. No. 89-97, covers "inpatient hospital care, home care, hospice care, and care in a skilled nursing facility." BLEVINS, *supra* note 28, at 5. Medicare beneficiaries are required to pay a deductible for each hospitalization. *Id.* Part A was and is financed through the Hospital Insurance Trust Fund ("HI"). *Id.* The HI trust fund is financed by a 2.9% payroll tax – workers and employers each contribute 1.45% of workers' earnings. *Id.* Although it is called a trust fund, the money taken out of each person's paycheck is not set aside for his or her own future healthcare costs; rather, today's Medicare taxes pay for the costs of today's beneficiaries. *Id.*

67. Supplementary Medical Insurance ("SMI"), established in Part B of Title XVIII, provides benefits for outpatient services, home health services, durable medical equipment, and diagnostic tests. See generally TERRY S. COLEMAN, *MEDICARE LAW* (2001); Eric Patashnik & Julian Zelizer,

the poor (Medicaid). Over time, Medicare expanded to include private medical insurance programs<sup>68</sup> and insurance for prescription drugs.<sup>69</sup>

Despite this achievement, the original bill and its later expansions reflect the United States' deep ambivalence for welfare benefits. Rather than allow Congress to create a government entitlement, the forces that aligned against universal health care – conservatives, the pharmaceutical industry, and the AMA – made sure that Medicare followed a recognizable insurance model. That is, Congress ensured that the hospitalization benefit of Part A and the medical insurance of Part B reflected the expressed desire for a government-sponsored insurance scheme.

As discussed below, the Medicare Secondary Payer Act best makes sense within the context of an insurance paradigm. But by amending the MSP, Congress created a remedy that has no basis in contract, tort, or insurance law.<sup>70</sup>

#### *B. Medicare As a Secondary Payer: An Insurance Based Approach To Fiscal Change*

As originally enacted in 1965, Medicare was the primary insurer, and thus the primary payer, for medical services provided to Medicare beneficiaries, with one exception: if the Secretary reasonably expected a

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*Paying for Medicare: Benefits, Budgets, and Wilbur Mill's Policy Legacy*, 26 J. HEALTH POL. POL'Y & L. 7 (2001). Part B is a voluntary program financed by general Treasury revenues and premiums paid by the insured. Under Part B, Medicare pays 80% (after seniors pay a \$100 deductible) of the services covered under Part B. BLEVINS, *supra* note 28, at 5. In 2001, approximately 73% of Part B was financed through general tax revenues, 23% was financed by premiums paid by seniors; and 4% was financed by interest and other miscellaneous income. *Id.*

68. In 1997, Congress created Medicare Part C. *See* Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4001, 11 Stat. 251, 275 (1997). Under Part C, which was originally called Medicare+Choice, individuals who receive benefits under Part A and Part B can purchase private insurance through the Medicare program and receive their care through coordinated care plans. *See* SOCIAL SECURITY ONLINE, MEDICARE ELECTRONIC BOOKLET 3, 7, Publication No. 05-10043 (Sept. 2007), available at <http://www.ssa.gov/pubs/10043.pdf>; 2005-2006 MEDICARE HANDBOOK § 1.01 (Judith A. Stein & Alfred J. Chiplin, Jr., eds. Aspen Publishers 2006); BLEVINS, *supra* note 28, at 5-6. In 2003, Congress changed the name of Part C to Medicare Advantage. *See* MMA, Pub. L. No. 108-173, 117 Stat. 2066 (2003).

69. "Part D initially provided access to prescription drug discount cards and transitional assistance to low-income beneficiaries." 2006 THE BDS. OF TRS. OF THE FED. HOSP. INS. AND FED. SUPPLEMENTARY INS. TRUST FUNDS ANNUAL REPORT I (2006) [hereinafter 2006 MEDICARE ANN. REP.]. After 2006, Part D provides subsidized access to drug insurance on a voluntary basis for all Medicare beneficiaries and premium and cost-sharing subsidies for low-income beneficiaries. *Id.*; *see* MMA, Pub. L. No. 108-173, 117 Stat. 2066 (2003).

70. *See infra* Part III.

workmen's compensation plan to cover a beneficiary's claims, Medicare would only make payment on the condition that the workmen's compensation plan would reimburse Medicare.<sup>71</sup> In other words, if a beneficiary was entitled to have a worker's compensation plan pay for her medical services, Medicare would act only as a secondary insurer, i.e. a secondary payer.

Other than that exception, from 1965 until 1980, Medicare paid benefits without regard to whether another insurer covered the services.<sup>72</sup> Other insurance companies, in fact, wrote their insurance policies around Medicare to fill the gaps created for those over 65.<sup>73</sup> During this period, however, Medicare expenses rapidly expanded beyond Congress' initial expectation,<sup>74</sup> and Congress scrambled to reign in the program's spending.

Medicare spending is a function of four factors: (a) the number of

71. See Social Security Amendments of 1965, Pub. L. No. 89-97, § 1862(b), 79 Stat. 286, 325 (1965). In 1965, section 1862(b) of the Social Security Act stated:

(b) Payment under this title may not be made with respect to any item or service to the extent that payment has been made, or can reasonably be expected to be made (as determined in accordance with regulations), with respect to such item or service, under a workmen's compensation law or plan of the United States or a State. Any payment under this title with respect to any item or service shall be conditioned on reimbursement to the appropriate Trust Fund established by this title when notice or other information is received that payment for such item or service has been made under such a law or plan.

*Id.*; see also *Blue Cross and Blue Shield Ass'n v. Sullivan*, 794 F. Supp. 1166, 1168 (D.D.C. 1992) (noting that "[f]rom its inception until 1980, Medicare was the primary source of payment for the medical expenses for nearly all of its beneficiaries" except when "payments had been, or reasonably could have been, made by a workers compensation law or plan") *aff'd in part, rev'd in part on other grounds sub nom Health Ins. Ass'n of Am., Inc. v. Shalala*, 23 F.3d 412 (D.C. Cir. 1994); *In re Dow Corning*, 250 B.R. 298, 335 (Bankr. E.D. Mich. 2000) ("Except for worker's compensation plans, Medicare was made the 'primary payer' for the health care claims of federal beneficiaries . . .").

72. From 1965 until 1980, Medicare was the "primary payer" for the "health care claims of federal beneficiaries with the beneficiaries' other health insurance plans filling in some or all of the coverage gaps" for all claims other than claims arising under worker's compensation plans. *Dow Corning*, 250 B.R. at 335; see also *Health Ins. Ass'n of Am., Inc. v. Shalala*, 23 F.3d at 414; *In re Zyprexa Prods. Liab. Litig.*, 451 F. Supp. 2d 458, 465 (E.D.N.Y. 2006).

73. See *Sullivan*, 794 F. Supp. at 1168 ("[Prior to 1980] most insurance companies' contracts with employers and [employer group health plans] only covered 'secondary' costs.").

74. "In its first years, Medicare costs vastly outpaced the actuarial projections made at the time of its enactment." OBERLANDER, *supra* note 26, at 47. In 1968 and 1969, costs rose at an average annual rate of 40.2%, prompting Russell Long, chairman of the Senate Finance Committee, to warn that Medicare had become a "a runaway program." *Id.* In its first five years, Medicare spending increased by more than 70% – from \$4.6 billion in 1967 to \$7.9 billion in 1971 – while the number of enrollees only grew by 6% from 19.5 to 20.7 million. BLEVINS, *supra* note 28, at 59-60 (citing Theodore Marmor & Julie Beglin, *Medicare and How it Grew. . . and Grew. . . and Grew.*, BOSTON GLOBE, May 7, 1995).

Medicare beneficiaries; (b) the prices paid for services, which reflect both wages for health care workers and price of the goods and services purchased by health care providers; (c) the number of services consumed by the beneficiaries; and (d) the average complexity of the services, i.e., the intensity of those services.<sup>75</sup> To some extent, the expenditures prior to 1980 rose because Congress expanded the number of beneficiaries eligible to receive services and because of inflation.<sup>76</sup> But neither inflation nor new enrollees can account for all of the increases in Medicare expenditures, as is clear when one looks at real dollar expenditures per enrollee. From 1967 through 1980, the total Medicare expenditures and administrative costs per enrollee rose rapidly. In 2005 dollars, Medicare spent \$976.50 per enrollee in 1967; by 1970, Medicare spent \$1,741.55 per enrollee, and by 1980, \$3,090.97 per enrollee.<sup>77</sup> Thus, one is left with the conclusion that the “volume of services” rendered to enrollees and the “intensity of [those] services” accounts for a great deal of the increase, and not the number of enrollees or the cost of the services.<sup>78</sup>

In December 1980, Congress passed, and President Carter signed, the Omnibus Reconciliation Act of 1980,<sup>79</sup> with the explicit intent of reducing the deficit.<sup>80</sup> This Act included the Medicare and Medicaid

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75. 2006 MEDICARE ANN. REP., *supra* note 69, at 30. One can also think of intensity as “the average complexity of the services reimbursed by Medicare. It can reflect not only technological progress, such as the ability to do open-heart surgery, but also changes in accounting practices and the coding of claims by health care providers to optimize Medicare payments.” Richard S. Foster, *Trends in Medicare Expenditures and Financial Status 1966-2000*, 22 HEALTH CARE FIN. REV. 35, 37 n.1 (2000).

76. In 1972, Medicare extended its coverage beyond the aged to two new categories of beneficiaries: the disabled and end-stage renal disease patients. *See* OBERLANDER, *supra* note 26, at 40; Social Security Amendments of 1972, Pub. L. No. 92-603, 86 Stat. 1329 (1972).

77. *See* RONALD J. VOGEL, MEDICARE: ISSUES IN POLITICAL ECONOMY 18 (1999) (adjusted to real 2005 dollars).

78. *See id.* at 19. Vogel also persuasively shows that various exogenous schemes (such as wage and price controls, voluntary efforts by the American Hospital Association and the American Medical Association to control hospital costs and medical fees, and a fee schedule set by Medicare) had little effect on the rise in Medicare spending. *See id.* at 17-19.

79. Omnibus Reconciliation Act of 1980, Pub. L. No. 96-499, 94 Stat. 2599 (1980).

80. *See* H.R. REP. NO. 96-1167, at 1 (1980), *as reprinted in* 1980 U.S.C.C.A.N. 5527 (reporting on the Omnibus Reconciliation Act of 1980) (“When Congress approved the budget targets for fiscal year 1981, it agreed that growth in Federal spending should be restrained.”); *Id.* at 2.

The Congress took unprecedented action by directing that these legislative changes be accomplished through the reconciliation process. To implement these spending and revenue policies. . . . Congress directed its spending and tax-writing committees to examine the laws within their jurisdictions and to recommend legislative changes which

Amendments of 1980.<sup>81</sup> The bulk of the Medicare amendments were aimed at regulating the services provided under Medicare<sup>82</sup> and eliminating fraud and waste in the system.<sup>83</sup> Thus, Congress attempted to control Medicare's rising costs by limiting the volume and intensity of services provided to Medicare beneficiaries.

Inserted among these other changes was a little-discussed amendment to section 1862(b) of the Social Security Act, which has come to be known as the Medicare Secondary Payer Act. Under the 1980 Amendment, for the first time since Medicare's inception, Congress made Medicare's liability secondary to additional sources of payment for Medicare beneficiaries' medical costs and services.<sup>84</sup> In addition to workers' compensation, Congress included automobile, liability, and no-fault insurance as payers of first resort. As before, if the Secretary reasonably expected any of these insurance plans to cover a beneficiary's claims, Medicare would only pay for the beneficiary's medical care when the Secretary could expect "reimbursement" for Medicare's payments.<sup>85</sup> "The intent of this statute was to cut the costs of the Medicare program by requiring that Medicare pay 'secondary' to

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would result in substantial savings in fiscal year 1981.

*Id.*

81. Omnibus Reconciliation Act of 1980, Pub. L. No. 96-499, § 900, et seq., 94 Stat. 2599, 2609 (1980).

82. *See* Omnibus Reconciliation Act of 1980, Pub. L. No. 96-499, §§ 930-939, 94 Stat. 2631-40 (1980).

83. *See* Omnibus Reconciliation Act of 1980, Pub. L. No. 96-499, §§ 911-929, 94 Stat. 2619-31 (1980).

84. After the Medicare and Medicaid Amendments of 1980, section 1862(b) stated:

Payment under this title may not be made with respect to any item or service to the extent that payment has been made, or can reasonably be expected to be made (as determined in accordance with regulations), with respect to such item or service, under a workmen's compensation law or plan of the United States or a State *or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance*. Any payment under this title with respect to any item or service shall be conditioned on reimbursement to the appropriate Trust Fund established by this title when notice or other information is received that payment for such item or service has been made under such a law or plan, *policy, plan, or insurance*. *The Secretary may waive the provisions of this subsection in the case of an individual claim if he determines that the probability of recovery or amount involved in such claim does not warrant the pursuing of the claim.*

Social Security Amendments of 1965, Pub. L. No. 89-97, § 1862(b), 79 Stat. 286, 325 (1965) (prior version); Omnibus Reconciliation Act of 1980, Pub. L. No. 96-499, § 953, 94 Stat. 2599, 2647 (1980) (amendment in italics).

