Where Are We with Medicare, Medicaid, and Lien Resolution

Paul K. Isaac, Esq.
Precision Lien Resolution
Buffalo

I. MANAGING MEDICARE CONDITIONAL PAYMENTS (MEDICARE "LIENS")

A. AN OVERVIEW OF MEDICARE

- Medicare is a federally funded health insurance program for qualified individuals 65 and older, or for certain individuals who have received Social Security Disability benefits for 24 months. It is also available for individuals who have been diagnosed with end-stage renal disease or Lou Gehrig's disease (ALS).

- Under the Medicare Secondary Payer (MSP) Act, Medicare is a secondary payer when payment has been made or can reasonably be expected to be made by a "Primary Plan." A primary plan is a worker's compensation law or policy, liability insurance (including self-insureds), and no-fault insurance. 42 U.S.C. §1395y(b)(2)(A).

- Liability insurance, including self-insured entities, means "insurance that provides payment based on legal liability for injury or illness or damage to property. It includes, but is not limited to, automobile liability insurance, ***uninsured motorist insurance, underinsured motorist insurance***, homeowner's liability insurance, malpractice insurance, product liability insurance, and general casualty insurance." 42 CFR §411.50(b).

- If a Primary plan has not, or cannot be reasonably expected to make payment promptly, Medicare may make a "conditional payment" on behalf of the primary plan. 42 USC §1395y(b)(2)(B)(i).

- Conditional payments are conditioned upon reimbursement from the primary plan, or an entity that receives payment from a primary plan (e.g., a beneficiary or attorney), if the primary plan has or had a responsibility to pay for those same items and services. Responsibility for payment is demonstrated by "a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment [for Medicare-covered items or services], or by other means," i.e., a settlement. 42 U.S.C. §1395y(b)(2)(B)(ii).

- If reimbursement of the conditional payments is not made, the MSP creates a cause of action against a primary plan or an entity which has received payment from a primary plan, for double damages, i.e., double the amount owed. 42 U.S.C. § 1395y(b)(2)(B)(iii).

- There is also a "private cause of action" for double damages if repayment is not made. 42 USC §1395y(b)(3)(A).

- Insurance companies have an obligation to report to Medicare certain events and information pursuant to Section 111 of Medicare Medicaid SCHIP Extension Act (MMSEA), known as Mandatory Insurer Reporting (MIR or Section 111). No-Fault and Worker's Compensation companies must report to Medicare when they have taken on the responsibility to pay for medicals, known as Ongoing Responsibility for Medicals (ORM), and when that obligation ends, either because a policy limit has exhausted, no further accident-related treatment is required, or because of a worker's compensation settlement that releases medicals. Liability insurance companies must likewise report when a settlement has occurred, called Total Payment Obligation to the Claimant (TPOC).

B. MEDICARE LIEN RESPONSIBILITIES

- Medicare is authorized to seek recovery directly against the primary plan (insurer or self-insured), or against the entity receiving the primary payment, "including a beneficiary, provider, supplier, physician, attorney, State agency or private insurer that has received a primary payment." 42 CFR §411.24(g).

- The following cases demonstrate exposure for both sides relative to reimbursement of Medicare conditional payments: *Merrifield v. United States*, 2008 U.S. Dist. LEXIS 25877 (D. N.J. Mar. 31, 2008) (exposure to plaintiff); *United States v. Harris*, 2009 U.S. Dist. LEXIS 23956 (N.D. W. Va. 2009) (exposure to plaintiff's counsel); and *U.S. v. Stricker*, 524 Fed. Appx. 500 (11th Cir. Ala. 2013) (exposure to insurers).

- Once a Final Demand is issued, the Medicare beneficiary has 60 days from the date the Demand letter was issued, including the date of issue, to repay Medicare before interest begins to accrue. 42 CFR 411.24(h).

- Interest continues to accrue during any appeal or challenge after the Demand is issued. There is no tolling of interest for challenges to the conditional payment amount.

- If the Medicare debt is not resolved within 120 days from the date of the Demand, the debt is referred to the United States Department of Treasury for collection or offset of the beneficiary's other Social Security Benefits. Prior to CMS referring the debt to the Treasury, an "Intent to Refer" letters will be issued to the beneficiary and authorized representatives.

- Section 111 Mandatory Insurer Reporting is the only affirmative obligation imposed upon insurance companies in the MSP Act. Although it holds insurance companies responsible to reimburse Medicare, it holds Medicare beneficiary plaintiffs and their attorneys equally responsible.

- However, it is incumbent upon the Medicare beneficiary plaintiff and his or her attorney to be in control of the Medicare reimbursement process. This means being in contact with the Medicare contractor, the Benefits Coordination and Recovery Center (BCRC), and obtaining accurate conditional payment information.

- The BCRC will only communicate with the Medicare beneficiary and those that the beneficiary specifically authorizes. It is therefore incumbent upon the attorney to keep track of the conditional payments, ensure their accuracy, and make sure Medicare is paid on time.

C. MANAGING THE BCRC CONDITIONAL PAYMENT FILE

(From www.cms.gov):

The BCRC:

- Is responsible for the collection and maintenance of the MSP information in CMS' systems.

- Develops and researches MSP occurrences, as appropriate. (Sources include: Identification of a pending NGHP claim by a beneficiary or his or her attorney or other representative, by an insurer or other entity, through claims processing information, through the Initial Enrollment Questionnaire [IEQ] completed by new beneficiaries, etc. Identification may also occur through MMSEA Section 111 reporting.)

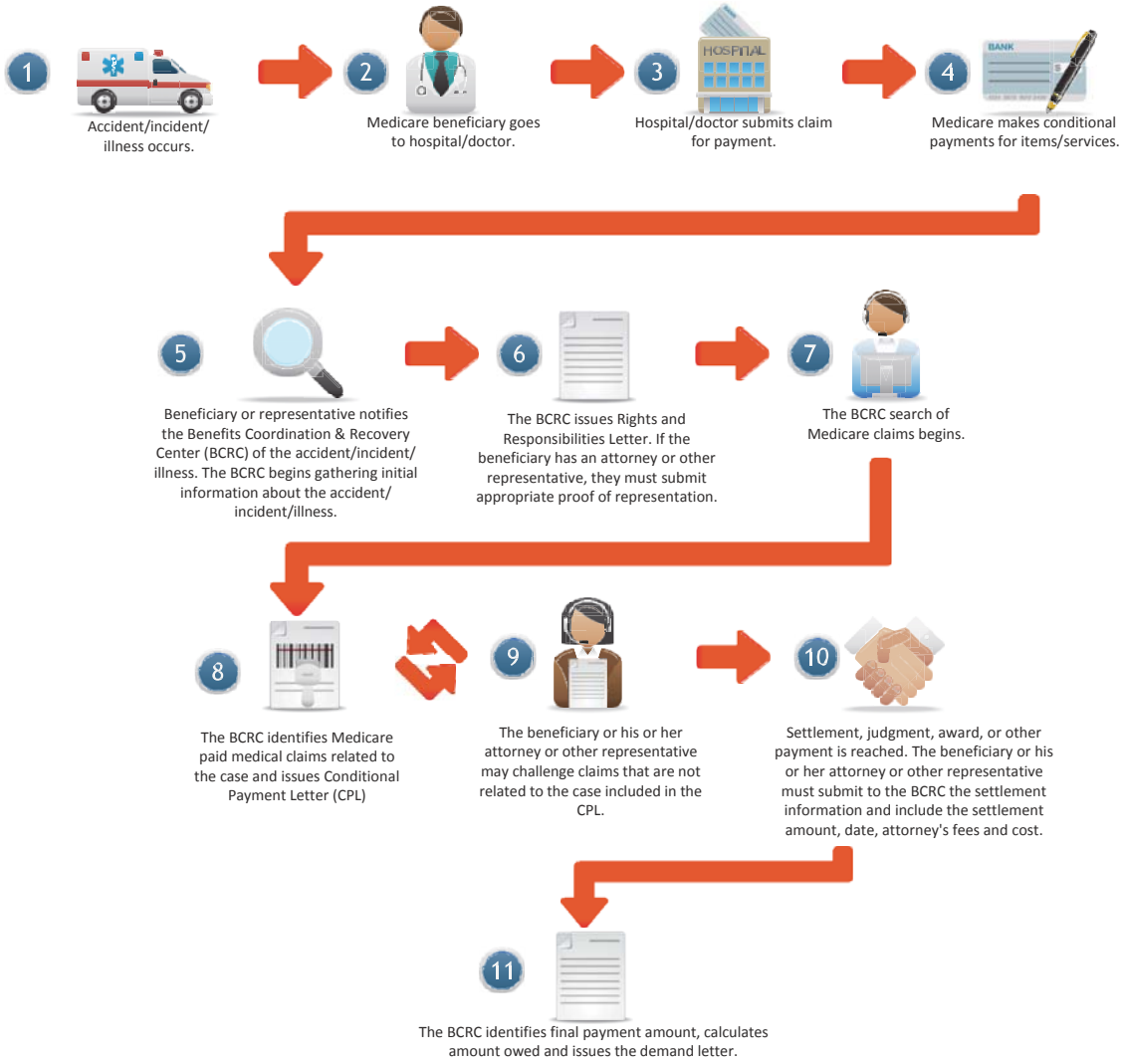
- Updates data in CMS' systems regarding MSP occurrences (terminations, changes in effective dates, address changes, etc).

- Contacting the BCRC is always the first step for interacting with Medicare if you have a pending liability claim.

- **Phone**: 1-855-798-2627

- **Fax**: 1-405-869-3309

- **Address**: NGHP, P.O. Box 138832, Oklahoma City, OK 73113



Overview of the Beneficiary NGHP Recovery Process

Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Workers' Compensation Cases

10.01.2015

COB&R Coordination of Benefits and Recovery

NGHP Correspondence Cover Sheet

Beneficiary's Name _____

HIC#: _____

Date of Incident: _____

Case ID#:_____*(can be found on Rights and Responsibilities letter)*

This cover sheet is for your use when mailing or faxing in correspondence to the Benefits Coordination & Recovery Center (BCRC). Please retain a COPY of this cover sheet for any future correspondence. The information above will ensure accuracy when handling your case documentation.

Please indicate the type of correspondence you are submitting to the BCRC to facilitate routing. Check all that apply:

- ☐ Check
- ☐ Settlement information
- ☐ Retainer agreement or other authorization documentation
- ☐ Other _____

Note: A Conditional Payment Letter is sent automatically, as soon as the information is available. Separate requests for initial Conditional Payment Amounts will not make Conditional Payment information available sooner.

In order to accurately associate claims to your case, please include a description of the injury. (i.e.: Knee, Physical Therapy, Slip and Fall, Lumbar Injury...)

_____

_____

_____

_____

Submit correspondence to the BCRC address listed below:

Liability Insurance, No-Fault Insurance, Workers' Compensation:

NGHP
PO Box 138832
Oklahoma City, OK 73113

Proof of Representation
Liability Insurance (Including Self-Insurance), No-Fault Insurance, or Workers' Compensation

Where to find Information on "Proof of Representation" vs. "Consent to Release"

Please refer to the PowerPoint document on this website titled: "Rules and Model Language for 'Proof of Representation' vs. 'Consent to Release' for Medicare Secondary Payer Liability Insurance (Including Self-Insurance), No-Fault Insurance, or Workers' Compensation" for detailed information on:

- **When to use a "proof of representation" document vs. a "consent to release" document,**
- Appropriate content for both documents,
- Use of attorney retainer agreements as proof of representation if certain criteria are met,
- The need for appropriate documentation when there are two layers of representatives involved (examples: attorney 1 refers a case to attorney 2; the beneficiary's guardian hires an attorney to pursue a liability insurance claim) or when a beneficiary's representative signs a "consent to release" document on the beneficiary's behalf,
- What liability insurers (including self-insurers), no-fault insurers, and workers' compensation entities must have in order to obtain conditional payment information, and
- Use of agents by insurers' or workers' compensation.

General

Proof of representation is required in order for the Benefits Coordination & Recovery Center (BCRC) to communicate with and provide information to a Medicare beneficiary's representative. Once the BCRC has the appropriate documentation, it can communicate with the representative and act upon requests made by the representative on behalf of the beneficiary. This includes furnishing conditional payment information and/or a recovery demand letter as well as addressing questions regarding the specific claims included in the conditional payment information, appeal requests or waiver of recovery requests.

Model Language

See attached. Use of the model language is not required, but any documentation submitted as a "Proof of Representation" document must include the information the model language requests.

Where to Submit Proof of Representation:

Liability Insurance, No-Fault Insurance, Workers' Compensation:
NGHP
PO Box 138832
Oklahoma City, OK 73113
Fax: (405) 869-3309

PROOF OF REPRESENTATION

The language below should be used when you, the Medicare beneficiary, want to inform the Centers for Medicare & Medicaid Services (CMS) that you have given another individual the authority to represent you and act on your behalf with respect to your claim for liability insurance, no-fault insurance, or workers' compensation, including releasing identifiable health information or resolving any potential recovery claim that Medicare may have if there is a settlement, judgment, award, or other payment. You are not required to use this model language, but proof of representation must include the information provided in this model language. Your representative must also sign that he/she has agreed to represent you. This model language also makes provisions for the information your representative must provide.

Type of Medicare Beneficiary Representative (Check one below and then print the requested information):

( ) Individual other than an Attorney:
( ) Attorney*
( ) Guardian*
( ) Conservator*
( ) Power of Attorney*

Name: _____
Relationship to the Medicare Beneficiary: _____
Firm or Company Name: _____
Address: _____
_____
_____
Telephone: _____

* Note -- If you have an attorney, your attorney may be able to use his/her retainer agreement instead of this language. (If the beneficiary is incapacitated, his/her guardian, conservator, power of attorney etc. will need to submit documentation other than this model language.) Please visit http://go.cms.gov/cobro for further instructions.

