MEDICAID AND MEDICARE LIENS, SETTLEMENTS, & SET-ASIDES

ROSSDALE CLE

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About our Speakers

BRETT NEWMAN, LIEN RESOLUTION GROUP

Brett Newman graduated with a degree in economics from Syracuse University in 1989. As managing partner of The Lien Resolution Group, Mr. Newman is known nationally by plaintiff attorneys for his expertise on claims avoidance and reduction. Recognizing the ever growing nature of lien resolution and the ever-increasing associated liability, Mr. Newman established The Lien Resolution Group and The Newman Structured Settlement Group to assist both individual claimants of personal injury lawsuits and mass tort claimants in the protection of their proceeds and government benefits.

About our Speakers

FRANKLIN P. SOLOMON, SOLOMON LAW FIRM LLC

A graduate of Rutgers University School of Law at Camden, Franklin Solomon is based in Cherry Hill, NJ, with a nationwide practice focused on evaluation, litigation and resolution of healthcare lien/reimbursement claims, representing personal injury victims and their attorneys against health plans and government benefits programs seeking payment from tort recoveries. He was counsel in both *Wurtz v. The Rawlings Company* (2d Cir. 2014) and *Levine v. United Healthcare* (3d Cir. 2005), class actions challenging ERISA plan insurers' reimbursement claims, and in *Taransky v. Sec. U.S. Dept. of Health & Human Svcs.* (3d Cir. 2014), a class action challenging Medicare reimbursement claims. Prior to opening his own firm, Mr. Solomon's practice included 20 years of litigating mass tort and individual personal injury claims on behalf of plaintiffs.

MEDICAID

MEDICAID

Statutes and Case Law

- 42 U.S.C. § 1396p(a)
- *Arkansas Dept. of Health and Human Svcs. v. Ahlborn*, 547 U.S. 268 (2006)
- *Wos v. E.M.A.*, 568 U.S. ___, 133 S.Ct. 1391 (2013)
- Bipartisan Budget Act of 2013
  - Amendments to 42 USC §1396a legislatively overrule *Ahlborn*.
    - ***Implementation delayed until Oct. 1, 2017***

MEDICAID

- *Ahlborn/Wos* proportionate share reduction
  - Procedure varies by state
    - Medicaid Managed Care
      - State statute or policy may prohibit MMC company claims
      - NJ does pursue MMC claims through DMAHS
  - Measure of damages
    - Comparable cases
    - Time-unit analysis
    - Multiple of medical expenses
- Offset for costs & fees

MEDICAID

- **TORT-RELATED CLAIMS v. ESTATE CLAIMS**
- ***3d Party Recovery Lien Statutes***
  - Written notice of 3d party claim to administering agency
  - Notice of any settlement to administering agency
  - Rules for perfecting agency claims against third parties
  - Reimbursement in full? Pro rata fees/costs?
  - Administrative process?
- ***Estate Lien Statutes***
  - State may seek recovery of **all assistance paid** on behalf of beneficiary age 55 or older, or if permanently institutionalized

MEDICAID

Estate Recovery Mandate (1993):

- States **must pursue recovery** of medical assistance costs for:
  - Nursing home or other long-term institutional services;
  - Home- and community-based services;
  - Hospital and prescription drug services provided while the recipient was receiving nursing facility or home- and community-based services
- At State option, any other items covered by the state Medicaid plan
- At a minimum, states must recover from assets that pass through probate (governed by state law). At a maximum, states may recover any assets of the deceased recipient.

MEDICAID

- States are **prohibited from making estate recoveries:**
  - During the lifetime of a surviving spouse, no matter where he or she lives
  - From a surviving child under age 21, blind or permanently disabled (SSI/Medicaid definition of “disability”), no matter where he or she lives
  - From a recipient’s former home, when a sibling with an equity interest in the home has lived there for at least 1 year immediately before the deceased Medicaid recipient was institutionalized and resided in the home continuously since the recipient's admission.
  - From a recipient’s former home, when an adult child has lived there for at least 2 years immediately before the deceased Medicaid recipient was institutionalized, has lived there continuously since that time, and can establish to the satisfaction of the State that he or she provided care that may have delayed the recipient’s admission to the nursing home or other medical institution.

