NEW YORK STATE BAR ASSOCIATION

PROTECTING PERSONAL INJURY RECOVERIES FOR PERSONS ON PUBLIC BENEFITS

LAWSUIT RECOVERIES FOR MEDICARE BENEFICIARIES

JOHN M. TOMSKY
Counsel to the Firm
Sullivan Papain Block McGrath & Cannavo P.C.
120 Broadway - 18th Floor
New York, New York 10271
jtomsky@triallaw1.com
212-732-9000

MEDICARE SECONDARY PAYER CLAIMS

Medicare has to be repaid from the settlement with an offset for the cost of collection, the percentage that litigation expenses (legal fees and disbursements) bore to the gross recovery, pursuant to the Medicare Secondary Payer Law.

Prior to the amendment of the Medicare Secondary Payor provisions of the Medicare Act, 42 U.S.C. § 1395y(b)(2)(1), (2), as part of the Medicare Drug Bill that President Bush signed into law on December 8, 2003, a number of Federal Circuit Court cases had held that Medicare was not a secondary payer to tortfeasors and their liability carrriers. The 2003 amendment "clarifies" the law to make it clear that tortfeasors and their liability carriers are indeed primary payers.

History of Medicare claims prior to 2003 amendments

As first enacted, Medicare was the primary payer for medical services supplied to a beneficiary, even when such services were covered by other insurance such as an employer group health plan or liability insurance.

Responding to skyrocketing Medicare costs, Congress in 1980 enacted the Medicare Secondary Payer Law (MSP) requiring that Medicare serve as the secondary payer when a beneficiary had overlapping insurance coverage. 42 U.S.C. 1395y(b).

Under MSP, when a Medicare beneficiary suffers an injury covered by a group health plan or liability, workers compensation, automobile, or no-fault insurance, Medicare conditionally pays for the beneficiary's medical expenses 42 U.S.C. 1395 y(b)(2)(B)(i). If the beneficiary receives a settlement from the primary insurer, Medicare is entitled to reimbursement from the beneficiary for the conditional outlays. 42 U.S.C. 1395 y(b)(2)(B)(ii).

Medicare has a right of action to recover such conditional payments from any entity required to have made such payments under a primary insurance plan of the Medicare recipient, or from any entity, including a beneficiary, supplier, physician, attorney or State agency that has received a third-party payment for which Medicare paid. 42 U.S.C.1395y(b)(2)(B)(i).

Pursuant to federal regulations, when Medicare is considered to have been conditionally provided, the Center for Medicare and Medicaid Services, CMS, must initiate recovery from a third party as soon as it learns that payment has been made or could be made under any primary insurance plan. 42 U.S.C.1395y (b)(2)(B)(i). If CMS does not have to take legal action to recover funds, it receives the lesser of the amount of the Medicare primary payment or the amount of the third-party payment. If it is necessary for CMS to take legal action to recover from the patient, CMS may recover twice that amount. CMS may recover without regard to any claims filing requirements that the insurance program or plan imposes on the beneficiary which may or may not have been followed. However, CMS must file a claim for recovery by the end of the year following the year in which the Medicare program that paid the claim has notice that the third party should have paid for those particular services. 42 U.S.C.1395y(b)(2)(B)(i).

Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007, provides that liability (including self-insurance) and no-fault insurers, must determine Medicare beneficiary status of all claims and report those claims involving a Medicare beneficiary to the Secretary at the time of the settlement, judgment, award, or other payment. If the reporting is not timely made the Secretary may enforce a civil monetary penalty of $1,000 per day per individual.

WHEN IS THERE A MEDICARE SECONDARY PAYER OBLIGATION

The plaintiff's attorney should suspect that Medicare has paid for hospital stays and physicians and up to 100 days in a skilled nursing facility when the plaintiff is over 65 or is under 65 but is disabled and receiving Social Security Disability benefits, has Lou Gehrig's Disease or has end stage renal disease.

It is imperative that the plaintiff's attorney be proactive and take the initiative to notify Medicare when representing Medicare eligible clients immediately.

The days of waiting until a case is nearing settlement or trial to start figuring out if there are liens or claims to pay are over.

SUGGESTED PRACTICE TO BE FOLLOWED

As of February 1, 2014, the Coordination of Benefits Contractor and the Medicare Secondary Payer Recovery Contractor have restructured to form one entity, the Benefits Coordination & Recovery Center (BCRC). This change took effect on February 1, 2014.

