

Presenting a live 90-minute webinar with interactive Q&A

Medicare, Medicaid and Private Health Insurer Liens in Personal Injury Cases

Negotiating Healthcare Liens or Claims for Reimbursement and Maximizing Settlement Awards

TUESDAY, AUGUST 26, 2014

1pm Eastern | 12pm Central | 11am Mountain | 10am Pacific

Today's faculty features:

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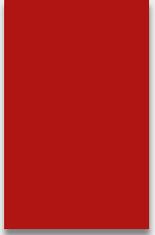
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Medicare, Medicaid and Private Health Insurer Liens in Personal Injury Cases

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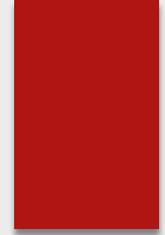
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August 26, 2014

A Primer On Public Benefits:



	Needs Based Benefits	Benefits Based on Entitlement
Cash Assistance	SSI (Supplemental Security Income)	SSD (Social Security Disability) CDB (Childhood Disability Benefits)
Medical Assistance	Medicaid	Medicare

Supplemental Security Income

- ▶ A means-based federal program that provides income through a cash assistance grant to certain **aged, blind, and persons with disabilities**;
- ▶ Administered by the Social Security Administration (SSA).
- ▶ Law is found at 42 U.S.C. § 1381 *et seq.* Regulations are found in Title 20 Part 416 of the Code of Federal Regulations (CFR).
- ▶ SSA Program Operating Manual System (POMS), and although not legally binding, POMS carries great weight as far as agency interpretation of the federal law.
- ▶ SSI sections of the POMS start with "SI."
- ▶ See: <http://www.ssa.gov/>.

Financial Requirements

- ▶ As a general rule, anything of value received during the month is considered income for the month received and a resourced as of the first day of the following month.
- ▶ 20 C.F.R. §416.1102
- ▶ **Important for settlement purposes.**

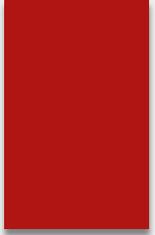
Basics of SSI Eligibility

Resources

- ▶ If an SSI beneficiary receives at least \$1 of SSI, the beneficiary then receives full scope free Medicaid automatically.

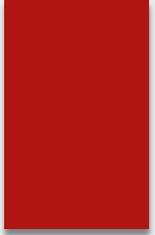
- ▶ **11 States Have Different Criteria For Medicaid Eligibility:**

Connecticut	Hawaii	Illinois	New Hampshire
Minnesota	Missouri	Indiana	North Dakota
Oklahoma	Ohio	Virginia	



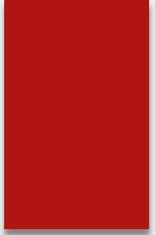
Social Security Disability Insurance (SSDI)

Social Security Disability Insurance is a national program for injured workers that have paid the requisite number of work credits into the Social Security System.



Social Security Disability Insurance (SSDI)

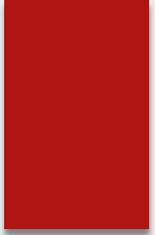
- ▶ The monthly Substantial Gainful Activity (SGA) amount for statutorily blind individuals for 2014 is \$1,800.
- ▶ For non-blind individuals, the monthly SGA amount for 2014 is \$1070



Social Security Disability Insurance (SSDI)

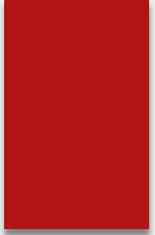
- ▶ SSDI has no income or resource limits. An SSDI recipient could win the lottery and remain eligible
- ▶ Earned income may cause ineligibility for benefits

Social Security Eligibility



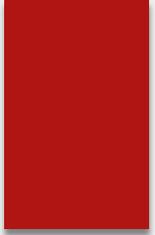
- ▶ Social Security's website to determine eligibility of a participant:
 - ▶ www.socialsecurity.gov/myaccount.

Medicare v. Medicaid



- ▶ **Medicare**: not tested by income or resources;
- ▶ **Medicaid** is a shared state-federal program, paid part by both entities and administered by state agencies with federal oversight;
- ▶ **Medicare** is entirely a federal program and benefits are paid entirely from federal resources;

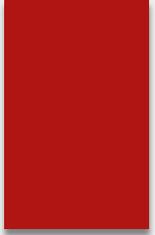
Both programs are overseen by the **Centers for Medicare and Medicaid Services** (CMS) formerly known as the Health Care Financing Administration (HCFA) a component of United States Department of Health and Human Services (HHS).



GOVERNMENT BENEFITS AND PERSONAL INJURY SETTLEMENT:

WHAT YOU MUST KNOW

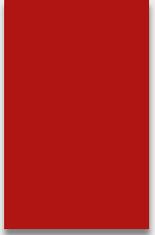
Introduction



- ▶ Know your client
- ▶ Know and understand the benefits that the client receives:
 - ▶ Medicare
 - ▶ SSDI
 - ▶ SSI
 - ▶ Food Stamps
 - ▶ Medicaid
 - ▶ Section 8

Who is entitled to Medicare?

- ▶ A person 65 years of age or older;
- ▶ A disabled person;
- ▶ A person (or child) with end stage renal disease.
- ▶ Individual must be insured; must have sufficient quarters of coverage
- ▶ Individual who is applying on basis of age who is not insured may pay into the system
- ▶ Individual who applies for SSDI is eligible for Medicare within 24 months of eligibility
- ▶ Compassionate Diseases



Medicare Secondary Payer Act (the MSP)

- ▶ Medicare was created in 1965
- ▶ Medicare Secondary Payer Act was created in 1980

The Law

- ▶ 42 U.S.C. §1395y
- ▶ 42 C.F.R. §§ 411.20 *et.seq.*
- ▶ Medicare is a secondary payer

Section 1862(b)(2)(A)(ii) 42 U.S.C. §1395y

- ▶ 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 (as defined in 42 CFR 411.50)

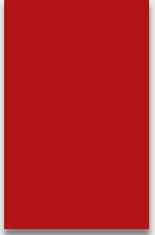
Three Compliance Parts; The Present, the Past and the Future

- ▶ In every liability settlement involving a Medicare beneficiary, the parties, including any group health plan or liability insurer, now has three distinct obligations:
 - ▶ 1) report the settlement to CMS (the present);
 - ▶ 2) resolve any conditional payments (the past)and
 - ▶ 3) provide for payment of future medical expenses as a term of the settlement, taking into consideration Medicare's interests (the future).
- ▶ Each obligation carries its own penalty for failure to fulfill it.

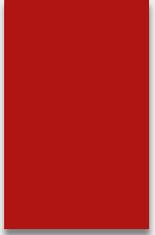
Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA)

- ▶ Enforces Medicare's basic right of recovery and to ensure that Medicare serves as a secondary payer, whenever possible.
- ▶ Section 111: reporting requirements

CMS

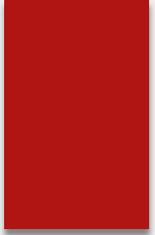


- ▶ CMS is the agency responsible for enforcement of the MSP
- ▶ The Website: <http://www.cms.gov/>
- ▶ CMS is short for the “Centers for Medicare & Medicaid Services”
- ▶ CMS is a sub-agency under The U.S. Department of Health and Human Services (“HHS”)



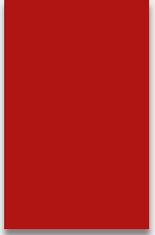
THE CONDITIONAL PAYMENT PROCESS OF MEDICARE AND THE NEW SMART ACT

Coordination of Benefits Contractor (COBC)



- ▶ CMS has consolidated all activities in support of the collection, management, and reporting of other insurance coverage of Medicare beneficiaries under a single entity, the Coordination of Benefits Contractor (COBC).
- ▶ The COBC is basically the information gatherer to coordinate benefits of Medicare recipients

MSP Recovery Contractor



- ▶ CMS contracted with the MSP Recovery Contractor (MSPRC) in 2006 to consolidate all functions related to MSP recovery. In 2014 the contractor name was changed to Benefits Coordinator & Recovery Contractor (BCRC).
- ▶ The BCRC manages all MSP after the COBC completes a record.
- ▶ Once the file is transferred from the COBC to the BCRC, the claimant will receive a “rights and responsibilities” letter (RAR) signed by the BCRC.

