MEDICAID, MEDICARE AND MEDICARE ADVANTAGE
LIEN CLAIMS, SETTLEMENTS & SET-ASIDES

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Franklin P. Solomon
Solomon Law Firm, LLC
Cherry Hill, NJ
fsolomon@franklinsolomonlaw.com
bnewman@helpwithliens.com

Brett Newman
Lien Resolution Group
West Nyack, NY
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” claims. Mr. Solomon represents personal injury victims and their attorneys in defending against claims by health plans and government benefits programs seeking payment out of tort recoveries, whether under ERISA, FEHBA, Medicare, Medicaid, Tricare/CHAMPVA, or other public or private health and disability programs.

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.
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.
Statute and Interpretation

- 42 U.S.C. § 1396p(a)
- Bipartisan Budget Act of 2013
  - HR 4302, signed into law Apr. 1, 2014, delays implementation until Oct. 1, 2016 (Section 211)
Medicare Secondary Payer Act

- 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 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA)
- Reporting requirements for Responsible Reporting Entities (“RREs”)
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)
MSP Liability

Action by United States

- The United States may bring an action against any entities required or responsible to make payment with respect to the item or service under a primary plan.
  - Includes insurer, self-insurer, TPA, employer sponsor of a group health plan, large group health plan, or otherwise

- The United States may collect double damages against any such entity and may recover from any entity that has received payment from a primary plan or from the proceeds of a primary plan’s payment to any entity.

42 USC § 1395y(b)(2)(B)(iii)
MSP Liability

Private cause of action

- There is established a private cause of action for damages (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).

42 USC § 1395y(b)(3)(A)
Recent Case Law

- *Bradley v. Sebelius,*
  621 F.3d 1330 (11th Cir. 2010)

- *Hadden v. United States,*
  661 F.3d 298 (6th Cir. 2012)

  760 F.3d 307 (3d Cir. 2014)
Recent Case Law

- 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) regardless of liability or coverage issues.*
Pleading the MSP 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*).
Pleading the MSP Cause of Action

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 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
Pleading the MSP 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 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 201 requires 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.
Considering Medicare’s Interest

- Workers Compensation
- Third-Party Liability
  - ANPRM 6047 Withdrawn 10-8-2014
MEDICARE SUBSTITUTE PLANS
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.
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.
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.


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.)
Cases to Watch

- **Emblem Health v. Yi** (SDNY)
  - Includes claims against plaintiff’s attorney and liability carrier
- **United Healthcare v. Kardoulias** (EDNY)
Federal Employees Health Benefits Act
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

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  (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.

- 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.

  - State anti-subrogation law bars FEHB plan’s reimbursement claim out of tort recovery
Nevils and Kobold both vacated by the U.S. Supreme Court and remanded for consideration in light of new agency rule.
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
  - 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), __ P.3d __, 2016 WL 1273024 (March 31, 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.”
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)
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 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