85. Omnibus Reconciliation Act of 1980, Pub. L. No. 96-499, § 953, 94 Stat. 2599, 2647 (1980).

alternate sources.”<sup>86</sup> In other words, Congress ostensibly intended to save money by shifting the costs of beneficiaries’ medical care from the Medicare program to private sources of payment.<sup>87</sup>

The legislative history reflects little debate and scholars and commentators largely ignored the amendment to the MSP. Neither the House nor the Senate report predicted that this provision would result in significant savings. The House Report predicted that after one year, this provision would save \$8 million and by fiscal year 1985 it would save \$112 million.<sup>88</sup> This is virtually insignificant compared to overall Medicare expenditures in 1980 and 1985: \$35 and \$71.4 billion respectively (a reduction of 0.02% and 0.16% respectively).<sup>89</sup> Further, there is little, if any, recorded debate about the wisdom of this change; the legislative record contains minimal discussion about the provision.<sup>90</sup> Likewise, there was no real scholarly work on the provision after these amendments.<sup>91</sup>

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86. *Blue Cross and Blue Shield Ass’n v. Sullivan*, 794 F. Supp. 1166, 1169 (D.D.C. 1992).

87. See CENTERS FOR MEDICARE & MEDICAID SERVICES, MEDICARE SECONDARY PAYER (MSP) MANUAL, REV. 34, § 10 (Sept. 7, 2005).

88. H.R. REP. NO. 96-1167, at 522 (1980), as reprinted in 1980 U.S.C.C.A.N. 5885.

89. See 2006 MEDICARE ANN. REP., *supra* note 69, at 187.

90. The House and Senate Reports do little more than repeat the wording of the statute. See generally H.R. REP. NO. 96-1167, at 389, 522 (1980), as reprinted in 1980 U.S.C.C.A.N. 5526, 5752, 5885 (explaining that the amendment will give Medicare “residual rather than primary liability for the payment of services required by a beneficiary as a result of an injury or illness sustained in an auto accident. . . .” and providing the amendment’s budgetary effects in cost reduction); H.R. REP. NO. 96-1479, at 133 (1980) (Conf. Rep.), as reprinted in 1980 U.S.C.C.A.N. 5903, 5924 (noting differences between the House, Senate, and Conference versions, but failing to discuss the import of those differences); STAFF OF COMM. ON THE BUDGET, 96TH CONG., RECONCILIATION (S. 2885) AND SPECIAL RULES FOR ITS CONSIDERATION TOGETHER WITH THE REPORTS TO THE BUDGET COMMITTEE OF THE INSTRUCTED COMMITTEES 92-93, 153 (Comm. Print 1980).

91. A Westlaw search of the JLR database, with search term “Medicare w/5 secondary” and restricted to 1978-1990 yielded only articles by the Practising Law Institute. Nor have later books or articles on the history of Medicare discussed this provision in depth. Although academics and practitioners largely ignored the amendment, insurance companies may have been concerned about this change, as it likely impacted their bottom line for contracts already written. The paradigmatic case after the 1980 Amendments was that of a Medicare beneficiary hit by a tortious driver. Before the 1980 Amendments, Medicare would pay for a beneficiary’s hospital stay and certain medical services regardless of whether either party had automobile insurance or whether the State had no-fault insurance. Private insurance (to the extent that the driver had it) would only pay to fill in the gaps left by Medicare’s coverage. After the 1980 Amendments, the driver’s private insurance company had to pay for the beneficiary’s medical care. See, e.g., *Colonial Penn Ins. Co. v. Heckler*, 721 F.2d 431, 435 (3d Cir. 1983); *Abrams v. Heckler*, 582 F. Supp. 1155, 1157 (S.D.N.Y. 1984). Thus, we can imagine that insurance companies had to pay more for medical costs for elderly that were injured in auto accidents, because Medicare refused to pay for medical costs that it used to

From 1980 until 2003, Congress amended the Medicare Secondary Payer Act a number of times. Each of these amendments “expanded the scope of the MSP scheme.”<sup>92</sup> But until 2003, the MSP kept its same basic shape.<sup>93</sup> The first paragraph of the MSP imposed certain requirements on group health plans.<sup>94</sup> For instance, a non-exclusion provision required group health plans offered by employers – except for those provided by small employers – to provide the same benefits to the aged employees and aged employees’ spouses as to other employees and spouses.<sup>95</sup> Similar provisions provided that group health plans could “not take into account” that an individual was disabled or suffering from end stage renal disease.<sup>96</sup> In short, these provisions nullified any private plan provision “that would ‘carve out’ expenses covered by Medicare

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cover. Private insurance companies likely increased their premiums to cover these anticipated additional costs.

92. *Blue Cross and Blue Shield Ass’n v. Sullivan*, 794 F. Supp. 1166, 1169 n.5 (D.D.C. 1992). For example, in 1981, Congress added secondary payer provisions for Medicare services provided to individuals receiving benefits to treat end-stage renal disease. *See Omnibus Budget Reconciliation Act of 1981*, Pub. L. No. 97-35, § 2146, 95 Stat. 357, 800-01 (1981). The next year, Congress truly expanded the scope of the statute by requiring employers who provide health insurance to employees to provide the same coverage to employees aged sixty-five to sixty-nine and making the group health plan the primary insurer. *Tax Equity and Fiscal Responsibility Act of 1982*, Pub. L. No. 97-248, § 116, 96 Stat. 324, 353-54 (1982). That is, Congress required employers to treat those over sixty-five the same as those under sixty-five with respect to the provision of medical benefits. In addition to expanding the scope of the MSP, Congress expanded the Secretary’s ability to recover for those benefits by adding an explicit cause of action for the government to recover when a primary plan failed to pay; *see Deficit Reduction Act of 1984*, Pub. L. No. 98-369 § 2344(a)–(c); 98 Stat. 494, 1095-96 (1984), and a private cause of action to recover against primary plans, which included incentives to encourage private citizens to recover on behalf of Medicare, *see Omnibus Reconciliation Act of 1986*, Pub. L. No. 99-509 § 9319(b), 100 Stat. 1874, 2011 (1986) (allowing double damages against a primary plan). *See also Social Security Act Amendments of 1994*, Pub. L. No. 103-432 § 151(a)(1)(A), 108 Stat. 4398, 4432-33 (1994) (requiring the Secretary to send a questionnaire to new beneficiaries to determine if the beneficiary had other insurance that should be considered a primary plan).

93. In 1989, Congress redrafted the MSP into its current structure. *See Omnibus Budget Reconciliation Act of 1989*, Pub. L. No. 101-239 § 6202, 103 Stat. 2106, 2225-35 (1989).

94. *See* 42 U.S.C. § 1395y(b)(1) (2002). Borrowing from the Internal Revenue Code, the MSP defines group health plans both as small group health plans: “a plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) or employee organization to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families,” and large group health plans: a small group health plan “that covers employees of at least one employer that normally employed at least 100 employees on a typical business day during the previous calendar year.” *See id.* at (b)(1)(A)(v), (B)(iii) (citing to 26 U.S.C. § 5000(b)(1) and (2)). For purposes of this paper, there is little reason to distinguish between the two and I will refer to both small group health plans and large group health plans simply as “group health plans.”

95. *See* 42 U.S.C. § 1395y(b)(1)(A)(i)(II) (2002).

96. *See id.* § 1395y(b)(1)(B) and (C).

and thus, in effect, make the plan's coverage secondary to Medicare."<sup>97</sup> These provisions reduced the number of beneficiaries for whom Medicare was the primary payer and concomitantly expanded the number of private primary payers.

The second paragraph of the MSP provided the means by which Medicare became the secondary payer with respect to coverage required under the first paragraph and provided the mechanism for recovery where the primary plan failed to make payments. Subparagraph (A) stated that Medicare would not pay for any medical service for a Medicare beneficiary where a "primary plan" – defined as a group health plan, large group health plan, workman's compensation plan, an automobile or liability insurance plan (including a self-insured plan), or no fault insurance – provided medical insurance for the beneficiary and Medicare expected the insurer to pay for the beneficiaries' medical care "promptly."<sup>98</sup>

Although this provision of the MSP was never a model of "clarity and coherence,"<sup>99</sup> courts read it charitably,<sup>100</sup> holding that the statute

97. *Health Ins. Ass'n of Am., Inc. v. Shalala*, 23 F.3d 412, 414 (D.C. Cir. 1994).

98. 42 U.S.C. § 1395y(b)(2) (2002); *see also Health Ins. Ass'n Am., Inc.*, 23 F.3d at 414-15 (discussing the statutory scheme before the MMA). Subparagraph (A) stated in relevant part:

Payment under [the Medicare program] 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, ... as required [under a group health plan], or*
- (ii) *payment has been made or can reasonably be expected to be made promptly (as determined in accordance with regulations) under a workmen's compensation law or plan of the United States or a State or under an automobile or liability insurance policy or plan (including a self-insurance plan) or under no fault insurance.*

*Id.* (emphasis added). Subparagraph (B) allowed the Secretary to make conditional payments and created a cause of action against recalcitrant primary plans. Subparagraph (B) stated in relevant part:

(i) Primary Plans

Any payment under this subchapter ... shall be conditioned on reimbursement to the appropriate Trust Fund established by this subchapter when notice or other information is received that payment for such item or service has been or could be made under such subparagraph...

(ii) Action by United States

In order to recover payment under this subchapter for such an item or service, the United States may bring an action against any entity which is *required or responsible (directly, as a third-party administrator, or otherwise) to make payment* with respect to such item or service (or any portion thereof) under a primary plan ..., or against any other entity (including any physician or provider) that has received payment from that entity with respect to the item or service, and may join or intervene in any action related to the events that gave rise to the need for the item or service. . . .

*Id.* at § 1395y(b)(2)(B) (2002) (emphasis added).

99. *Brown v. Thompson*, 252 F. Supp. 2d 312, 317 n.5 (E.D. Va. 2003). For example, the

worked as follows: If a Medicare beneficiary had medical insurance provided by a primary plan, then Medicare could not pay for the beneficiary's medical services except to provide secondary coverage. If the primary plan failed to pay or reimburse Medicare, the Secretary could make a conditional payment on the beneficiary's behalf. The Secretary could then seek reimbursement for those payments by suing the insurance entity that should have provided the primary coverage for the amount of the conditional payment or for double damages.<sup>101</sup>

In sum, before the amendments to the MSP, if the Secretary reasonably expected that another *insurer* would pay for the beneficiary's medical costs, the other *insurer* – not Medicare – was primary. Where it was unclear whether a primary insurer was responsible or where a primary insurer was not likely to pay promptly for costs associated with treating the beneficiary, Medicare made payments to the health care provider expecting that it could (and would) recover from the rightful primary insurer.

What is clear from this is what the MMA ignored. Before 2003, the MSP focused solely on the insurance industry: the government only could recover “from ‘primary plans,’ whose definition lists only entities which are clearly ‘within’ the insurance industry.”<sup>102</sup>

This common understanding changed in 2003 with the amendment to the MSP. The seeds of that change are discussed in the next Section.

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statute prohibited Medicare from making conditional payments except as authorized by subparagraph (B). But subparagraph (B) did “not authorize any Medicare payments; it deal[t] only with reimbursement for certain payments.” *Id.* That is, before the MMA, Medicare was allowed to seek reimbursement for conditional payments, but was not technically authorized to *make* conditional payments.

100. See generally *Thompson v. Goetzmann*, 337 F.3d 489, 496-97 (5th Cir. 2003).

101. 42 U.S.C. 1395y(b)(2)(A) (2002). The statute also created a private right of action by which private citizens could seek double damages from recalcitrant primary plans. See *id.* § 1395y(b)(3)(A) (2002). In addition, the federal government was subrogated (to the extent of any payment for an item or service to which subparagraph (2)(A) applies) “to any right under this subsection of an individual or any other entity to payment with respect to such item or service under a primary plan.” *Id.* § 1395y(b)(2)(B)(iii).

102. *United States v. Rhode Island Insurers' Insolvency Fund*, 80 F.3d 616, 622 n.5 (1st Cir. 1996); see also *Health Ins. Ass'n of Am., Inc.*, 23 F.3d at 427 (Henderson, J., concurring) (concluding that, in light of the definition of primary plan and the legislative history, the statute was intended “to allow recovery only from an insurer”); *United States v. Philip Morris, Inc.*, 116 F. Supp. 2d 131, 146 n.22 (D.D.C. 2000) (noting that “[c]ourts have uniformly recognized that the statute's clear purpose was to grant the Government a right to recover Medicare costs from [insurers]”); *In re Dow Corning Corp.*, 250 B.R. 298, 337 n.22 (Bankr. E.D. Mich. 2000) (stating that “unless an alleged tortfeasor qualifies as a primary plan or received payment from a primary plan, the MSPA does not grant the United States the right to initiate a direct action against it”).