Reporting Requirement

- ▶ 42 USC 1395y(b)(8) and 42 C.F.R. Section 411.25
- ▶ All settlements, judgments, awards or other payments resolving medical for a Medicare Beneficiary claimant must be reported
- ▶ Reported by Payer—not Claimant or Plaintiff
- ▶ Failure to give timely notice of a settlement to Medicare results in a civil money penalty of “\$1000 for each day of noncompliance with respect to each claimant.” 42 U.S.C. 1395y (b)(8)(E)(i) (But See SMART Act)

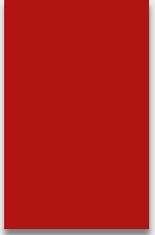
What Triggers Reporting?

- ▶ The RRE must report a **Total Payment Obligation to the Claimant (TPOC)** which generally represent a 'one-time' or 'lump sum' payment of a settlement, judgment, award, or other payment intended to resolve or partially resolve a claim. The RRE must also report no-fault/Med Pay/PIP and workers' compensation claims.
- ▶ **Mandatory reporting is required when the TPOC date and settlement amount are as follows:**
 - ▶ Over \$100,000 – On or after October 1, 2011
 - ▶ Over \$50,000 – On or after April 1, 2012
 - ▶ Over \$25,000 – On or after July 1, 2012
 - ▶ Over \$5,000 – On or after October 1, 2012
 - ▶ Over \$2,000 – On or after October 1, 2013
 - ▶ Over \$300 – On or after October 1, 2014

Section 111 and Discovery

- ▶ Section 111 required extensive information disclosure, including a client's SSN for the defendant to report the claim
 - ▶ CMS has not been willing to accept less than complete information
 - ▶ Information sought is generally not the type exchanged, especially in simple settlements
 - ▶ Court compelled disclosure of SSN reasonable in light of defendant's reporting requirements:
 - ▶ **Seger v. Tank Connection, LLC**, Docket No.: 8:08CV75, US Dist. LEXIS 49013, D.Neb. (Apr. 22, 2010)
 - ▶ **Hackley v. Garofano**, 2010 Conn. Super. LEXIS 1669 (Sup.Ct. July 1, 2010)

Conditional Payments



- Medicare has the right to recover any conditional payment made against the settlement proceeds of a Worker's Compensation or third-party liability case.
- Sometimes referred to as a "super lien" because of the broad power CMS has
- From the date of incident to the date of settlement

What are Conditional Payments?

- ▶ Payments by Medicare when another payer is responsible.
- ▶ Examples:
 - ▶ Where the claim is denied by the carrier or self-insured;
 - ▶ The carrier or self-insured does not pay promptly;
 - ▶ The patient elects to pursue unauthorized treatment;
 - ▶ The claimant fails to file a claim or fails to notify CMS of the existence of other insurance;
 - ▶ There is a long delay between the filing of the claim and the court proceeding.

The Conditional Payment Process (by Telephone) Cont.

- ▶ **STEP #1**: Phone the Coordination of Benefits Coordinator. (COBC) 1-800-999-1118. Be prepared to give them the following information.
 - ▶ The client's/beneficiary's name.
 - ▶ The Health Insurance Claim Number (HICN). Typically this is the client's Social Security Number, plus an alpha character.
 - ▶ The gender and date of birth.
 - ▶ The client's/beneficiary's address and phone number.
 - ▶ The date of the incident/accident.
 - ▶ A description of the injury by body part. If possible, they would prefer ICD-9 codes.
 - ▶ The type of claim- for example, a liability insurance claim.
 - ▶ Your attorney and firm name along with your address and phone number.

The Conditional Payment Process (by Telephone) Cont.

- ▶ **STEP #2:** Proof of Representation to Medicare Secondary Payer (MSPRC) located in Oklahoma City: 1-866-677-7220 Use their PROOF OF REPRESENTATION form.
 - ▶ Check the box for attorney.
 - ▶ Provide the attorney name, your relationship as an attorney, the firm name and address and phone number.
 - ▶ Fill in the client's name and HICN and the date of the incident.
 - ▶ Have this signed by the client and dated.
 - ▶ Fax this to them at 405-869-3309.
- ▶ **STEP #3:** They will now send you a RIGHTS AND RESPONSIBILITIES LETTER. This will be a standard form but with the particulars regarding your claim. You should then prepare a tickler for 65 days later in order to monitor the process as shown below.

The Conditional Payment Process (by Telephone) Cont.

- ▶ **STEP #4**: In response to the RIGHTS AND RESPONSIBILITIES LETTER, you need to respond and send the following:
 - ▶ Send a copy of your retainer agreement. Be sure it is fully filled out and signed by both the client and by your firm.
 - ▶ Place on the top of the retainer agreement the client's name and the HICN number.
 - ▶ Send them the name, address and telephone number of the insurer and also the adjuster.

The Conditional Payment Process (by Telephone) Cont.

- ▶ **STEP #5:** 65 days from the date of the RIGHTS AND RESPONSIBILITIES LETTER, they will automatically send you a CONDITIONAL PAYMENT LETTER (CPL). However, if it has not been received by this time, you may want to call and inquire. (Do not call in less than 65 days; if you do, your request will put you at the end of the line. Each call is considered a new request and, as such, the time restarts.) At this time, they post all conditional payments information under the "MyMSP" tab of the www.MyMedicare.gov website, which is updated weekly. Thus, you can track it thereafter whenever necessary.
- ▶ It is at this point that they will have also sent you a CORRESPONDENCE COVER SHEET which includes pre-printed information on your case and will have boxes to check. This will facilitate all matters with them.
- ▶ NOTE: If the treating provider has trouble with reimbursement by Medicare, have them check the box for a conditional payment. This will facilitate their getting paid by Medicare.

The Conditional Payment Process (by Telephone) Cont.

- ▶ **STEP #6:** Review the CPL and send back a letter to BCRC if some payments are not related to the injury. It will help if you have previously sent a description of the injury and included the ICD9 codes.

- ▶ If you object, this will trigger another 65 day wait for a NEW CONDITIONAL PAYMENT LETTER. Once again, do not call in less than 65 days but thereafter, a call will escalate the review.

- ▶ **STEP #7:** Once a settlement is reached, send a letter to MSPRC with all the pertinent information. Use their FINAL SETTLEMENT DETAIL DOCUMENT.
 - ▶ The date of settlement or judgment.
 - ▶ The amount of the settlement or judgment.
 - ▶ An itemized statement of the attorney fees and costs.
 - ▶ Whether or not any PIP or Med-pay was applicable.
 - ▶ If the case has been dropped, or lost, send them the documentation so that they can close their file.

The Conditional Payment Process (by Telephone) Cont.