The suggested practice to be followed is that as soon as the attorney is retained the Benefits Coordination & Recovery Center (BCRC) should be contacted to initiate the opening of a MSP potential recovery case. The BCRC can be called at the new contact phone number, 1-855-798-2627.

When contacting the BCRC to report a case, the following information is needed:

Beneficiary Information:

- Full Name
- Medicare Health Insurance Claim Number (HICN). Effective April 2019, Social Security Numbers must be removed from all Medicare cards, and replaced by a new unique Medicare number.
- Gender and Date of Birth
- Complete Address and Phone Number
- Case Information:
  - Date of Injury/Accident, or Date of First Exposure, Ingestion or Implant
  - Description of Alleged Injury, Illness or Harm
  - Type of Claim (Liability Insurance, No-Fault Insurance, Workers' Compensation)
  - Insurer or Workers' Compensation Name and Address
- Attorney Information:
  - Attorney or Law Firm Name
  - Complete Address and Phone Number

Once all information has been obtained, the BCRC, who is also responsible for processing Medicare recovery cases involving liability (including self-insurance), no-fault insurance or Workers' Compensation, will issue a Rights and Responsibilities letter and brochure. The Rights and Responsibilities letter is mailed to all parties associated with the case. The Rights and Responsibilities letter explains:

- What happens when the beneficiary has Medicare and files an insurance or workers' compensation claim;
- What information is needed from the beneficiary;
- What information can be expected from the BCRC and when;
- How and when the beneficiary is able to elect a simple, fixed-percentage option for repayment; and
- How to contact the BCRC;

USING THE MEDICARE SECONDARY PAYER RECOVERY PORTAL:

A better alternative to the telephone program is the MEDICARE SECONDARY PAYER RECOVERY PORTAL (MSPRP), https://www.cob.cms.hhs.gov/MSPRP/login.

The Centers for Medicare & Medicaid Services (CMS) has implemented a new web-based tool designed to assist in the resolution of Liability Insurance, No-Fault Insurance, and Workers' Compensation Medicare recovery cases. The new tool is called, The Medicare Secondary Payer Recovery Portal (MSPRP). All attorneys should be utilizing the BCRC Portal.

The MSPRP gives users (attorneys, insurers, beneficiaries, and TPAs) the ability to report new cases and access and update case specific information online. Activities that currently require written communication or telephone calls to the Medicare Secondary Payer Recovery Contractor will soon be able to be done through the portal.

The MSPRP will allow users the ability to electronically perform the following activities:

- **Report a New Case to Medicare:**
- **Submit Proof of Representation or Consent to Release documentation** - *Instead of mailing in an authorization, users will be able to upload authorizations through the portal.*
- **Request conditional payment information** - *Requesting an updated conditional payment amount or a copy of a current conditional payment letter will be as simple as clicking a few buttons.*
- **Dispute claims included in a conditional payment letter** - *Users will be able to view the claims listed on the conditional payment letter and dispute unrelated claims online.*
- **Submit case settlement information** - *Users will be able to input settlement information online and upload a copy of the settlement documentation through the portal. Once settlement information is uploaded to the Portal the Final Demand Letter should be supplied within approximately 20 business days. There is nothing to do the "rush" it.*

CMS has also established three new options for determining Medicare's claim in certain situations:

- New Option to Self-Calculate Your Conditional Payment Amount (cases under $25,000 and medical treatment concluded)
- New Fixed Percentage Option For Medicare's Recovery Claim (25% of settlements of $5,000 or less)
- Beneficiary Alert: $750 Threshold on Liability Settlements (if case settles for $750 or less, Medicare gets nothing)

The Self-Calculated Conditional Payment Amount enables the client to self-calculate the final conditional payment amount before settlement in certain situations. The following conditions must be met for Medicare to provide the final conditional payment amount before settlement is reached:

- The claim and settlement must be for an injury caused by physical trauma. The settlement cannot involve or relate to injuries caused by exposure, ingestion, or medical implant.

- Medical treatment for the injury must be completed with no further treatment expected. Treatment must have been completed at least 90 days before you submit the proposed conditional payment amount to Medicare. These requirements are proven to Medicare by providing either: A physician's written confirmation or beneficiary certification that he/she has not had care related to the case within the last 90 days and expects no further care.
- The total settlement, judgment, award, or other payment cannot exceed $25,000.