C. *The Government Wants More: The Secretary Takes on Mass Tort Settlements*

In the late 1990s the government found a potential new source of revenue for Medicare and a new avenue to expand the MSP's reach. In a series of high-stakes and high-profile mass torts, the government sought to recover Medicare's expenditures from alleged tortfeasors who settled with injured Medicare beneficiaries and from the proceeds of any such settlement (i.e., from settlement funds or from any party that received the proceeds of the settlement).<sup>103</sup> This was a clear departure from the common understanding of the MSP's purpose: to force *traditional insurers* to provide and pay for the healthcare costs of individuals whom Medicare would otherwise cover. One can assume that the number of Medicare beneficiaries involved in mass tort cases and the settlement numbers at stake drew the government to this strategy.<sup>104</sup> With large settlement dollars available, and pressure on the government – as always – to “save” Medicare and Social Security, it was only natural that the government would push to recover from these funds.<sup>105</sup>

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103. See, e.g., *Mason v. Am. Tobacco Co.*, 212 F. Supp. 2d 88 (E.D.N.Y. 2002), *aff'd* 346 F.3d 36 (2d Cir. 2003) (tobacco); *In re Silicone Gel Breast Implants Prods. Liab. Litig.*, 174 F. Supp. 2d 1242 (N.D. Ala. 2001), *rev'd sub nom* *United States v. Baxter Int'l Inc.*, 345 F.3d 866 (11th Cir. 2003); *In re Orthopedic Bone Screw Prods. Liab. Litig.*, 202 F.R.D. 154 (E.D. Pa. 2001); *In re Diet Drugs Prods. Liab. Litig.*, No. 99-20593, 2001 WL 283163 (E.D. Pa. Mar. 21, 2001) (Phentermine, Fenfluramine, Dexfenfluramine also known commonly as Phen Fen); *Phillip Morris*, 116 F. Supp. 2d 131; *In re Dow Corning Corp.*, 250 B.R. 298, 307 (Bankr. E.D. Mich. 2000) (silicone breast implants). Before the government's claims in *Phillip Morris* and *Dow Corning*, the “case law [was] devoid of any instances in which the Government attempted to sue a tortfeasor under the MSP, despite the fact that the statute had been in existence for twenty years.” *Orthopedic*, 202 F.R.D. at 165.

104. For example, in the Dow Corning bankruptcy, the United States filed proofs of claims seeking to “recover the costs of medical care either provided or paid for by” certain government agencies, including CMS, “as a result of injuries allegedly caused by breast implants.” *Dow Corning*, 250 B.R. at 307. The government sought reimbursement for at least \$32,588,197.02 in Medicare payments on behalf of or to 11,614 Medicare beneficiaries. See *id.* at 316. Likewise in 1999, shortly after a number of cigarette manufacturers settled lawsuits brought by individual states, the United States brought suit against eleven tobacco-related entities seeking, to recover “conditional payments for items and services for Medicare beneficiaries whose injuries and diseases were caused by Defendants’ tortious and unlawful conduct.” See Amended Complaint ¶ 169, *United States v. Philip Morris*, 99 CV 2496 (GK) (1999), available at <http://www.usdoj.gov/civil/cases/tobacco2/>. The government alleged that the tobacco defendants were “primazy [sic] plans from whom repayment is required for items and services paid for by the United States for the care and treatment of Medicare beneficiaries. . . .” *Id.* ¶ 170.

105. Shortly thereafter, the government used this same logic for the first time in a case with an individual tort plaintiff. See *Thompson v. Goetzmann*, 337 F.3d 489 (5th Cir. 2003).

The crux of the government's argument in the pre-MMA cases lay in the ambiguity caused by the definition of "primary plan." Before 2003, the MSP defined a "primary plan" as "a group health plan," "large group health plan," or "a workman's compensation law or plan, an automobile or liability insurance policy or plan (*including a self-insured plan*) or no fault insurance" to the extent that one of these latter groups could "reasonably be expected" to make payment "promptly."<sup>106</sup> The statute did not, however, define "self-insured plan."<sup>107</sup> The government exploited this ambiguity in its suits against mass tort defendants and mass tort settlement funds.

According to the government, an alleged tortfeasor who settled with a plaintiff was, "*ipso facto* a 'self insurer' under the MSP statute."<sup>108</sup> That is, the government argued that by paying its own money to injured parties, an alleged tortfeasor demonstrated, as a matter of law, that the alleged tortfeasor was "self-insured," because it carried its own risk of causing an injury instead of taking out insurance with a carrier.<sup>109</sup> Further, according to the government, by paying all or part of the settlement, an alleged tortfeasor demonstrated that it was "required or responsible"<sup>110</sup> for making payments to Medicare beneficiaries.<sup>111</sup> The governments' argument also necessarily implied that it had made conditional payments to Medicare beneficiaries for their medical costs caused by the alleged tortfeasors.

Despite the government's plea, almost every court to rule on the issue before the Medicare Modernization Act of 2003 rejected the government's claim.<sup>112</sup> The courts based their holdings on both a general theoretical objection and a close reading of the statute. First, the courts reasoned that claims against insurers are different from claims against tortfeasors. Although both claims create a means for society to

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106. 42 U.S.C. § 1395y(b)(2)(A) (2002) (emphasis added).

107. The implementing regulations defined a "self-insured plan" as "a plan under which an individual, or a private or governmental entity, carries its own risk instead of taking out insurance with a carrier." *See Dow Corning*, 250 B.R. at 338 (citing 42 C.F.R. § 411.50(b)(2)). This general definition did not persuade courts that it was appropriate to transform a tortfeasor into a primary insurer.

108. *Goetzmann*, 337 F.3d at 497; *see also Philip Morris*, 116 F. Supp. 2d at 145.

109. *See In re Orthopedic Bone Screw Prods. Liab. Litig.*, 202 F.R.D. 154, 164 (E.D. Pa. 2001) (quoting United States brief). Presumably this same argument would hold even if the alleged tortfeasor's insurance carrier funded part of a settlement and the tortfeasor funded another part, because the tortfeasor would be self-insured to at least some part of the risk.

110. 42 U.S.C. § 1395y(b)(2)(B)(ii) (2002).

111. *See generally id.*; *Goetzmann*, 337 F.3d at 495.

112. *See supra* note 14.

distribute the costs of injuries to non-injured parties, the mechanisms for determining who should bear the costs are different under both systems. Insurers, unlike tortfeasors, enter into a contract to assume the risk that a specified contingency will occur and undertake to indemnify an insured or pay a certain sum if that contingency does, in fact, occur.<sup>113</sup> Tortfeasors, in contrast, owe compensation to injured parties because of some wrong committed by the tortfeasor. In short, although both systems allow an injured party to share the costs of his injury, the distributive rights under the insurance system arise from a contractual relationship; the distributive rights under the tort system do not. Thus, in part, these courts rejected the government's claim, because the MSP did "not mention a right by the Government to recover from a tortfeasor. Rather, the express wording of the statute create[d] a cause of action against insurers and their payees."<sup>114</sup>

More specifically, the courts concluded the term "self-insurance," although not defined in the statute, was subject to a narrow definition in the context of the MSP. Under the MSP, Medicare was the secondary insurer "if and only if a Medicare recipient ha[d] another source of medical coverage under a 'primary plan.'"<sup>115</sup> That is, the Medicare reimbursement provisions were not triggered unless a Medicare recipient could expect a primary plan to pay for her medical expenses – whether from a group health plan, workmen's compensation plan, liability insurance, or self-insurance plan.<sup>116</sup> The term "plan," in turn, indicated a program or a method for accomplishing a goal.<sup>117</sup> As applied to a "plan" of "self-insurance," the courts held that the term "connotes some type of formal arrangement by which an entity consciously undertakes to set aside funds to cover potential future liabilities and a formal procedure for processing claims made against that fund pursuant to the terms of the 'plan.'"<sup>118</sup> In other words, a "primary plan of self-insurance" only existed where an entity had an *ex ante* arrangement to pay its own liability claims and a plan for distributing the proceeds of those claims.<sup>119</sup>

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113. See *Goetzmann*, 337 F.3d at 497-98 (citing 3 LEE R. RUSS, COUCH ON INSURANCE 3d § 39.1 (2002)).

114. *Orthopedic*, 202 F.R.D. at 165.

115. *Goetzmann*, 337 F.3d at 497 (emphasis in original); 42 U.S.C. § 1395y(b)(2)(A) (2002).

116. See *Goetzmann*, 337 F.3d at 497.

117. See *id.*

118. *Orthopedic*, 202 F.R.D. at 166; *Goetzmann*, 337 F.3d at 497 n.22; *In re Diet Drugs Prods. Liab. Litig.*, Nos. MDL 1203, 99-20593, 2001 WL 283163, at \*10 (E.D. Pa. Mar. 21, 2001).

119. See *Goetzmann*, 337 F.3d at 498. As one leading treatise noted:

A defendant settling a tort claim or a series of tort claims, the courts reasoned, was not automatically a self-insurance plan. The government could not simply show that the defendant was using its own funds to settle tort claims; the government had to show that the defendant had actually created a plan of self-insurance.

#### D. Congress Amends the Medicare Secondary Payer Act

Congress moved swiftly to amend the MSP to reflect the government's failed litigation positions. With little debate and no fanfare, Congress changed the MSP as a small part of the MMA. Although Congress claimed that it intended to make only "technical" and "clarifying" amendments,<sup>120</sup> in truth, the amendments were designed to legislate around the court decisions striking down the government's arguments regarding the MSP's scope.<sup>121</sup>

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although there is no precise definition of self-insurance, to meet the conceptual definition of self-insurance, an entity would have to engage in the same sorts of underwriting procedures that insurance companies employ: estimating likely losses during the period, setting up a mechanism for creating sufficient reserves to meet those losses as they occur, and, usually, arranging for commercial insurance for losses in excess of some stated amount.

1 LEE R. RUSS, COUCH ON INSURANCE 3d § 10:1 (1997).

120. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 301(a) ("Technical amendment concerning Secretary's authority to make conditional payment when certain primary plans do not pay promptly."); *id.* § 301(b) (noting that the amendments are "[c]larifying Amendments to conditional payment provisions"); *see also* 149 CONG. REC. H12026 (daily ed. Nov. 20, 2003) ("The list of primary plans for which conditional payment could be made would be clarified; an entity engaging in a business, trade, or profession would be deemed as having a self-insured plan if it carries its own risk. . . ."); 149 CONG. REC. S8499, S8535, (daily ed. June 25, 2003) ("The technical changes in Section 301 make clear that Medicare may make a conditional payment when the primary plan has not made or is not reasonably expected to make prompt payment.") (letter from William E. Moschella, Assistant Attorney General); *Id.* ("The technical amendments of section 301 clarify other provisions of the MSP statute. . . .").

121. A House Report stated that the 2003 MMA amendments were added to address "recent court decisions" that allowed "firms that self-insure for product liability . . . to avoid paying Medicare for past medical payments related to the claim." H.R. REP. NO. 108-178 (II), at 189-90 (2003). The Report stated more explicitly that:

Recent court decisions such as *Thompson v. Goetzmann* resulted in a narrow interpretation of the statutory reference to 'promptly.' Liability insurers would have been able to draw out their settlements and avoid repaying Medicare for payment of medical expenses. Moreover, firms that self-insure for product liability would have been able to avoid paying Medicare for past medical payments related to the claim.

*Id.* Lastly, as William Jordan, Senior counsel to the Assistant Attorney General for the Civil Division testified before the House Ways and Means Committee:

Finally, I would like to restate the Department's support for section 301 of H.R. 1, the

The amendments left the structure of the MSP in place and the additions to the text of the statute are not extensive. Nonetheless, the amendments wrought significant change. As before, the first paragraph of the MSP imposes certain requirements on group health plans and the second paragraph creates the means by which Medicare can make conditional payments. Congress made no changes to the first paragraph, but four significant changes to the second.

First and foremost, Congress added a definition of “self-insured plan” to the statute. Post MMA, an entity has a “self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.”<sup>122</sup> The intent of this provision is clear from the legislative history. It is meant to correct the courts that rejected the government’s litigation position by sweeping into the definition of self-insured plan any party that pays its own judgment or settlement.<sup>123</sup>

Second, Congress augmented a primary plan’s duty to repay Medicare and adopted the government’s litigation position that the Secretary could recover from a primary plan even when a court had not determined that the primary plan was liable to pay the medical costs of a Medicare beneficiary by a judgment. The MMA added the following: a “primary plan’s responsibility” for any conditional payment made by Medicare:

may be demonstrated by a judgment, a payment conditioned upon the recipient’s compromise, waiver, or release (whether or not there is a

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‘Medicare Prescription Drug and Modernization Act of 2003,’ which would protect the integrity of the Medicare Trust Fund by clarifying that Medicare must be reimbursed whenever another insurer’s responsibility to pay has been established. *This section is consistent with the litigation positions taken by this Department and the Department of Health and Human Services in numerous court cases.*

*Waste, Fraud, and Abuse in Federal Programs: Hearing Before the H. Comm. on Ways & Means, 108th Cong. 88 (July 17, 2003) (statement of William Jordan, Assistant Att’y Gen. for the Civil Division) (emphasis added).*

122. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 301(b)(1) (codified at 42 U.S.C. § 1395y(b)(2)(A) (2006)).

123. “The list of primary plans for which conditional payment could be made would be expanded; an entity engaging in a business, trade, or profession would be deemed as having a self-insured plan if it carries its own risk. Failure to obtain insurance would be required as evidence of carrying risk.” H.R. REP. NO. 108-178 (II), at 189-90, (2003). Further, as Senator Grassley noted:

The purpose of the [MSP] is to ensure that Medicare pays first for seniors’ medical needs when other sources should be, in fact, paying instead of the taxpayer paying. . . . [W]hen a Medicare beneficiary is injured by wrongful conduct of another entity, that entity’s liability insurance or the entity itself, if it has no insurance, or it might be self-insured, is always required to pay first instead of having the taxpayers pay.