- ▶ Medicare pays its proportionate share of attorney fees and costs and they will make that calculation.
- ▶ **STEP #8**: They will now send you a final demand. It will have an itemization of the bills they paid. Once again, carefully check to be sure that these are accident related bills. If not, you must file a letter contesting that fact.
- ▶ You have 60 days within which to pay their demand. You have to pay the demand even if you are contesting it. You pay the demand, and file the contest. They will reimburse you when you win. If you fail to pay within 60 days, they will charge interest and penalties.

New Automated Number

(866-677-7220)

What you will need:

- ▶ Case Identification Number (as found on the Rights and Responsibilities letter)
- ▶ Date of Loss
- ▶ Beneficiary's Date of Birth
- ▶ Last four digits of the SSN
- ▶ First four letters of beneficiary's last name
- ▶ Medicare Number

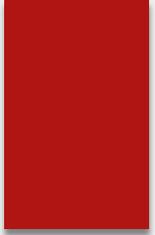
ICD9 Codes

- ▶ Conditional payments should only be made to those bills related to the injury
- ▶ Circle unrelated bills and provide back-up documentation
- ▶ CMS will determine the amount owed; response must be filed within 60 days
- ▶ The options permitted in the answer are as follows:
 1. Everything claimed is owed and a check is disbursed for the claimed amount;
 2. Some items claimed are owed, while others are not;
 3. All claimed items are denied and there will be no check enclosed for reimbursement.

Example for Handling a Conditional Payment (Portal)

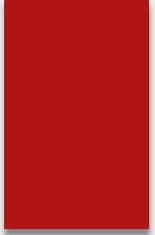
1. When you sign up the client get a copy of their Medicare card, Medicaid card and health insurance cards (prior insurance at time of accident?).
2. Go to www.cms.gov. Click on "Medicare"-then "Attorney Services."
3. Use the website forms-even if you have to attach information.
4. Print out model Proof of Representation & Consent to Release Forms-client signs.

Conditional Payment Example



5. Report case (directions in “Reporting a Case” in Attorney Services’ tab).
6. Mail proof of representation and consent to release forms to BCRC (use Correspondence Cover Sheet).
7. Go to www.mymedicare.gov and create an account for client so you can access claim information with client’s permission.

Conditional Payment Example



8. Keep checking my medicare.gov for client information, or call automated number to check status of conditional payments.
9. Review for any non-injury related expenses on conditional payment sheet. Prepare documentation to correct non-injury related expenses.
10. Final Settlement Detail Document to MSPRC- attach unsigned settlement statement.
11. Wait 4-6 weeks or more.

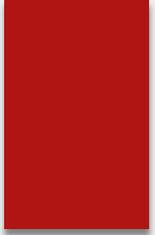
Hadden v. United States of America, 661 F. 3d 291 (6th Cir. 2011)

- ▶ Sixth Circuit found in favor of the government, holding that the MSP does not provide for apportionment and Medicare's claim for conditional payments does not need to be equitably reduced by the amount recovered.
- ▶ Medicare's right to reimbursement is statutory, not equitable. As a result, they do not consider factors that limited the recovery, such as insufficient insurance coverage, comparative negligence, etc.
- ▶ See also: Weinstein v. Sebelius, 2013 WL 1187052 (ED PA, 2-13-2013).

Farmers Insurance v. Forkey, 764 F. Supp. 2d 1205, U.S. Dist. Ct. D. NV, Dec. 29, 2010

- ▶ Medicare may seek reimbursement via direct action or through subrogation. Subrogation is limited to certain circumstances-and basically only where an individual or entity is entitled to payment for an item or service which Medicare paid.
- ▶ Most Medicare reimbursement actions are not subject to apportionment under state subrogation laws because they are direction actions.
- ▶ When exercising the Department's right of direction action, apportionment does not apply, and Medicare's right to recover is superior to individual claims against insurance.

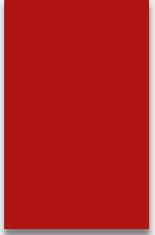
Procurement Costs



- ▶ Medicare reduces its recovery automatically to take into account the cost of procuring the judgment or settlement.
- ▶ The costs include attorney's fees, expert witness fees and court costs. In order to properly calculate this reduction, the claimant's attorney must provide a copy of the fee agreement along with documentation of costs incurred during litigation. 42 C.F.R. 411.37.

Haro v. Seblius, 789 F. Supp. 1179 (U.S. Dis. Ct. AZ May 9, 2011)

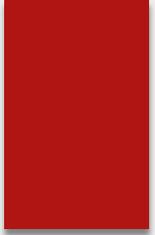
- ▶ The Court found that demanding conditional payment reimbursement within 60 days against beneficiaries who were disputing the claim was irrational and inconsistent with the statutory scheme providing waiver and appeal rights.



CONRADLASKA v. GENERAL CASUALTY COMPANY OF WISCONSIN
Appeal No. 2010AP2410
COURT OF APPEALS OF WISCONSIN, DISTRICT FOUR
2013 Wisc. App. LEXIS 234
March 14, 2013, decided

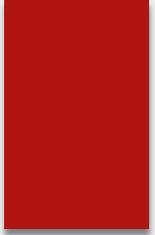
- ▶ Hospital cannot be forced to accept Medicare conditional payments.
- ▶ A provider may hold out for their full fee and assert a lien under state law against any insurance proceeds, or accept a Medicare conditional payment at the Medicare fee schedule, typically the lowest rate accepted.
- ▶ If the provider does not elect to bill Medicare within a year, then it can only recover against insurance proceeds and if no insurance payment is ever made or the jury favors the defendants, the provider will get paid nothing.
- ▶ It is a gamble and the decision is the providers alone to make. The Medicare beneficiary has no say in the matter.

Hardship



- ▶ After settlement, the plaintiff can apply for a hardship waiver to further reduce or eliminate the lien. Medicare can issue a full or partial waiver, or deny the waiver completely. The standard that is adhered to is whether recovery would be against equity and good conscience. To determine this, the following factors may be considered:
 - ▶ The degree to which the beneficiary contributed to causing the overpayment;
 - ▶ The degree to which Medicare and/or its contractors contributed to causing the overpayment;

Hardship (con'd)



- ▶ The degree to which recovery or adjustment would cause undue hardship for the beneficiary;
- ▶ Whether the beneficiary would be unjustly enriched by a waiver of adjustment of recovery;
- ▶ Whether the beneficiary changed their position to their material detriment as a result of receiving the overpayment or as a result of relying on erroneous information supplied to the beneficiary by Medicare.

Medicare and Wrongful Death Cases

- ▶ **Bradley v. Sebelius**, 621 F.3d 1330 (11th Cir. 2010) A child's loss of parental companionship claim is a property right belonging to the child, not Medicare.
- ▶ **Benson v. Sebelius**, 2011 WL 1087254 (D.D.C. 2011), Plaintiff factored his mother's medical claims into the settlement calculation. The conditional payments were recoverable by CMS.

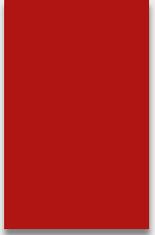
Medicare Advantage Plans (Part C) and the MSPA

- ▶ Third Circuit Cases –Decided June 28, 2012
- ▶ **In re Avandia Marketing, Sales Practices and Products Liability Litigation**, 685 F. 3d 353 (3rd Cir. 2012) the court held that the Medicare Secondary Payer Act (“MSP”) provides Medicare Advantage Organizations (“MAOs”) with a private cause action to seek recovery against a primary payer (such as a liability insurer or self-insured defendant in a personal injury matter) in Federal court.
- ▶ The court concluded that the plain text of the MSP is broad and unrestricted, and therefore, allows any private plaintiff with standing, including MAOs, to bring a cause of action against primary payers.

