To: Emerging Issues in Mass Torts MDL Conference

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In re: Anatomy of a Mass Settlement

This memo gives background on claims processing issues related to product liability and consumer claims and is intended to supplement our panel discussion. We want to focus on why certain claims processing issues matter, how failure to pay attention to such issues impacts the effectiveness and efficiencies intended by the MDL process, and how MDL courts can help facilitate the settlement process.

Claims processing issues are often present in "mega" MDLs (those with over 1,000 plaintiffs) and product liability MDLs. Recent available data shows that approximately 25% of current MDLs are product liability MDLs. Also while 90% of MDLs are relatively small, over 90% of MDL plaintiffs are in 10% of the mega MDLs.

Settlement Tail

The parties and the court's involvement in an MDL do not end when a settlement is reached. In fact, our experience shows that the settlement tail can be quite lengthy, although no specific data on settlement tails is readily available.

Our collective experience reveals that work on product liability MDLs averages between 18-36 months post-execution of a settlement agreement. MDLs involving consumer claims generally have shorter settlement tails. A settlement tail can be streamlined and shortened with up-front planning of the mechanics of the settlement that account for lien issues and anticipate payment complications. Doing so allows money to move to plaintiffs[1] faster, reduces settlement-related disputes, conserves judicial resources, and reduces the parties' expenses.

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[1] Throughout this memo, the individuals whose claims are being settled are referred to as "plaintiffs" even though such individuals may not necessarily be plaintiffs involved in litigation. Mass settlements commonly cover both plaintiffs in litigation as well as claimants asserting claims outside filed lawsuits. These claimants are subsumed within the term "plaintiffs" for purposes of this memo.

Settlements Types

How a settlement is structured dictates how claims are processed. There are two main types of MDL settlements—global and inventory. The type of settlement used depends on a variety of factors, including the extent of coordination among plaintiffs' counsel, goals and strategic considerations by both plaintiffs' counsel and defendants, and the number of claims and types of injuries known to be involved in a particular litigation.

A global settlement is one in which plaintiffs' leadership reaches a settlement with a defendant that resolves all claims in a particular MDL (and possibly also state actions and unfiled claims). Examples of global settlements include the Vioxx, Pradaxa, and Guidant MDLs. Key features of a global settlement are (1) use of a settlement matrix to achieve horizontal and vertical equity (i.e., similarly situated plaintiffs are treated the same and those plaintiffs with proof of greater signature injuries are compensated accordingly) and (2) designated plaintiffs' counsel are selected to lead the settlement program.

An inventory settlement is one in which one plaintiffs' firm or a group of firms negotiates a settlement with the defendant involving only that firm's or group's case inventory. Examples of recent inventory settlements include the TVM, Avandia, and Yaz (VTE injury) litigations. With inventory settlements, terms and values of each settlement in the litigation vary, depending on the plaintiffs in a particular inventory.

Eligibility and Allocation[2]

With both global and inventory settlements, eligibility criteria are established to determine whether a plaintiff is entitled to settlement compensation. In product liability cases, most commonly plaintiffs' counsel are required to provide specified evidence, usually involving medical records, of product use and injury to meet the criteria. Often additional medical information is needed to complete the process of determining the amount of compensation available to each individual. For example, medical risk factors for the injury at issue that are independent of the defendant's product may be evaluated for purposes of determining a plaintiff's appropriate allocation from a settlement fund.

In many modern torts, a "point system" is utilized to allocate an aggregate settlement amount among eligible plaintiffs according to objective criteria. The points system begins by categorizing relevant injuries according to severity, most often with the guidance of medical experts or special masters. Base points are assigned to specific injuries, and adjustment factors for such criteria as age, weight, and health history are used as additional objective criteria impacting settlement values. In addition, a certain percentage of the settlement amount often is

[2] It is beyond the scope of our panel and this memo to address in detail ethical issues under Model Rules of Professional Responsibility 1.4 and 1.8, which can arise with allocations involving aggregate settlements—i.e., those settlements involving claims of two or more individual plaintiffs in which the resolution of the claims is interdependent. *See e.g., A Practical Approach to Proactive Client-Counseling and Avoiding Conflicts of Interest in Aggregate Settlements*, 6 Loy. J. Pub. Int. L. 19 (Fall 2004).

placed in an Extraordinary Injury Fund ("EIF") to compensate plaintiffs in unique circumstances, assuming they can provide proper evidence of same.

