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Federal Court Finds Carrier is not Liable for Double Damages Under the Medicare Secondary Payer Act

The Case

On November 20, 2018, the United States District Court for the Central District of California granted a motion to dismiss filed by 21st Century Insurance Company ("Defendant") in the matter of *Bacon v. 21st Century Ins. Co*., 2018 U.S. Dist. LEXIS 198816. In 2012, John Bacon ("Plaintiff") was injured in an automobile accident. In June 2014, Plaintiff entered into a settlement agreement with Defendant, who insured Plaintiff under an uninsured motorist policy. As part of the settlement, Defendant agreed to payment of $50,000 in exchange for Plaintiff's agreement to reimburse, indemnify, and hold harmless Defendant with respect to any right to recovery from the Centers for Medicare & Medicaid Services ("Medicare").

Shortly after executing the settlement agreement, Defendant reported the settlement to Medicare, pursuant to its Section 111 reporting obligations, and issued a check for $50,000 made payable to both Plaintiff and Medicare. In August 2014, Medicare sent Plaintiff a notice asserting conditional liens in the amount of $67,685.36 for treatment in connection with the automobile accident. When no payment was made, the Department of Treasury, who serves as the statutory recovery agent for Medicare, eventually began reducing Plaintiff's Social Security payments to satisfy the asserted debt. In June 2018, Plaintiff filed suit against Defendant pursuant to Medicare's private cause of action contained at 42 U.S.C. § 1395y(b)(3)(A) seeking double damages from Defendant for failure to reimburse Medicare for the conditional payments. Defendant filed a motion to dismiss alleging Plaintiff's third amended complaint failed to establish that Defendant had failed to reimburse Medicare for the amount owed.

The Court, citing *Parra v. PacifiCare of Arizona, Inc*., 715 F.3d 1146, 1152 (9th Cir. 2013), noted that Medicare's private cause of action was intended to vindicate wrongs occasioned by the failure of primary plans to make payment and that it was not intended to apply to a primary plan which has interpleaded a sum subject to conflicting claims. The Court held that the Defendant settling with Plaintiff and issuing a check for its full potential liability made payable to both the Plaintiff and Medicare was all that the Medicare Secondary Payer ("MSP") Act required, and it was Plaintiff who had failed to reimburse Medicare. Plaintiff's complaint was dismissed without leave to amend. A copy of the opinion can be accessed here.

Analysis and Commentary

The Court's determination that it was the Plaintiff that had failed to properly reimburse Medicare for conditional payments once the Defendant had tendered payment to Plaintiff and made Medicare a payee on the settlement check is assuring news for carriers and self-insureds with primary payer responsibilities. Too often satisfying Medicare conditional payment demands becomes a protracted and drawn out process, with uncertain results. The parties did the right thing in this case by discussing Medicare's interest as part of the settlement and incorporating a plan for the satisfaction of the lien into the settlement agreement. However, when the party responsible for handling the lien post settlement doesn't follow through, problems will no doubt arise.

In most cases, when a primary payer provides funds to reimburse CMS for conditional payments as part of the settlement and CMS "follows the money" to recover their conditional payments, a more equitable and efficient result is likely to be achieved, at least from the perspective of the primary payer. This is typical in liability cases, and CMS

will likely pursue recovery from a beneficiary since the Defendant will not become a primary payer until a settlement, judgment, or award occurs and the beneficiary has received the settlement funds. CMS' recovery rights allow them to pursue recovery directly from a beneficiary who has received primary payment. (See 42 C.F.R. § 411.24(g)).

Carriers and self-insureds should be wary of tendering payment and simply relying on the Plaintiff to follow through with reimbursement. If the Plaintiff fails to reimburse Medicare within 60 days of receiving a settlement, judgment, or award, it is important to remember that courts have held that under 42 C.F.R. § 411.24(i)(1), CMS may pursue recovery from a primary plan even when they have already paid a beneficiary directly for conditional payments. CMS' recovery rights post-settlement are expansive and can enable them to collect double damages from a primary payer, even after a beneficiary has been reimbursed directly for conditional payments through settlement. This robust recovery right can lead to instances of a primary payer having to pay triple the amount asserted by Medicare if they have tendered funds for conditional payments to a beneficiary as part of settlement and later have a judgment against them requiring double damages when the beneficiary does not reimburse Medicare appropriately, in addition to defense costs. (*Humana Med. Plan, Inc. v. Western Heritage Ins. Co*., 832 F.3d 1129 (11th Cir. 2016)).

To the best of their ability, primary payers should continue to make sure that Medicare's interests are protected and ensure that conditional payments are appropriately reimbursed as part of settlement. Discussing which party will be responsible for resolving the lien issues as part of the settlement, as in the case here, is always the best strategy. However, to the extent they can, primary payers should attempt to carve out post-settlement protections for themselves or other mechanisms to ensure that Medicare is appropriately reimbursed. Different strategies may be useful for this, including withholding a portion of the settlement funds until proof that the lien (or liens) has been satisfied or, as in the case here, listing Medicare as a payee on the settlement check. While adding Medicare onto the settlement check as mechanism of protection may make the check option a less practical one, it can be appropriate if no other suitable lien resolution methods can be negotiated by the parties in the settlement process.

While there will no doubt be resistance to these types of conditions from the Plaintiff in some instances, the difficulty of compelling a party to act after settlement is reason enough to insist on such conditions prior to the settlement being finalized. Bargaining the terms of the settlement in good faith and being forthcoming with the opposing party is always the best practice. Surprises rarely work out in the end and can lead to the deterioration of the settlement (see *Tomlinson v. Landers*, 2009 U.S. Dist. LEXIS 38683, 2009 WL 1117399, holding that Defendants did not have the right to unilaterally insert Medicare as payee on a settlement check without the act being viewed as a change in the settlement terms).

Finally, it is important that primary payers not limit the lien discussions to only consider traditional Medicare liens under Medicare Parts A and B. Consideration should also be given to potential liens that can be asserted by a beneficiary's Medicare Advantage plan under Medicare Part C and/or Medicare prescription drug plan under Medicare Part D and how any liens will be identified and paid. During settlement talks, a primary plan should be sure to have the beneficiary confirm what plan they are enrolled in presently and what plans they have been enrolled in since the incident leading to the claim. Since a beneficiary may change their plan on an annual basis and if the litigation has persisted over multiple years before a settlement is reached, it is possible that there may be multiple liens present in a given case.

In very plain English, primary payers should have an internal policy as to how all Medicare liens are handled as part of any settlement. Their policy should be communicated to counsel and counsel must negotiate how the Medicare liens will be identified and paid as part of the settlement process. The parties' agreed-upon actions, to identify and resolve the Medicare liens, should then be memorialized in the settlement agreement. Taking the time on the front end to take the actions noted are likely the ounce of prevention that is worth much more than a pound of cure when double damages and litigation costs may be part of the potential end result in a case like the one brought by Mr.

Bacon.

The Dickie, McCamey & Chilcote Medicare Compliance Group is available to your organization for all aspects of MSP compliance, including establishing a compliance program for your entity or reviewing an existing program, preparing Medicare Set-Asides, obtaining CMS approval of MSAs, and resolving conditional payment issues. If you have any questions regarding the information outlined above, or any other inquiries, please feel free to contact us.

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