MEDICARE

MEDICARE (Medicare Secondary Payer)

- 42 U.S.C. § 1395y(b)(2) - (8)
- Effective 12-5-1980
  - Date significant for exposure/ingestion claims
- Substantially modified by the Prescription Drug and Medicare Improvement Act of 2003
- Now includes Section 111of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) and “SMART” Act of 2012
- Reporting requirements for Responsible Reporting Entities (“RREs”); electronic portal access

MEDICARE - MSP Liability

Repayment required

- A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this subchapter with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service.

42 USC § 1395y(b)(2)(B)(ii)

MEDICARE (Medicare Secondary Payer)

Recent Case Law

- ***Bradley v. Sebelius,***
  621 F.3d 1330 (11th Cir. 2010)
- ***Hadden v. United States,***
  661 F.3d 298 (6th Cir. 2012)
- ***Taransky v. Secty, U.S. Dept. of HHS,***
  760 F.3d 307 (3d Cir. 2014)

MEDICARE (Medicare Secondary Payer)

- The take-away:
  - *To the extent a defendant has ANY liability to plaintiff, Medicare is deemed to be entitled to full reimbursement (less pro rata fees & costs) from the beneficiary's recovery regardless of liability or coverage issues.*

MSP Private Cause of Action

- **42 U.S.C. § 1395y(B)(3)(A):**

"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)."

MSP Private Cause of Action

- *Bio-Medical Applications of Tenn. v. Central States,* 656 F.3d 277 (6th Cir. 2011)
  - Provider sued health plan as participant's assignee
- *In Re Avandia,* 685 F.3d 353 (3d Cir. 2012)
  - Medicare Advantage plan sued mass tort defendant
- *Michigan Spine & Brain Surgeons v. State Farm Auto,* 758 F.3d 787 (6th Cir. 2014)
  - Provider sued automobile no-fault insurer
  - ***a primary plan fails to reimburse when it "causes Medicare to step in and (temporarily) foot the bill"*** (quoting *Bio-Medical*).

MSP Private Cause of Action

- No-Fault and Liability Insurers are Named Defendants
  - No-fault insurance coverage provided by defendant PIP CARRIER – or – liability insurance coverage provided by defendant LIABILITY CARRIER is a “primary plan” with respect to Medicare for payment of medical expense benefits on behalf of plaintiff
- MSP Private Cause of Action is NOT a qui tam action.
- Must be brought on behalf of a claimant who has actually suffered a loss.

Pleading the MSP Private Cause of Action

- As a direct and proximate result of the failure and refusal of defendant PIP/LIABILITY CARRIER to make payment with respect to items and services required for diagnosis and treatment of the injuries incurred by plaintiff in the aforesaid accident, plaintiff has been required to seek and rely on conditional benefits of the Medicare program, which has exposed and will in the future expose plaintiff to additional costs and financial liability, including but not limited to liability to the Medicare program, all to the detriment of plaintiff.

MSP Claim Reduction

- MSP claims are automatically reduced by a proportionate share of attorney fees and litigation costs.
  - Provide documentation with Final Settlement Detail.
  - Once Settlement Detail is submitted, Medicare will issue its initial determination and demand.

42 CFR § 411.37

SMART Act

- ‘Strengthening Medicare and Repaying Taxpayers Act of 2012”
  - Section 201requires an “electronic portal” for notice of final conditional payment amounts.
  - Section 202 requires an annual “settlement threshold” exempting small settlements from MSP reporting and repayment. As of October 2014, most liability settlements of $1000 and under are exempted.
  - Section 205 sets a 3-year limitations period for CMS to pursue MSP recoveries, beginning when a claim is reported. SOL effective July 10, 2013.

SMART Act Portal Process

- Not less than 185 days before settlement provide CBRC with initial notice of pending liability claim.
  - CBRC posts conditional payments.
- Not more than 120 days before settlement notify CBRC of pending settlement through portal.
  - Provide notice one time only!
- At least 8 business days before settlement, request Claims Refresh.
  - Must receive confirmation of Claims Refresh before you can get final Conditional Payment Amount.
- Not more than 3 days before settlement, download time- and date-stamped Conditional Payment Summary through portal.
  - As long as case settles within 3 days, you can rely on this Summary.