Special masters are routinely engaged to assist with the allocation process and/or hear appeals from plaintiffs who are unhappy with their allocation amounts. This ensures an independent review of claims.

Qualified Settlement Funds

Settlement monies are often deposited in escrow so that they are available for disbursement when settlement-eligible plaintiffs have accepted their settlement allocations and executed the required settlement documents.

A qualified settlement fund ("QSF") is a fund, account, or trust established under Treasury Regulations that effectively owns the settlement funds and is responsible for paying income taxes on fund earnings. This prevents plaintiffs for whose benefit the fund is created from taking constructive receipt of settlement monies before they are disbursed. This affords plaintiffs time to address critical settlement payment complications, such as the impact receipt of settlement monies may have on public assistance benefits and determining the appropriate form of payments (i.e., lump sum payment or periodic payments over time). It also permits defendants to receive immediate tax benefits associated with making settlement payments.

Under Treasury Regulation 1.468B-1(c), each QSF must:

1. Be created by a court or other governmental authority and be subject to continuing court supervision;
2. Resolve claims related to the subject of the lawsuit; and
3. Qualify as a trust under state law or have its assets otherwise segregated from other assets of the transferor.

By filing a joint or unopposed motion or stipulation, parties most often ask either the MDL court or a state court to create a QSF and appoint a QSF administrator to manage the funds, handle ongoing claims resolution, and work with the plaintiffs and their counsel to determine the QSF's payout structure. A QSF administrator is an independent, qualified trustee, often an accountant or a lawyer. The trustee manages the funds, handles ongoing claim resolution, and works with the parties to determine the trust's payout structure. The QSF administrator is typically paid for its services based on a pre-established agreement with plaintiffs' counsel, with funds for services coming directly from the QSF, interest earned on the QSF, or as a portion of the common benefit fund (or a combination thereof). Occasionally, QSFs also can be created by other means such as reference to a court order approving a settlement agreement that requires a QSF. And because a QSF is subject to the continuing supervision of a court, the documents creating the QSF often provide for the court's review of the process, which is flexible enough to permit the court as much supervision as is deemed appropriate and desired depending on the mechanics of a particular settlement.

Health Insurance Liens

One of the most challenging and least well understood elements of the process of settlement administration concerns health insurance lien claims. The law in this area has been evolving, and health insurance carriers have been increasingly aggressive in pursuit of such claims.

A "lien" is the legal vehicle through which a healthcare insurer that paid for treatment of the alleged injury for which settlement compensation is being paid asserts a right to be reimbursed for the cost of such treatment from a plaintiff's recovery. A healthcare insurer may be the federal or a state government that provided coverage under Medicare or Medicaid or some other program. Or the insurer may be a private insurance carrier that provided coverage. The lien may be rooted in federal law, state law, contractual agreement between a plaintiff and insurer, or a combination of these sources. A lien holder's right to be reimbursed is generally triggered when a third party is found to be responsible for an alleged injury, as demonstrated by a settlement, judgment, award, or other payment (whether or not there is a determination or admission of liability).

Sometimes the settling defendant is responsible to assure that the lien interest is identified and resolved. If it does not, then the settling defendant could be held liable to the lienholder even though it paid the plaintiff in full. But settling plaintiffs' counsel can also be held liable for failing to assure that lien interests are identified and resolved. Thus, settling plaintiffs, plaintiffs' counsel, and defendants and their insurers all have interests in ensuring proper lien resolution. Indeed, in the Medicare context there, is a risk of double damages, plus interest, if Medicare's payments are not reimbursed properly. And there is a risk of penalties being assessed at $1,000 per plaintiff per day if settlements with Medicare beneficiaries are not properly reported. *See* 42 U.S.C. §1395y. When settlements involve large numbers of plaintiffs, the risks associated with non-compliance as to settlement reporting and lien resolution are magnified exponentially.