Medicare Beneficiary Information and Signature/Date:

Beneficiary's Name (please print exactly as shown on your Medicare card):

Beneficiary's Health Insurance Claim Number (number on your Medicare card):

Date of Illness/Injury for which the beneficiary has filed a liability insurance, no-fault insurance or workers' compensation claim: _____

Beneficiary Signature:_____ Date signed: _____

Representative Signature/Date:

Representative's Signature:_____ Date signed: _____

[Print Date]

Insert name
Insert address 1
Insert address 2
Insert city, state, zip code

SUBJECT: Medicare Secondary Payer Rights and Responsibilities Letter for:
Beneficiary Name:
Medicare Number:
Case Identification Number:
Insurer Claim Number:
Insurer Policy Number:
Date of Incident:

Dear [Addressee Name]

You are receiving this letter because we were notified that you filed a liability insurance (including self-insurance), no-fault insurance, or workers' compensation claim. This is confirmation that a Medicare Secondary Payer (MSP) recovery case has been established in our system.

If we know that you have a lawyer or other person representing you, we have sent him or her a courtesy copy of this letter and you will see him or her listed as a "cc" at the end of this letter.

This letter gives you information on the following:

1. What happens when you have Medicare and file an insurance or workers' compensation claim;
2. What information we need from you;
3. What information you can expect from us and when;
4. How and when you are able to elect a simple, fixed percentage option for repayment; and,
5. How to contact us.

What Happens When You Have Medicare and You file a Liability Insurance (including Self-Insurance), No-Fault Insurance, or Workers' Compensation Claim

Applicable Medicare law says that liability insurance (including self-insurance), no-fault insurance, and workers' compensation must pay for medical items and services before Medicare pays. This law can be found at 42 U.S.C. Section 1395y(b)(2)(A) and (B).

However, Medicare makes "conditional payments" while your insurance or workers' compensation claim is being processed to make sure you get the medical services you need when you need them. If you get a(n) insurance or workers' compensation settlement, judgment, award, or other payment, Medicare is entitled to be repaid for the items and services it paid for conditionally.

If you receive a settlement, judgment, award, or other payment related to this claim and Medicare determines that it has made conditional payments that must be repaid, you will get a demand letter. The demand letter explains how Medicare calculated the amount it needs to be repaid and it also explains your appeal and waiver rights. *If you decide to appeal or request a waiver of recovery, Medicare will not take any collection action while your appeal or waiver of recovery request is being processed.*

What Information We Need From You

- ***Do you have a lawyer or other person representing you?***

  Medicare works to protect your privacy. We are not allowed to communicate with anyone other than you about your MSP case unless you tell us to do so. If you have a lawyer or other person representing you, please see the enclosed brochure. It explains what type of information we need from you in order to work directly with your lawyer or representative.

- ***Is the information we have on your claim correct?***

  If the information at the top of this letter is incorrect or if you filed a no-fault insurance or workers' compensation claim and do not see the insurer/carrier listed as a "cc" at the end of this letter, please contact the Benefits Coordination & Recovery Center (BCRC) immediately at 1-855-798-2627 (TTY/TDD for the hearing or speech impaired: 1-855-797-2627)..

- ***Has your insurance or workers' compensation claim already been resolved?***

  If you already got a settlement, judgment, award, or other payment, we need the following information:

  - The date and total amount of your settlement, judgment, award, or other payment.
  - A list of the attorney fees and other costs that you had to pay in order to get your settlement, judgment, award, or other payment.

  If your insurance or workers' compensation claim was dismissed or otherwise closed, we need documentation of that so that we are able to close your MSP case.

What Information Can You Expect From Us and When

- ***Medicare's Conditional Payment Amount***

  Our system will automatically send you a Conditional Payment Letter within 65 days of the date on this letter. It includes a Payment Summary Form, which lists medical items and services Medicare has paid for that we believe are related to your claim. Keep in mind that this list is not final or complete until your insurance or workers' compensation claim is resolved.

  If you would like the most up-to-date claims information, please visit www.MyMedicare.gov. Once your letter is issued, you will be able to access conditional payment amount information through the MyMSP tab, as well as current claims information using the MyMedicare.gov "blue button."

How to Elect a Simple, Fixed Percentage Option For Repayment If You Have Experienced a Physical Trauma-Based Injury

If you experienced a physical trauma-based injury and you get a liability insurance settlement, judgment, award, or other payment of $5,000 or less, Medicare offers the option to pay 25% of your gross settlement, judgment, award, or other payment, instead of the amount that Medicare would otherwise calculate.

If you wish to choose this option, you must formally elect it at the same time that you send us information on your settlement, judgment, award, or other payment. Please visit the Beneficiary or Attorney Toolkit sections of the BCRC website (http://go.cms.gov/cobro) for all of the additional details. You will find model language that can be used to elect this option, as well as a special mailing address to ensure efficient processing.

How You Can Contact Us

Please mail any documents to: [BCRC Fixed Percentage Option, P.O. Box 138880, Oklahoma City, OK 73113 or fax documents to: [BCRC 405-869-3309.

For more information, please visit http://go.cms.gov/cobro or call 1-855-798-2627 (TTY/TDD for the hearing or speech impaired: 1-855-797-2627).

Sincerely,
BCRC

Enclosure:
BCRC Brochure

CC:

D. MEDICARE SECONDARY PAYER RECOVERY PORTAL

(The following can be found on the CMS Website)

Medicare Secondary Payer Recovery Portal

The Medicare Secondary Payer Recovery Portal (MSPRP) is a web-based tool designed to assist in the resolution of liability insurance, no-fault insurance, and workers' compensation Medicare recovery cases. The MSPRP gives you the ability to access and update certain case specific information online.

CMS has made available a curriculum of computer-based training (CBT) courses for the MSPRP. These courses provide in-depth training on use of the MSPRP. You can access or download these CBTs from the **Dynamic List** on this page. Please see the *MSPRP Curriculum* for a complete listing of the courses and their descriptions. If you have any questions or feedback on this material, please click the Training Feedback link.

MSPRP Features & Benefits:

The MSPRP provides you with the following features and related benefits:

1. Submit Beneficiary Proof of Representation, Beneficiary Consent to Release or Insurer Letter of Authority documentation

2. Request conditional payment information:

- Obtain current conditional payment amount
- Request a copy of a current conditional payment letter
- Request a final conditional payment amount for a case that is approaching settlement

3. Dispute claims included in a conditional payment letter:

- View the claims listed on the conditional payment letter and dispute unrelated claims
- Upload documentation to support the claim dispute

4. Submit case settlement information:

- Input settlement information and upload a copy of the settlement documentation

5. Multi-Factor Authorization (MFA) and Identity Proofing

- Request access to view unmasked claims data. Individuals requesting this access must complete the ID Proofing and Multi-Factor Authentication (MFA) process.

Note: Only those actions that are applicable to the case will be available.

How to Access the MSPRP

Beneficiaries will access the MSPRP through the MyMedicare.Gov Web site. They will login to their MyMedicare account via the MyMedicare.gov Web site. This Web site can be accessed from the link: My Medicare.Gov. The beneficiary will enter their established Login ID and Password for that application in the Secure Sign In section of the web page. After they successfully login to the MyMedicare.Gov site and enter the MSP section, they can access the MSPRP in two different ways:

- Click the **[Case ID]** in the "Payment Details" box on the MyMedicare page of the case they would like to access.
- Click the **[Go to MSPRP]** button.

Insurers and attorneys will access the MSPRP using the following MSPRP Application link: https://www.cob.cms.hhs.gov/MSPRP. Please note that registration must occur before access to the MSPRP is permitted. Additionally, you must complete the Identity Proofing and Multi-Factor Authentication process on the MSPRP if you wish to request access to unmasked claims data. See the MSPRP User Guide and the *Remote Identity Proofing (RIDP) - Multifactor Authentication (MFA) on the Medicare Secondary Payer Recovery Portal (MSPRP) Frequently Asked Questions* in the Downloads section below.

E. TIPS FOR DEALING WITH THE BCRC AND RESOLVING CONDITIONAL PAYMENTS

- Start early. Do not wait until settlement to start the process. Best case scenario for receiving information back from Medicare after initial case reporting is about 2 weeks. Very often it takes at least a month. By starting early you can be more confident that you know where you stand with Medicare prior to settlement.

- An advantage to starting early is the availability of disputing Medicare's conditional payments. A dispute may be submitted as many times as you wish prior to settlement and the issuance of a Final Demand Letter.

- Typically in cases where the lien amount consumes a disproportionate amount of the plaintiff's net recovery, a compromise may be requested from the CMS Regional Office, not from the BCRC.

- Be aware of the plaintiff's treatment history. If the conditional payment amount seems lower than it should be, make sure all of the plaintiff's treatment is included on the Payment Summary. If something is missing, it may only come up when a Final Demand is requested, leading to a much higher than anticipated reimbursement demand. CMS does not give much credence to the attorney's detrimental reliance on conditional payment letters which are labeled "interim" and subject to change.

II. MEDICARE ADVANTAGE PLANS (MAPS)

A. MEDICARE ADVANTAGE GENERALLY—PART C OF THE MEDICARE ACT.

In 1997, the Medicare Advantage Program (hereinafter "MA"), Part C of the Medicare Act, was created as an alternative to the government Medicare program. Under the Medicare Advantage Program, enrollees have the option of receiving their Medicare insurance from private insurers instead of direct benefits from the federal government.

B. STATUTES AND REGULATIONS

The Medicare Secondary Payer (MSP) Act provides that Medicare is secondary to other insurers, called primary plans: group health plans, workers compensation plans, liability insurance policies and plans, and no-fault insurance. See 42 U.S.C. § 1395y(b)(2)(A). Medicare makes conditional payments, i.e., it pays for services and if it later learns that those services are covered by a primary plan, the primary plan (or an entity that receives payment from a primary plan) must reimburse Medicare for those services. See 42 U.S.C. § 1395y(b)(2)(B).

1. The Medicare Advantage Secondary Payer Statute

The Medicare Advantage (MA or Part C) statute includes its own provision regarding the role of an MA plan as secondary payer. The MA statute's secondary payer provision, at 42 U.S.C. § 1395w-22(a)(4), states that:

> Notwithstanding any other provision of law, a Medicare+Choice organization may (in the case of the provision of items and services to an individual under a Medicare+Choice plan under circumstances in which payment under this subchapter is made secondary pursuant to section 1395y(b)(2) of this title) charge or authorize the provider of such services to charge, in accordance with the charges allowed under a law, plan, or policy described in such section—
>
> (A) the insurance carrier, employer, or other entity which under such law, plan, or policy is to pay for the provision of such services, or
>
> (B) such individual to the extent that the individual has been paid under such law, plan, or policy for such services.

2. The Medicare Advantage Secondary Payer Regulations

On January 28, 2005, the Medicare Advantage regulations were amended. The Secretary of Health and Human Services, in respect for the basic rule that Medicare does not pay for services to the extent that Medicare is not the primary payer, adopted 42 CFR § 422.108 which provides for the secondary payer responsibilities of a MA plan:

(a) Basic rule. CMS does not pay for services to the extent that Medicare is not the primary payer under section 1825(b) of the Act and part 411 of this chapter.

(b) Responsibilities of the MA organization. The MA organization must, for each MA plan—

(1) Identify payers that are primary to Medicare . . . ;

(2) Identify the amounts payable by those payers; and

(3) Coordinate its benefits to Medicare enrollees with the benefits of the primary payers, including reporting, on an ongoing basis, information obtained related to requirements in paragraphs (b)(1) and (b)(2) of this section in accordance with CMS instructions.

(c) Collecting from other entities. The MA organization may bill, or authorize a provider to bill, other individuals or entities for covered Medicare services for which Medicare is not the primary payer, as specified in paragraphs (d) and (e) of this section.

(d) Collecting from other insurers or the enrollee. If a Medicare enrollee receives from an MA organization covered services that are also covered under State or Federal workers' compensation, any no-fault insurance, or any liability insurance policy or plan, including a self-insured plan, the MA organization may bill, or authorize a provider to bill any of the following—

(1) The insurance carrier, the employer, or any other entity that is liable for payment for the services under section 1862(b) of the Act and part 411 of this chapter.

(2) The Medicare enrollee, to the extent that he or she has been paid by the carrier, employer, or entity for covered medical expenses.

Finally, 42 CFR § 422.108(f) states that:

The rules established under this section supersede any State laws, regulations, contract requirements, or other standards that would otherwise apply to MA plans. A State cannot take away an MA organization's right under Federal law and the MSP regulations to bill, or to authorize providers and suppliers to bill, for services for which Medicare is not the primary payer. The MA organization will exercise the same rights to recover from a primary plan, entity, or individual that the Secretary exercises under the MSP regulations in subparts B through D of part 411 of this chapter.

42 CFR § 422.108(f).

3. MSP Private Cause of Action for Double Damages

There have been a number of cases in both state and federal courts that have considered the issue of whether there is a federal cause of action providing for MA plans to enforce their rights under the Medicare Advantage statutes, the MSP Act, and the accompanying regulations.