S15584-85, 108th Cong. (2003).

determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means.<sup>124</sup>

That is, post MMA, a defendant who settles a tort claim with a Medicare beneficiary is liable for Medicare's conditional payments to the beneficiary even if the defendant explicitly denies liability for the Medicare beneficiaries' injuries in the settlement document. The defendant is responsible for the conditional payments, as long as the beneficiary "compromise[d], waive[d], or release[d]" her claims against the defendant as part of a settlement. It is hard to imagine a settlement agreement that would not include such a waiver and release of claims.

Third, Congress enhanced Medicare's ability to recover from entities that receive payments from primary plans. Fearing, in part, that Medicare would not be able to partake in the bounty of mass tort settlement funds, Congress added that the Secretary could "recover [on behalf of Medicare] . . . from the proceeds of a primary plan's payment to any entity."<sup>125</sup> That is, after the amendment, the Secretary can take money from a plaintiff who receives a settlement from a tort defendant, an attorney who receives a portion of that settlement fund, or from the settlement fund itself.

Fourth, the MMA clarified that the Secretary could, in fact, make payments if a "primary plan . . . has not made or cannot reasonably be expected to make payment" for medical treatments.<sup>126</sup> Congress intended this change to fix the ambiguity created in earlier versions of the statute, which allowed the Secretary to recover conditional payments, but did not explicitly allow the Secretary to make conditional payments.<sup>127</sup>

Congress hastily added these changes and barely contemplated the potential ramifications. The legislative history makes clear that Congress' overriding concern regarding the MMA was the radical

124. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 301(b)(2)(A) (codified at 42 U.S.C. § 1395y(b)(2)(B)(ii) (2006)) (emphasis added).

125. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 301(b)(3) (codified at 42 U.S.C. § 1395y(b)(2)(B)(iii) (2006)). As stated in the House Report, "A primary plan, as well as an entity that receives payment from a primary plan, would be required to reimburse the Medicare Trust Funds for any payment made by the Secretary if the primary plan was obligated to make payment." H.R. REP. NO. 108-178(II), at 189-90 (2003).

126. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 301(a)(2)(B) (codified at 42 U.S.C. § 1395y(b)(2)(B)(i)).

127. See generally *Brown v. Thompson*, 252 F. Supp. 2d 312, 317 n.5; see also *supra* note 99 and accompanying text.

additions to Part D, the new prescription drug benefit, not the relatively minor changes to the MSP. The impact of these changes on the Medicare fisc was unclear. Senator Grassley and the CBO predicted a savings of \$9 billion over ten years.<sup>128</sup> Presumably, however, any estimate was based on an assumption that Medicare beneficiaries would continue to bring tort lawsuits, mass torts would continue to settle, and parties from any tort lawsuit would continue to pay their due to Medicare. There is no discussion in any of the legislative history or CBO reports regarding the impact that these amendments would have on the ability of individual or mass tort lawsuits to settle or bring lawsuits.

So, what is the practical impact of these changes and what does this mean for settling parties? First, under the MSP Congress irrefutably transformed settling tort defendants into primary insurers. Any time a Medicare beneficiary compromises or releases his claims in exchange for a settlement with an alleged tortfeasor, a court must hold that the alleged tortfeasor has a primary plan under the MSP. As such, the defendant is responsible to Medicare for Medicare's payments to the beneficiary. The regulations suggest that the government will not seek more than the amount of the settlement.<sup>129</sup> That restriction, however, is not apparent in the text of the statute.<sup>130</sup> At a minimum, a defendant may have to pay twice any settlement amount – once to a settling Medicare beneficiary and once to Medicare. But the defendant could have to pay more. Because Medicare may recover “double damages” against a primary plan that fails to recompense Medicare,<sup>131</sup> a settling tort defendant may actually have to pay three times the settlement

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128. See S15584-S15585, 108th Cong. (2003) (“These measures in [Title III of the MMA, titled Combatting Waste, Fraud, and Abuse] directly reduce Medicare’s spending on overpriced, wasteful, fraudulent items, and services to the tune of \$31.3 billion over 10 years. . . . According to the Congressional Budget Office, [the clarifications to the MMA] alone promise to restore Medicare over \$9 billion out of that \$31 billion.”).

129. See 42 C.F.R. § 411.37(d) (2006) (“If Medicare payments equal or exceed the judgment or settlement amount, the recovery amount is the total judgment or settlement payment minus the total procurement costs.”).

130. If the statute applied to traditional insurers, as it did as originally enacted, the maximum amount of the payment would be clear: an insurance plan’s exposure would be capped at the value of the insurance policy. That is, the government likely could not force an insurance company to pay for more than the limits of the policy at issue. That reasoning, however, does not apply to defendants who have no set policy limits.

131. 42 U.S.C. § 1395y(b)(2)(B)(ii) (2002) (“The United States may, in accordance with paragraph 3(A) collect double damages against any [primary plan].”); see also 42 C.F.R. § 411.24(c)(2) (2006) (“If it is necessary for CMS to take legal action to recover from the primary payer, CMS may recover twice the amount specified in paragraph (c)(1)(i).”).

amount – once to the settling beneficiary and twice the amount of Medicare’s expenditures to Medicare.<sup>132</sup>

Further, post MMA, the Secretary can collect from Medicare beneficiaries and any other entity that receives a part of the proceeds of a settlement.<sup>133</sup> In other words, the government can seek recovery from a settling beneficiary, the beneficiary’s counsel – if counsel received a contingent payment from the settlement funds – and possibly defense counsel.<sup>134</sup> Although the regulations limit recovery to the amount the entity received from the primary insurer,<sup>135</sup> the Secretary may be entitled to take the entire settlement amount, even if a plaintiff paid no out of pocket expenses for medical care and settled only for pain and suffering.<sup>136</sup> That is, “the MSP legislation [allows] full reimbursement of conditional Medicare payments even though a beneficiary receives a discounted settlement from a third party.”<sup>137</sup>

To put this in stark terms, consider again the case of Ms. Loftin from the Introduction. Medicare paid \$143,881.82 for Ms. Loftin’s medical care resulting from complications related to hip replacement surgery. But those were not Ms. Loftin’s only damages. It is likely that Ms. Loftin had legitimate claims for pain and suffering, lost wages, and/or other medical expenses which Medicare did not pay. In compromise of those claims, the manufacturer paid Ms. Loftin \$256,000, out of which her attorney kept a contingency fee of \$102,400. Thus, after paying her attorney, Ms. Loftin only received \$153,600 in settlement of her claims.<sup>138</sup>

Had the government prosecuted its case post MMA, the Secretary

132. The law is not settled as to when the double damages provision is applicable. The regulations suggest that the Secretary only can seek double damages when the primary plan has refused the government’s request for payment and necessitated litigation. *See* 42 C.F.R. §§ 411.24(c)(1) and (c)(2) (2006). At least one court, however, has suggested that the Secretary can seek double damages when the primary plan knew that Medicare paid the plaintiff’s medical expenses, but the defendant paid the settlement funds to the plaintiff anyway. *See* *Health Ins. Ass’n of Am., Inc. v. Shalala*, 23 F.3d 412, 417 (D.C. Cir. 1994).

133. The MSP authorizes the Secretary to recover conditional payments from any “entity that received payment from primary plan,” 42 U.S.C. § 1395y(b)(2)(B)(ii) (2002), or from “the proceeds of a primary plan’s payment to any entity,” 42 U.S.C. § 1395y(b)(2)(B)(iii) (2006).

134. *See generally* *United States v. Sosnowski*, 822 F. Supp. 570 (W.D. Wis. 1993); Steven M. Kohn & Colleen T. Davies, *Avoiding Traps for the Unwary: Understanding U.S. Government Reimbursement Rights*, 66 DEF. COUNS. J. 193, 200 (1999).

135. *See* 42 C.F.R. § 411.24(c) (2006).

136. *Zinman v. Shalala*, 67 F.3d 841 (9th Cir. 1995); *see also* *Denekas v. Shalala*, 943 F. Supp. 1073 (S.D. Iowa 1996).

137. *Zinman*, 67 F.3d at 845.

138. *See supra* notes 1-10 and accompanying text.

could have taken almost all that Ms. Loftin received in settlement of her claims to compensate Medicare. That is, once the manufacturer settled with Ms. Loftin for any amount, the Secretary could rightly claim that the manufacturer had a plan of self-insurance. As such, the Secretary could have recovered up to the full amount of its payments<sup>139</sup> and Ms. Loftin would have been left with less than \$10,000 to compensate her for the pain and suffering from her botched surgeries and hip replacement. Thus, this full reimbursement rule “deprives poor and injured individuals of needed compensation for their pain and suffering, lost wages, and other non-medical damages.”<sup>140</sup>

Alternatively, the Secretary could have taken Mr. Goetzmann’s entire fee or forced the manufacturer to pay three times the settlement amount – once to Ms. Loftin and twice to Medicare under the double damages provision. As will be discussed below, this drives up the potential costs of any settlement, makes it difficult to settle tort lawsuits, and makes it difficult for Medicare beneficiaries to obtain legal representation.

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139. See 42 C.F.R. § 411.37(d) (2006); *Zinman*, 67 F.3d at 845. In *Arkansas Department of Health and Human Services v. Ahlborn*, the Supreme Court held that States could not recover the full amount of their payments for medical expenses to Medicaid recipients. 547 U.S. 268 (2006). Rather, the Court held that a State may only recover that portion of the settlement or judgment that is attributable to repayment of medical services. See *id.* at 285. As summarized by Judge Weinstein:

The Court first held that the assignment provisions of federal Medicaid law requiring states to enact laws providing for assignment of Medicaid beneficiaries' rights to seek and collect payment for medical care from a responsible third party only provide for a limited assignment from the recipient to the state for payment for medical items and services from a liable third party. It then concluded that any state statute providing for a greater assignment or lien would be inconsistent with the Medicaid “anti-lien” statute, 42 U.S.C. § 1396p, which prohibits states from placing liens against or seeking recovery of benefits from a Medicaid beneficiary before her death. According to the Court, while the assignment provisions create an exception to the anti-lien statute for recovery of payments that constitute reimbursement for medical costs paid by Medicaid, any recovery by the state of settlement funds intended to reimburse the Medicaid beneficiary for pain and suffering, lost wages, or other non-medical damages would constitute an impermissible lien on the beneficiary's property.

*In re Zyprexa Prods. Liab. Litig.*, 451 F. Supp. 2d 458, 470 (E.D.N.Y. 2006) (citations omitted). That same rationale is not applicable in the Medicare context because there is no equivalent “anti-lien” provision in the Medicare regime.

140. *Id.*

### III. SUING AND SETTling UNDER THE MSP: INDIVIDUAL TORT LAWSUITS AND MASS TORT LITIGATION

It should be intuitively obvious that Medicare beneficiaries will have difficulty settling tort claims under the MSP. What may not be as intuitively obvious is that the MSP's effects could be greater than a simple failure to reach a negotiated settlement between individuals. The MSP's harsh liability rule could make it difficult to settle or even bring mass tort litigation. Mass tort settlements sit at a tipping point, and it is not unreasonable to think that any additional burden on the settlement of mass tort cases could result in a total failure of the settlement process. These settlements are the lifeblood of mass tort litigation. Without settlements, plaintiffs' attorneys likely cannot bring mass tort claims.

#### A. *An Economic Model of Individual Tort Settlements*

Under the neoclassical economic model of litigation, parties make settlement decisions by comparing their estimated economic position after a judgment to their estimated economic position after a settlement.<sup>141</sup> In short, a party will settle a lawsuit if it expects to be better off after settlement than it would be after a judgment, taking into account the probability of a plaintiff's victory and the costs of litigation and settlement.

The neoclassical classic model makes certain assumptions about the parties. First, the model assumes the parties will behave rationally; in the sense that the parties will attempt to maximize their expected wealth through the litigation process.<sup>142</sup> Second, the model assumes that the parties are risk neutral; that is, that they are equally attracted to a settlement amount, and a fifty percent chance of receiving twice that amount. Lastly, the model assumes that parties have equivalent stakes in

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141. See generally Frank B. Cross, *In Praise of Irrational Plaintiffs*, 86 CORNELL L. REV. 1, 3 (2000) (summarizing the classic economic model); Russell Korobkin & Chris Guthrie, *Psychological Barriers to Litigation Settlement: An Experimental Approach*, 93 MICH. L. REV. 107, 111-14 (1994); Janet Cooper Alexander, *Do the Merits Matter? A Study of Settlements in Securities Class Actions*, 43 STAN. L. REV. 497, 501-02 (1991); George L. Priest & Benjamin Klein, *The Selection of Disputes for Litigation*, 13 J. LEGAL STUD. 1, 3-6 (1984); Richard A. Posner, *An Economic Approach to Legal Procedure and Judicial Administration*, 2 J. LEGAL STUD. 399, 417-20 (1971); see also Joseph A. Grundfest & Peter H. Huang, *The Unexpected Value of Litigation: A Real Options Perspective*, 58 STAN. L. REV. 1267 (2006) (describing the real options model of litigation).

