# 3M MASS TORT SETTLEMENT REMINDS US THAT SUBROGATION MATTERS

Written By Ron E. Peck

On Thursday, June 22, 3M followed other companies' example by announcing that it had reached an agreement to settle claims that their polyfluoroalkyl and perfluoroalkyl substances (PFAS), known as "forever chemicals," had contaminated water supplies in the United States.

Specifically, the settlement will see 3M pay up to $10.3 billion over 13 years to municipalities in the U.S. that have detected these chemicals in their drinking water.  This is only the most recent in a series of settlements regarding water contamination by PFAS producers, who also announced that they would pay over $1 billion to settle similar lawsuits; with this likely heralding a new series of litigation and settlements, akin to the well-known asbestos proceedings.

Many are familiar with the recent advent of PFAS testing conducted by municipal water authorities, and the resultant identification of unacceptable PFAS levels in drinking water. This in turn led to various lengthy and costly remediation procedures, to remove the offending chemicals from public drinking water.

The aforementioned settlement is primarily meant to address abatement claims, compensating municipalities for damage suffered to property and costs incurred in said remediation projects.

As entities funding and/or servicing self-funded health benefit plans, the importance and relevance of this news to our industry cannot be overstated. That is because these settlements are not focused on potential illness caused by exposure to and consumption of PFAS chemicals, nor do they resolve what promises to be a substantial number of medical claims.

The lawsuits and settlements we are witnessing now are more likely than not just the tip of the iceberg. That is why it is so important for health benefit plans to act now and assert their and their participants' rights – at the beginning of what promises to be a long process.

Furthermore, this type of lawsuit – and opportunity – is not unique. Class actions, and the lesser-known toxic tort and mass tort cases, represent substantial chances for health benefit plans to recoup funds they had previously paid – sometimes years prior – through specialized subrogation.

As a refresher, whenever a third party causes – or potentially causes – an illness or injury to a participant of a health benefit plan, and that plan pays to treat those illnesses or injuries, subrogation enables the aforementioned benefit plan to either "step into the shoes" of the injured participant – and pursue a claim against the liable third party – or, seek to recoup what the plan paid from the plan participant; (after that participant has recovered from a liable third party funds that are meant to pay for illness or injuries that are deemed to be the liable third party's responsibility, but were already paid by the plan).

Subrogation is a legal concept grounded in fairness. It is one of those few rights, supported by both statute and equity, that has repeatedly withstood judicial review at every level.

The reason why subrogation is so durable is because society recognizes the justice inherent in ensuring parties pay for the damages they cause; guaranteeing that victims and their health benefit plans are not left paying for damages caused by someone else.

The most common and recognizable "type" of subrogation case usually involves one victim, one liable party, and one incident. These often take the form of a car accident, slip and fall at a place of business, or injury at one's place of employment… resulting in subrogation against automobile insurance carriers, businesses, and workers' compensation.

There exist other types of subrogation cases which, despite being far less common, represent a massive opportunity for health benefit plans and their participants to recoup substantial funds. These cases are often called class action, toxic tort, or mass tort cases, and they occur when a substantial entity – such as 3M – is deemed to be responsible (or avoids liability through settlement) for injuries or illnesses caused to a large population over a meaningful period.

These lawsuits usually occur in Federal Court, following consolidation into multi-district litigation ("MDL") by the judicial panel on multidistrict litigation ("JPML"). As a result, there are many plaintiffs involved, at least one – but sometimes more than one – sizeable defendant organization, and a lot of money at stake.

Identifying such subrogation opportunities is no easy feat. Unlike a motor vehicle accident – where the accident, injury, and treatment all occur within days (if not hours) of each other – with mass torts, exposure to the hazard, development of the illness or injury, identification of the link between the two, and filing of the case can take years or even decades to unfold.