C. MEDICARE ADVANTAGE REIMBURSEMENT: CASE LAW

1. *Care Choices HMO v. Engstrom*, 330 F.3d 786 (6th Cir. 2003)

In this case, the private insurer was not a Medicare Advantage plan, but rather a Medicare-substitute HMO. The HMO sought reimbursement from a plaintiff who recovered a settlement in a third-party liability action. The U.S. Court of Appeals for the Sixth Circuit considered whether the applicable statute, 42 U.S.C. § 1395mm(e)(4), contains a private right of action in federal court. The court found no such right and held:

> Reading the statute as a whole, it is clear that Section 1395mm(e)(4) is intended to permit Medicare-substitute HMOs to create a right of reimbursement for themselves in the context of their own insurance agreements with Medicare beneficiaries. The statute does not confer any affirmative rights to reimbursement, much less contain an implied right of action. . . . If an HMO chooses to include such a provision in its insurance policy, its remedy would be based on a standard insurance contract claim and not on any federal statutory right.

Care Choices is frequently cited in cases deciding the issue of a private right of action for MA plans. Although the plan in *Care Choices* was not an MA plan, the issues raised and the statutory language in 42 U.S.C. § 1395mm(e)(4) are essentially the same as the issues raised in the context of MA plans and the statutory language in the MA statute, 42 U.S.C. § 1395w-22(a)(4). Thus, *Care Choices* continues to be favorably cited.

2. *Nott v. Aetna U.S. Healthcare, Inc.*, 303 F. Supp. 2d 565 (E.D. Pa. 2004)

Here, the Federal District Court for the Eastern District of Pennsylvania considered whether a Medicare Advantage plan's right to assert subrogation against an enrollee's tort recovery arose under the Medicare Advantage statute. The court noted that the language of the statutory provision, 42 U.S.C. § 1395w-22(a)(4), does not create a federal scheme for the civil enforcement of an MA plan's subrogation rights.

Rather, the Act only authorizes, but does not require, the private insurer to include subrogation provisions in the insurance contract. This permissive language, along with the absence of an express remedial provision, is evidence of Congress's intent not to create an explicit right of action for private MA plans. Thus, if the MA plan includes a subrogation provision in the insurance policy, the right to subrogation remains a private contractual right which may be enforced in state court.

NOTE: It is important to note that this case may have been rendered irrelevant by the recent Third Circuit decision in *In re Avandia* that is discussed below. *Nott*, along with *Care Choices*, is frequently cited in cases holding that there is no express or implied federal right of action for Medicare Advantage plans to enforce their rights of subrogation and/or reimbursement. *In re Avandia* held that an MA plan may bring an action under 42 U.S.C. §1395y(b)(3)(A) of the MSP Act. *In re Avandia* concluded that *Nott* only considered 42 U.S.C. Sections 1395mm(e)(4) and 1395w-22(a)(4), and did not consider 1395y(b)(3)(A). Therefore, *Nott* was irrelevant to its decision. Although not explicitly overruled, *Nott* has no real impact in the Third Circuit because *In re Avandia* held that there is another federal avenue of relief for MA plans, through the private cause of action under 42 U.S.C. § 1395y(b)(3)(A).

3. *Primax Recoveries, Inc. v. Yarmosh,* Case No. 3: 03CV01931, 2006 U.S. Dist. LEXIS 98858 (D. Conn. 2006)

In this case, Primax, as the subrogation and collection agent for a Medicare Advantage plan, sued in federal court to enforce its right of subrogation and reimbursement. Here, the Federal District Court for the District of Connecticut agreed with the reasoning in *Care Choices* and concluded that there was no express or implied private right of action in the statutes to allow a Medicare Advantage plan to sue in federal court. It noted that the Second Circuit had not addressed the issue, but the *Care Choices* decision relied on the same standard to determine whether there is an implied cause of action that is applicable in the Second Circuit. "This court agrees with the *Care Choices* court that there is no private cause of action for a Medicare+ Choice HMO under the Medicare+ Choice statute, 42 U.S.C. § 1395mm(e)(4)." Primax, 2006 U.S. Dist. LEXIS 98858 at *13.

The MA plan in this case also argued that the MSP Act itself, in 42 U.S.C. §1395y(b)(2)(B)(ii) entitled it to sue in federal court. That provision, however, only authorizes the United States to bring a lawsuit in federal court. The statute does not expressly grant a cause of action to any entity other than the United States. The court found the language of the statute clear and unambiguous, dismissed the MAO's federal action, and allowed them to replead in state court under a state contract law claim.

4. *Konig v. Yeshiva,* 12-CV-467, (E.D. N.Y. March 30, 2012)

Here, the District Court in the Eastern District of New York found that MA plans do not have a right of action under the Medicare laws. "Although the Medicare statute clearly authorizes the government to bring an action to enforce its subrogation rights under its own Medicare insurance

contracts, see 42 U.S.C. § 1395y(b)(2)(B)(iii), the statute does not expressly accord private MAP providers the same right." Konig, 12-CV-467, at 5. The court noted that "every court" to address the issue has found that the laws also fail to create an implied cause of action.

In *Konig*, the MA plan argued that the corresponding regulation, at 42 CFR § 422.108(f), provides that Medicare Advantage Plan organizations (MAO) exercise the same right to recover as the Secretary, and therefore this places them in the same shoes as the government, thereby granting them the power to bring a private right of action. The court disagreed, stating that the reasoning is faulty. The court reasoned that "[l]anguage in a regulation may invoke a private right of action that Congress through statutory text created, but it may not create a right that Congress has not." Id. at 5, fn. 2 (citing *Alexander v. Sandoval*, 532 U.S. 275, 291 (2001)). Since there is nothing in the Medicare statutes that creates a cause of action, then the parties cannot fashion one by invoking the regulations. The Medicare laws offer no private right of action—express or implied—to MA plans to enforce any claimed subrogation rights.

5. *In re Avandia Marketing, Sales Practices and Products Liability Litigation*, 685 F.3d 353 (3d Cir. 2012)

The U.S. Court of Appeals for the Third Circuit, in *In Re Avandia*, came to a different conclusion than every previous decision. The lower court decision in this case, in U.S. District Court for the Eastern District of Pennsylvania, ruled in line with previous decisions that an MA plan does not have a private right of action in federal court, and the MA plan is limited to state court to enforce the subrogation terms in the insurance contract.

The plan argued that the MSP Act itself, even without reference to the Medicare Advantage statutes, is broad enough to include a Medicare Advantage plan within the parties that may bring a private right of action for double damages under 42 U.S.C. § 1395y(b)(3)(A). The private cause of action statute states:

There is established a private cause of action for damages (which shall be in an amount double the amount otherwise provided) in the case of a primary plan which fails to provide for primary payment (or appropriate reimbursement) in accordance with paragraphs (1) and (2)(A).

The Court here agreed, and reversed the lower court's ruling. The Third Circuit concluded that an MAO has the same right to recover as the Medicare Trust Fund. The Medicare statute has two separate causes of action. When the Medicare Trust Fund makes a conditional payment and the primary payer does not reimburse it, the United States may bring suit pursuant to § 1395y(b)(2)(B)(iii). Also, there is a private right of action with no particular plaintiff specified under § 1395y(b)(3)(A) any time a primary payer fails to make required payments.

Even though the MSP Act was enacted before Part C, private Medicare risk plans were authorized at the time. The Court felt that Congress was aware that private Medicare providers existed; and had Congress intended to prevent them from suing under the private cause of action provision, Congress could have done so explicitly.

The MA plan here did not argue that the MA secondary payer provision provides a cause of action through its reference to the MSP Act, but it argued that the language of the MSP Act itself is broad enough to encompass an MA plan, regardless of the existence of 42 U.S.C. §1395w-22(a)(4). The Court concluded that there is nothing in the text or legislative history of the MA secondary payer provision that demonstrates a congressional intent to deny MA plans access to the MSP private cause of action.

The Court disregarded the decisions of *Care Choices HMO v. Engstrom*, and *Nott v. Aetna U.S. Healthcare, Inc*. In both decisions, the Court noted that the question of whether a Medicare Advantage plan could have brought suit as a private actor directly under the MSP Act under 42 U.S.C. 1395y(b)(3)(A) was neither raised nor addressed. Therefore, those decisions were irrelevant.

The Court found nothing in the text or the legislative history of the statute to imply that Congress did not intend to facilitate recovery for MA plans in the same fashion as that of traditional Medicare, and found the text of the statute to be clear and unambiguous.

Even if the statute was ambiguous as to whether an MA plan has the same rights as traditional Medicare in the MSP Act, the Chevron defense would apply to reach the same conclusion. The Supreme Court in Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837 (1984) established a test to determine when a court should defer to the interpretation of a statute embodied in a regulation enacted by the federal agency charged with implementing the statute.

CMS regulations state that an "MA organization will exercise the same rights to recover from a primary plan, entity, or individual that the Secretary exercises under the MSP regulations in subparts B through D of part 411 of this chapter." 42 C.F.R. 422.108(f). The court found that the plain language of the regulation suggests that the Medicare Act treats MA plans the same way it treats the Medicare Trust Fund for purposes of recovery from any primary payer. So, deference to the agency's interpretation in the regulations suggests that there is a private cause of action under the MSP Act for MA plans:

The language of the MSP private cause of action is broad and unrestricted and therefore allows any private plaintiff with standing to bring an action. Since private health plans delivered Medicare services prior to the 1980 passage of the MSP Act, Congress was certainly aware that private health plans might be interested private parties when it drafted the cause of action, and it did not exclude them from that provision's ambit. That decision is logically consistent because affording MAOs access to the private cause of action for double damages comports with the broader policy goals of the MA program. Further, even if we were to find the statutory text to be ambiguous on the issue, Chevron deference to CMS regulations, which grant MAOs parity with traditional Medicare, would require us to find in favor of [the MAO] here.

6. *Potts v. Rawlings Company, LLC,* No. 11 Civ. 9071 (S.D.N.Y. September 25, 2012).

In this case, a class of Medicare Part C beneficiaries challenged the collection activities of various collection agents who had worked on behalf of MA Plans. They argued that the plans' claims arise under state contract law and the New York anti-subrogation statute (General Obligations Law § 5-335), and not under the Medicare Act.

Here, the court held that the issue of whether a MA plan has a private cause of action to pursue reimbursement is irrelevant. The issue is that the Medicare Act expressly pre-empts state law, and thus General Obligations Law § 5-335 does not apply:

> First, that the Medicare Act does not create a private right of action for MA organizations is not at all clear, as there is a split of authority on the issue. Second, given the broad express preemption clause in the Medicare Act, whether there is a private right of action for MA organizations is immaterial to the question whether GOL § 5-335 is preempted.
> . . .
> Because Plaintiffs' claims, in essence, are claims seeking the retention of benefits, they arise under the Medicare Act, and Plaintiffs were obligated to exhaust their administrative remedies before bringing this action. Thus, the Court is without subject matter jurisdiction to consider those claims.

7. *Trezza v. Trezza*, 2012 N.Y. Slip. Op. 09048 (N.Y. App. Div. 2d Dept. 2012)

In a reversal of arguments as to the enforceability of claims for reimbursement of Medicare Advantage Plans, on December 26, 2012 [*argued September 21, 2012*] the New York State Appellate Division, Second Judicial Department has reversed the lower court's decision in the appeal of the matter of the Kings County Supreme Court decision of *Trezza v. Trezza*, 32 Misc 3d 1209[A], 2011 NY Slip Op 51237[U] (Sup Ct, Kings County).

The Second Department held that: "General Obligations Law §5-335, insofar as applied to Medicare Advantage organizations under Part C, is preempted by federal law since it would impermissibly constrain contractual reimbursement rights authorized under the "Organization as secondary payer" provisions of the Medicare Act."

By way of relevant background, Janine Trezza was injured in a motor vehicle accident while riding in a vehicle operated by her husband. Oxford Health Plus, the Medicare Advantage plan, paid $37,787.64 in medical expenses for plaintiff's accident-related injuries. Plaintiff received a settlement of $75,000.00 out of which Oxford Health Plus claimed entitlement to reimbursement of $37,787.64.

The Supreme Court, Kings County, granted the plaintiff's motion to extinguish the purported lien and/or claim for reimbursement based upon the following reasoning:

> Courts have held that because the Medicare Act did not establish a federal scheme for the civil enforcement of HMO subrogation rights, it did not create a private cause of action (*Nott, 303 F.Supp.2d at 570*; *See also Care Choices HMO v. Engstrom, 330 F.3d 786, 789 [6th Cir. 2003]).* The Medicare Act therefore does not create a statutory right of reimbursement; instead, it allows HMOs to include subrogation rights in its contracts with beneficiaries (*Nott, 303 F.Supp.2d at 570*). Because "the Medicare Act permits, but does not mandate, HMO insurers to contract for subrogation rights" (*id. at 571*), subrogation in this context remains a state contract law issue (*id. at 572*; *Care Choices, 330 F.3d at 790*).

In a matter of first impression before the Appellate Division, the Court further examined the preemptive effect the Medicare Act may have on General Obligation Law §5-335.

In its analysis, the Appellate Division observed:

> Thus, the Medicare Act provides that Medicare Advantage organizations may create a right of reimbursement for themselves in their insurance agreements with Medicare insureds. Moreover, "[t]he standards established under [Part C] shall supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency) with respect to [Medicare Advantage] plans which are offered by [Medicare Advantage] organizations under [Part C]" (42 USC § 1395w-26[b][3]), and "[a] State cannot take away [a Medicare Advantage] organization's right under Federal law and the MSP regulations to bill, or to authorize providers and suppliers to bill, for services for which Medicare is not the primary payer" (42 CFR 422.108[f]).
>
> Yet General Obligations Law § 5-335 would prohibit Medicare Advantage organizations from exercising the contractual right to reimbursement in that it would constrain contractual reimbursement rights where the insured entered into a personal injury settlement. In other words, General Obligations Law § 5-335, which, insofar as at issue here, clearly does not constitute a licensing law or a law relating to plan solvency, would, in the context of such personal injury settlements, "take away [a Medicare Advantage] organization's right under Federal law and the MSP regulations to bill, or to authorize providers and suppliers to bill, for services for which Medicare is not the primary payer" in contravention of the federal regulations enabled by 42 USC § 1395w-26(b)(1) (42 CFR 422.108[f]).