142. There are really two assumptions contained here: 1) that the parties maximize their expected utility and 2) that parties' utility function of wealth is just wealth, i.e.,  $U(W) = W$ .

the dispute. That is, that neither side will receive a benefit other than the explicit terms of the settlement (e.g., the parties do not have equivalent stakes if one side benefits more from the precedential effect of a favorable verdict).<sup>143</sup>

Under the neoclassical economic model, a plaintiff will settle a lawsuit when she expects to get more out of the settlement than she would from trying a case to a judgment, whether through a trial or through judgment by motion. If the case settles, a plaintiff would not have to expend money on procuring the judgment; thus, the plaintiff subtracts the amount of the costs of procuring the judgment from the expected value of the litigation. But the plaintiff will require that the minimum offer cover her costs of settlement. More specifically, a plaintiff will settle when the defendant's offer ( $O$ ) is more than the value the plaintiff has placed on the claim ( $V_p$ ) discounted by the probability that the plaintiff estimates she will win ( $P_p$ ) minus the expected cost of procuring and collecting on the judgment ( $C_{pj}$ ) plus the costs associated with negotiating and entering into a settlement ( $C_{ps}$ ). Represented in a formula, the plaintiff will settle when:

$$\text{Formula (1): } O > (V_p * P_p) - C_{pj} + C_{ps}$$

In turn, a defendant will settle any time it can settle for less than it would expect to lose via judgment, including the costs of litigating the case to that judgment or the cost of settling the case. Thus, a defendant will settle when a plaintiff's demand ( $D$ ) is less than the amount the defendant estimates it will have to pay out post-judgment should the plaintiff win ( $V_d$ ) multiplied by the defendant's belief that the plaintiff will win ( $P_d$ ) plus the costs of defense at trial ( $C_{dj}$ ) minus out-of-court settlement cost ( $C_{ds}$ ).<sup>144</sup> That is, a defendant will settle where:

$$\text{Formula (2): } D < (V_d * P_d) + C_{dj} - C_{ds}$$

It is clear that these formulae generate the following conclusions. In a simple two-party dispute, a defendant will only perceive a benefit from paying the plaintiff an amount less that it expects the plaintiff to recover in a judgment, plus the costs of litigation, minus the cost of settlement. Likewise, a plaintiff will perceive a benefit from any offer over the amount she expects to attain from judgment, minus the cost of attaining that judgment, plus the costs associated with settlement. The

143. See generally Korobkin & Guthrie, *supra* note 141, at 112-14.

144. See generally Robert D. Cooter & Daniel L. Rubinfeld, *Economic Analysis of Legal Disputes and Their Resolution*, 27 J. ECON. LIT. 1067, 1075-82 (1989); see also Korobkin & Guthrie, *supra* note 141, at 111; Posner, *supra* note 141, at 417-20.

defendant's maximum offer ( $O_{\max}$ ) is represented in formula (3) and the minimum amount the plaintiff will demand ( $D_{\min}$ ) is represented in formula (4):<sup>145</sup>

$$\text{Formula (3): } O_{\max} = (V_d * P_d) + C_{dj} - C_{ds}$$

$$\text{Formula (4): } D_{\min} = (V_p * P_p) - C_{pj} + C_{ps}$$

As long as  $O_{\max} - D_{\min} > 0$ , the parties should settle a lawsuit.<sup>146</sup>

A simple example will help illustrate this model. Consider a lawsuit where the parties agree that the plaintiff has a 20% chance to win its jury demand of \$500,000. The weighted average recovery, ( $V * P$ ), is \$100,000. Assume further that each side estimates its litigation costs at \$35,000 and the cost of settlement at \$5,000. In this example the defendant may offer up to \$130,000 ( $\$100,000 + \$35,000 - \$5,000$ ) to settle the suit, but no more. After that, the defendant will not recognize any benefit. Likewise, a plaintiff will perceive a benefit from, and thus should accept, any offer over \$70,000 ( $\$100,000 - \$35,000 + \$5,000$ ). Thus, there is a window for settlement, and the parties should settle for some amount between \$70,00 and \$130,000. Assuming equal bargaining power, the parties will split the difference, and settle for \$100,000.

Under the MSP, the window for settlement is smaller, if it exists at all, because of the additional liability created by settling the lawsuit. A defendant will consider its cost of settling to be the transaction costs associated with settlement plus any potential liability to Medicare (which could include double damages should the defendant force the Secretary to seek recovery via litigation). On the other hand, a plaintiff will perceive the Secretary's claim as reducing the defendant's offer by

145. If the parties are relatively close in their assessment of the outcome of litigation, they will likely reach a negotiated settlement, because it is in their economic interest to do so as litigation costs are generally greater than settlement costs. *See generally* Cross, *supra* note 141, at 3-4. That is, where  $(V_p * P_p) = (V_d * P_d)$ , the parties will likely settle, because  $C_j > C_s$ .

146. Robert Cooter, Stephen Marks, and Robert Mnookin famously proposed that most settlements break down not because the parties do not have a settlement window, but because they cannot decide how to divide the surplus created by the window. *See* Robert Cooter, et al., *Bargaining in the Shadow of the Law: A Testable Model of Strategic Behavior*, 11 J. LEGAL STUD. 225 (1982). Thus, they claim that trials occur in part because of strategic bargaining. This criticism, like others of the classic model, does not change the underlying understanding of litigation: to settle a lawsuit, the parties must, at a minimum, have a settlement window. And the conclusions of this article are not changed by this criticism. The MSP significantly closes the window for settlement.

the amount of potential liability.<sup>147</sup>

Consider again the hypothetical above. Assume the plaintiff is a Medicare beneficiary, and that Medicare paid \$100,000 for medical care for the plaintiff's claims. Assume first that the Secretary seeks recovery only from the defendant. As noted above, the defendant will consider the \$100,000 as an additional cost of settlement. Thus, the defendant's maximum offer would be \$30,000 ( $\$100,000 + \$35,000 - \$105,000$ ). This amount is well below the plaintiff's minimum demand, and the case will not settle.

The same result occurs if the Secretary tries to recover from the plaintiff. Because the plaintiff will perceive the Secretary's claim as reducing the defendant's offer, the defendant's offer must be greater than  $D_{\min}$  plus the total amount of Medicare liability; i.e., the defendant must offer more than \$170,000. This a defendant will not do.<sup>148</sup>

In sum, economic theories of settlement suggest that the window for settlement is defined by the amount between the expected value of the suit and the expected costs of litigating suit and settling. Because settling a suit creates immediate liability to Medicare, defendants will perceive this as an additional cost of settlement and plaintiffs will perceive the liability as reducing the amount that they can expect to receive from a settlement. In either case, this additional – and automatic – liability narrows or eliminates any potential settlement window.<sup>149</sup>

Later economic models criticize the neoclassical model arguing that litigants are not motivated solely by wealth maximization, that they are poor estimators of the probability of winning, and thus litigants make

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147. Alternatively, the plaintiff may also perceive the Medicare liability as additional settlement costs as the defendants do. Either way, the algebra is the same, and  $D_{\min}$  will rise as a result of the Medicare liability.

148. Even if one assumes that the plaintiff and the defendant will split the risk of liability to Medicare – that is, the defendants will incur \$50,000 of additional costs and the plaintiff will reduce her settlement by \$50,000 – the parties would not have a settlement window. In this hypothetical, a defendant's maximum offer will be \$80,000, but the minimum a plaintiff would accept to settle is \$120,000. Thus, there can be no settlement.

149. In 2006, the Supreme Court ruled that States could not impose a lien on tort judgments or settlements earned on Medicaid recipients for the full value of the State's medical expenses on behalf of the Medicaid beneficiary. *See Ark. Dep't of Health and Human Servs. v. Ahlborn*, 547 U.S. 268 (2006). Although the Court based its decision on the statutory construction of the Medicaid anti-lien statute, it addressed the policy issues associated with imposing a full lien with absolute priority, stating: "For just as there are risks in underestimating the value of readily calculable damages in settlement negotiations, so also is there a countervailing concern that a rule of absolute priority might preclude settlement in a large number of cases, and be unfair to the recipient in others." *Id.* at 288 (emphasis added).

seemingly inconsistent or irrational decisions throughout litigation.<sup>150</sup> However, these criticisms can be overstated and, with respect to the MSP liability, these criticisms will likely not change the underlying problems. It is, of course, true that parties act for reasons other than wealth maximization. Plaintiffs may initiate a lawsuit to bring wrongdoing to light, to cripple an industry, or merely to have their day in court.<sup>151</sup> Presumably, however, plaintiffs' lawyers are paid to provide expertise in negotiation and litigation. These attorneys may dampen these emotional responses because they are less likely to bring or continue lawsuits simply for the psychological benefits.<sup>152</sup> Moreover, where attorneys bring claims on contingency, the attorneys have an economic incentive to tamp down on their clients' non-monetary desires. Further, the Secretary can force a defendant to pay two to three times the settlement amount or recover from, and thus eliminate, a plaintiff's settlement or a plaintiff's attorney's contingency fee. As such, the effects of the MSP can be quite large. Parties' non-economic motivations would have to be equally as large to counteract the effects of the MSP. Likewise, even if parties are poor estimators of winning or otherwise fail to behave as wealth-maximizers, the parties will instantly recognize the automatic liability that attaches under the MSP. As such, it will be more difficult for the parties to reach a settlement. Thus, although the criticisms are justified, they do not change the conclusions of this article: under the MSP, the window for creating a benefit for both sides is smaller, if it exists at all.<sup>153</sup>

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150. See generally Cross, *supra* note 141, at 15-19; Korobkin & Guthrie, *supra* note 141, at 109.

151. See Cross, *supra* note 141, at 19-20 (observing that plaintiffs, especially mass tort plaintiffs, may forgo their economic interest to get their "day in court," exact "vengeance," or to "impose punishment" on an industry they view as "morally blameworthy"); Deborah R. Hensler, *Resolving Mass Toxic Torts: Myths and Realities*, 1989 U. ILL. L. REV. 89, 99 ("[T]he most frequently cited objective of lay litigants in adjudicatory proceedings was to 'tell my side of the story.'"); Roy D. Simon, Jr., *The Riddle of Rule 68*, 54 GEO. WASH. L. REV. 1, 63 (1985) (explaining that a plaintiff may "want to complete the process of litigation in order to feel that she has had her day in court," even when a "settlement would be more favorable to the outcome at trial").

152. See generally Peter H. Huang & Ho-Mou Wu, *Emotional Responses in Litigation*, 12 INT'L REV. L. & ECON. 31, 32 (1992); Peter H. Huang, *Lawsuit Abandonment Options in Possibly Frivolous Litigation Games*, 23 REV. LITIG. 47, 78 (2004).

153. Later scholars have introduced new models of litigation that consider a number of factors including the timing of litigation costs, the ability of the parties to learn throughout the litigation process, and the ability to abandon litigation. One model that adds a significant advancement is the real options model. See generally Grundfest & Huang, *supra* note 141, at 1272-75, 1289-92 (defining the real options model and related literature); Huang, *supra* note 152, at 50-53, 56-59.

### B. *The Structural, Ethical, and Practical Barriers To Settling Mass Torts*

As with individual torts, the MSP creates disincentives to settle mass tort litigation. Even more than individual litigations, however, settlement is of the utmost importance to the parties to mass tort litigation and the courts that administrate them. Parties and courts face a “specter of thousands, if not millions of similar trials of liability proceeding in thousands of courtrooms around the nation,”<sup>154</sup> and cannot possibly handle the workload associated with these trials.<sup>155</sup> But even

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While there is value in adding complexity to the classic, expected value economic model of litigation, it is not necessary in this article. My conclusions are robust and not dependent on any particular model. For instance, the MSP changes both the expected values for settlement and the options values for settlement, such that Medicare beneficiaries have no incentive to bring or settle tort lawsuits.

154. *Castano v. Am. Tobacco Co.*, 160 F.R.D. 544, 555-56, 560 (E.D. La. 1995).

155. Claims against pharmaceutical companies are typical of mass tort litigation today. In any pharmaceutical mass tort, hundreds of thousands, if not millions, of individuals could be exposed to an allegedly harmful product. See Byron G. Stier, *Resolving the Class Action Crisis: Mass Tort Litigation as Network*, 2005 UTAH L. REV. 863, 869-70 (2005). As Stier noted:

For example over thirty million pregnant women took Benedictin, an antinausea drug involved in litigation pertaining to birth defects; at least two million women used Dalkon Shields, an intrauterine antipregnancy device involved in litigation regarding infections and miscarriages; more than two million women received silicone breast implants, which were involved in litigation regarding autoimmune disease; and tens of millions were exposed in the workplace to asbestos that spawned litigation concerning lung cancer and mesothelioma.