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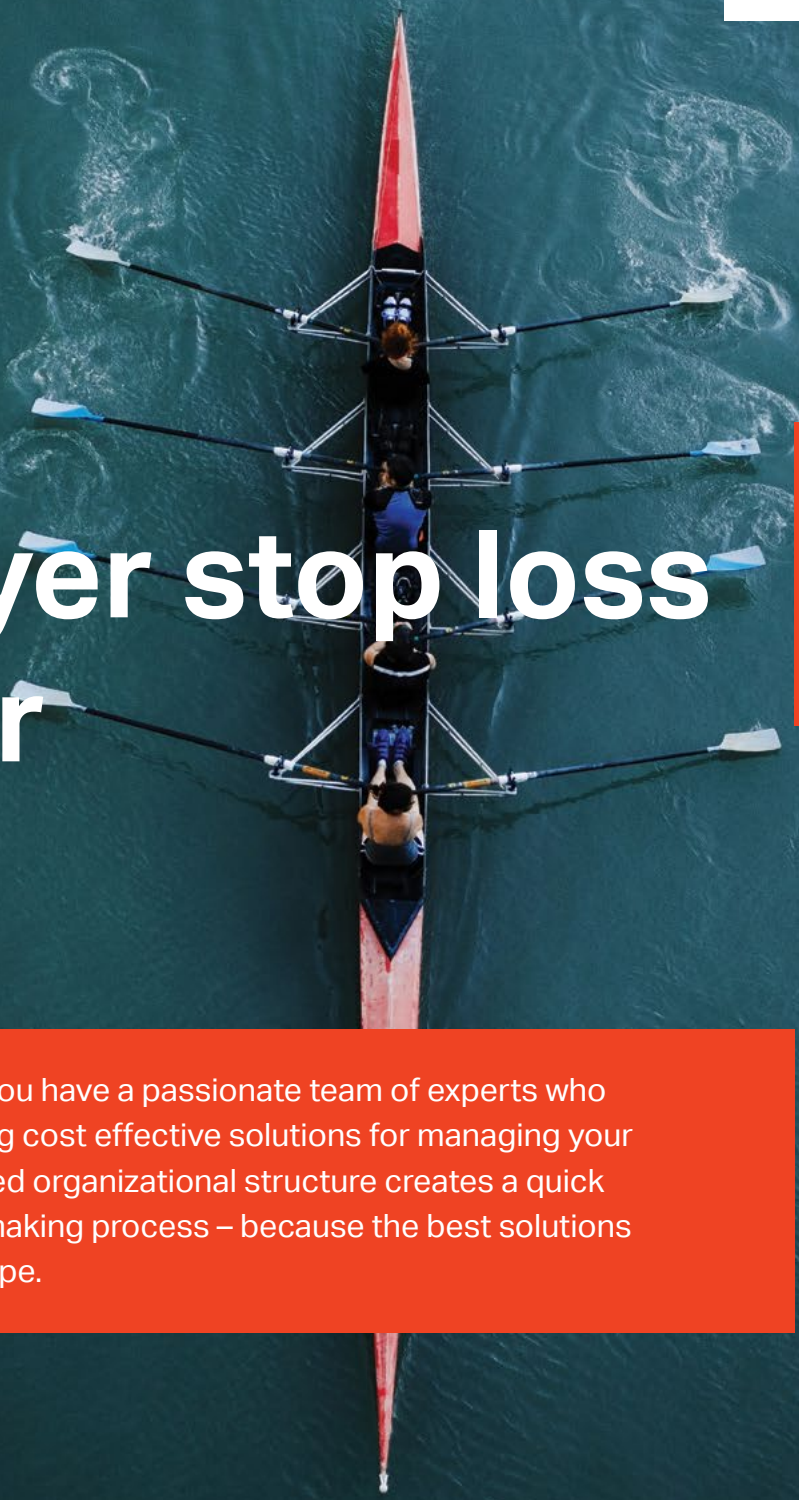

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That means plans and their service providers must remain aware of developing cases, know which conditions are deemed to be caused by the accused tortfeasors, and exercise a capacity to audit old claims to flag treatments that are indicative of said conditions, before investigating whether the affected participants encountered the accused tortfeasors' substance or device in question.

Is it worth the effort? Absolutely. Setting aside the tremendous plan funds at stake, consider also every plan administrator's fiduciary duty to prudently manage plan assets and enforce the terms of the plan. As such, it is arguably every plan administrator's duty to investigate and pursue such cases.

Admittedly, it requires more sophistication than most plan sponsors and even third-party administrators may possess; but fortunately, fiduciaries can satisfy their duty by utilizing agents acting on their behalf.

## HOW MUCH IS AT STAKE, AND WHAT DO THESE CASES LOOK LIKE?

In June of 2012, the FDA announced a voluntary recall of Stryker Orthopedics' Rejuvenate Modular-Neck and ABG II Modular-Neck Hip Stems. Litigation ensued, and a subsequent settlement followed. In total, the proceedings only addressed an estimated 20% of the failed devices, meaning an estimated 80% of the episodes were not addressed.

This is particularly worrisome, given that just the revision surgeries associated with the removal of the recalled devices cost health plans approximately $45,000.00 per procedure.

Similarly, another case involved the Exactech knee replacement systems. Like Stryker, Exactech launched a recall in February of 2022 of more than 140,000 Optetrak, Optetrak Logic and Truliant knee replacement systems, after it discovered a defect in its packaging that exposed a polyethylene insert component to oxygen.