The Court noted that although Medicare Advantage plans had no "statutory right of reimbursement" as used in General Obligations Law § 5-335, the Medicare Act expressly pre-empted the application of § 5-335.

The Court concluded that "because General Obligations Law § 5-335 is expressly preempted by the Medicare Act, the Supreme Court erred in granting the plaintiff's motion to extinguish the purported lien and/or claim for reimbursement based on that section."

Although the decision reinstated the claim of reimbursement of the Medicare Advantage Plan against the settlement proceeds, it did not preclude other arguments to attack the validity and amount of the purported claim.

As such, this case should not be considered a windfall for Medicare Advantage-type Plans in asserting liens and/or claims for reimbursement from personal injury settlements. As in cases involving ERISA self-insured type plans, the language in the plan should be examined in each particular case to ascertain grounds to attack the amounts claimed in addition to other arguments and defenses.

8. *Parra v. Pacificare of Arizona, Inc.*, 715 F.3d 1146 (9th Cir. 2013)

The Ninth Circuit recently issued a similar opinion. In this case, the Ninth Circuit held that the Medicare Advantage statute itself does not create a cause of action for MA plans and the MSP Act's private cause of action did not apply to MA plans.

Regarding the MA statute, the court held that: "On its face, the MAO Statute does not purport to create a cause of action. Rather, it simply describes when MAO coverage is secondary to other insurance, and permits (but does not require) a MAO to include in its plan provisions allowing recovery against a primary plan."

Likewise, it found that the regulation at 42 CFR § 422.108(f) adds nothing to a MAO's claim to a private right of action because language in a regulation cannot create a right that Congress has not created by statute. The Private Cause of Action statute was intended to allow private parties to vindicate wrongs occasioned by the failure of primary plans to make payments, not plaintiff beneficiaries. The court went on to distinguish the Third Circuit's *In re Avandia* case (discussed below), as there the plan sought recovery directly against the third-party tortfeasors and not the Plaintiffs.

9. *Collins v. Wellcare Healthcare Plans, Inc.*, No. 13-6759 L(3) (E.D. LA 2014).

Wellcare, a MAO, made payments for Collins' medical bills as a result of a motor vehicle accident. Collins seeks declaratory judgment as to Wellcare's subrogation and reimbursement rights in regards to Collins' personal injury settlement. Wellcare then removed the case to federal court on diversity jurisdiction.

Wellcare first argued that Collins was required to exhaust administrative remedies before seeking declaratory judgment, and thus the court should dismiss Collins' claim. The court determined

that Collins' claim did "arise under" Medicare because it was essentially a claim to retain benefits by arguing that MSP did not apply. *See Eihnorn*, 2014 WL 4385912. Therefore, Collins' case did arise under Medicare, and exhaustion was required.

Wellcare also argued that as a MAO, it was entitled to reimbursement through the MAO or MSP statutes. The court failed to make a determination on whether the MAO statute created a specific right of reimbursement, or only created the right to charge such reimbursement in their contracts, but did acknowledge the circuit split. The Court did, however, determine that the MSP statute was broad enough to include MAOs.

After it was determined that MAOs had a private right of action generally, the court decided whether Wellcare's claim satisfied the requirements of the MSP to enforce a private cause of action. The main issue was whether tort settlements were considered primary plans for purposes of paragraph (1) and (2)(A) of 42 U.S.C. §1395(y)(3)(A). The court deferred to other circuit holdings that this cause of action included tort settlements, and not just group health plans as set out in paragraph (1). Furthermore, the court held that Wellcare was indeed making conditional payments even though it did not know of any other primary payers. *See* 42 C.F.R. §411.21.

Lastly, assessing double damages was inappropriate for this case because Collins placed the settlement funds into a trust account pending a determination of Wellcare's rights.

10.*Humana Med. Plan, Inc. v. W. Heritage Ins. Co.*, No. 15-11436, 1:12-cv-20123-MCG (11th Cir. Aug. 8, 2016).

Ms. Reale was the injured plaintiff in a personal injury case against Hamptons West Condominium Association. Hamptons West was insured by Western Heritage Insurance Company. Humana paid medical bills for Ms. Reale's injuries, as a Medicare Advantage plan; it paid $19,155.41 in expenses. Humana requested reimbursement while the personal injury suit was still pending.

Ms. Reale and Western Heritage agreed to settle the personal injury claim for $115,000.00. Ms. Reale represented in the Release that there was no Medicare lien, and she also agreed to indemnify and hold harmless defendant and its insurance company.

Humana first attempted to sue Ms. Reale and her attorney in federal district court seeking reimbursement. The district court initially dismissed Humana's complaint for lack of subject matter jurisdiction, but it later vacated that order after Humana moved to correct the order. However, prior to the hearing to consider Humana's motion, Humana voluntarily dismissed its action against Ms. Reale and her attorney.

At this time, Western Heritage had still not tendered the settlement check to plaintiff because Western Heritage demanded that Humana be included as a payee on the settlement check. The state court ordered that Western Heritage tender the check without Humana as payee, but also ordered Ms. Reale's attorney to hold $19,155.41 in trust, pending resolution of the dispute on the claimed lien. Ms. Reale then sued Humana in state court seeking a declaration as to the amount

owed. The state court applied Florida law regarding collateral indemnity and subrogation and concluded that Humana was only entitled to $3,685.03. On appeal by Humana, Ms. Reale's case was dismissed for lack of jurisdiction by the Florida appellate court, determining that only upon exhaustion of the administrative process does the Medicare Act provide for federal judicial review, and it expressly preempts state law. *See* 42 U.S.C. §§ 1395w-22(g)(5) and 1395w-26(b)(3), respectively.

Still unpaid, and perhaps motivated by double damages, Humana then sued the liability carrier, Western Heritage, for failure to reimburse, arguing that the Medicare Secondary Payer Act's private cause of action provision allows a suit for double damages when an insurance company fails to reimburse a Medicare Advantage plan. (Note that this double damages provision is found nowhere within the wording of the Medicare Advantage statute, 42 U.S.C. §§ 1395w-21, et.seq.)

The district court agreed with Humana, and followed the Third Circuit's decision in *In re Avandia Mktg., Sales Practices & Prods. Liab. Litig.*, 685 F.3d 353 (3rd Cir. 2012).

Circuit Judge William Pryor authored a brief but thoughtful and logical dissent which concluded that the majority ignored key words in the statutes, such as "Secretary" and "Trust Fund." Under the Medicare Secondary Payer Act, only the Secretary of Health and Human Services may make conditional payments, which are conditioned on reimbursement to the Medicare Trust Fund.

However, the majority decision is now controlling in the Eleventh Circuit, which will no doubt further embolden collection agents in their attempts to collect on behalf of private insurance companies providing Medicare Advantage coverage.

D. Liability of Plaintiff's Attorney

The case law cited above clearly establishes that various courts throughout the country have held plaintiff Medicare beneficiaries and primary plans liable for double damages.

Medicare Advantage plans have also sued the plaintiff's attorney in these cases where the plan is not reimbursed. The Eastern District of Virginia, in *Humana v. Paris Blank, LLP*, 187 F.Supp.3d 676 (E.D. Va. 2016), held that "regulation dictates that MAOs 'exercise the same rights to recovery from a primary plan, entity, or individual that the Secretary exercises under the MSP regulations in subparts B through D of part 411 of this chapter.' 42 C.F.R. § 422.108(f). CMS has promulgated regulations identifying attorneys as an entity from which recovery may be sought under the MSP law by the Secretary. *See id.* § 411.24(g). Accordingly, Plaintiff may maintain suit against Defendants for recovery of conditional payments." *Paris Blank*, 187 F.Supp.3d at 682-83.

In this case's aftermath, plaintiff's attorney has been sued by Medicare Advantage plans in cases throughout the country, in addition to plaintiffs themselves. *See, e.g., Humana Health Benefit Plan of Louisiana, Inc. v. Falcon*, 3:17-cv-00596-JWD-EWD (M.D. La., Complaint filed August 30, 2017); *Humana Ins. Co. v. Pelham*, 4:17-cv-00374-RH-CAS (N.D. Fla., Complaint

filed August 18, 2017); *United Healthcare Ins. Co. v. Kardoulis*, 1:16-cv-735 (E.D.N.Y., Complain filed February 11, 2016).

E. Where Do We Stand In New York?

Take advantage of the unsettled nature of the law while you still can. In New York State, the most problematic case law regarding MAP reimbursement rights is from the Third and Eleventh Circuits and not binding authority. In fact, the cases closest to home do have some favorable elements. *Konig v. Yeshiva* is an obvious one. *Potts* and *Trezza* have held that New York's anti-subrogation statute, NY General Obligations Law § 5-335 is preempted by the Medicare Act. However, even *Trezza* states that the reimbursement right itself is limited, i.e., there must be language in the contract giving it such rights.

Keep in mind that MAP reimbursement is not a matter of settled law in the State of New York. Barring that, a Medicare Advantage plan's best case scenario for recovery is only that which traditional Medicare has, and nothing more. Therefore, all applicable challenges that might have been made in the regular Medicare context, including an automatic reduction for the costs of litigation, must be applied in the Medicare Advantage context.

III. MEDICARE SET-ASIDES (MSAs)

A. What is the Basis for an MSA?

- The MSP Act's General Rule states that Medicare may not make payment for any medical items and services "to the extent that payment has been made . . . 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." 42 U.S.C. §1395y(b)(2)(A).
- The MSP General rule makes clear that in the event there has been a payment by a primary plan, Medicare shall not pay for any items or services.
- The risk that the MSP imposes for future medicals incurred after the date of a liability insurance settlement is clear, i.e., that Medicare will not cover accident-related medical treatment costs after the date of a liability settlement.
- The question becomes: to what extent must the parties to a settlement ensure that Medicare does not cover future accident-related medical expenses, and who bears the responsibility to protect Medicare's future interests?
- The Medicare Set-Aside—the creation of a separate bank account that a Medicare beneficiary utilizes solely to privately pay for accident-related and otherwise Medicare-covered treatment occurring after the date of a settlement—has emerged as Medicare's preferred method that Medicare beneficiaries utilize to protect Medicare's future interests in a settlement.
- That said, there is no statute or regulation which mandates the use of a MSA in any case.

B. MSAs in Worker's Compensation Cases

1. In worker's compensation cases, when the carrier settles with the claimant to extinguish the carrier's future obligations in exchange for a lump sum payment to the claimant, the need to protect Medicare's future interests is clear. In this situation, it is unequivocally a shifting of the burden of medical care from the carrier to the Medicare Trust Fund. Medicare cannot pay for medical care in a situation where there has been a payment from a worker's compensation carrier. Therefore, there is a clear need to protect the Medicare Trust Fund.

2. While there is no requirement for an MSA in a worker's compensation case, CMS has promulgated thresholds for cases in which it will review an MSA allocation:
    - The claimant is currently a Medicare beneficiary and the total settlement amount is greater than $25,000;

- The claimant has a "reasonable expectation" of Medicare enrollment within 30 months of the settlement date and the anticipated total settlement amount for future medical expenses and disability/lost wages over the life or duration of the settlement agreement is expected to be greater than $250,000.

3. CMS Memorandum dated May 11, 2011: Submission of a WCMSA proposal to CMS for review and approval is a recommended process. There are no statutory or regulatory provisions requiring that a WCMSA proposal be submitted to CMS for review. However, if an entity chooses to use the WCMSA review process, CMS requests that it comply with the established policies and procedures referenced on its Web site. Claimants, employers, carriers, and their representatives should be encouraged regularly to monitor this dedicated workers' compensation Web site for changes in policies and procedures.

C. MSAs in Liability Cases

1. In liability cases, the burden-shifting for the payment of medicals is much less clear than in worker's compensation cases.

2. On May 25, 2011, a CMS memorandum reiterated that there was no requirement for a MSA, but that: "The law requires that the Medicare Trust Funds be protected from the payment for future services whether it is a Worker's Compensation or liability case. There is no distinction in the law." It specifies distinct roles/responsibilities for the plaintiff Medicare beneficiary and his/her counsel, and for defendants and their carriers.

3. CMS Memo September 29, 2011: "Where the beneficiary's treating physician certifies in writing that treatment for the alleged injury has been completed as of the date of the settlement, and that future medical items and/or services for that injury will not be required, Medicare considers its interest, with respect to future medicals for that particular settlement, satisfied." See the Stalcup Memorandum which is included in its entirety below.

4. Proposed Regulations for Liability MSAs. There was advanced notice of proposed rulemaking to promulgate rules related to Liability MSAs. After a very active comment period, CMS withdrew the proposed rules on August 1, 2013. It is important to note that at the time, CMS proposed several different options to protect Medicare's future interests. All of those options were the plaintiff Medicare beneficiary's responsibility to address.

5. On June 8, 2016, CMS made the following announcement: "The Centers for Medicare and Medicaid Services (CMS) is considering expanding its voluntary Medicare Set-Aside Arrangements (MSA) amount review process to include the

review of proposed liability insurance (including self-insurance) and no-fault insurance MSA amounts. CMS plans to work closely with the stakeholder community to identify how best to implement this potential expansion. CMS will provide future announcements of the proposal and expects to schedule town hall meetings later this year. Please continue to monitor CMS.gov for additional updates."