*Id.* Although only fractions of those exposed generally file suit, these cases threaten to overwhelm the judicial system, which has no real means to try each of the cases. For instance, by August of 2006, two years after withdrawing Vioxx, a popular anti-arthritis drug, from the market, Merck faced over 14,000 federal and state lawsuits, which covered approximately 27,000 plaintiffs related to Vioxx. See Alex Berenson, *Legal Stance May Pay Off for Merck*, N.Y. TIMES, Aug. 4, 2006, at C1. Of those 27,000 claims, close to 17,000 were consolidated in front of one state court judge and 2,900 claims were consolidated in front of one federal judge. See Andrew Pollack, *Mixed Verdicts for Merck in Vioxx Cases*, N.Y. TIMES, Mar. 3, 2007, at C8; Alex Berenson, *A Mistrial is Declared in 3d Suit Over Vioxx*, N.Y. TIMES, Dec. 13, 2005, at C1. Similarly, in Baycol litigation, over the effects of an anti-cholesterol drug, Bayer and GSK faced over 13,000 lawsuits, many of which were consolidated for pretrial purposes in one federal court. See Joyce Gannon, *Bayer's Latest Job Cuts Spare Region*, THE PITTSBURGH POST GAZETTE, Dec. 3, 2004, at C1; Mark Landler, *Investors Unfazed by Risks Associated with Bayer Drug*, N.Y. TIMES, Dec. 22, 2004, at W1.

If each of these cases were tried separately, the cases could clog a court's docket for hundreds of years. For example, if trials in a mass tort with only 2,000 plaintiffs took two weeks per plaintiff, a single court, working every week of the year would take over seventy years to complete the litigation. This hypothetical, however, vastly overestimates the efficiency of the courts. In the Vioxx litigation, for instance, each individual trial has ranged from a low of two weeks to over eight weeks. See Berenson, *supra*, at C1 (reporting on results of a two-week federal trial); Alex Berenson, *Jury Begins to Deliberate Vioxx Case*, N.Y. TIMES, Nov. 2, 2005, at C1 (reporting that jurors began to deliberate after seven weeks of testimony); Susan Todd, *Idaho Couple's Second Vioxx Trial Pins*

under the best of circumstances, parties to a mass tort who wish to settle face numerous barriers to settlement. Parties face structural barriers that make it difficult to bring or settle claims as a class, ethical barriers that make it difficult to settle claims in a non-class aggregate fashion, practical barriers to achieving finality, and a whole host of economic and motivational barriers that make it difficult to reach a settlement number that is acceptable to all parties involved. It is reasonable to think that adding the MSP into the mix could make it nearly impossible to enter into mass tort settlements.

Under the current federal rules, courts generally cannot certify mass torts as class actions for trial or settlement.<sup>156</sup> Most mass tort litigation includes individualized issues related to choice of law, causation, and damages.<sup>157</sup> In light of these issues, putative class representatives in a mass tort likely cannot satisfy the Rule 23 requirements of typicality, adequacy, commonality, predominance, superiority, and notice.<sup>158</sup> Thus, courts have regularly denied plaintiffs' motions to certify mass torts as

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*Merck with \$47.5M Verdict*, THE STAR LEDGER, Mar. 17, 2007, at 43; John Curran, *Ticktock — Watch the Clock; Attorneys Agree to Punch In, Limit Presentation*, HOUSTON CHRONICLE, Feb. 25, 2006, at Business 1 (reporting that after several Vioxx trials, Judge Carol Higbee attempted to limit the time it took to try a case by limiting the plaintiffs to 40 hours of trial time for their presentation of opening, closing, and witness examination, and limiting the defendants to 35 hours of trial time). And, from August 2005 to August 2006, only 8 trials reached juries nationwide. See Alex Berenson, *Legal Stance May Pay Off for Merck*, N.Y. TIMES, Aug. 4, 2006, at C1. In light of these numbers, it is not hard to see how mass torts with tens or hundreds of thousands plaintiffs could easily overwhelm the court system. Thus, a court must think systematically about settlement from the moment mass tort cases are filed.

156. Although state fora may be more amenable to certifying mass tort class actions, under the Class Action Fairness Act of 2005, cases filed as national class actions in state court likely will be removed to a federal forum. Class Action Fairness Act of 2005, Pub. L. No. 109-2, § 4(a), 119 Stat. 9 (2005).

157. See generally Stier, *supra* note 155, at 879-84.

158. As Byron G. Stier noted:

The presence of such [individualized] issues may mean that (1) the claims of class representatives are not typical, because class members' claims rely on varying factual information or a different legal standard; (2) class representatives are not adequate representatives, because their claims differ factually or legally from the class members; (3) there may be no common issue among representatives and absent class members; (4) common issues may not predominate over individual issues; or (5) a class action may not be superior, because the adjudication of individualized issues may make the class action unmanageable.

*Id.* at 878. See also Francis E. McGovern, *Class Action Symposium: The Twentieth Anniversary of Phillips Petroleum Co. v. Shutts: Article: A Proposed Settlement Rule for Mass Torts*, 74 U.M.K.C. L. REV. 623, 626 (2006) ("[T]he civil procedure of mass torts has discouraged mass treatment by ensuring full due process for each plaintiff. Rule 23 is less hospitable to personal injury cases.").

class actions for either trial or settlement.<sup>159</sup> The Supreme Court has twice considered whether mass torts can be certified for settlement purposes. In both cases, the Court took a narrow view of Rule 23's requirements, and all but eliminated the class as a settlement mechanism in products liability cases.<sup>160</sup>

Because courts will not certify mass torts as class actions, parties must settle each claimant's case individually or must settle each case as part of a large aggregate settlement.<sup>161</sup> Although each individual plaintiff is represented in a mass tort, given the numbers of plaintiffs represented by the same attorneys, many individuals do not get the unique attention often considered concomitant with individual representation.<sup>162</sup> Thus, aggregate settlements can raise basic concerns about conflicts of interest and fairness.<sup>163</sup> Without a rule, like Rule 23(e), which governs court approval for class action settlements,

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159. See generally Stier, *supra* note 155, at 878-79.

160. See *Amchem Prods., Inc. v. Windsor*, 521 U.S. 591 (1997); *Ortiz v. Fibreboard Corp.*, 527 U.S. 815 (1999); see also McGovern, *supra* note 158, at 627-28. Even if parties could certify a class for settlement, some defendants might be unwilling to do so given the opt-out requirements under *Amchem* and *Ortiz*. In the diet drug litigation, American Home Products created a \$3.75 billion trust to handle the class claims, but tens of thousands of plaintiffs opted out of the settlement. See Shannon P. Duffy, *Judge Approves Fen Phen Settlement, American Home Products Could Pay as Much as \$3.75 Billion*, 223 THE LEGAL INTELLIGENCER 41 (Aug. 9, 2000). Thus, the defendant bought little peace from a class action settlement.

161. Further, without a class mechanism, the court has no role in the settlement process. The court has neither the responsibility nor rule-mandated authority to determine whether the settlement is procedurally and substantively fair. Therefore, parties have been left with little guidance from case law regarding the proper means to settle these aggregated, but non-class, claims.

162. See Chamblee, *supra* note 17, at 172 ("In all types of aggregated actions, lawyers representing similar claims necessarily prepare the litigation on a group basis with little personal client involvement."); Howard M. Erichson, *Beyond the Class Action: Lawyer Loyalty and Client Autonomy in Non-Class Collective Representation*, 2003 U. CHI. LEGAL F. 519, 533 (2003).

163. Because plaintiffs' attorneys often represent multiple mass tort claimants against the same defendant or defendants, these attorneys may face a conflict of interest between securing an aggregate settlement with the defendant for all of the claimants the attorney represents and securing the best possible settlement for a single client. Plaintiffs' counsel may have incentives to favor or ignore one pivotal plaintiff's claims in the settlement over the claims of others. See Chamblee, *supra* note 17, at 172 ("Representing catalogues or inventories of claimants often leads to conflicts of interest that attorneys may not be able to foresee at the beginning of litigation, such as differences among bargaining positions, clients' divergent desires to settle or litigate, or the extent of latent injuries."); John C. Coffee, Jr., *Class Action Accountability: Reconciling Exit, Voice, and Loyalty in Representative Litigation*, 100 COLUM. L. REV. 370, 386 (2000) (recognizing four distinct conflicts in mass tort representative litigation: internal conflicts within a class or between subclasses, where members compete over allocation of a capped fund; external conflicts where some members or attorneys favor a settlement over litigation; conflicts that arise because different members or counsel have a different amount of tolerance for risk; and conflicts over control of the litigation).

dismissals, or compromises of claims,<sup>164</sup> attorneys are governed only by the ethical rules in fashioning settlements.<sup>165</sup> The ethical rules, however, create a further barrier to aggregate settlements. Under Model Rule of Professional Conduct Rule 1.8(g),<sup>166</sup> which has been adopted in some form in every jurisdiction,<sup>167</sup> attorneys representing multiple clients must (a) inform each of their clients of the terms of an aggregate settlement; and (b) each client must consent to the settlement in writing.<sup>168</sup> An attorney must follow these procedures for each of his clients who are covered by the settlement, even if the settlement involves hundreds or thousands of parties.<sup>169</sup> The attorneys to any valid aggregate settlement must adhere strictly to the requirements of these rules or risk sanction and dissolution of the settlement.<sup>170</sup>

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164. FED. R. CIV. P. 23(e)(1)(A) (“The court must approve any settlement, voluntary dismissal, or compromise of the claims, issues, or defenses of a certified class.”).

165. See MODEL RULES OF PROF’L CONDUCT R. 1.8(g) (2002); MODEL CODE OF PROF’L RESPONSIBILITY DR. 5-106 (1980). See also Chamblee, *supra* note 17, at 170-77 (arguing that because multiple plaintiffs are often represented by a small number of attorneys, there are opportunities for collusion in the settlement process).

166. Rule 1.8(g) states:

A lawyer who represents two or more clients shall not participate in making an aggregate settlement of the claims of or against the clients, or in a criminal case an aggregated agreement as to guilty or nolo contendere pleas, unless each client gives informed consent, in a writing signed by the client. The lawyer’s disclosure shall include the existence and nature of all the claims or pleas involved and of the participation of each person in the settlement.

MODEL RULES OF PROF’L CONDUCT R. 1.8(g) (2002).

167. See Paul J. Lesti, STRUCTURED SETTLEMENTS, Appendix Y.1, fn. 8 (2d ed. 1993); ALI Principles of the Law of Aggregate Litigation § 3.15, (Discussion Draft 2006).

168. See, e.g., Tax Auth., Inc. v. LeMaire-McCumsey Group, Inc., 898 A.2d 512 (N.J. 2006).

169. See, e.g., State *ex rel.* Okla. Bar Ass’n v. Watson, 897 P.2d 246 (1994) (rejecting lawyer’s argument that he was required to consult only with his “true client,” the representative of the decedent’s estate); Quintero v. Jim Walter Homes, Inc., 708 S.W.2d 225 (Tex. 1986) (holding that an aggregate settlement void and unenforceable when plaintiffs’ attorney consented to settlement on behalf of 349 clients without informing each client of the existence and value of the other claims before obtaining consent).

170. There are several potential consequences to the parties, their counsel, and the settlement if counsel fails to meet the requirements of Rule 1.8(g). First, a plaintiff’s attorney who fails to comply with the rule may face forfeiture of his fees, see, e.g., Burrow v. Arce, 997 S.W.2d 229 (Tex. 1998), or disciplinary penalties for failing to obtain his clients’ informed consent, see *In re Hoffmann*, 883 So.2d 425, 435 (La. 2004) (attorney suspended for three months for failure to obtain clients’ informed consent); *In re Jaeger*, 213 B.R. 578 (Bankr. C.D. Cal. 1997) (disqualifying attorneys from representing all defendants in the proceeding). Likewise, defendant’s counsel may run afoul of ethical rules for encouraging a settlement that violates Rule 1.8(g) by assisting or inducing another lawyer to violate the Rules of Professional Conduct. See James M. McCormack, *Ethical Pitfalls in Representing Multiple Parties: How to Get Through the Case Without Tripping*, 19th Annual Asbestos Litigation Conference, 2004 WL 1718493 (April 29-30, 2004). Second, the settlement may not be binding upon a plaintiff who claims he never consented to the terms. This

However, it is neither simple nor efficient to gather all of the necessary approvals during the settlement process. Given the number and diversity of plaintiffs in mass tort litigation, the unanimity requirement may create further expense and delay in a settlement, impose on the privacy of settling parties, and encourage individual plaintiffs to withhold their consent until they receive disproportionately large settlement allotments.<sup>171</sup> It may also preclude some aggregate settlements altogether if unanimous consent is impossible, especially if plaintiff “holdouts” undermine collective action.<sup>172</sup>

In addition to the structural and ethical barriers, the parties to a mass tort can struggle to achieve finality. In any tort, the parties must try to resolve a number of claims in addition to the claims of the injured party. For example, defendants will want to resolve claims derivative to the injured party, such as survivor claims, wrongful death claims, and spousal and dependent claims, at the same time they settle with the plaintiff. Settling defendants will also want to resolve any potential claims by or against non-settling defendants for contribution and indemnity. If defendants settle only with the plaintiffs, they can gain no true peace through settlement. In any tort case, parties may struggle to identify each of the potential claimants and get releases for all current and future claims. In a mass tort, this process can be a logistical morass. For instance, the parties must determine who can bring and potentially release wrongful death claims, who has a right to bring a loss of consortium or society claim, and which non-settling defendants might have other potential future claims. The answers to these questions are often jurisdiction dependent. With thousands of potential plaintiffs, simply gathering the appropriate releases can be costly and labor intensive.<sup>173</sup>

Moreover, defendants in mass torts are repeat players in the litigation. Defendants must be concerned about the outcome of each of the individual cases in a mass tort, both in terms of actual precedent and

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not only affects plaintiffs' counsel, but also undermines the defendant's goal of achieving finality and an aggregate resolution of claims against them. Third, a court may reject the entire settlement as void for violating Rule 1.8(g). *See, e.g.,* Quintero v. Jim Walter Homes, Inc., 708 S.W.2d 225, 229 (Tex. 1986).