Medicare Advantage Plans (Part C) and the MSPA

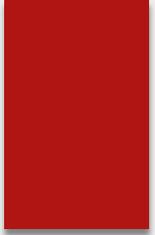
- ▶ Parra v. PacifiCare of Arizona, No. 11-16069, holding that a private insurer operating as a Medicare Advantage Organization Plan is not permitted to bring an action in federal court seeking reimbursement for \$136,630.90 from a tort settlement secured by survivors of the deceased in a wrongful death action.
- ▶ The Court holds that the federal statute, 42 U.S.C. § 1395y(b)(3)(A), "was intended to allow private parties to vindicate wrongs occasioned by the failure of primary plans to make payments." This statute does not authorize a suit for reimbursement against its insured (or survivors) for reimbursement.

SMART Act History



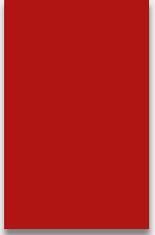
- ▶ Known as the **S**trengthening **M**edicare **A**nd **R**epaying Taxpayers (SMART) Act
- ▶ One of the co-sponsors, Rep. Tim Murphy (R-Pa.) indicated the bill stemmed from a constituent who was in a car accident and had to wait years for a settlement on medical bills covered by Medicare;
- ▶ The bill's lead Democratic sponsor was Rep. Ron Kind (D-Wis.)
- ▶ SMART Act was signed by President Obama on January 10, 2013

SMART Act Purpose



- ▶ The SMART Act was passed as part of H.R. 1845 and attached onto a Medicare IVIG Access Bill;
- ▶ It reforms several aspects of the conditional payment and MMSEA Section 111 processes
- ▶ Amends Section 1862(b)(2)(B) of the Social Security Act (42 U.S.C. 1395y(b)(2)(B))

SMART Act: Section 201

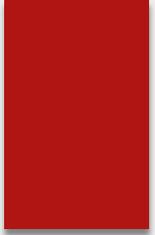


- ▶ Titled *“Determination Of Reimbursement Amount Through CMS Website To Improve Program Efficiency.”*
- ▶ Where conditional payments have been made, a claimant or “applicable plan” may at any time 120 days prior to the settlement, judgment or award notify the Secretary of the expected date and amount.
- ▶ The Secretary must provide conditional payment information through a website and update the information no later than 15 days after a payment is made.

The Website Requirements

- ▶ (aa) The information shall be as complete as possible and shall include provider or supplier name, diagnosis codes (if any), dates of service, and conditional payment amounts.
- ▶ (bb) The information accurately identifies those claims and payments that are related to a potential settlement, judgment, award, or other payment to which the provisions of this subsection apply.
- ▶ (cc) The website provides a method for the receipt of secure electronic communications with the individual, representative, or plan involved.
- ▶ (dd) The website provides that information is transmitted from the website in a form that includes an official time and date that the information is transmitted.
- ▶ (ee) The website shall permit the individual, representative, or plan to download a statement of reimbursement amounts (in this clause referred to as a `statement of reimbursement amount') on payments for claims under this title relating to a potential settlement, judgment, award, or other payment.

Website Download: Final Conditional Payment Demand

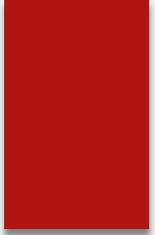


- ▶ If certain conditions are met, the last statement downloaded from the website can be considered the final demand.
- ▶ From the date of notice, the Secretary has 65 days to respond, otherwise the conditional payment becomes final.
- ▶ The Secretary may extend for an additional 30 days if the Secretary shows that there was a failure in the claims and payment posting system and the failure was justified due to exceptional circumstances .

Resolution of Discrepancies

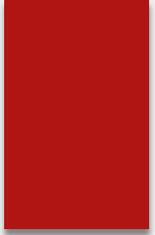
- ▶ If the claimant believes there is a discrepancy over the conditional payment amount, the individual (or representative) must provide documentation explaining the discrepancy and a proposal to resolve such discrepancy.
- ▶ The Secretary must respond/resolve the dispute within 11 business days or the proposed resolution by the claimant/applicable plan will be deemed accepted.
- ▶ If made within the 11 days, the Secretary may reject the proposal if it is determined that there is not a reasonable basis to include or remove claims on the statement of reimbursement.
- ▶ Within the 11 day period the Secretary must respond in a timely manner by agreeing to the proposal to resolve the discrepancy or by providing documentation showing with good cause why the Secretary is not agreeing to such proposal and establishing an alternate discrepancy resolution.
- ▶ There is no administrative or judicial review of the Secretary's determinations.

Effective Date



- ▶ This process will go into effect 9 months after H.R. 1845 goes into effect – or on October 10, 2013 (effective date of H.R. 1845 is January 10, 2013).
- ▶ This section also provides that the Secretary create an appeals process for conditional payments.

Section 202-Thresholds



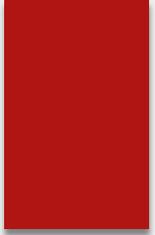
- ▶ By November 15th each year, the Secretary will have to publish a threshold wherein reporting and conditional payment reimbursement will not apply.
- ▶ This will begin in the year 2014.

Section 203- Reporting Requirements

- ▶ Amends Section 1862(b)(8) of the Social Security Act (42 U.S.C. 1395y(b)(8))
- ▶ Removes the mandatory civil penalty of \$1000 a day for non-compliance with the Section 111 reporting requirements and instead provides that failure to report `may be subject to a civil money penalty of up to \$1,000 for each day of noncompliance with respect to each claimant.'; and
- ▶ The Secretary is required to develop regulations for identification of practices for which sanctions will or will not be imposed.
- ▶ The regulations shall include not imposing sanctions for good faith efforts to identify a beneficiary

Section 204 – Social Security Numbers

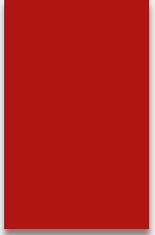
- ▶ Amends Section 1862(b)(8)(B) of the Social Security Act (42 U.S.C. 1395y(b)(8)(B))
- ▶ Reporting requirements are modified so that a RRE will no longer be required to report SSNs and/or health identification claim numbers going forward.



Section 205 – Statute of Limitations

- ▶ Amends 1862(b)(2)(B)(iii) of the Social Security Act (42 U.S.C. 1395y(b)(2)(B)(iii))
- ▶ The statute of limitations for conditional payment recovery is 3 years after the receipt of notice of a settlement, judgment, award or other payment made.

CURRENT STATE OF THE SMART ACT

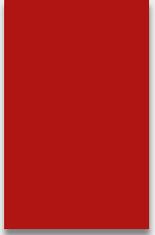


- ▶ The final rule will be published in 2014
- ▶ Interim final rule extends the time period for CMS to approve a settlement to as long as 245 days.
- ▶ IFR “ignores the 120-day statutory time-frame” on CMS responding to a request for approval of a settlement.