6. On February 3, 2017, it was announced that CMS systems would be updated effective October 1, 2017. "Medicare does not make claims payment for future medical expenses associated with a settlement, judgment, award, or other payment because payment "has been made" for such items or services through use of LMSA or NFMSA funds." Department of Health and Human Services, Centers for Medicare & Medicaid Services, MLN Matters, N*ew Common Working File (CWF) Medicare Secondary Payer (MSP) Type for Liability Medicare Set-Aside Arrangements (LMSAs) and No-Fault Medicare Set-Aside Arrangements* (NFMSAs), MLN Matters, (Feb. 3, 2017).

   The existence of a LMSA or NFMSA fund will now be incorporated into Medicare's Common Working File (CWF) shared file system. And all of the claims related to the liability and no fault files will be denied, with instructions that payment is to be made from the LMSA or NFMSA fund.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Division of Financial Management and Fee for Service OP!rations, R!Qion VI

1301 Young Stree Room 833
Pallas, Texas 75202
Phone (214) 767 1
Fax (214) 767 0

May 25, 2011

This specific handout was prepared as a service to the public and is not intended to grant rights or impose obligations. It may contain certain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. Readers are encouraged to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. It is intended to provide consolidated guidance to those attomeys, insurers, etc., working liability, no fault and general third party liability cases for any Medicare beneficiary residing in Oklahoma, Texas, New Mexico, Louisiana and Arkansas and is not to be considered a CMS official statement of policy.

If the Medicare beneficiary involved in your case is not a resident of one of these states, please contact the appropriate Centers for Medicare & Medicaid Services' (CMS) Medicare Secondary Payer Regional Office (MSP RO). If you do not have that information please contact Sally Stalcup (contact infom1ation below) for that infmmation.

Medicare's interests must be protected; however, CMS does not mandate a specific mechanism to protect those interests. The law does not require a "set-aside" in any situation. The law reguires that the Medicare Trust Funds be rotected from a ment for future services whether it is a Workers' Compensation or liability case. There IS no istmctwn m the aw.

Set-aside is our method of choice and the agency feels it provides the best protection for the program and the Medicare beneficiary.

Section l862(b)(2)(A)(ii) of the Social ::->ecurity, Act [42 USC 1395 y(b)(2)], precludes Medicare payment for services to the extent that payment has been made or can reasonably be expected to be made promptly under liability insurance. This also governs Workers' Compensation. 42 CFR 411.50 defines the tenn "liability insurance". Anytime a settlement, judgment or award provides funds for future medical services, it can reasonabJy be expected that those monies are available to pay for future services related to what was claimed and/or released in the settlement, judgment. or award. Thus, Medicare should not be billed for future services until those funds are exhausted by payments to providers for services that would otherwise be covered and reimbursable by Medicare. If the settlement, judgment, award .yare not funded there is no reasonable expectation that third party funds are available to pay for those services.

The new provisions for Liability Insurance (including Self-Insurance), No-Fault Insurance, and Workers' Compensation found at 42 U.S.C. 1395y(b)(8) add reporting mles and do not eliminate any existing statutory provisions or regulations. The new provisions do not eliminate CMS' existing processes if a Medicare beneficiary (or his/her representative) wishes to obtain interim conditional payment amount infonnation prior to a settlement, judgment, award, or other payment. The new provisions do NOT require a set-aside when there is a recovery for future medicals, in fact this legislation does not address that subject This legislation is unofficially known as "Mandatory Insurer

Reporting" because it does just and only that. It specifies the entity mandated to report a settlement/judgment/award/recovery to Medicare and addresses specifics of that issue.

There is no formal CMS review process in the liability arena as there is for Worker' Com ensation. However, CMS does expect the funds to e exhausted on otherw1se Medicare covered and otheiWJse reimbursable services related to what was claimed and/or released befote Medicare is ever billed. CMS review is decided on a case by case basis.

The fact that a settlement/judgment/award does not specify payment for future medical services does not mean that they are not funded. The fact that the agreement designates the entire amount for pain and suffering does not mean that future medicals are not funded. The only situation in which Medicare recognizes allocations of liability payments to nonmedical losses is when payment is based on a court of competent jurisdiction's order after their review on the merits of the case. A review of the metits of the case is a revi.ew of the facts of the case to determine whether there are future medicals - not to detennine the proper allocation of funds. If the court of competent jurisdiction has reviewed the facts of the case and determined that there are no future medical services Medicare will accept the Court's designation.

While it is Medicare's position that counsel should know whether or not their recovery provides for future medicals, simply recovers policy limits, etc, we are frequently asked how one would 'know'. Consider the following examples as a guide for determining whether or not settlement funds must be used to protect Medicare's interest on any Medicare covered otherwise reimbursable, case related, future medical services. Does the case involve a catastrophic injury or illness? Is there a Life Care Plan or similar document? Does the case involve any aspect of Workers' Compensation? This list is . by no means all inclusive.

We use the phrase "case related" becaus we consider more than just services related to the actual injury/illness which is the basis of the case. Because the law precludes Medicare payment for services to the extent that payment has been made or can reasonably be expected to be made promptly under liability insurance, Medicare's right of recovery, and the prohibition fi'om billing Medicare for future services, extends to all those services related to what was claimed and/or released in the settlement, judgment, or award. Medicare's payment for those same past services is recoverable and payment for those future services is precluded by Section 1862(b)(2)(A)(ii) ofthe Social Security Act.

"Otherwise covered" means that the funds must be used to pay for only those services Medicare would cover so there is a savings to the Medicare trust funds. For exan1ple, Medicare does not pay for bathroom grab bars, handicapped vans, garage door openers or spas so use of the funds for those items is inappropriate. We include the designation of"othcrwise reimbursable" because Medicare does not pay for services that are not medically necessary even if the specific service is designated as a covered service and Medicare does not pay primary when Group Health Plan insurance has been detem1ined to be the primary payer.

At this time, the CMS is not soliciting cases solely because of the language provided in a general release. CMS does not review or sign off on counsel's determination of the amount to be held to protect the Trust Fw1d in most cases. We do however urge counsel to consider this issue when settling *a* ctt.so;; and recommend that their determination u.s to whctho;;I or not thdr ca;-;c provided recovery funds for future medicals be documented in their records. Should they determine that future services are funded, those dollars must be used to pay for future otherwise Medicare covered case related services.

CMS does .not revi w or sign off on counsel's determination of whether or not there is recovery for future medical serviCes and thus the need to protect the Medicare Trust Funds and *only* in limited cases do they review or sign off on counsel's determination of the amount to be held to protect the Trust Funds.

There is no formal CMS review process in the liability arena as there is for Worker' Compensation, however Regional Offices do review a number of submitted setwaside proposals. On occasions, when the recovery is large enough, or other unusual facts exist within the case, this CMS Regional Office will review the settlement and help make a determination on the amotmt to be available for future services.

We are still asked for written confirmation that a Medicare set-aside is, or is not, required. As we have already covered the "set-aside" aspect of that request we only need to state that IF there was/is funding for otherwise covered and reimbursable future medical services related to what was claimed/released, the Medicare Trust Funds must be protected. If there was/is no such funding, there is no expectation of 3rd party funds with which to protect the Trust Funds. Each attomey is going to have to decide, based on the specific facts of each of their cases, whether or not there is funding for future medicals and if so, a need to protect the Trust Funds. They must decide whether or not there is funding for future medicals. If the answer for plaintiff's counsel is yes, they should to see to it that those funds are used to pay for otherwise Medicare covered services related to what is claimed/released in the settlement judgment award. If the answer for defense counsel or the insurer, is yes they should make sure their records contain documentation of their notification to plaintiff's counsel and the Medicare beneficiary that the settlement does ftmd future medicals which obligates them to protect the Medicare Trust Funds. It will also be part of their report to Medicare in compliance with Section III,Mandatory Insurer Reporting requitements.

Medicare educates about laws/statutes/policies so that individuals can make the best decision possible based on their situation. This is not new or isolated to the MSP provisions. Probably the best example I can give is the 2008 final rule adopting payment and policy changes for inpatient hospital services paid under the Inpatient Prospective Payment System. That final rule also adopted a number of important changes and clarifications to the physician self referral rules sometimes known as the Stark provisions. The physician self-referral law prohibits physicians from referring Medicare and Medicaid patients to certain entities with which the physician or a member of their immediate family has a financial relationship. Exceptions apply. Requests for determinations as to whether or not the physician met the exception criteria, or whether or not their situation was covered by this prohibition poured in. CMS!Medicare did not and continues to make no such determinations. It is the responsibility of the provider to know the specifics of their situation and determine their appropriate course of action.

Sally **Stalcup**
MSP Regional Coordinator
CMS
Medicare Fee for Service Branch
Division of Financial Management
and Fee for Service Operations
1301 Young Street, Room 833
Dallas, Texas 75202
(214) 767-6415
(214) 767-4440 fax

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C3-14-00
Baltimore, Maryland 21244-1850

MEMORANDUM

DATE: September 29, 2011

FROM: Acting Director
Financial Services Group
Office of Financial Management

SUBJECT: Medicare Secondary Payer—Liability Insurance (Including Self-Insurance) Settlements, Judgments, Awards, or Other Payments and Future Medicals -- INFORMATION

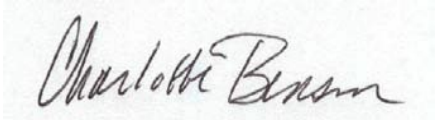
TO: Consortium Administrator for Financial Management and Fee-for-Service Operations

The purpose of this memorandum is to provide information regarding proposed Liability Medicare Set-Aside Arrangement (LMSA) amounts related to liability insurance (including self-insurance) settlements, judgments, awards, or other payments ("settlements").

Where the beneficiary's treating physician certifies in writing that treatment for the alleged injury related to the liability insurance (including self-insurance) "settlement" has been completed as of the date of the "settlement", and that future medical items and/or services for that injury will not be required, Medicare considers its interest, with respect to future medicals for that particular "settlement", satisfied. If the beneficiary receives additional "settlements" related to the underlying injury or illness, he/she must obtain a separate physician certification for those additional "settlements."

When the treating physician makes such a certification, there is no need for the beneficiary to submit the certification or a proposed LMSA amount for review. CMS will not provide the settling parties with confirmation that Medicare's interest with respect to future medicals for that "settlement" has been satisfied. Instead, the beneficiary and/or their representative are encouraged to maintain the physician's certification.

The above referenced guidance and procedure is effective upon publication of this memorandum.



Charlotte Benson

IV. MEDICAID LIENS

A. The Federal Anti-Lien Statute [42 U.S.C. § 1396p(a)(1)]:

(a) Imposition of lien against the property of an individual on account of medical assistance rendered to him under a State plan.

(1) No lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan, except —

(A) in circumstances not relevant to personal injury cases].

B. New York Anti-Lien Statute [NY Soc Serv Law §§ 369(2)(a), 369(2)(c)]

2. (a) Notwithstanding any inconsistent provision of this chapter or other law, no lien may be imposed against the property of any individual prior to his or her death on account of medical assistance paid or to be paid on his or her behalf under this title, except [in cases not relevant to personal injury claims]

. . .

(c) Nothing contained in this subdivision shall be construed to alter or affect the right of a social services official to recover the cost of medical assistance provided to an injured person in accordance with the provisions of section one hundred four-b of this chapter.

C. New York State Social Services Law Section 104-b:

§ 104-b. Liens for public assistance and care on claims and suits for personal injuries.

1. If a recipient of public assistance and care shall have a right of action, suit, claim, counterclaim or demand against another on account of any personal injuries suffered by such recipient, then the public welfare official for the public welfare district providing such assistance and care shall have a lien for such amount as may be fixed by the public welfare official not exceeding, however, the total amount of such assistance and care furnished by such public welfare official on and after the date when such injuries were incurred. In all such cases, notice of the commencement of such an action shall be served upon the public welfare district that has provided or is providing such assistance and care, or upon the department of health.

The commissioner shall endeavor to ascertain whether such person, firm or corporation alleged to be responsible for such injuries is insured with a liability insurance company, as the case may be, and the name thereof.

2. No such lien shall be effective, however, unless a written notice containing the name and address of the injured recipient, the date and place of the accident, and the name of the person, firm or corporation alleged to be liable to the injured party for such injuries, together with a brief statement of the nature of the lien, the amount claimed and

that a lien is claimed upon the said right of action, suit, claim, counterclaim or demand by the public welfare official be served prior to the payment of any moneys to such injured party, by certified with return receipt or registered mail upon such person, firm or corporation, and his or her, its or their attorney, if known, and upon any insurance carrier which has insured such person, firm or corporation against such liability. A copy of the notice of lien shall be mailed to such carrier at least twenty days prior to the date on which such carrier makes a payment to the injured party. Except as against such carrier, the effectiveness of the lien against any other party shall not be impaired by the failure to mail the required notice to such carrier. In addition, a true copy of such notice shall be served by regular mail to the welfare recipient and to his or her attorney, if known. Such mailing shall be deemed to be effective, notwithstanding any inaccuracy or omission, if the information contained therein shall be sufficient to enable those to whom the notice is given to identify the injured recipient and the occurrence upon which his or her claim for damages is based.

3. Upon the service of the notice, as aforesaid, the local public welfare official shall file a true copy thereof in the office of the clerk of the county in which his office is located, and, thereupon the lien of the public welfare official in the amount therein stated shall attach to any verdict, decision, decree, judgment, award or final order in any suit, action or proceeding in any court or administrative tribunal of this state respecting such injuries, as well as the proceeds of any settlement thereof, and the proceeds of any settlement of any claim or demand respecting such injuries prior to suit or action.