MEDICARE SET-ASIDES

Considering Medicare's Interest

- Workers Compensation
- Third-Party Liability
  - ANPRM 6047 Withdrawn 10-8-2014

MEDICARE SUBSTITUTE PLANS

MEDICARE SUBSTITUTE PLANS (Medicare Advantage)

- Medicare Advantage (formerly Medicare+Choice) is privately issued insurance subsidized by the government, offered in lieu of “traditional” Medicare.
- MA plans typically offer additional benefits, such as expanded medical expense and prescription drug coverage.
- MA plans are specifically governed by Part C of the Medicare statute

MAO as Secondary Payer

- Where payment would be secondary under the Medicare Secondary Payer Act, a Medicare Advantage organization may 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**.

42 USC § 1395w-22(a)(4)

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

- Part C statute does not create a private cause of action to enforce reimbursement claims.
- Part C statute does not confer any affirmative right to reimbursement; any reimbursement claim must be based on contract provision.
  - *See also* ***Nott v. Aetna,*** 303 F.Supp.2d 565 (EDPA 2004)
  - *Comment: To the extent MA plan contract may require reimbursement, it is limited by the Part C Secondary Payer provision.*

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

- Reiterates holdings of *Engstrom* and *Nott.*
- Neither statutory reference to MSPA nor 42 CFR §422.108(f), granting MAOs "the same rights to recover … that the Secretary exercises," create any substantive right to a private cause of action.
- Medicare Act does not authorize creation of a common law of subrogation for plan claims.

In Re Avandia, 685 F.3d 353 (3d Cir. 2012)

- *Cert. denied,* 133 S.Ct. 1800, *sub nom GlaxoSmithKline, LLC v. Humana Medical Plans, Inc.* (2013).
- Allows MAOs to access "private cause of action" provision under MSPA, 42 U.S.C. § 1395y(b)(3)(A).
- By its terms, private cause of action is exercisable only against a "primary plan" that has failed to make payment.
  - *But see* ***Collins v. Wellcare****,* 2014 WL 7239426 (E.D. La.)

Humana Medical Plan v. Western Heritage Ins. Co., --- F.3d --- (11th Cir., Aug. 8, 2016)

- Follows 3d Circuit's *In Re Avandia* decision
- Allows MAO to bring claim against liability carrier under MSPA private cause of action
- Assesses double damages for liability carrier's failure to "provide for appropriate reimbursement"
  - Insurer had constructive knowledge and ability to discern nature of coverage
  - Holding funds in trust doesn't suffice

Cases to Watch

- ***Humana Ins. Co. v. Paris Blank LLP*** (E.D.Va., May 10, 2016)
  - Denies motion to dismiss MAO's claim against plaintiff's attorney under MSP private cause of action
    - Double damages
- ***Emblem Health v. Yi*** (S.D.N.Y.)
  - Includes claims against plaintiff's attorney and liability carrier

FEDERAL EMPLOYEES

Federal Employees Health Benefits Act

FEDERAL EMPLOYEES HEALTH BENEFITS (FEHB)

Federal OPM contracts with 38 Plans, including:

American Postal Workers Union (APWU)
National Association of Letter Carriers (NALC)
Mail Handlers Benefit Plan (MHBP)
SAMBA
GEHA
BCBS
UHC
CareFirst

EXPRESS PREEMPTION:

- **5 U.S.C. § 8902. Contracting authority**

***

(m)(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.

FEHBA: The Developing Case Law

- ***Empire Healthchoice Assurance, Inc. v. McVeigh,*** 547 U.S. 677 (2006)
  - Reimbursement right based on a FEHBA contract is not a prescription of federal law.
  - Reimbursement right stems from recovery on a personal-injury claim governed by state law. “We are not prepared to say … an OPM-BCBSA contract term would displace every condition state law places on that recovery.”

Fun fact: 2d Cir. opinion by J Sotomayor questions constitutionality of preemption clause

- ***Nevils v. Group Health Plans, Inc.,*** 418 S.W.3d 451, (Mo. 2014)
  - Insurer's right to subrogation does not "relate to" issues of coverage and benefits, which defines the scope of preemption; FEHB plan subro/reimbursement claims remain subject to state-law restrictions.
- ***Kobold v. Aetna Life Ins. Co.,*** 233 Ariz. 100, 309 P.3d 924 (Ariz. 2013)
  - State anti-subrogation law bars FEHB plan's reimbursement claim out of tort recovery

Final Rule 890.106

- Published in Federal Register Jan. 7, 2015; Comment period closed Feb. 6, 2015; Effective June 22, 2015
  - Subro/reimbursement clauses are mandatory
  - Subro/reimbursement is a condition and limitation of benefits; relates to nature, provision & extent of coverage
  - First-priority right regardless of nature of recovery