171. *See* Lynn A. Baker & Charles Silver, *Mass Lawsuits and the Aggregate Settlement Rule*, 32 WAKE FOREST L. REV. 733, 736 (1997).

172. *See id.*

173. *See* Richard L. Berkman & Rick Swedloff, *Settlement Issues in Mass Torts*, in MASS TORTS (Sean Wajert & Andrew Gaddes eds., Law Journal Press) (forthcoming 2009).

creating a norm for settlement.<sup>174</sup> As such, resolving each individual lawsuit may have value beyond the intrinsic value of one person's claim. There is pressure on defendants to litigate each case for the value of the precedent and to signal to the plaintiffs that the defendant will not settle cheaply. There may also be pressure on plaintiffs' attorneys in early suits to signal a willingness to fight.<sup>175</sup> Early victories in court may set a high standard for settling later cases. Thus, the parties may skew the value of each individual case such that settlement becomes more difficult.

Each of these problems exists in any mass tort case. The structural and ethical problems drive up the transaction costs related to settlement, and thus make settlement a less attractive alternative to litigation.<sup>176</sup> As is clear from formulae (3) and (4) above, when the cost of settlement grows, a defendant's maximum offer will shrink and the minimum amount a plaintiff will accept to settle the suit will grow. The valuation problems also make it less likely that the parties can find a common ground for settlement. Thus, these barriers to settlement make it more difficult to settle a lawsuit.

As in an individual tort, the MSP adds an additional difficulty for parties trying to settle mass tort litigation: automatic liability for Medicare's costs. As such, a Medicare beneficiary settling a tort claim could find herself without any compensation after Medicare has taken its due. Likewise, a defendant could find itself liable to Medicare for double the amount of settlement or more without ever admitting liability for the underlying tort. It is reasonable to think that the additional liability the MSP creates makes it more difficult, if not impossible, for Medicare beneficiaries to settle claims in the mass tort setting. Indeed, Judge Weinstein made this same observation stating: "Settlement of mass tort litigations for personal injuries have [sic] become extraordinarily complex and difficult as a result of the attempts by the United States to collect on Medicare liens and of the states to enforce their Medicaid liens."<sup>177</sup>

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174. See generally Cross, *supra* note 141, at 7- 15.

175. Although ostensibly individual plaintiffs drive the litigation in a non-class setting, because plaintiffs' attorneys represent multiple clients, they are often driving much of the litigation strategy in mass torts. See *infra* note 184 and accompanying text.

176. See Deborah R. Hensler & Mark A. Peterson, *Understanding Mass Personal Injury Litigation: A Socio-Legal Analysis*, 59 BROOK. L. REV. 961, 1031 (1993) ("Transaction costs – chiefly, legal fees – dwarf the amounts paid to injured claimants, who often wait years to receive compensation.").

177. *In re Zyprexa Prods Liab. Litig.*, 451 F. Supp. 2d 458, 461 (E.D.N.Y. 2006).

Given the number of Medicare beneficiaries in recent mass tort litigation, it is not hard to imagine that these beneficiaries likely make up a significant percentage of the plaintiffs in many mass tort cases.<sup>178</sup> In aggregate settlements – even those in which each individual plaintiff is theoretically acting autonomously or in each of the individual settlements that make up a global settlement of a mass tort – the total settlement dollars at stake matter. Defendants certainly track their total exposure, plaintiffs want to know their total recovery, and plaintiffs' attorneys must be concerned with their total fees. If the Secretary can automatically increase a defendant's exposure, take a share of the settlement, or collect from a contingency fee, the total settlement numbers change and the window for settlement shrinks. Additionally, settlement becomes less likely if it is possible at all.

### C. *Can't Settle, Can't Sue*

If it is more difficult for Medicare beneficiaries to settle tort claims, three outcomes are possible. (1) Medicare beneficiaries will have no difficulty finding representation and continue to bring tort claims to trial; (2) Plaintiffs' attorneys will refuse to represent Medicare beneficiaries in individual or mass tort lawsuits; or (3) Plaintiffs' attorneys will not bring claims as a mass tort. The first of these outcomes is unlikely and the last two lead to an inefficiency in the tort system.

As with the decision about whether to settle a lawsuit, a plaintiff makes her decision about whether to bring a legal claim based upon her subjective valuations of the claim and the expense of succeeding on the claim. Where a plaintiff expects to receive a greater benefit from a favorable court judgment or settlement than the cost of achieving that judgment or settlement, she will bring the claim.<sup>179</sup> In a dispute where a plaintiff pays for her attorneys' fees on a fee-for-service basis, the plaintiff alone is the decision maker. She will bring suit if she anticipates a benefit. If she does not anticipate a benefit from bringing suit, she will not do so. In personal injury torts, however, plaintiffs are typically represented on a contingent fee basis. The only costs that

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178. See, e.g., *supra* note 104 and accompanying text.

179. See Cooter & Rubinfeld, *supra* note 144, at 1082 (citing RICHARD A. POSNER, ECONOMIC ANALYSIS OF LAW (3d ed. 1986); Steven Shavell, *Suit, Settlement, and Trial: A Theoretical Analysis Under Alternative Methods for the Allocation of Legal Costs*, 11 J. LEGAL STUD. 55 (1982)). As discussed above, the benefits included in the plaintiff's calculations can be non-monetary benefits, including a desire to have her day in court or a desire to punish an industry perceived of wrongdoing.

accrue to the plaintiff, if any, are court costs, time, and opportunity cost. Thus, the decision about whether to litigate a case rests in large part with an attorney. As with a plaintiff, a contingency fee attorney will bring a claim when she believes that it would be profitable to do so, and will not bring a claim when it is not.

The MSP discourages Medicare beneficiaries and their contingency fee attorneys from bringing suit in simple tort disputes for two reasons. First, the MSP increases the costs of resolving the dispute by forcing tort lawsuits to trial instead of settlements.<sup>180</sup> Second, the MSP reduces the total recovery beneficiaries and their contingency fee attorneys expect. The imposition of Medicare liability means that to consider bringing a lawsuit, plaintiffs must expect to recover significantly more than the amount Medicare expended for the plaintiff's medical care. Represented in a formula, if  $M$  represents the costs Medicare expended on behalf of a plaintiff, a plaintiff would only bring suit when:

$$\text{Formula (5): } (V_p * P_p) - C_{pj} > M^{181}$$

Under the MSP,  $V_p$  is lower because the Secretary may take a portion of any recovery and  $C_{pj}$  is higher because the MSP forces trials rather than settlements.

Similarly, the MSP dissuades attorneys from taking a Medicare beneficiary's tort claims on a contingent basis. Because a contingency fee attorney is compensated based on the size of the plaintiffs' recovery minus the costs of procuring that recovery, a lower  $V_p$ <sup>182</sup> and a higher  $C_{pj}$  will make a potential case less attractive. Under the MSP,

180. See Cooter & Rubinfeld, *supra* note 144, at 1083 (“[L]aws that increase the costs of resolving disputes are likely to decrease the frequency with which legal claims are asserted and increase the cost of settling those that are asserted.”). As noted by Judge Weinstein:

[b]ecause it may deprive them of any compensation for their injuries, the full reimbursement approach gives many beneficiaries little incentive to pursue valid claims or, if they do, to accept otherwise reasonable settlement offers, thereby tending to push them into uncertain litigation that burdens the courts and may result in little or no recovery for either the beneficiaries or for Medicare or Medicaid.

*Zyprexa*, 451 F. Supp. 2d at 470.

181. Assuming that beneficiaries have standing to bring a claim for medical expenses expended by Medicare on their behalf,  $V_p$  includes  $M$  as part of its value, in which case, it is more likely that the value of plaintiff's claim will exceed the value of  $M$ . This assumption is represented in formula (5). If, on the other hand, beneficiaries cannot bring claims on behalf of Medicare, a plaintiff will only bring a claim where her damages (including pain and suffering and medical expenses not covered by Medicare) exceed  $(M + C_{pj})/P_p$ .

182. Even if a contingency fee attorney is compensated based on the settlement amount rather than the amount paid to the beneficiary after the Secretary takes Medicare's share, the MSP could reduce  $V_p$ . If there is a window for settlement after the MSP is accounted for, the surplus will be lower. Thus, the settlement amount is likely to be smaller as well.

contingency fee attorneys will have to bring claims to trial and thus invest more time into a given representation. Lastly, the MSP may dissuade contingency fee representation because the Secretary can recover Medicare conditional payments from any “entity that [] receive[s] payment from a primary plan.”<sup>183</sup> To the extent that an attorney accepts a contingency fee from a settling tortfeasor (now a primary plan under the MSP), the Secretary may claim a right to recover from the attorneys. If attorneys cannot recover their contingency fees from Medicare beneficiaries even if they win or settle a case, there is little incentive to represent them.

Mass torts are like other personal injury claims. Plaintiffs’ attorneys in a mass tort generally work on a contingency fee basis and, thus, the decision about whether to bring individual claims is made by an attorney. But mass torts raise further complex questions about the incentives for bringing suit, because some law firms represent hundreds or thousands of individual plaintiffs and represent plaintiffs with serious claims, minor injuries, and latent claims.<sup>184</sup> The attorneys know from the minute they begin recruiting plaintiffs that some of their claims will be profitable, even if they go to trial, while other claims have value only if plaintiffs’ attorneys can negotiate an aggregate settlement. Thus, an attorney may not care whether a single case is profitable when determining whether to bring mass tort claims. Rather, plaintiffs’ attorneys base their estimates about the expected value of mass tort litigation on the number of claims brought, the commonality among those claims, and the interdependence of the case values.<sup>185</sup> “The larger the number of potential claims and the greater the likelihood that the

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183. 42 U.S.C. § 1395y(b)(2)(B)(iii) (2006).

184. The motivation for this aggregation is simple: a large roster of clients provides economies of scale in the litigation and translates into more power when it becomes time to select a steering committee and a greater piece of a settlement pie once the settlement range is set. Although there is a promise of individual representation, when individual firms represent a large number of individual claimants in the same litigation, it is clear these firms, not individual plaintiffs, drive litigation decisions.

185. See Hensler & Peterson, *supra* note 176, at 1033. In an early work describing the nature of mass torts, Hensler and Peterson noted that three factors distinguish mass torts from other high volume personal injury litigation, such as automobile accidents: “the large number of claims associated with [the litigation]; the commonality of the issues and actors within a litigation; and the interdependence of the claim values.” *Id.* at 965. The authors explain that because of the commonality of facts and players, the “likely amount that one plaintiff will receive for a claim depends upon the values of other claims.” *Id.* at 967. Thus, the expected value of any claims may rise or fall with plaintiff awards, defense verdicts, or evidentiary rulings in other cases within the litigation. See *id.*

common factors among claims will pull the values of many claims upward, the larger the expected value of the litigation.”<sup>186</sup>

Mass torts tend to follow a predictable litigation pattern. At the beginning, plaintiffs’ attorneys identify a potential mass claim. They then recruit clients who have suffered the injury and file complaints. After, or while, seeking discovery, the parties try a small group of cases to determine whether the claims at issue are viable – that is, whether the plaintiffs can establish causation and liability – and the range of damages.<sup>187</sup> If, in fact, the claims are viable, the parties use the trials as data points to set the settlement range and ultimately enter a global settlement.<sup>188</sup>

So long as the mass tort litigation follows this predictable course, plaintiffs’ attorneys expect that early cash outlays toward enrolling a large roster of clients, seeking complex and extensive discovery, and bringing individual trials will yield great profits at the time of aggregate settlements.<sup>189</sup> That is, the truly profitable aspect of mass torts is settling a large number of claims where the attorney has invested little to no time or money, regardless of the level of injury sustained by the plaintiff.

The MSP, however, could disrupt the expected progression toward an aggregate settlement. At least with respect to some portion of represented plaintiffs – Medicare beneficiaries – the MSP makes it more difficult to settle mass tort claims. As such, plaintiffs’ attorneys may decline to represent Medicare beneficiaries in mass tort actions. Alternatively, to the extent that Medicare beneficiaries make up a large percentage of the potential claimants, plaintiffs’ attorneys may decline to

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186. *Id.*

187. See Francis E. McGovern, *Settlement of Mass Torts in a Federal System*, WAKE FOREST L. REV. 871, 872 (2001); Hensler & Peterson, *supra* note 176, at 1034. In picking these early trials, plaintiffs’ attorneys push the most meritorious and sympathetic claimants and defendants often push the weaker claims. The strategic bargaining over these early cases can impact the ultimate settlement numbers.