4. An amended notice of lien may be served and filed by such public welfare official in the same manner and subject to the provisions of this section governing the notice of lien originally served and filed pursuant to this section.

5. (a) The person, firm, corporation or insurance carrier, having notice that a social services official has served and filed a notice of lien, and intending to make payment on the personal injury claim upon which the lien was filed, shall notify the social services official by certified or registered mail, at least ten days prior to the date such payment is proposed to be made, of the amount and date thereof.

(b) Notwithstanding any inconsistent provision of this section, the social services official shall have the right to serve and file by certified or registered mail, within five days after receipt of such notice, excluding Saturdays, Sundays, and holidays, an amended notice of lien to include the amount of public assistance and care furnished to the recipient after the date such official served and filed the notice of lien or the last previous amendment thereof.

(c) A person, firm, corporation or insurance carrier that fails to give the notice required by paragraph (a) of this subdivision shall be liable to the social services official to the same extent that it would have been liable had such notice been given and the social services official had filed the amended notice of lien provided for in paragraph (b) of this subdivision.

6. Such lien may be enforced by action against those alleged to be liable for such injuries, as aforesaid, by the local public welfare official in any court of appropriate jurisdiction.

7. The aforesaid lien shall be valid and effective, when the notice thereof and the statement are served and filed as aforesaid, and shall continue until released and discharged by the local public welfare official by an instrument in writing and filed in the said county clerk's office, and no release, payment, discharge or satisfaction of any such claim, demand, right of action, suit or counterclaim shall be valid or effective against such lien.

8. The county clerk shall, at the expense of the county, provide a suitable book with proper index, to be called the public welfare lien docket, in which he shall enter the names of the public welfare official and the recipient, the date and place of the accident and the name or names of those alleged to be liable for such injuries, as aforesaid.

9. The provisions of this section to the contrary notwithstanding, the lien herein created shall be subject and subordinate to the lien on the amount recovered by verdict, report, decision, judgment, award or decree, settlement or compromise, of any attorney or attorneys retained by any such injured person to prosecute his claim for damages for personal injuries, having or acquiring by virtue of such retainer a lien on the cause of action of any such injured person, or on the verdict, report, decision, judgment, decree made in, or any settlement or compromise of, any such

action or claim for damages for personal injuries.

10. The provisions of this section to the contrary notwithstanding, the lien herein created shall be subordinate to the lien of any hospital claimed under and to the extent recognized by section one hundred eighty-nine of the lien law, but only for treatment, care and maintenance given, prior to or in excess of the public assistance and care granted by the public welfare official.

11. The provisions of this section shall not be deemed to adversely affect the right of a public welfare official who has taken an assignment of the proceeds of any such right of action, suit, claim, counterclaim or demand, to recover under such assignment the total amount of assistance and care for which such assignment was made.

12. The provisions of this section to the contrary notwithstanding, the lien herein created shall not apply with respect to any claim or benefits payable to the recipients of any form of public assistance or care, part of which is paid for by the government of the United States or any agency thereof when, in the opinion of the commissioner, such lien would jeopardize the continuation of such federal contribution.

13. The provisions of this section to the contrary notwithstanding, the public welfare official may in his discretion release to the injured person an amount not to exceed the cost of two years' maintenance from the lien herein created.

This section shall not apply to any claim or award which is or may be allowed pursuant to the provisions of the workmen's compensation law or the volunteer firemen's benefit law.

14. Any inconsistent provision of this chapter or of any other law notwithstanding, a social services official may not assert any claim under any provision of this chapter to recover payments of public assistance if such payments were reimbursed by child support collections.

D. ***Arkansas Dept. of Health and Human Services v. Ahlborn*, 547 U.S. 268 (2006)**

Ahlborn was a college student who suffered brain damage after she was involved in an automobile accident. She settled with the defendant for $550,000, which represented approximately one-sixth of the full value of her case. The settlement included past and future medical expenses as well as other types of damages. It did not allocate amounts for each type of damage. Arkansas Medicaid argued that it was entitled to the *full* balance of what it had paid in medical expenses – $215,615.30 – from the settlement proceeds. Ahlborn, on the other hand, argued that Medicaid was entitled to only one-sixth of the entire recovery, since she had only settled for one-sixth of what she was entitled to herself.

The United States Supreme Court unanimously held that federal Medicaid laws did not authorize Arkansas to recover an amount in excess of Ahlborn's recovery for medical expenses because the federal anti-lien provision affirmatively prohibited such recovery. The federal anti-lien provision allowed Arkansas to recover *only that portion of the settlement that represented past medical expenses*. That amount was equivalent to one-sixth of the recovery. Any recovery beyond that was unauthorized as it was Ahlborn's property.

Justice Stevens of the U.S. Supreme Court made an additional observation in dicta:

> Read literally and in isolation, the anti-lien prohibition contained in §1396p(a) would appear to ban even a lien on that portion of the settlement proceeds that represents payments for medical care. Ahlborn does not ask us to go so far, though; she assumes that the State's lien is consistent with federal law insofar as it encumbers proceeds designated as payments for medical care. Her argument, rather, is that the anti-lien provision precludes attachment or encumbrance of the remainder of the settlement.

Ahlborn, 547 U.S. at 284.

E. ***Wos v. E.M.A.*, 568 U.S. ___ (2013)**

In a more recent decision, *Wos v. E.M.A.*, the Supreme Court held that the Federal Anti-Lien Statute preempted North Carolina's statute. North Carolina's statute created a presumption that in every settlement, one-third of the proceeds represented compensation for past medical expenses. It permitted the state to recover the lesser of this amount or the amount it had actually paid. The United States Supreme Court ruled that this statute was preempted because it allowed for the *possibility* that North Carolina could take a portion of the plaintiff's proceeds that were not for past medical expenses. This was because one-third or the actual amount paid were not necessarily equivalent to or less than the amount the plaintiff received from the settlement for past medical expenses. The court noted that this was unacceptable under *Ahlborn* because a state could not recover from proceeds that were not designated as payment for medical expenses:

> And it is pre-empted for that reason. ***The defect in §108A-57 is that it sets forth no process for determining what portion of a beneficiary's tort recovery is attributable to medical expenses.*** Instead, North Carolina has picked an arbitrary number-one-third-and by statutory command labeled that portion of a beneficiary's tort recovery as representing payment for medical care. Pre-emption is not a matter of semantics. A State may not evade the pre-emptive force of federal law by resorting to creative statutory interpretation or description at odds with the statute's intended operation and effect. *Wos v. E.M.A.*, slip op. at 7 (emphasis mine).

F. **BIPARTISAN BUDGET ACT OF 2018**

On February 9, H.R. 1892 became law: The Bipartisan Budget Act of 2018. Deep within the bill, at Section 53102(b)(1), there is a complete repeal of the Medicaid changes that were included in the 2013 budget bill, which extended the Medicaid lien to reach the entire settlement proceeds effective October 1, 2017. As of that date, Medicaid could arguably collect on 100% of its lien, regardless of the settlement amount, and regardless of whether any part of that settlement included a past medical component. However, that 2013 law was completely repealed, effective

September 30, 2017, negating its effects permanently and retroactively. The Medicaid lien laws therefore remain as they had always been, as described in the sections above.

Precision Resolution's position is that this 2018 repeal of the 2013 amendments, effective retroactive to September 30, 2017, does far more than restore the *Ahlborn* allocation principle. As many of you know, prior to the effective date of the "*Ahlborn* repeal" on October 1, 2017, our office had always taken the position that Medicaid liens cannot exist against the property of a plaintiff. This position is rooted in the unambiguous terminology of the federal ***Anti-Lien Statute (42 U.S.C. § 1396p(a)(1):***

> **No lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan**, except . . .

This is not to say that the Medicaid agency does not have recovery rights, however. We have always argued that the Medicaid right is limited to subrogation by means of "automatic assignment" of the medical component of the case. That is because the Medicaid act also mandates:

> (a) For the purpose of assisting in the collection of medical support payments and other payments for medical care owed to recipients of medical assistance
> (b) under the State plan approved under this title [42 USCS §§ 1396 et seq.], a State plan for medical assistance shall--(1) provide that, as a condition of eligibility for medical assistance under the State plan to an individual who has the legal capacity to execute an assignment for himself, the individual is required—
> (A) ***to assign the State any rights, of the individual or of any other person who is eligible for medical assistance*** under this title [42 USCS §§ 1396 et seq.] and on whose behalf the individual has the legal authority to execute an assignment of such rights, to support (specified as support for the purpose of medical care by a court or administrative order) and ***to any payment from a third party that has a legal liability to pay for care and services available under the plan;*** 42 USCS § 1396k (emphasis added).

In *Ahlborn*, 547 U.S. 268 (2006), when the Arkansas Medicaid agency sought recovery of the entire amount of its lien on a limited recovery, Ms. Ahlborn fought back. In doing so, she acknowledged that Arkansas had a lien, but that it was limited to the "automatically assigned" medical component of the claim. The United States Supreme Court agreed but appeared to want to go further. Justice Stevens wrote for a unanimous Court:

> Read literally and in isolation, the anti-lien prohibition contained in § 1396p(a) would appear to ban even a lien on that portion of the

> settlement proceeds that represents payments for medical care. ***Ahlborn does not ask us to go so far,*** though; she assumes that the State's lien is consistent with federal law insofar as it encumbers proceeds designated as payments for medical care. Her argument, rather, is that the anti-lien provision precludes attachment or encumbrance of the remainder of the settlement. *Ahlborn*, 547 U.S. at 284 (emphasis added).

The *2013* Bipartisan Budget Act therefore not only legislatively overruled *Ahlborn*, but also gutted the plain language and intent of the federal anti-lien statute. Ironically, for a few short months the revised "***Anti-Lien*** statute" actually ***created a lien*** that had previously not existed.

The 2018 repeal of those Medicaid provisions in the 2013 Act not only restored the "*Ahlborn* allocation" but also restored the original congressional intent of the Medicaid Act (Social Security Act) signed into law by President Johnson in 1965 that states, "No lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan." 42 USC § 1396p.

V. "OTHER" LIEN CLAIMS: VETERAN'S ADMINISTRATION, TRICARE, FEDERAL EMPLOYEES

A. VA and Tricare

VA Benefits are administered by the Veterans Health Administration, an agency run by the Department of Veteran Affairs. TRICARE is administered by the Department of Defense.

Enrollment into the VA comprehensive health plan is determined by priority based on severity of the disability, whether or not it was service-connected, and one's income level. In the instance of service-connected disability, the cost of care is generally free. For other priority groups, there may be a copayment required. When a veteran is treated for non-service connected conditions, the VA will bill the veteran's private insurance, if other coverage exists, this includes billing TRICARE. VA will not, however, bill Medicare or Medicaid.

TRICARE is the United States Military's health insurance program, which falls under the Department of Defense. TRICARE covers active and retired service members, including veterans, from any seven of the uniformed services, including those in the National Guard and Reserves if they have been called to active duty for more than 30 consecutive days. Additionally, TRICARE covers spouses, children, and surviving spouses and surviving children.

Eligibility for TRICARE plans are broken into three major categories, and is dependent on the status, age, and location of the member. Active and retired members who live in a TRICARE Prime service area must enroll in the TRICARE Prime plan. Active duty members pay nothing out of pocket while retirees pay annual enrollment fees and copayments.

TRICARE Standard is a voluntary program for those not required to be enrolled in TRICARE Prime. For TRICARE Standard plans there is a nominal deductible and possible cost sharing depending on the location and services. Additionally, TRICARE Standard offers premium-based plans, which are more akin to private healthcare or HMOs.

Finally, TRICARE For Life is for anyone eligible for TRICARE benefits and who is enrolled in Medicare Parts A and B. Medicare's Part B premium is the only cost for TRICARE For Life. TRICARE For Life is secondary to Medicare, and the payer of last resort if there is any other insurance involved.

1. Federal Medical Care Recovery Act

The Federal Medical Care Recovery Act (FMCRA), 42 USC § 2651, authorizes the right of recovery by the United States for medical treatment paid by the federal government in situations where there is "tort liability." This right is independent of the injured person's right to recover. In addition, in third party tort liability situations, the US government has a right to recover the amount of pay that is incurred, or will be incurred, as a result of an armed services

member being injured or disabled and unable to perform active duty. The FMCRA applies to both TRICARE and VA benefit situations when tort liability is involved.

42 U.S.C. § 2651. The Federal Medical Care Recovery Act.

(a) Conditions; exceptions; persons liable; amount of recovery; subrogation; assignment. In any case in which the United States is authorized or required by law to furnish or pay for hospital, medical, surgical, or dental care and treatment (including prostheses and medical appliances) to a person who is injured or suffers a disease, after the effective date of this Act, under circumstances creating a tort liability upon some third person (other than or in addition to the United States and except employers of seamen treated under the provisions of section 322 of the Act of July 1, 1944 (58 Stat. 696), as amended (42 U.S.C. 249)) to pay damages therefor, the United States shall have a right to recover (independent of the rights of the injured or diseased person) from said third person, or that person's insurer, the reasonable value of the care and treatment so furnished, to be furnished, paid for, or to be paid for and shall, as to this right be subrogated to any right or claim that the injured or diseased person, his guardian, personal representative, estate, dependents, or survivors has against such third person to the extent of the reasonable value of the care and treatment so furnished, to be furnished, paid for, or to be paid for. The head of the department or agency of the United States furnishing such care or treatment may also require the injured or diseased person, his guardian, personal representative, estate, dependents, or survivors, as appropriate, to assign his claim or cause of action against the third person to the extent of that right or claim.