INTERIM FINAL RULE

9/20/2013

- ▶ CMS ISSUES RULES-OBTAINING FINAL CONDITIONAL PAYMENTS VIA WEB PORTAL
- ▶ As directed by SMART Act-conforms existing Web Portal to comply
- ▶ Effective 11/19/2013
- ▶ Go to: www.federalregister.gov. Search for "medicare smart act"
- ▶ Will allow attorneys, who are registered, to have access to conditional payment information for a case, including dates of services, provider names, ICD9 Codes, payment amounts.
- ▶ To be implemented no later than 1/1/2016

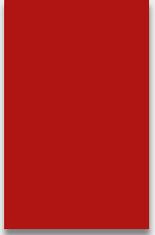


THE MEDICARE SECONDARY PAYER STATUTE

Medicare Set-Aside (MSA) Arrangements

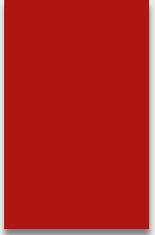
- ▶ Section 1862(b)(2)(A)(ii) of the Social Security, Act [42 USC 1395 y(b)(2)], precludes Medicare payment for services to the extent that payment has been made or can reasonably be expected to be made promptly under liability insurance.
- ▶ Medicare has the right to scrutinize any settlement of worker's compensation case or third-party liability case to determine if its right must be protected against a shift to Medicare of any third parties' liability as it relates to future medical care.
- ▶ Unless funds are set aside that will meet the participant's future medical bills, Medicare will not assume liability for future medical treatment when a third party is responsible.

Medicare Set Aside



- ▶ The law does not require them; it's merely a device to use to comply with the law.
- ▶ No definition of "MSA" is in the MSP, its regulations or other law.
- ▶ MSA is an allocation of settlement proceeds among the various damage components of a settled claim.

History of the MSA



- ▶ Memo issued July, 2001 (known as the “Patel Memo”) formally introduced the Medicare Set Aside (MSA) arrangement regarding workers’ compensation
- ▶ (WC) settlements.
- ▶ MSA became an effective means to manage exposure under the MSP.
- ▶ CMS embraced MSAs as the preferred means of complying with the MSP and minimizing future conditional payments.

NEW CMS REFERENCE GUIDE FOR WCMSA

- ▶ Issued March 29, 2013
- ▶ CMS will review a proposed WCMSA amount when the following workload review thresholds are met:
- ▶ The claimant is a **Medicare beneficiary** and the total settlement amount is **greater than \$25,000.00**; or
- ▶ 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 \$250,000.00**.

NEW CMS REFERENCE GUIDE FOR WCMSA

- ▶ A claimant has a reasonable expectation of Medicare enrollment within 30 months if any of the following apply:
- ▶ The claimant has applied for Social Security Disability Benefits
- ▶ The claimant has been denied Social Security Disability Benefits but anticipates appealing that decision
- ▶ The claimant is in the process of appealing and/or re-filing for Social Security Disability benefits
- ▶ The claimant is 62 years and 6 months old
- ▶ The claimant has an End Stage Renal Disease (ESRD) condition but does not yet qualify for Medicare based upon ESRD.
- ▶ If the threshold is met, a WCMSA can be submitted to CMS for approval.
- ▶ These thresholds are created based on CMS' workload, and are not intended to indicate that claimants may settle below the threshold with impunity. Claimants must still consider Medicare's

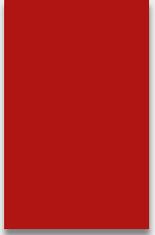
NEW CMS REFERENCE GUIDE FOR WCMSA

- ▶ The goal of establishing a WCMSA is to estimate, as accurately as possible, the total cost that will be incurred for all medical expenses otherwise reimbursable by Medicare for work-related conditions during the course of the claimant's life, and to set aside sufficient funds from the settlement, judgment, or award to cover that cost. WCMSAs may be funded by a lump sum or may be structured, such that a fixed amount of funds are provided each year for a fixed number of years.
- ▶ Once the CMS-approved set-aside amount is exhausted and accurately accounted for to CMS, Medicare will pay primary for future Medicare-covered expenses related to the WC injury that exceed the approved set-aside amount.

When to Consider an MSA

- ▶ Does the settlement involve a medical claim?
- ▶ Is it reasonably likely that the injured person will have ongoing or future medical expenses related to the claimed injury?
- ▶ Are these medical expenses otherwise covered by Medicare?
- ▶ Is the beneficiary likely to be a Medicare beneficiary when such medical expenses are incurred?

Argument for LMSA

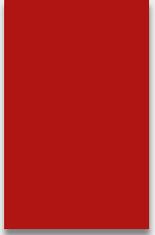


- ▶ Statute is pretty clear: Medicare is prohibited from making payment when “payment has been made, or can reasonably be expected to be made under a plan of insurance.”
- ▶ Our Regional Office has indicated that MSA’s should be used in tort cases to protect CMS’s interests, and the same criteria used in Worker’s Compensation cases should be applied.
- ▶ If the parties make a good faith effort to allocate the LMSA and CMS later reviews the file, the burden is on CMS to prove the allocation was unreasonable.
- ▶ Recent Memos and request for rules.
- ▶ Failure to adhere could cause the Medicare beneficiary to be denied benefits The defendants and their insurers might be forced to pay for future care that was already compensated for as a component of the settlement. The plaintiff’s attorney is faced with the possibility of a CMS recovery action against his fee from the settlement. Attorneys on both sides may face malpractice actions.
- ▶ CMS retains a retrospective review to determine if its rights were protected.

Argument Against LMSA

- ▶ 42 C.F.R. Sections 411.46 and 411.47 expressly provide a manner by which Medicare must adjust its benefits, should an allocation for future medical expenses be provided in a workers' compensation settlement; no such regulation for liability cases.
- ▶ CMS memo in July, 2001 indicating MSAs would now be *recommended* in certain instances of case settlement, the memo mentioned only workers' compensation claims. There was no language, processes, or procedures that applied to liability claims.
- ▶ CMS is refusing to review most LMSAs.
- ▶ There are cases where the settlement is not enough to cover the allocation.
- ▶ Workers' compensation does not involve policy limits.
- ▶ In liability, the four elements of negligence must be analyzed (duty owed, duty breached, injury and proximate cause). After that analysis, concepts such as comparative or contributory negligence must be taken into consideration. Clearly, workers' compensation is an easier concept to comprehend than determining negligence in a liability accident.
- ▶ Settlement should be enjoyed by plaintiff; not given to CMS if not necessary.

CMS Guidance



- ▶ 4/22/03 Memo in WCMSA:
 - ▶ The facts of the case demonstrate that the injured individual is being compensated for past medical expenses only.
 - ▶ There is no evidence that the individual is attempting to maximize the other aspects of the settlement to Medicare's detriment.
 - ▶ The individual's treating physicians conclude (in writing) that to a reasonable degree of medical certainty the individual will no longer require any Medicare covered treatments.

Sally Stalcup Memo – 5/25/11

- ▶ Stalcup is the MSP Regional Coordinator-Dallas, Texas (pertains to AR, OK, TX, NM, LA).
- ▶ “The Law requires that the Medicare Trust Funds be protected from payment for future services whether it’s a Worker’s Compensation or liability case. There is no distinction in the law.”
- ▶ There is no formal process for review of liability cases.
- ▶ Attorneys must decide based upon the facts of their case whether the Trust Fund must be protected.

Sally Stalcup Memo – 5/25/11

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

Charlotte Benson Guidance

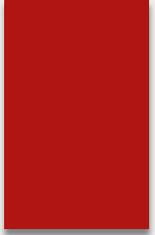
Memo – 9/30/11

- ▶ Benson is the Acting Director of the Financial Services Group of the Office of Financial Management in Baltimore, Maryland
- ▶ Where the beneficiary's treating physician certifies in writing that treatment for the alleged injury related to the liability "settlement" has been completed as of the date of the "settlement," and future medical services for injury will not be required, Medicare considers its interest, with respect to future medicals for that particular "settlement" satisfied.
- ▶ When there is such a certification, there is no need for the beneficiary to submit the certification or a proposed LMSA 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.
- ▶ The beneficiary and/or their representative are encouraged to maintain the physician's certification.