A lawsuit was filed, with 27 complaints pending in 11 different federal district courts – as well as a motion to centralize the cases. Again, this represents only a fraction of the estimated patients and health plans that expended money to pay for procedures that should be funded by Exactech. Likewise, in 2002, a study suggested that the long-term use of Wyeth Pharmaceuticals' Prempro (a hormone therapy drug used to treat menopausal symptoms) significantly increased the likelihood of developing breast cancer.

After several years of litigation, a settlement was reached to pay patients who developed hormone-receptor positive breast cancer[1], however, only about 10,000 individuals[2] (a mere 5% of the estimated 200,000 women who developed this type of breast cancer), ever asserted a claim.

The average cost in these instances is estimated to be $50,000,[3] meaning that the unrecovered medical expenses associated with treating breast cancers caused by Prempro and similar drugs – payments made by health plans – are estimated to exceed $9.5 billion. These, along with other examples – such as the Chantix recall, Paragard IUDs lawsuits, and Elmiron MDL – represent billions of dollars spent by health plans, and only a fraction in reimbursement being paid back.

Finally, many readers are likely familiar with the recent lawsuits involving RoundUp. In 2015 the World Health Organization's (WHO) International Agency for Research on Cancer classified glyphosate – a key component of RoundUp – as a probable cancer-causing agent.

Additional research over the years subsequently suggested that RoundUp exposure increases the risk of developing Non-Hodgkin's Lymphoma and other cancers. As with the other examples of mass tort described herein, here too the matter became an MDL, instituted by the Federal Courts.

Some claims have settled, whilst many others remain open. Specifically, as of December


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2022, Bayer reached an agreement to settle about 100,000 cases, with $10.9 billion being paid out.

These are just a few examples of mass tort cases. Looking again at the recent claims involving PFAS, chemical seepage into drinking water may not be the only target for mass tort consideration. PFAS that is present in household items may soon also become a subject of litigation, including items which may more easily introduce potentially harmful substances into human bodies – such as feminine hygiene products and baby wipes.

Likewise, extensive use of PFAS chemicals by airports, firefighters, and all divisions of the military, promises to result in more claims and more damages arising from this issue. The amount of potential recovery health benefit plans could be pursuing are substantial and meaningful.

These assets, once returned to the plan, could be used to fund other claims and simultaneously prevent contribution, co-pay, and deductible increases. It therefore behooves all self-funded plans, administrators, and fiduciaries to investigate what their plans are doing to identify and manage these types of claims.

How does this impact self-funded health benefit plans, and the entities that service them?

Great question. In a word: money.

These types of cases almost always impact numerous participants, and result in a lot of funds changing hands. Self-funded benefit plans almost certainly have spent substantial amounts of plan assets on treatments about which these cases relate.

Every plan administrator has a fiduciary duty to identify opportunities to recoup such funds for their plan. The question, then, is how to do it.

With traditional subrogation and third-party liability work, the process is fairly straightforward. You monitor claims as they come in, and flag those that – based on a diagnosis code – tend to relate to an accident or injury which, more often than not, entails third party liability.

In other words, if claims arrive for a broken bone, an ambulance, whip lash, facial injuries, and other similar trauma codes – all within the same 24 to 48 hour period – it's a safe bet that these injuries all relate to one accident for which a third party may be responsible. With mass tort claims, however, it's much less straightforward.

In 2015, a plan member may have incurred $200,000 in claims for the treatment of Non-Hodgkin's Lymphoma. In 2015, there was no reason to think these claims relate in any way to third party liability.

Then, in 2020, someone proves that the use of a chemical herbicide causes Non-Hodgkin's Lymphoma.

Then, in 2022, a lawsuit is filed against the producer of said herbicide. To maximize this opportunity, self-funded plans must themselves – or with a partner – monitor instances like this, where some substance or product is tied to an illness or injury.

When instances like this arise, the plan – or their partners – must then identify the illness or injury caused by the substance or product and audit their historical claims to identify if and when participants treated for (and the plan paid for) such illness or injury.

Then, they must communicate with the impacted participant, or their family, to identify if that patient came in contact with the substance or product in question.

Then (phew) the plan or the plan's partner must work with the attorney's managing the mass tort case, to assert the plan – and if at the patient's behest, the patient's – rights. It's not easy, but with the right process and partners in place, it is more than worth it. ■

*Sources:*

*[1] Feeley, Jef, Pfizer Paid $896 Million in Prempro Settlement, Bloomberg Business, June 19, 2012*

*[2] Id.*

*[3] See e.g. Campbell, J.D. and Ramsey, S.D. The Costs of Treating Breast Cancer in the US: a Synthesis of Published*

*Evidence, Pharmacoeconomics 2009 27(3): 199-209. ("The estimates of lifetime per-patient costs of breast cancer ranged from $US20 000 to $US100 000.")*