…

(d) Enforcement procedure; intervention; joinder of parties; State or Federal court proceedings. The United States may, to enforce a right under subsections (a), (b), and (c)[,] (1) intervene or join in any action or proceeding brought by the injured or diseased person, his guardian, personal representative, estate, dependents, or survivors, against the third person who is liable for the injury or disease or the insurance carrier or other entity responsible for the payment or reimbursement of medical expenses or lost pay; or (2) if such action or proceeding is not commenced within six months after the first day in which care and treatment is furnished or paid for by the United States in connection with the injury or disease involved, institute and prosecute legal proceedings against the third person who is liable for the injury or disease or the insurance carrier or other entity responsible for the payment or reimbursement of medical expenses or lost pay, in a State or Federal court, either alone (in its own name or in the name of the injured person, his guardian, personal representative, estate, dependents, or survivors) or in

conjunction with the injured or diseased person, his guardian, personal representative, estate, dependents, or survivors.

2. Case Law

***United States v. Trammel*, 899 F. 2d 1483 (6th Cir. 1990)**

An active United States Navy member was involved in a motor vehicle accident in Kentucky for which the government provided medical expenses. Kentucky's no-fault laws provide for an abolition of tort liability for the first $10,000.00 in economic loss, but allow for recovery of other non-economic damages. The government then sued the tortfeasor and insurer under the Recovery Act for medical expenses it paid. However, under the FMCRA, the government is only allowed to bring a separate suit against the tortfeasor in situations that create tort liability against the third party. The court therefore held that the FMCRA limits recovery to those circumstances where tort liability is created under state law.

> The government's independent right of recovery, therefore, is not independent in the sense that it is based upon a separate pecuniary loss distinct from Tramell's right of recovery under a state law cause of action in tort. Instead, the FMCRA only confers a right of recovery when a beneficiary is injured by conduct which subjects the third-party actor to tort liability to the beneficiary. In essence, the government stands in the position similar to that of a subrogee to the state law claim of the beneficiary against the tortfeasor…Accordingly, state substantive law is the basis for determining whether tort liability exists for purposes of an FMCRA claim. *Trammel*, at 1487-1488.

***Holbrook v. Anderson Corp.*, 996 F. 2d 1339 (1th Cir. 1993)**

The dependent of an active Navy member suffered injuries after falling out of a window in their apartment building. The plaintiff notified the government of their lawsuit, but the government did not choose to intervene. The district court *sua sponte* modified the settlement agreement to place funds in an escrow account pending satisfaction of the government's lien. The government then moved to intervene and have the escrowed funds released pursuant to the FMCRA. On appeal, the First Circuit took issue with the government asserting its lien against the plaintiff's settlement. It held that reimbursement may not be sought against the injured party themselves.

> All courts which have considered the question have agreed that the statute gives the Unites States an independent right of recovery against the tortfeasor…Thus, the government's right is not extinguished by the injured person's settlement and release with the tortfeasor. Indeed the government's right against the tortfeasor under the Recovery Act is not defeated even by certain restrictions that might bar the injured person's own recovery. There is thus no necessity for the United States to look to the injured party's settlement for compensation.

> If the United States wishes to invoke the Recovery Act to recover its medical payments in this case, we think under the plain language of the statute it must proceed against Andersen and seek to establish Andersen's tort liability. The language of the statutes does not authorize the government to collect under the Recovery Act out of a settlement negotiated between the injured person and the tortfeasor. Nor is there any case law that permits such a recovery absent an express agreement designating for the government a portion of the settlement. *Holbrook*, at 1341 (internal citations omitted).

***Mosey v. United States*, 3 F. Supp. 2d 1133 (D. NV. 1998)**

Mosey received a settlement in her personal injury lawsuit; some of the resulting treatment from the accident was provided at a VA hospital. The VA attempted to recoup its payments from Ms. Mosey's attorney under the FMCRA. Negotiations broke down and Mosey filed a declaratory judgment action to determine what portion of the VA's claim they were entitled to. The parties agreed that the government was entitled to some share of the settlement proceeds, but there was a dispute as to whether the VA's claim should be reduces based on equitable principles.

The court weighed 3 factors: (1) whether the government passively allowed the injured party to bear all the risks and costs of litigation, (2) whether, in the case of settlement, the award obtained reflects a "settlement discount," and (3) the terms of any agreement between the government and the victim, or the tortfeasor and the victim, as to the government's right to reimbursement. The last two factors were inapplicable, so the court balanced only the first factor. It reasoned that since the government passively let Mosey assume the risks and costs of litigation, its share of recovery must be reduced to take into account what it would have had to pay for attorney's fees. So the court analogized the case to the common fund recoveries, federal False Claims Act cases, and hypothetical hiring of attorneys and concluded that it was fair to reduce the government's recovery by 25% to account for attorney's fees.

Cockerham v. Garvin, 768 F. 2d 784 (6th Cir. 1985)

A veteran plaintiff held moneys in escrow for medical treatment received at a VA Hospital, which he received as the result of a settlement with the tortfeasor. Under the Medical Care Recovery Act, 42 UCS § 2651, the VA moved to be awarded reimbursement for the care they provided out of the escrowed funds in the underlying lawsuit. Ultimately the Court of Appeals held that the VA was entitled to the escrow funds, but remanded the case to address the VA's improper standing, and to hold an evidentiary hearing to determine the "reasonable value" of medical services rendered. The Sixth Circuit applied equitable principals to the settlement funds and held:

> In this hearing, the Court should consider the equities of the two parties. Although diligent research reveals no case law on the subject, it is clear that the government should not be reimbursed for the full amount of its claim in this case because it

> passively has allowed the veteran to bear all the risks and costs of pursuing litigation…The settlement agreement which created the fund expressly contemplates "appropriate settlement" between the plaintiff and the government. The government is not suing the tortfeasor. It seeks recovery only as a beneficiary of the fund, and therefore equitable considerations apply. If an insured veteran has accepted a discounted settlement for his claims of wage loss, pain and suffering, loss of future earning potential, and the like, it is not equitable to require full reimbursement for services the government was duty-bound to render. If Cockerham establishes on remand that his settlement was discounted, the government's portion should be reduced accordingly. Cockerham, at 787.

Additionally, the court found that under these circumstances, a six-year statute of limitations under 28 USC § 2415(a) applied. The court acknowledged that when the government seeks recovery directly against the tortfeasor, it involved tort liability, and § 2415(b) would apply for a three-year statute of limitations. However, in this situation, the beneficiary and tortfeasor entered into a settlement agreement, specifically segregating funds for medicals. Thus, the government's action here was based in contracts and the six years limitations period applied.

B. Federal Employees: Federal Employee Health Benefit Act

Most federal employees are provided health benefits through the Federal Employee Health Benefits Act. Benefits are provided through private insurance carriers, and the federal government, along with employees, pay a premium to the carriers. Benefits are administered through the Office of Personnel Management (OPM). There is no statutory right of FEHB plans to assert reimbursement rights.

However, there is a provision which states that the terms of any FEHB contract which relate to the coverage of benefits preempt state law related to health insurance.

> FEHBA Preemption clause 5 U.S.C. §8902(m)(1):
> (1) The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.

The relevant question became: does contract language in these types of plans, which relate to subrogation and reimbursement, "relate to the nature, provision, or extent of coverage or benefits" and thus preempt state law, e.g., New York General Obligations Law §5-335.

The answer had a long and tortured history which was finally resolved by the United States Supreme Court in *Coventry Health Care of Missouri, Inc. v. Nevils*, 581 U.S.___(April 18, 2017. The Court explained that there is an expansive view of Congress' use of the phrase

"relate to." The purpose of the statute also supported the Court's view, reasoning that there is a strong federal interest in uniform administration of the Federal Employee Health Benefits program, free from interference by the individual states.

Going further, the Court held that the statute does not violate the Supremacy Clause because it is the statute itself, not contract provisions, which preempt state law, while also noting that other federal statutes have similar effect and have been held to be valid, such as ERISA and the Federal Arbitration Act.

Ultimately the case was remanded for further proceedings consistent with the opinion.

Contract terms would therefore govern the scope of reimbursement rights in cases involving federal employees.

VI. SELF-FUNDED HEALTH BENEFIT PLANS: ERISA

Any retirement/pension or welfare benefit plan, including a health benefit plan, which is provided through a person's employer, is governed by Employee Retirement Income Security Act of 1974 (ERISA). 29 U.S.C. §1001 et seq. (There are a few exceptions, including any government plan or a church plan). As a federal statute, ERISA has great preemptive force over state laws, specifically anti-recovery and anti-subrogation statutes, which are normally used to bar recovery of settlement proceeds from health insurance providers.

A. SELF-FUNDED HEALTH PLANS VS. INSURED PLANS.

1. The distinction between self-funded ERISA plans and those that are insured ERISA plans is a significant one, as it is part of the determination of whether ERISA preempts state law.

2. Self-funded plans are often created by large employers that are better able to fund a group health and pension plan. The employer uses its own assets, usually in combination with contributions from the employees, to fund the plan. Using this method of funding the plan, the employer bears the risk of loss should the need for benefits to be paid occur. In this scenario, a commercial insurance company simply acts as a claims administrator, bearing no risk for payment of benefits, but processes claims and manages the fund out of which benefits are paid.

3. By contrast, an insured ERISA plan is one where the employer purchases insurance from a commercial insurer to cover the risk of loss should any benefits be paid out. Here, the employer (and employee through a contribution) pay a premium to the insurance company, which is on the risk for payment of benefits.

B. ERISA PREEMPTION

ERISA's express preemption statute consists of three parts, typically called the preemption clause, the savings clause, and the deemer clause:

1. The Preemption Clause:

> Except as provided in subsection (b) of this section, *the provisions of [ERISA] shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan* described in section 1003(a) of this title and not exempt under section 1003(b) of this title.

29 U.S.C. § 1144(a) (emphasis added).

2. The Savings Clause:

> Except as provided in subparagraph (B), *nothing in this subchapter shall be construed to exempt or relieve any person* from any *law of any State which regulates insurance,* banking, or securities.

29 U.S.C. § 1144(b)(2)(A) (emphasis added).

3. The Deemer Clause:

> Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, *shall be deemed to be an insurance company or other insurer,* bank, trust company, or investment company *or to be engaged in the business of insurance* or banking *for purposes of any law of any State purporting to regulate insurance companies, insurance contracts,* banks, trust companies, or investment companies.

29 U.S.C. 1144(b)(2)(B) (emphasis added).

4. *FMC Corp. v. Holliday*, 498 U.S. 52 (1990)

This Supreme Court case decided in 1990 involved a state anti-subrogation statute from Pennsylvania and a self-funded ERISA plan. In interpreting ERISA's preemption scheme, the Court held:

> We read the deemer clause to exempt self-funded ERISA plans from state laws that 'regulate insurance' within the meaning of the saving clause. . . State laws that directly regulate insurance are 'saved' but do not reach self-funded employee benefit plans because the plans may not be deemed to be insurance companies, other insurers, or engaged in the business of insurance for purposes of such state laws. On the other hand, employee benefit plans that are insured are subject to indirect state regulation. An insurance company that insures a plan remains an insurer for purposes of state laws, 'purporting to regulate insurance' after application of the deemer clause [of ERISA]. The insurance company is therefore not relieved from state insurance regulation. The ERISA plan is consequently bound by state insurance regulations insofar as they apply to the plan's insurer.

FMC, 498 U.S. 52, 62 (1990).

In other words, *FMC* created the preemption distinction between self-funded plans, and insured plans. If a plan is self-funded, state laws regulating insurance are preempted, and ERISA applies. For insured plans, any state law which regulates insurance is applicable.

5. New York State General Obligations Law § 5-335.

GOL § 5-335 is New York State's anti-subrogation statute. The statute applies only to settlements, but precludes health insurers from making a claim for subrogation or reimbursement against the settlement proceeds. The statute states:

> Limitation of reimbursement and subrogation claims in personal injury and wrongful death actions. (a) **When a person settles a claim**, whether in litigation or otherwise, against one or more other persons **for personal injuries, medical, dental, or podiatric malpractice, or wrongful death, it shall be conclusively presumed that the settlement does not include any compensation for the cost of health care services, loss of earnings or other economic loss to the extent those losses or expenses have been or are obligated to be paid or reimbursed by an insurer**. By entering into any such settlement, a person shall not be deemed to have taken an action in derogation of any right of any insurer that paid or is obligated to pay those losses or expenses; nor shall a person's entry into such settlement constitute a violation of any contract between the person and such insurer. **No person entering into such a settlement shall be subject to a subrogation claim or claim for reimbursement by an insurer and an insurer shall have no lien or right of subrogation or reimbursement against any such settling person or any other party to such a settlement, with respect to those losses or expenses that have been or are obligated to be paid or reimbursed by said insurer.**

NY CLS Gen. Oblig. § 5-335 (emphasis added).

An "insurer" as is used in GOL §5-335 is defined as:

> As used in section 5-335 of this article, the term "insurer" means any insurance company or other entity which provides for payment or reimbursement of health care expenses, health care services, disability payments, lost wage payments or any other benefits under a policy of insurance or an insurance contract with an individual or group.

NY CLS Gen. Oblig. § 5-101(4).

C. EQUITABLE RELIEF UNDER ERISA.

Under the provisions of ERISA, a civil action may be brought by a member of the plan, or by a fiduciary who administers the plan, to enforce certain rights under ERISA and/or the terms of the benefit plan. ERISA dictates which courts have jurisdiction to hear these actions, and what specific relief may be sought.