Medicare Secondary Payer and 'Future Medicals' Proposed Rule Making

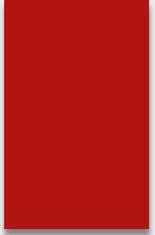
- ▶ On May 3 of 2012, CMS submitted to the Office of Management and Budget advanced notice of proposed rulemaking (ANPRM) entitled "Medicare Secondary Payer and 'Future Medicals' (CMS-6047-ANPRM).
- ▶ Solicits comment on options to "clarify how beneficiaries can meet their obligations to protect Medicare's interest with respect to Medicare Secondary Payer (MSP) claims involving automobile and liability insurance (including self-insurance), no-fault insurance, and workers' compensation when future medical care is claimed or the settlement, judgment, award, or other payment releases (or has the effect of releasing) claims for future medical care."

Proposed Rule Making



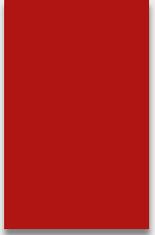
- ▶ The CMS proposed general rule states if an “individual or Medicare beneficiary” anticipates receiving Medicare covered services after the date of the settlement, then such person is required to satisfy Medicare’s interest with respect to “future medicals” using any one of several options.
 - ▶ Option 1: The Medicare beneficiary pays for all future injury related expenses out of the settlement proceeds until exhausted.
 - ▶ Option 2: No MSA is required if individual is not expected to become a Medicare beneficiary within 30 months of the settlement and the injury is not “chronic” as defined and the settlement amount is below a certain amount. Comments were solicited on what the threshold amount should be. This would be similar to the procedure employed in workers compensation cases.
 - ▶ Option 3. No MSA is required if the treating physician certifies there are no future injury related expenses to be incurred.
 - ▶ Option 4. A proposed MSA is submitted to CMS for approval.
 - ▶ Option 5. The Medicare beneficiary participates in one of the CMS recovery options. This option to cover the smaller settlements.
 - ▶ Option 6. The Medicare beneficiary makes an upfront payment.
 - ▶ Option 7. The individual receives a compromise or waiver from CMS at the time of the settlement.

Proposed Rule Making



- ▶ The public comment period ended on August 14, 2012
- ▶ CMS initiated the MSA rulemaking on their own; no funding by Congress
- ▶ This issue has taken a back-seat to the SMART Act implementation requirements.

Allocations



- ▶ Medicare is not bound by the parties' allocation of settlement funds
- ▶ The court can determine whether future medical expenses are likely and the amount of the allocation necessary for a MSA. See, **Big R Towing v. Benoit**, No. 6:2010cv00538 (W.D. La 2010); 2011 WL 43219; **Finke v. Hunter's View**, 2009 WL 6326944 (D.Minn.); **Schexnayder v. Scottsdale**, No. 6:2009cv01390, (W.D. La); 2011 WL 3273547

ALLOCATION DETERMINATION

- ▶ Comprehensive Medical Records Review Performed by MSCC (Medicare Set-Aside Certified Consultant)
- ▶ Medical Records (Last 2 years): identify missing medical records
- ▶ Supporting Medical Records (Last 2 years) i.e. Therapy Services, FCE, IME
- ▶ Pharmacy Summary (Last 2 years)
- ▶ Settlement (Proposed) Documents

In Re: Oil Spill by the Oil Rig “Deepwater Horizon” in the Gulf of Mexico, on April 20, 2010. This Document Relates To: No. 12-968, Plaisance, et al. v. BP Exploration

& Production Inc., et al. and All Actions. MDL 2179 SECTION J UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF LOUISIANA
2013 U.S. Dist. LEXIS 4595

- ▶ The court acknowledged not only the reimbursement rights for related medical expenses already incurred, but also quoted the Federal Register solicitation last summer as authority supporting Medicare’s assertion of an interest in future medical care.
- ▶ The most interesting section of the order contained the statements about the negotiation with CMS to ensure that class members would not be without coverage.

Smith v. Marine Terminals of Arkansas, 2011 WL 3489806, U.S. E.D. AR, Aug. 9, 2011

- ▶ Currently eligible Medicare plaintiff can settle based on third-party assessment of future medical expenses to avoid litigation and encourage settlement to avoid cost and time related to litigation.
- ▶ Litigation would have set forward determination of, among other things, future medical expenses.

Court involvement in Issues of Equitable Allocation

- ▶ **Sterrett v. Klebart**, 2013 Conn.Super. LEXIS 245 (filed February 5, 2013)
- ▶ February 5, 2013, the Court, granted the settling parties' motion to determine that the parties have reasonably considered Medicare's interests as required by the Medicare Secondary Payer ("MSP") Act.
- ▶ The parties had concluded that they had reasonably considered Medicare's future interest and that a liability Medicare Set-aside Arrangement ("LMSA") was not needed as part of settling the liability claim.
- ▶ The Court, after reviewing the evidence presented, agreed that the parties had reasonably considered Medicare's future interest in concluded that no settlement proceeds had been "allocated" for future medical expenses otherwise covered by Medicare within the gross award.

Frank v. Gateway Insurance Company,
2012 WL 868872, U.S. Dist. Ct.,
W.D. LA, Mar. 13, 2012

- ▶ Court orders that despite Medicare not participating in allocation of future medical, conditional payments are ordered to be paid, future expenses will be set in interest-bearing account and based on third-party estimate of future expenses; once interest-bearing account is depleted by Medicaid charges then Medicare must pay even if related to suit.

Sipler v. Trans Am Trucking, Inc., US District Court – New Jersey

- ▶ Plaintiff involved in PI case and receives Medicare
- ▶ Court concludes that no Medicare allocation is necessary.
- ▶ The settlement in this case did not arise in the worker's compensation context and it does not indicate a particular amount to compensate Mr. Sipler for future medical expenses arising out of the accident.
- ▶ Tort cases involve non-economic damages and not determined by a specific formula
- ▶ To require personal injury settlements to specifically apportion future medical expenses would prove burdensome to the settlement process and, in turn, discourage personal injury settlements.

Bruton v. Carnival Corporation, 2012 WL 1627729, US Dist. Ct. S. Dist. FL, May 2, 2012

- ▶ After reaching settlement agreement with general term that plaintiff must release defendant from future liability from Medicare claims, plaintiff strikes provision from release of liability that requires plaintiff to set up a separate account to hold set-aside amount. Defendant argues that “could” make them liable to Medicare for not protecting Medicare’s interest.
- ▶ Court holds that account is not required, agreement does not specifically require it, and defendant is sufficiently protected despite the fact that Medicare has not given sufficient indication of what protects their interest. Plaintiff’s motion to compel granted, and defendant required to pay settlement amount.

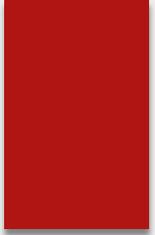
Early v. Carnival Corporation, No. 12-20478-CIV-Goodman (S.D. Fla. February 7, 2013)

- ▶ The settling parties asked the Court to determine whether a liability Medicare Set-aside Arrangement (“LMSA”) was required as part of settling the claim.
- ▶ The Court concluded, after reviewing the evidence, that the parties, in fact, did not have a settlement agreement as they did not agree to every essential term.