<u>Medicare</u>

The Medicare Secondary Payer Act, enacted in 1980 and as amended in 2003, 2007, and 2013, attempts to reduce Medicare costs by requiring that Medicare be a secondary payer when a third-party payer or other "primary" insurance is available. *See* 42 U.S.C. §1395y(b). Medicare has what is frequently referred to as a "super lien." Medicare has both a subrogation right and an independent priority right of reimbursement, which allows the government to seek reimbursement from virtually everyone involved in a personal injury claim, including the beneficiary, the defendant, and the attorneys. Most importantly, Medicare is not required to notify anyone of its right to reimbursement, nor is it required to make a request for reimbursement in order to enforce its right to recovery. Instead, Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (the "MMSEA") requires that providers of liability insurance (including self-insurance), no fault insurance, and workers' compensation insurance determine the enrollment status of each claimant with whom it reaches a settlement or other award in resolution of a claim and report certain information about those claims to Medicare to ensure that Medicare's interest is protected. *See* 42 U.S.C. § 1395(y)(b)(8).

The Medicare Program is made up of four separate parts: Part A, Part B, Part C, and Part D. Medicare Parts A & B are often referred to as "federal" or "traditional" Medicare.

Medicare Part C Plans (commonly referred to as "Medicare Advantage Plans") allow Medicare beneficiaries to enroll in a private plan as an alternative to traditional Medicare. Such plans provide the same benefits as Medicare Part A and Part B and may also include prescription drug coverage. Part C plans are provided by a private insurer. These plans must offer at least the same benefits as original Medicare, but they can do so with different rules, costs and coverage restrictions. Circuit court case law from the Third and Eleventh Circuits accords Part C private providers the same rights as Medicare has under Part A and B, notably in respect to not being required to notify anyone of a right to reimbursement or to make a request for reimbursement in order to enforce a right to recovery. *See Humana Medical Plans, Inc. v. Western Heritage Ins. Co.*, Westlaw cite, (11th Cir. 2016); *In re Avandia*, 685 F.3d 353 (3d Cir. 2012).

Medicare Part D is delivered through private companies that contract with the Centers for Medicare & Medicaid Services ("CMS") to provide prescription drug benefits.

<u>Medicaid</u>

Medicaid is a government-sponsored health insurance program providing coverage to qualifying low-income individuals, including parents, children, and the disabled. 42 U.S. C. §§ 1396(a), (k). The program is funded by federal and state governments but administered by individual state agencies. States have some discretion to determine Medicaid eligibility criteria, so Medicaid beneficiary demographics can vary significantly from state to state. There are currently 52 Medicaid agencies administering 52 separate Medicaid lien recovery programs. Resolution of Medicaid liens is required by state and federal law and individual settlement agreements.

<u>Other Governmental Providers</u>

The lien rights of military and other federal government entities providing health insurance coverage to member plaintiffs generally stem from the Federal Medical Care Recovery Act ("FMCRA"). *See* 42 U.S.C. §§ 2651-2653. These federal entities are typically granted an independent right of recovery against a third party responsible for a member's medical care along with a right of subrogation, assignment, and ability to intervene or join the plan member plaintiff's claim. Such providers include the U.S. Department of Veterans Affairs ("VA"), TRICARE, and Indian Health Service ("IHS").

<u>Private Health Insurance</u>

Private health insurance is primarily provided by employers and individual policies purchased on the market. The associated lien and subrogation rights are a matter of contract, state law, federal law (including the Employment Retirement Income Security Act ("ERISA")), judicial decisions, and other considerations such as whether a private health plan is fully self-insured. Private insurers have become increasingly aggressive in asserting claims and pursuing lien recoveries in mass tort settlement programs. As a result, the process for resolving these lien interests has evolved significantly.

Healthcare Lien Resolution

Resolving healthcare insurance liens follows a similar path, although specifics within the path are dictated by the type of lien at issue. In general, the first step toward lien resolution is having a plaintiff submit data concerning his or her healthcare plans and medical treatment to identify possible liens. The second step is verification of entitlement ("VOE"), wherein it is determined whether a plaintiff received healthcare benefits from a particular plan during the relevant time period. If so, then that plaintiff's claims and medical records are reviewed to ensure that the plaintiff repays the lienholder only for expenses actually paid by the lienholder and directly related to the alleged injury for which settlement compensation is being paid. After that, the final lien amount is determined using various strategies, depending on the type of lien at issue.