188. See McGovern, *supra* note 187, at 872.

189. See generally Samuel Issacharoff & John Fabian Witt, *The Inevitability of Aggregate Settlement: An Institutional Account of American Tort Law*, 57 VAND. L. REV. 1571, 1602 (2004). Given the precedent-setting effect of early lawsuits, defendants are willing to expend great amounts to defend these early trials. Plaintiffs’ attorneys must be willing to match those outlays. They can only do so when they represent enough clients that they have an incentive to match the outlays of the defense attorneys. If plaintiffs’ attorneys do not aggregate all of the potential claims against a defendant, they will not enjoy the same economies of scale that the defendant enjoys, and may not invest properly in the prosecution of the claims. That is, the defendants will have a greater incentive to expend money to defend the claims than the plaintiffs have to expend money to prosecute the claims. See generally David Rosenberg, *Mandatory-Litigation Class Action: The Only Option for Mass Tort Cases*, 115 HARV. L. REV. 831, 847 (2002).

bring claims in aggregate or mass tort form altogether. That is, if plaintiffs' attorneys determine that they cannot obtain a significant aggregate settlement because the Medicare beneficiaries make up a large percentage of the potential claimants or because Medicare beneficiaries otherwise make it more difficult to settle the claims, the attorneys may choose to abandon the mass tort form. In doing so, the attorneys may expect that they can bring individual claims without the defendants gearing up to defend hundreds or thousands of similar claims.

Thus, the MSP could discourage worthy claimants from bringing suit and discourage attorneys from bringing mass torts altogether.

#### IV. AN INEFFICIENT LIFE WITHOUT MASS TORTS

At a minimum, because of the MSP, Medicare beneficiaries will be underrepresented in torts generally and mass torts specifically. Let's call this the "weak theory." But the MSP could yield a greater problem. Because Medicare beneficiaries can make up a significant percentage of claimants in a mass tort, plaintiffs' attorneys may determine that it is inefficient to invest the time and energy to bring mass aggregate claims. Rather, they will cherry pick the plaintiffs who have the greatest probability of victory (those plaintiffs that are the most sympathetic, the most injured, or some combination of both) and bring these as individual claims. Let's call this the "strong theory." Both the weak and the strong theory lead to inefficient outcomes for achieving corrective justice and deterrence. Moreover, under both theories the government likely suffers.

First, and quite simply, from a corrective justice standpoint, if Medicare beneficiaries go unrepresented in any of the forms discussed above, significant numbers of plaintiffs will not find redress for some portion of the damages they suffer – pain and suffering, lost wages, and uncovered medical bills.<sup>190</sup> Under the strong theory – that plaintiffs' attorneys cannot afford or will otherwise refuse to bring mass tort actions because the MSP disrupts the financial life cycle of a mass tort – many claims will never be brought. Plaintiffs' attorneys may be willing to chase large damage awards for those plaintiffs who have particularly high damages and/or who will be particularly sympathetic to a jury. Plaintiffs' attorneys will be unwilling to do so for all other plaintiffs,

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190. Presumably Medicare has already covered some portion of the beneficiary's medical bills. If the beneficiary chooses not to bring suit, the Secretary will not seek recovery from the beneficiary.

including potential claimants who are not Medicare beneficiaries, because it would be inefficient to bring mass tort actions.

Even under the weak theory – that lawyers will not represent Medicare beneficiaries in individual or mass tort litigation – some claims will not find redress, because the claims of Medicare beneficiaries will not be brought. Even if the Secretary brings direct or subrogation claims against the tortfeasors to recover Medicare’s costs, the beneficiaries’ other costs will not be compensated.

Second, from a deterrence standpoint, if tortfeasors are not made to redress the harms they cause, they will not invest the proper amount in preventing harm.<sup>191</sup> Optimal deterrence occurs when firms are made to internalize *all* of the negative externalities that their harmful conduct creates. When threatened with liability for all of the harms caused, firms will invest efficiently to prevent these harms. That is, each firm will invest “up to the point at which the expense of taking an additional unit of precaution exceeds the benefit of the additional risk avoided.”<sup>192</sup> When firms invest up to that point, the firms will avoid unreasonable risk, and both society in the abstract and each individual therein will recognize an increase in welfare.<sup>193</sup> If defendants do not internalize all of the harms, they will not invest optimally.

Under both the strong and the weak theory, attorneys will not bring claims on behalf of all potential plaintiffs. Thus, even if the defendants are forced to pay for all of the harms caused to some set of plaintiffs, other plaintiffs will not find representation and defendants will not pay for (and not internalize) the full extent of the injuries caused.

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191. Whether one supports corrective justice or a deterrence rationale for tort, and whether one focuses on procedural fairness for each individual claimant or on efficiency in the overall process, the goal of any tort regime should be, in part, to reduce the rate of negligent conduct. See generally Gary T. Schwartz, *Mixed Theories of Tort Law: Affirming Both Deterrence and Corrective Justice*, 75 TEX. L. REV. 1801, 1827-28 (1997) (reconciling deterrence and corrective justice theories by arguing, in part, that both schools of thought are generally interested in reducing negligent conduct).

192. Rosenberg, *supra* note 189, at 843-44.

193. See *id.* (arguing that *ex ante* individuals prefer firms to invest in the proper amount of precaution; thus, when firms invest efficiently, the welfare of society and the individual increases).

Even those claims that are brought may reap smaller rewards either in litigation or settlement, because plaintiffs' attorneys may under-invest in developing their clients' claims. Plaintiffs' attorneys will invest "in developing [their clients'] side of a claim to the extent that [their] net return on investment is maximized."<sup>194</sup> When plaintiffs' attorneys, acting in concert, represent fewer than all who are harmed, their expected return will be lower, and it is unlikely that they will invest the optimal amount in their claim. As such, they may not achieve the maximum damage award for those claims that they choose to bring. This, of course, will not create the proper incentives for optimal deterrence.<sup>195</sup>

Third, under the MSP, the Secretary may have a more difficult time recovering from tortfeasors on behalf of Medicare. First party liability litigation can be (and has been) a free source of information about potential suits that the government could bring against alleged tortfeasors as a subrogee. Under the strong theory, plaintiffs' attorneys may not invest properly in the litigation, which could, for instance, result in a narrower discovery campaign or a more limited scope of litigation strategies. Thus, the Secretary may be deprived of valuable information that plaintiffs could have obtained through discovery and the Secretary will not get a preview of the defendants' responses to a more fulsome set of plaintiffs' theories.

## V. BALANCING THE EQUATION

I am not suggesting that Medicare should have no recourse against tortfeasors. To the extent that Medicare covers medical costs that result from a tortious act, the Secretary must have a claim against tortfeasors for the harms that the tortfeasors cause Medicare beneficiaries. Otherwise, the tortfeasor would reap a windfall, would not internalize all

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194. *Id.* at 848. Rosenberg argues that the only way that mass tort plaintiffs' attorneys will have the proper incentives to optimally invest in trial preparation is to create mandatory class actions for mass torts. However, many plaintiffs' attorneys unofficially aggregate claims together and share the costs of litigation by pooling their resources. *See generally* Stier, *supra* note 155 (arguing that plaintiffs' attorneys can, and do, work in litigation networks to achieve efficiencies of scale). Although this may increase transaction costs, it is not clear that those additional transaction costs are significantly greater than the transaction costs incurred when a defendant is represented by national counsel or multiple law firms, as is quite common today.

195. Although mass tort litigation soaks up scarce judicial resources, Congress likely did not enact the MSP as a means to curb mass tort litigation. And it should not be used as such. Accidental tort reform – especially when based on a provision designed to increase the Secretary's power to refill his own coffers – is not the answer to problems created by mass torts

of its negative externalities, and would not invest in the proper amount of precaution. The cause of action, however, should not strip an *alleged* tortfeasor of its rightful defenses as the MSP does. The MSP creates a disincentive to settle because a defendant is automatically liable if it settles – that is, it has no defense to the Secretary’s claim for reimbursement post MMA.

Even if Medicare differs in some respects from private health insurance, it is a quintessential insurance program. Like a private insurer that distributes the risk of individual harm across a portfolio of insureds, the government insures Medicare beneficiaries from the cost of illness and disability, and distributes the costs of the individual financial risks across all workers.<sup>196</sup> When an insurer pays benefits to an insured that a third party should have paid, the insurer generally has rights to recover against the third party. Those rights may be direct or derivative depending on the nature of the third party. If the third party is a primary insurer, the secondary or excess insurer has a direct cause of action against the primary insurer for indemnification. If the third party is a tortfeasor, the insurer has a derivative cause of action through the insured – a right of subrogation.<sup>197</sup> The direct and derivative rights are very different actions.

The direct cause of action is based on the insurer’s contractual rights and responsibilities vis-à-vis the insured and other insurers. The extent of a primary insurer’s liability should be clear from the face of the insurance contracts. Likewise, the primary insurer’s defenses sound in contract. For instance, a primary insurer could argue that it is not liable to Medicare because the insurance policy was not in force at the time of the harm, that the scope of the contract did not cover the insured’s harms, or that another insurer should be the primary insurer. Each of these defenses will be based on the contract and the common law of insurance contract interpretation.

In contrast, when an insurer has paid its insured for injuries caused by a third party’s tortious act, the insurer can step into the shoes of the

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196. Of course, Medicare is forced to cover everyone who is Medicare eligible – e.g., individuals who are sixty-five or older and have worked, or be a spouse of one who worked, for ten years in a Medicare eligible job, those with end stage renal disease or are otherwise disabled – while private insurers can exclude certain risks. Therefore, it is not an exact analogy and there may be a reason to treat Medicare differently in some circumstances. Nonetheless, the MSP strategy is self-defeating, as discussed above.

197. See generally Hanoch Dagan & James J. White, *Governments, Citizens, and Injurious Injuries*, 75 N.Y.U. L. REV. 354, 384-85, 399 (2000) (defining subrogation).

insured and sue the tortfeasor for its harmful acts. Because the insurer merely stands in the shoes of its insured, the insurer's rights are no greater than those of the insured and the tortfeasor retains all of its tort defenses.<sup>198</sup> For instance, the tortfeasor could argue that her actions were not negligent or that the tortfeasor did not cause the insured's harms.

Unfortunately, post MMA, the MSP conflates these two actions. Congress originally enacted the MSP as a means of defraying Medicare costs by forcing other insurers to act as a primary insurer. As discussed above, post MMA, the MSP transforms settling tortfeasors into primary insurers and transforms what should be an action sounding in tort into an action sounding in contract. In this, the statute strips the settling tortfeasor of its potential tort defenses. Defendants settling tort claims with Medicare beneficiaries lose any tort defenses they may have had against Medicare, and could be liable to Medicare for the settlement amount, the amount of Medicare's expenditures, or more.

The solution to this problem is simple: revert to the understanding of the MSP before the MMA. Give the government a direct indemnity claim against insurers. Give the government a derivative claim – a claim of subrogation – against tortfeasors. The statute contemplates both of these causes of action.

The natural reading of the MSP is to give the Secretary a direct cause of action against primary insurers.<sup>199</sup> In other words, the Secretary should retain its right to bring direct claims against insurers or those companies with defined and distinct *ex ante* self-insurance plans when those plans fail to cover Medicare beneficiaries. If, as before the MMA, the government is limited to claims against “entities which are clearly ‘within’ the insurance industry,”<sup>200</sup> the direct cause of action will make sense internally and will not impact tort settlements. This will help define the limit and scope of the Secretary's claims against the primary insurer. For instance, the primary insurer's policy limit would determine the maximum amount the Secretary could recover.<sup>201</sup>

The statute also grants the Secretary the right to be subrogated to

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198. As Dagan and White explain, a subrogee's rights are “derivative of those of the direct victims, due to and to the extent of the unsolicited benefits conferred. As such, the subrogee's rights can be no greater than the rights of the subrogor.” *Id.* at 398.

199. See 42 U.S.C. § 1395y(b)(2)(B)(ii) (2002).

200. *United States v. R.I. Insurers' Insolvency Fund*, 80 F.3d 616, 622 n.5 (1st Cir. 1996); see also *supra* note 102 and accompanying text.

201. See *supra* note 130 and accompanying text.

the beneficiaries' claims. The statute states: "The United States shall be subrogated (to the extent of payment made under this subchapter for such an item or service) to any right under this subsection of an individual or any other entity to payment with respect to such item or service under a primary plan."<sup>202</sup> Thus, the Secretary can step into the shoes of the beneficiary and assert a tort claim against a third party to the extent of Medicare's expenditures.

Reverting to this understanding and giving the Secretary both the direct and derivative rights of other insurers corrects the problems created by the MMA. The Secretary can still force other insurers to live up to their primary obligations via a direct cause of action. Further, the Secretary can force tortfeasors to internalize all of the negative externalities their actions create by threatening the tortfeasors with full liability. Yet, alleged tortfeasors can settle lawsuits with Medicare beneficiaries without fear of additional, automatic liability because they retain their tort defenses. Likewise, plaintiffs' attorneys can continue to represent Medicare beneficiaries and bring mass tort claims. As a result, the Secretary can gain valuable information about potential third party tortfeasors for future suits or intervene in suits brought by beneficiaries. In short, reverting to the pre-MMA understanding of the MSP would balance the equation and restore the natural balance of the tort system.

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202. 42 U.S.C. § 1395y(b)(2)(B)(iv) (2006).