Types of Arrangements

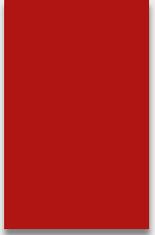
- ▶ *Self-Administered*
- ▶ *Custodial Accounts*
- ▶ *Special Needs Trust*
- ▶ *Pooled Trust*

Administration



- ▶ Distributions from the MSA may only be made for medical expenses that would be covered by Medicare.
- ▶ Each MSA must have reasonable investment policy rules and provide accountings.
- ▶ The accountings must be made on an annual basis to the Benefits Contractor responsible for monitoring the case.
- ▶ **Hinsinger v. Showboat Atlantic City**, 2011 N.J. Super. LEXIS 96, (January 21, 2011), allowed attorney fees to be paid from the MSA.

Self-Administration



- ▶ Must complete annual attestation, interest reported, eligible/covered items, payment records, related to MSA
- ▶ Minor Cases (Rx or Orthotics only)
- ▶ Understanding Medicare allowable items

Professional-Administration

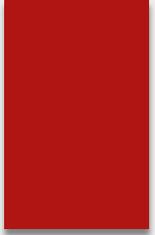
- ▶ Allows for a licensed, insured and bonded insurance professional to administer the funds similar to a workers' compensation or group health plan
- ▶ Administrator is a custodian of an account, that is established on behalf of the claimant
- ▶ Completion of the annual attestation filed with CMS

Funding



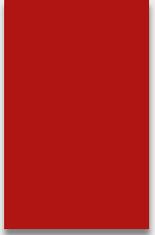
- ▶ Lump sum
- ▶ Structured Settlements

Structuring an MSA



- ▶ Payer receives out-of-pocket discount by purchasing an annuity to fund total amount
- ▶ If funds are exhausted before year-end, Medicare covers funding

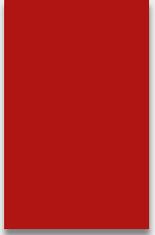
Death



- ▶ Once CMS determines that the claims have been paid, any amounts remaining in the MSA may be distributed pursuant to state law.

Veteran's Administration

- ▶ *U.S. Dept. of Veterans Affairs v Boresi*, No. SC 92541 (Mo. 2013); [2013 MO Lexis 25](#) (lexis.com), [2013 MO Lexis 25](#) (Lexis Advance) (April 30, 2013); allows the VA to intervene in a workers comp case to recover their medical treatment costs from the injury.
- ▶ The court concluded that federal law was controlling and that 38 U.S.C. § 1729 allowed an unequivocal right to intervene in any action brought a veteran covered under a worker's compensation law or plan. The Supremacy Clause trumped any state comp law. The Missouri comp law had no provision for intervention in these circumstances, and the civil rules for intervention under Rule 52.12 did not apply.



MEDICAID LIENS: MORE COMPLICATION

Other Benefits that Must be Considered

- ▶ SSI
- ▶ Medicaid

These “means-tested” benefits could be jeopardized by the receipt of a settlement.

Many recipients of Medicaid have no other form of health insurance. The loss of Medicaid could be devastating.

Protecting Other Means Tested Benefits

- ▶ An MSA does not protect other “means tested benefits” and will impact ongoing eligibility.
- ▶ An MSA should be a sub-trust in a Special Needs Trust.
- ▶ Summary
 - ▶ Two issues; maintaining “means tested benefits”
 - ▶ Dealing with – RSMo. 208.215 - Medicaid Lien;
 - ▶ Maintaining “means tested benefits”
 - ▶ Special Needs Trusts
 - ▶ Other options

Self-Settled or Pay Back – Special Needs Trusts 42 U.S.C. 1396(d)(4)(A)

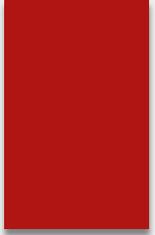
- ▶ The individual must be under age 65 at the time the trust is created and funded
- ▶ The trust may be established by a parent, grandparent, legal guardian, or a court
 - ▶ See RSMo. §475.092 and RSMo. §511.030
- ▶ The individual must be disabled (same definition for disability as used for SSDI or SSI)
- ▶ The Trust must contain pay-back provisions
 - ▶ Missouri has special requirements
 - ▶ See RSMo. §475.092
- ▶ The trust must be irrevocable

Medicaid Reimbursement at Settlement

- ▶ The federal Medicaid statute, 42 U.S.C. § 1396 et. seq., essentially forces states to subrogate personal injury claims where the state agency has paid claims on the plaintiff-beneficiary's behalf.

Ark. Dep't of Health & Hum. Servs. v. Ahlborn, 126 S. Ct. 1752 (2006)

- ▶ The US Supreme Court ruled unanimously to limit state Medicaid agencies' claims for reimbursement to the portion of any tort settlement attributable to past medical expenses.
- ▶ The agencies may not claim any part of a plaintiff's recovery for lost wages, pain and suffering, or other nonmedical damages.



WOS v. EMA, U.S. Supreme Court, No. 12-98

- ▶ North Carolina claimed over \$900,000 of a legal medical malpractice settlement won by the parents of a 13-year-old girl born with serious injuries that left her unable to live or work independently.
- ▶ Anti-lien provision in federal Medicaid statute preempted North Carolina's irrebuttable statutory presumption that one-third of tort recovery was attributable to medical expenses
- ▶ The court stated that when “there has been a judicial finding or approval of an allocation between medical and nonmedical damages—in the form of either a jury verdict, court de-cree, or stipulation binding on all parties—that is the end of the matter.” “With a stipulation or judgment under this procedure, the anti-lien provision protects from state demand the portion of a beneficiary’s tort recovery that the stipulation or judgment does not attribute to medical expenses.”

Section 202 of the Bipartisan Budget Act of 2013

- ▶ Congress has delayed by two years a provision in last December's budget bill that gives states the ability to recover Medicaid costs from a beneficiary's full personal injury settlement or award.
- ▶ The law, which amends the Social Security Act to negate the U.S. Supreme Court's decisions in *Arkansas Department of Health and Human Services v. Ahlborn* and *Wos v. E.M.A.*, was set to take effect October 1, 2014.

NEGOTIATING LIENS AND CLAIMS FOR REIMBURSEMENT WITH PRIVATE HEALTH INSURERS

AUGUST 26, 2014

AFTER MCCUTCHEN

PRACTICE APPROACHES

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A. ERISA PLANS

IMPACT OF U.S. SUPREME COURT RULING IN U.S. AIRWAYS V. MCCUTCHEN ON HEALTH PLAN CLAIMS FOR REIMBURSEMENT AND SUBROGATION

US AIRWAYS V. MCCUTCHEN

Facts: James McCutchen was injured seriously in a car accident. His health insurance plan administered by US Airways paid \$66,866 to cover medical bills. Mr. McCutchen recovered over \$100,000 from third parties. The plan required Mr. McCutchen to pay back medicals paid by the plan out of any amount recovered by third parties. The plan demanded full reimbursement of the \$66,866 paid. McCutchen argued that that US Airways failed to take into account his legal fees. US Airways filed suit for “appropriate equitable relief” under provisions of the Employment Retirement Security Income Act. (ERISA)

US AIRWAYS V. MCCUTCHEN

Procedure:

- (1) The District Court ordered McCutchen to pay the full amount of the medical bills paid: \$66,866.
- (2) The U.S. Court of Appeals for the Third Circuit reversed, holding that ERISA is subject to equitable defenses. To determine appropriate equitable relief, the District Court must take into account the distribution of the amount recovered from third parties between McCutchen and his attorneys.

Issue for SCOTUS:

Does ERISA § 502(a)(3) authorize the court to use equitable principles to determine appropriate equitable relief?