The traditional process resolving Medicare's in an ordinary physical injury case requires requesting, reviewing, auditing, and disputing itemized claims. It is a tedious, extremely time consuming, and often inconsistent process that involves requesting and obtaining Medicare's conditional payments for injury-related care for each identified Medicare beneficiary and then auditing and finalizing each claim with Medicare and/or its recovery contractor. There may be additional steps necessary such as disputing unrelated charges and pursuing administrative remedies like compromises, waivers, and/or appeals. These additional steps can take two or more years in some cases.

Global (aggregate) resolution is an alternate method for resolving Medicare liens in mass tort settlements. In large settlements, the parties often engage and request that the court appoint a lien resolution administrator ("LRA") to develop global and other innovative resolution strategies designed to achieve fair reimbursement amounts while avoiding the time delays associated with resolving thousands of claims on a traditional case-by-case basis. To enable communication between the LRA and Medicare (and also with other lienholders), the court overseeing a settlement will usually be asked to issue an order authorizing the disclosure and exchange of settling plaintiffs' protected health information ("PHI").[3]

Using global modeling, the LRA can analyze routine costs associated with the medically accepted standard of care for the treatment and management of each specified injury category, while also taking into account other factors, including the timing when a plaintiff became entitled to Medicare vis-à-vis his or her date(s) of injury and treatment. Based on these considerations, the LRA then works directly with CMS to establish Global Reimbursement Values for specified injury categories related to a particular MDL. Depending on the specified injury categories, global resolution is not always appropriate because there may not be a readily

[3] Such an order is sometimes referred to as a Qualified Protective Order ("QPO"), which can be confusing because it is different than the standard QPOs a court may order under HIPAA that prohibits the parties from using or disclosing PHI for any purpose other than the litigation or proceeding for which such information was requested and requires the return to the covered entity or the distribution of the PHI at the end of the litigation proceeding. *See* 45 C.F.R. § 164.512(e)(1)(v).

determinable common course of treatment associated with the injury (i.e., Medicare's payments might vary considerably for each plaintiff with that injury). In such instances, if an alternative arrangement cannot be reached with CMS, Medicare's interests must be resolved through the traditional process described above.

There are different procedures to follow for Tricare and the VA, but generally, the LRA can establish the procedures and protocols to establish which plaintiffs are also beneficiaries under the Tricare or VA health insurance paradigms. For those plaintiffs who are affirmatively verified as being such beneficiaries, the LRA engages in an audit to determine injury-relatedness, and then reaches agreement on final lien values for reimbursement. An LRA follows a similar process for IHS liens.

Because there are 52 separate state Medicaid lien recovery programs, resolving Medicaid liens in mass tort settlements is a complicated process. To combat the complexity and streamline the resolution process, an LRA can construct a settlement-specific set of proposed procedure and protocol agreements to achieve an effective, equitable resolution of all parties' interests. As part of this process, the LRA can request that individual agencies agree to an established lien cap and apply an injury related-expenditure offset to lien amounts. Additionally, an LRA audits each asserted Medicaid lien to ensure claim validity and appropriateness as part of an expenditure-based analysis.

Resolving private liens in mass litigations, including Medicare Part C liens, presents additional difficulties because, unlike federal Medicare and state Medicaid programs, there is no centralized repository of data through which an LRA can affirmatively identify whether each plaintiff is entitled to benefits pursuant to one of the thousands of potential private health plans. However, many private insurers hire private entities known as recovery contractors to manage their lien recovery claims. Given this, parties are using—or settlements are requiring the use of—a Private Lien Resolution Program ("PLRP"). PRLPs established for recent settlement programs have captured as many as 75%-80% of the private plans in the marketplace, which when combined with plaintiff self-identification, helps ensure proper identification of the plans who are the most aggressive about asserting their recovery rights. To establish a PLRP, an LRA negotiates with recovery contractors and health plans to construct a uniform verification and resolution process that untangles the historic complexities associated with private lien interests and ensures best outcomes for plaintiffs.

Plans are not required to participate in any PLRP and may choose to decline participation. Plaintiffs may also decline to participate in a PLRP. For those private insurers and plaintiffs, an LRA may be engaged to resolve the relative private interests associated with their claims through a traditional resolution process.

Non-Healthcare Liens

Entities may also assert non-healthcare-related liens against a settlement, and settlement agreements may reference the resolution of such liens. Examples include child or spousal support liens and attorney liens relating to dual representation.