- ***Coventry Health Care of Mo. v. Nevils, (Mo.), Kobold v. Aetna Life Ins. Co (Ariz.)***

  (US Supreme Court, June 29, 2015)

  - New OPM rules expressly link reimbursement rights to provision of coverage and benefits, interpret FEHBA to grant preemptive effect to health contract provisions approved by OPM.
    - *Remanded for consideration in light of new agency rule*
    - *Does not resolve constitutional issue*

- ***Helfrich v. BCBS Assn.***, 804 F.3d 1090 (10th Cir. 2015)
  - FEHBA preempts state anti-subrogation law
  - *Chevron* deference to OPM rule
  - Declined to address constitutional issue as not raised below

- ***Kobold v. Aetna*** (on remand), 370 P.3d 128 (Ariz. 2016)
  - *"Chevron* deference … compels us to apply OPM's interpretation even though we view the analysis of *Kobold I* and *Nevils* as more faithful to the text of the statute."

- ***Nevils v. Group Health Plan*** (on remand), 492 S.W.3d 918 (Mo. 2016)
  - Chevron deference does not apply
  - FEHBA does not preempt state law
  - ***Petition for certiorari granted 11-04-2016***

- ***Bell v. BCBS of Okla.,*** 823 F.3d 1128 (8th Cir. 2016)
  - Expressly disagrees with *Nevils II*
  - Even without *Chevron* deference, FEHBA preempts state law
  - Constitutionality issue forfeited because not raised in defense of plan's motion for judgment on the pleadings
  - ***Petition for certiorari conference set for 01-06-2017***

FEDERAL MEDICAL CARE RECOVERY

FEDERAL MEDICAL CARE RECOVERY ACT (FMCRA)

- FMCRA provides the statutory authority for US government subrogation claims against tortfeasors
  - Includes:
    - Military personnel and dependents/survivors
    - Veterans and dependents/survivors
    - 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.

- **42 U.S. Code § 2651 - Recovery by United States**
- "under circumstances creating a tort liability upon some third person … the United States shall have a right to recover … from said third person, or that person's insurer, the reasonable value of the care and treatment … and shall, as to this right be subrogated to any right or claim that the injured or diseased person … has against such third person."
  - *Statute creates no claim against a beneficiary.*

- **Enforcement procedure: intervention or joinder**
  - The United States may
    - (1) intervene or join in any action brought by the injured person against the third person liable for the injury, or the insurance carrier or other entity responsible for medical expenses or lost pay; or
    - (2) Institute legal proceedings in state or federal court against the third person liable for the injury, or the insurance carrier or other entity responsible for medical expenses or lost pay, if an action has not been otherwise commenced within 6 months after care is first paid for by the United States.

42 U.S.C. § 2651(d)

Veterans Administration

- **Recovery by the United States of the cost of certain care and services.**
  - 38 U.S.C. § 1729(b)(1). The United States shall be subrogated to any right or claim that the veteran) may have against a third party.
  - 38 U.S.C. § 1729(i)(3). ``Third party'' means-- (A) a State or political subdivision of a State; (B) an employer or an employer's insurance carrier; (C) an automobile accident reparations insurance carrier; or (D) a person obligated to provide, or to pay the expenses of, health services under a health-plan contract.

TriCare & CHAMPVA

- TRICARE is a regionally managed health care program for active duty and retired members of the uniformed services, their families, and survivors.
- CHAMPVA (Civilian Health and Medical Program of the Department of Veterans Affairs) is a healthcare program for spouses, dependent children or survivors of veterans, not otherwise eligible for TRICARE.
  - CHAMPVA is always the secondary payer to Medicare.

- **Collection from third-party payers**
  - The United States shall have the right to collect from a third-party payer … to the extent that the person would be eligible to receive reimbursement or indemnification from the third-party payer … less the appropriate deductible or copayment amount.
  - "Third-party payer" means an entity that provides an insurance, medical service, or health plan … designed to provide coverage for expenses incurred by a beneficiary for health care services or products.
  - In cases of tort liability, collection from a third-party payer that is an auto liability insurance carrier is governed by FMCRA.

10 USC § 1095


THE LIEN RESOLUTION GROUP
PROTECTING PROCEEDS AND GOVERNMENT BENEFITS


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