US AIRWAYS V. MCCUTCHEN

Held:

The terms of the ERISA plan govern. Neither general unjust enrichment principles nor specific doctrines such as the double recovery rule or the common fund rule can override specific language of the contract. The plan is paramount, Court will hold parties to the terms of the contract.

US AIRWAYS V. MCCUTCHEN

Effect:

1. Application of Double Recovery Rule precluded by plan.
2. BUT: Where plan language is silent as to a particular issue, participant may be able to apply equitable defenses.
3. Plan was silent on allocation of attorney fees and the common fund doctrine provides appropriate default rule.
4. *“The plan is silent on the allocation of attorney’s fees, and in those circumstances, the common-fund doctrine provides the appropriate default. In other words, if US Airways wished to depart from the well-established common-fund rule, it had to draft its contract to say so—and here it did not.”*

FIRST DOLLAR RECOVERY

No One Gets Paid Until Health Plan Gets Paid

Health Plan First

GOING FORWARD AFTER MCCUTCHEN

Effect:

- **Application of Double Recovery Rule precluded by plan.**
- **BUT: Where plan language is silent as to a particular issue, participant may be able to apply equitable defenses.**
- **Plan was silent on allocation of attorney fees and the Common Fund Doctrine provides appropriate default rule.**

STATE LAW

Some States prohibit Subrogation

- **By state statute, some states prohibit insurance companies from placing subrogation clauses into health insurance policies.**

Look to statute and case law

- **Example: Massachusetts statute and case law held to enforce full recovery to health care plan, rejecting payment of attorney fees or costs.**

Pierce v. Christmas Tree Shops, Inc., 706 N.E.2d 633 (1999)

PIERCE V. CHRISTMAS TREE SHOPS

ISSUE:

Whether Health Care Plan, a lienholder under the medical lien statute [MGL c. 111, § 70a-70b] may be ordered to contribute to the attorney fees and costs incurred by the plaintiff in pursuing a tortfeasor.

FACTS:

Donna Pierce was injured on the premises of the Christmas Tree Shops store. The HPHC plan paid medical expenses of \$10,165. Pierce brought suit in Superior Court. Settled before trial. Pierce brought motion in court to determine her obligations to HPHC seeking a compromise to the lien amount and an order requiring the plan to share attorney fees and costs.

HELD:

The statute does not require the lienholder to pay any portion of the plaintiff's fees and costs.

PRACTICE STRATEGIES

1. INTAKE INTERVIEW

All health insurance cards [Medicare-Medicaid-private-other?]

Summary Plan Description

- ✓ If no SPD:
- ✓ Signed authorization for copy
- ✓ Alternative: client obtains

Copy of coverage selections page all other insurance

- ✓ Auto Insurance
- ✓ Umbrella insurance?
- ✓ Homeowners?

PRACTICE STRATEGIES

2. EXHAUST ALL OTHER MEDICAL INS. BENEFITS

Car Insurance:

- No-Fault Benefits [“PIP”]
- Med-Pay Benefits

Premises Liability:

- Med pay
- Get med pay info ASAP – often early submission deadlines

Use these to “pay down” Health Ins Lien

PRACTICE STRATEGIES

3. OBTAINING THE LIEN

- Letter of representation and request
- Briefly describe type of injury & date of loss
- HIPAA compliant authorization

PRACTICE STRATEGIES

4. PARSING THE LIEN

After receipt:

- Mail/email otherwise provide copy to client
- Read lien itemization with client
- Review line by line in person or at least on telephone
- Is each item on lien solely related to injuries caused by accident or other medical issues.
- Send query/challenge to Health Ins.

PRACTICE STRATEGIES

5. NEGOTIATING LIEN

- Contest unrelated items : Insist unrelated items deleted
- Challenge questionable items, multiple reasons for visits
- Dispute excessive costs [3,000 for x-ray?]
- Speak to decision makers
- Use cool calm professional approach – belligerence never helps
- Account for comparative fault – likelihood of success at trial
- Tell “war stories” about losses. (Only time in career to discuss cases lost)

PRACTICE STRATEGIES

6. PRELITIGATION AGREEMENT

- **Based on uncertainty of trial**
- **Attorney fee**
- **Costs**
- **Experts required**
- **Delay**
- **Signed writing acknowledging agreement by Health Plan**

RESOLVE LIEN BEFORE SETTLEMENT

FIRST OFFER

- Duty to communicate with client
- Show lienholder actual 3D party analysis

STATUS OF NEGOTIATION

- Notify lienholder with incremental offer increases

NEGOTIATE FINAL LIEN RESOLUTION BEFORE THIRD PARTY SETTLEMENT

- After client signs release – no leverage against lienholder
- Before settlement everything is contingent: leverage rests with client and attorney over whether or not they should accept onerous demands of lienholder

B. NON-ERISA PLANS

HEALTH PLAN TACTICS

PERSONAL INJURY COUNSEL STRATEGIES

WHAT IS IT

- ❑ **Right of subrogation**
- ❑ **Right of reimbursement**
- ❑ **Enforcement of statutory lien**
- ❑ **“Letter of Protection”**
- ❑ **Other contractual right**

LETTERS OF PROTECTION

- **“By signing a letter of protection the lawyer is taking a position that is potentially in conflict with the client’s stated interest.”**

Another Look at Letters of Protection, Minnesota Lawyer, Aug 5, 2002.

- ***For thorough treatment of “ethical and legal pitfalls when asked to assist clients in dealing with their difficult economic and medical issues in personal injury cases” see:***

Florida Bar Board of Governors, Opinion 02-4, April 2, 2004.

“MAKE WHOLE DOCTRINE”

- The make whole doctrine , generated by common law, holds that health insurers should be reimbursed only where the injured plaintiff has been “made whole” in a settlement or judgment, and only to the extent that the settlement or judgment exceeds the “make whole amount”.
- **EXAMPLE:** Injury victim would be “made whole” by judgment or settlement of \$50,000. This injured party would only have to pay back the health insurer to the extent that the recovery exceeds \$50,000.

NEGOTIATION POINTS

- ✓ **Follow “Practice Strategies” in previous materials.**
- ✓ **Notify health insurer of key events including trial , pretrial, mediation or other ADR. Invite to participate.**
- ✓ **Alternative Dispute Resolution.**
- ✓ **Interpleader of Health Ins. or Motion but only if case is clear.**

CLIENT INVOLVEMENT

- ❑ **Notify client of existence of language in health insurance contracts giving right of reimbursement if they are injured by a defendant and if they recover money from that defendant.**
- ❑ **Make sure client understands up front – early in case. Bad surprises blamed on the attorney.**
- ❑ **Paint insurer or plan as entity wearing “black hat”. Attorney is only explaining client’s obligation to insurer.**
- ❑ **Point out refusal to satisfy valid lien endangers client’s future health benefits and risks litigation by lienholder**

CLIENT INVOLVEMENT

- ❑ **Keep client informed as to possible outcomes. Encourage realistic expectations. If lien is adequately sizeable to endanger most or all of settlement/judgment, client should know. May effect incentive to pursue case. Lienholder should be notified.**
- ❑ **Provide literature regarding legal obligation underlying liens / rights of recovery. Provides third party authority for counterintuitive idea they have to pay an insurance company back.**
- ❑ **Here's mine, feel free to print and use: [next page]**

CLIENT INVOLVEMENT



LIENS ON PERSONAL INJURY CASES

Like locks on a gate, liens prevent final settlement of personal injury cases until they are addressed.



<http://www.attorney-myers.com/2013/01/liens-on-personal-injury-cases/>