How big an impact such third-party liens have on a settlement tail depends on the relevant settlement language, the parties' procedures for dealing with such liens, whether the settlement is high-profile, and the type of settlement (global or inventory).

Common Benefit Funds

Members of a Plaintiffs' Steering Committee ("PSC") provide necessary services that consume time and costs, such as consolidating discovery materials and litigating bellwether cases before the MDL court, but they are not compensated for these services in the same way as defense counsel. Over the years, courts and plaintiffs' counsel have employed various methods to ensure that the PSC and its subcommittees are compensated for both services rendered and for the risk of carrying through with the litigation. *See* Judge Eldon E. Fallon, *Common Benefit Fees in Multidistrict Litigation*, 74 La. L. Rev. 371 (2014).

Since the work that the PSC performs inures to the common benefit of all plaintiffs and their primary counsel, MDL courts often establish a procedure at the beginning of an MDL to create a "common benefit fee" on each individual settlement award to compensate the members of the PSC and the members of any subcommittees who have done common benefit work. *Id*. These orders typically outline what funds should be collected, where such funds shall be held, and how hours and expenses should be recorded and tracked. *Id*. Plaintiffs who have not brought actions in federal court may challenge the MDL court's jurisdiction to impose an assessment against their recoveries on the grounds that the MDL court lacks jurisdiction to do so. *See, e.g. In re Genetically Modified Rice Litig.*, 764 F.3d 864, 873 (8th Cir. 2014). Although beyond the scope of this memo, MDL courts have used a variety of approaches both to anticipate such challenges in the common benefit fund orders that are adopted and in the methods by which challenges are addressed.

Separate from providing the method by which a common benefit fund is created, the MDL court must also formulate a methodology for establishing the total amount of the common benefit fund and procedures for determining how the fund should be disbursed. *See e.g., In re Vioxx Products Liability Litigation*, 574 F. Supp. 2d 606, 614 (E.D. La. 2008). The total amount of the common benefit fund should be reasonable under the circumstances, and the method for distributing it should be fair, transparent and based on accurately recorded data. *Id*.

Because the common benefit fund is funded from plaintiffs' proceeds, issues related to the common benefit fund must be resolved prior to the disbursement of plaintiff awards. With global settlements, the timing of such decisions is relatively straightforward, and a portion of common benefit fund is usually reserved to pay for the PSC's time post-settlement. Although inventory settlements also can be as straightforward as global settlements with respect to the common benefit fund, issues can arise when certain case inventories are settled slowly over a long period of time or at relatively low values.

Payment Complications Involving Probate and Bankruptcy

Because the settlement tail can be long, plaintiffs may die after executing settlement documents but before payment is made.[4] Or, based on certain circumstances, a plaintiff may not have anyone to receive settlement monies in a fiduciary capacity on the plaintiff's behalf. Depending on the type of injury involved in a particular litigation, this representative capacity payment complication can occur with more frequency in some litigations than in others. How these plaintiffs' settlements are dealt with can significantly delay the resolution and payment of a settlement.

Plaintiffs' counsel traditionally deal with such cases by complying with local probate law and working a case through the probate system to find the appropriate person to whom payment can be made. In certain cases, parties and courts have worked together to find ways to expedite this process such as using small estate procedures as was used in the BP oil spill medical benefit class action settlement. In those cases, the MDL courts establish procedures to address the necessary steps to ensure proper representative capacity exists and that state distribution laws are followed.

If a plaintiff has filed bankruptcy prior to the disbursement of settlement proceeds, that bankruptcy action will also impact how settlement proceeds are distributed, depending on when the injury occurred as compared to the date of the bankruptcy petition, what type of bankruptcy petition was filed, and whether the litigation was made part of the bankruptcy petition. With these bankruptcy payment complications, the question is not whether there exists anyone to manage a plaintiff's claim, but instead, whether the plaintiff is in fact the real party in interest. The intersection of the federal bankruptcy code with settlements causes a different level of payment complexities. In some cases, depending on the type of bankruptcy filed by the plaintiff-debtor, a bankruptcy trustee may require review and execution of the settlement documents, and in other cases, gross settlement proceeds (including common benefit fees) may need to be distributed to the bankruptcy trustee for further distribution to creditors, the debtor, and return of those common benefit fee funds after proper disclosure to, and review by, the federal bankruptcy court.

[4] This situation is different than a wrongful death claim.