1. Section 502(a)(1)(B), 29 U.S.C. §1132(a)(1)(B)

(a) <u>Persons empowered to bring a civil action</u>
A civil action may be brought—
(1) by a participant or beneficiary—
(A) for the relief provided for in subsection (c) of this section, or
(B) o recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

2. Section 502(a)(3), 29 U.C.S. §1132(a)(3).

A civil action may be brought—
(3) by a participant, beneficiary, *or fiduciary*

(A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or

(B) o obtain other ***<u>appropriate equitable relief</u>***
(i) to redress such violations or
(ii) ***<u>to enforce</u>*** any provisions of this subchapter or ***<u>the terms of the plan.</u>***

29 U.S.C. § 1132(a)(3) (emphasis added).

3. *Great-West Life & Annuity Insurance Co. v. Knudson*, 534 U.S. 204 (2002)

Knudson was a plan member who was involved in a motor vehicle accident for which his plan initially paid medical benefits. After Knudson settled his personal injury case against the tortfeasor, the plan filed suit in federal court under §502(a)(3) to seek reimbursement for the medical expenses they paid. Pursuant to the language of 502(a)(3), the plan must obtain reimbursement by seeking "appropriate equitable relief." The Court explained that in order for a reimbursement claim to sound in equitable relief, there must be a constructive trust or an equitable lien, while an action in law (which is not permitted under ERISA's civil enforcement scheme) seeks to impose personal liability on the plan member to reimburse the plan, as a general creditor.

The Court held that in order to obtain appropriate equitable relief, the plan must seek recovery against a particular fund, and that particular fund must be in the possession of the member. In this case, by the time the Plan sued the Knudsons, the settlement proceeds had

already been placed into a special needs trust. Since the funds were not in Knudson's possession, the plan could not properly seek equitable relief.

4. *Sereboff v. Mid-Atlantic Services, Inc.*, 547 U.S. 356 (2006)

Four years after *Knudson* was decided, the Supreme Court decided *Sereboff*. Similar to *Knudson*, Sereboff was injured in a motor vehicle accident and was provided medical benefits through his ERISA plan. The plan filed suit in district court under 502(a)(3) seeking reimbursement after Sereboff received a settlement from the car accident. Through a stipulation by the parties in district court, a portion of the settlement funds were segregated accounting for the medical expenses paid by the plan.

The Supreme Court elaborated on the rules found in *Knudson*, and held that it was the plan language that controlled whether or not the plan was seeking equitable relief. By this the court meant that the recovery language in the plan must specify a specific fund in the member's possession, which the Court stated was separate from the member's general assets, and the particular share of that fund that the plan was entitled to. Here, unlike in *Knudson*, the funds were in a separate fund held by the Sereboffs for which equitable relief could be sought.

5. *U.S. Airways v. McCutchen*, 133 S.Ct. 1537 (April 16, 2013)

In *McCutchen*, the question was presented as to what is means by "appropriate" equitable relief in the statute. The Third Circuit held that appropriate equitable relief meant that any and all equitable defenses could be asserted against a plan seeking reimbursement under the equitable relief provision. However, the U.S. Supreme Court ruled that so long as the plan specifically waives the application of an equitable defense, it is unavailable. The U.S. Supreme Court held:

> US Airways . . . is seeking to enforce the modern-day equivalent of an "equitable lien by agreement." And that kind of lien—as its name announces—both arises from and serves to carry out a contract's provisions. . . . So enforcing the lien means holding the parties to their mutual promises. . . . Conversely, it means declining to apply rules—even if they would be "equitable" in a contract's absence—at odds with the parties' expressed commitments. McCutchen therefore cannot rely on theories of unjust enrichment to defeat US Airways' appeal to the plan's clear terms.
> . . .
> Even in equity, when a party sought to enforce a lien by agreement, all provisions of that agreement controlled. So too, then, in a suit like this one.
> . . .
> The plan, in short, is at the center of ERISA. And precluding McCutchen's equitable defenses from overriding plain contract terms helps it to remain there.

This is a major holding that confirmed that the terms of the plan, contracting away equitable defenses like the made-whole doctrine or common-fund doctrine, were enforceable against the member.

In *McCutchen*, the case was remanded back to the district court for a determination of whether the plan at issue specifically waived the application of the common fund doctrine.

6. *Montanile v. Bd. of Trustees of the Nat'l Elevator Industry Health Benefit Plan*, 136 S.Ct. 651 (January 20, 2016).

In 2016, a major decision was passed down by the Supreme Court analyzing the equitable relief rules established under *Knudson* and *Sereboff*, mainly, what recourse, if any, the plan had when settlement funds were dissipated and no longer in the possession of the plan member. The Court determined that:

> In sum, at equity, a plaintiff ordinarily could not enforce any type of equitable lien if the defendant once possessed a separate, identifiable fund to which the lien attached, but then dissipated it all. The plaintiff could not attach the defendant's general assets instead because those assets were not part of the specific thing to which the lien attached.

Therefore, the Supreme Court held that if the plan member's funds were dissipated and could not be traced to a tangible item, the plan had no recourse against them.

D. WHAT IS THE "AGREEMENT" IN "EQUITABLE LIEN BY AGREEMENT?"

29 U.S.C. § 1024(b)(4) under ERISA mandates that upon written request by the plan member, to the plan administrator, certain plan documents must be furnished to the plan member. Among these documents are the Summary Plan Description (SPD) and the plan document. Under ERISA, these are two different documents, both requirements for a plan. However, in some cases, the terms of the SPD differ from the terms of the plan document. Therefore, it is important to have all documents related to the plan at your disposal when analyzing any claim for reimbursement.

1. *Cigna v. Amara*, 131 S.Ct. 1866 (May 16, 2011)

The Supreme Court was faced with distinguishing the difference between the Plan Document and the SPD. The Court held:

> We cannot agree that the terms of statutorily required plan summaries (or summaries of plan modifications) necessarily may be enforced (under § 502(a)(1)(B)) as the terms of the plan itself.
>
> ***

> Summary documents, important as they are, provide communication with beneficiaries *about* the plan, but that their statements do not themselves constitute the *terms* of the plan for purposes of §502(a)(1)(B).

This holding confirmed that the Plan Document language controlled over the language contained in the SPD.

2. *McCutchen* Continued*:* Remand to the Western District of Pennsylvania.

The Supreme Court remanded this case to determine whether or not the common fund doctrine had been dispensed of by virtue of the plan language.

A very important issue in *McCutchen* was relegated to a footnote, but the issue reappeared in the remand to the district court. The Supreme Court noted that the document at issue in the case was the U.S. Airways SPD. Despite repeated requests for the actual plan document, U.S. Airways did not disclose it until it was specifically requested by the Solicitor General of the United States in preparation for the Supreme Court case. Because the plan document was never in the record before it, the Supreme Court decided the case on the basis of the SPD.

It turned out that the actual plan document had much different reimbursement language than the Summary Plan Description.

When the case was remanded, McCutchen's attorneys moved to amend their Answer, six years after the fact, to add causes of action for breach of the plan's fiduciary duty for failure to disclose the plan document. The motion was granted.

> In *Amara*, the Court found it improper to enforce the terms of the SPD over the plan language reasoning that the syntax of another section of ERISA, § 102(a), which obliges the plan administrators to furnish SPDs and requires that participants and beneficiaries "be advised of their rights and obligations 'under the plan,'" suggests that the information about the Plan provided by the SPDs "is not itself part of the plan." Since *Amara*, courts have agreed that the summary plan provisions, including stipulations not present in the plan certificate, are unenforceable.

The district court then enforced the terms of the plan that were contained in the Plan Document, and not those in the SPD.

E. REQUESTING AND REVIEWING PLAN DOCUMENTS

ERISA requires certain documents to be furnished to the plan member upon written request to the designated plan administrator. 29 U.S.C. § 1024(b)(4). Failure by the plan

administrator to furnish the requested documents within 30 days of receipt of the request can result in a penalty of $110.00 per day that the administrator is in breach. 29 U.S.C. § 1132(c)(1) and 29 CFR § 2575.502c-1.

1. Requesting all relevant documents.

The following form letter can be used to request all relevant documentation, and was provided by Professor Roger Baron of the University of South Dakota School of Law.

Date

(Name of Plan Administrator – should be set forth in SPD)
Plan Administrator for_____Medical Plan
Street address
City, State, Zip Code

CERTIFIED MAIL: Return Receipt Requested

Dear Mr./Ms.,

My name is_____. Pursuant to my right as a participant and beneficiary of _____ Plan, I respectfully request copies of the following materials:

Copies of the Summary Plan Description (SPD) and other Plan Documents relating to my health insurance coverage for the years (year preceding date of injury through current year);

Copies of the Plan Document relating to my health coverage for the years (year preceding date of injury through current year);

Administrative Services Contract between (Employer/Plan) and (Plan Insurer(s)/Claims Administrator) for the years (year preceding date of injury through current year);

Copies of all contracts including, but not limited to: Insurance contracts, Stop Loss Contracts, Health Insurance Contracts, Insurance Intermediary Services Contracts, and Administrative Services Contracts related to_____Medical Plan serving (insert name of state or region encompassing client) participants for the years (year preceding date of injury through current year);

Amendments to the Plan Documents for_____Medical Plan (including, but not limited to the Summary Plan Description) for the years (year preceding date of injury through current year);

Copies of the SMM (Summary of Material Modifications) statements for the years (year preceding date of injury through current year);

Copies of form 5500, including all attached schedules, filed with the U.S. Department of Labor for the years (year preceding date of injury through current year).

Please forward these materials to my attorney, Mr./Mrs._____, (street address), (city), (state), (zip code).

Thank you.

_____ (signature)
(Name of Participant/Beneficiary – Printed)
Plan Participant
Plan Beneficiary

2. *Popowski v. Parrott*, 461 F.3d 1367 (11th Cir. 2006).

Following the decision in *Sereboff*, the Eleventh Circuit applied the equitable relief test to two different plans. The plans contained the following reimbursement language:

United Distributors Plan:

> In any event, the Plan has a lien on any amount recovered by the Covered Person whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full.
>
> The Covered Person…must repay to the Plan the benefits paid on his or her behalf out of the recovery made from the third party or insurer.

Mohawk Plan:

> If, however, the Covered Person receives a settlement, judgment, or other payment related to the accidental injury or illness from another person, firm, corporation, organization or business entity paid by, or on behalf of, the person or entity who allegedly caused the injury or illness, the Covered Person agrees to reimburse the Plan in full and in first priority, for any medical expenses paid by the Plan relating to the injury or illness.

The Eleventh Circuit held that the United Plan required repayment to be made *out* of the settlement proceeds, thereby identifying a particular fund to which reimbursement is sought. By contrast, the Mohawk Plan did not require payment to be made from the settlement itself, but instead made the receipt of settlement proceeds a triggering event that would enable the Plan to seek reimbursement. Under this interpretation, the Mohawk Plan did not identify a particular fund because once a settlement was reached, the member was free to reimburse the plan out of any assets.

3. Form 5500

This document is an annual report about the funding, administration, and participation of the plan, which is required to be annually submitted to the U.S. Department of Labor. The "plan funding arrangement" should be noted, and contain a "Schedule A" for every insurance contract which is associated with the plan. The information contained therein may be useful in determining whether a health plan is self-funded, either through a trust or the employer's general assets, or by insurance.

F. JURISDICTION

In cases brought by ERISA plans as plaintiffs to enforce a lien or reimbursement right, the United States District Courts have exclusive jurisdiction. However, when a participant or beneficiary of an ERISA plan brings a claim under Section 502(a)(1)(B) "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan," there is concurrent jurisdiction with the state courts:

> Except for actions under subsection (a)(1)(B) of this section, the district courts of the United States shall have exclusive jurisdiction of civil actions under this subchapter brought by the Secretary or by a participant, beneficiary, fiduciary, or any other person referred to in section 1021(f)(1) of this title. **State courts of competent jurisdiction and district courts of the United States shall have concurrent jurisdiction of actions under paragraphs (1)(B) and (7) of subsection (a) of this section**. 29 U.S.C. §1132(e) (emphasis added).

In a case in the Northern District of New York, *In re Boisseau*, 2017 U.S. Dist. LEXIS 11964, 2017 WL 395124 (N.D.N.Y. January 30, 2017), a case involving an ERISA lien was remanded to state court using the "probate exception" to federal jurisdiction. This was a case in which the ERISA plan participant sued the plan in state court to vacate the asserted lien on the proceeds of a medical malpractice and wrongful death settlement. The Northern District made it a point to acknowledge that the plan participant ("Petitioner") made repeated requests to obtain plan information and failed to receive a satisfactory response:

> Petitioner sent repeated requests to the Plan seeking information in order to ascertain the validity of the lien. After failing to receive a satisfactory response from the Plan, Petitioner filed a petition in the Oswego County Surrogate's Court under section 1809 of the Surrogate's Court Procedure Act seeking to vacate the lien. As a result, on April 1, 2016, the Surrogate's Court issued an order to show cause as to why the lien should not be dismissed. The

> Plan responded by removing the action to this Court, asserting federal question jurisdiction under ERISA, and Petitioner moved to remand.

In re Boisseau, 2017 U.S. Dist. LEXIS at *2-3. The Northern District then applied the probate exception to federal jurisdiction, noting that the exception has two purposes, as outlined by the United States Supreme Court:

> (1) it "reserves to state probate courts the probate or annulment of a will and the administration of a decedent's estate" and (2) it "precludes federal courts from endeavoring to dispose of property that is in the custody of a state probate court." This case falls squarely within the scope of the second application of the probate exception because it necessarily involves the Court's interference with a res in the custody of the state probate court. As Petitioner makes clear, "[t]he res of Mr. Boisseau is subject exclusively to the jurisdiction of the Oswego County Surrogate's Court. . . . Any claim against the settlement proceeds is a claim against his estate."

Id. at *8 (internal citations omitted).