The date of the incident must have occurred at least six months before submitting the self-calculated final conditional payment amount to Medicare.

The client will be asked to give up the right to appeal the amount or existence of the debt. However, client will keep the right to pursue waiver of recovery

Once there is a settlement, judgment or award, the BCRC must be notified in writing of the date of the settlement, the amount of the settlement, and any attorneys' fees or other procurement costs borne by the beneficiary.

If the first notification to BCRC is made by the plaintiff's attorney or the defendant at the time of settlement, a Conditional Payment Notice will be generated rather than a Conditional Payment Letter.

If a Conditional Payment Notice is sent the plaintiff's attorney will have just 30 days to object to items in the notice, after which BCRC will issue the Demand Letter.

If there is no response to BCRC within 30 days of the Conditional Payment Notice BCRC will issue the Demand Letter BUT WILL NOT REDUCE THE AMOUNT OF REIMBURSEMENT BY THE COSTS OF COLLECTION. Who wants to try to explain that to a client?

On the BCRC website are "toolkits", one specifically tailored for the plaintiff's attorney to facilitate communication with BCRC and should be utilized, located at http://cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Attorney-Services/Attorney-Services.html

The entire recovery process has been set out at by BCRC at its website, which should be reviewed by all plaintiffs' attorneys.

As we all know, getting Medicare claim information is not always easy, but you can go a long way to helping yourselves by following the procedures outlined above.

CMS has released an updated Non-Group Health Plan (NGHP) User Guide version 5.3. The primary change to the User Guide involves detailing CMS' transition with its Social Security Number Removal Initiative (SSNRI) and how this transition will impact MMSEA Section 111 Reporting. The SSNRI initiative mandates CMS to replace all SSN-based Medicare

identifiers and distribute a new 11-byte Medicare Beneficiary Identifier (MBI) to beneficiaries by April 2019.

In summary, regarding Section 111 reporting, the most current Medicare ID (HICN or MBI) will be returned in the Section 111 response files in the "Medicare ID" field. Further, if an RRE submits information with a HICN and the Medicare beneficiary has received their MBI, the MBI will be returned. Otherwise, the most current HICN will be returned. Responsible Reporting Entities (RREs) may submit subsequent Section 111 information for the Medicare beneficiary using either the HICN or MBI. *Interestingly, the changes in the User Guide state that RREs are permitted to continue to still use the full SSN, HICN, or MBI. We believe that CMS mistakenly omitted that an RRE may also use the last full digits of the SSN if the full SSN is not available.*

Regarding conditional payment correspondence, the Benefits Coordination and Recovery Center (BCRC) and Commercial Repayment Center (CRC) correspondence will use the Medicare identifier that RREs most recently provided when creating or updating a Medicare Secondary Payer (MSP) record. Therefore, if the most recent information that was received used a HICN, all subsequent issued correspondence will be generated with the HICN as the Medicare ID. If the most recent information received used an MBI, all subsequent issued correspondence will be generated with the MBI as the Medicare ID.

As required by Section 501 of the Medicare Access and CHIP (Children's Health Insurance Program) Reauthorization Act (MACRA) of 2015, CMS must discontinue all Social Security Number (SSN)-based Medicare identifiers and distribute a new 11-byte Medicare Beneficiary Identifier (MBI)-based card to each Medicare beneficiary by April 2019. CMS has exempted all Medicare Secondary Payer (MSP) processes from exclusive use of the MBI. Therefore, Non-Group Health Plan (NGHP) RREs are permitted to continue to report for Section 111 mandatory insurer reporting using: full SSN, Health Insurance Claim Number (HICN), or MBI. All fields formerly labeled as "HICN" have been relabeled as "Medicare ID" and can accept either a HICN or the new MBI

Reporting Requirement Thresholds

Medicare has a $750 settlement amount threshold for certain liability insurance (including self-insurance) recovery cases. If all of Medicare's criteria are met, the BCRC will not seek reimbursement against the beneficiary's settlement, judgment, award, or other payment.

Thus, Medicare is interested in whether the case is a no-fault, workers compensation or liability case. Therefore, when reporting a automobile or workers compensation case it is necessary to say that there are two claims; one for no-fault, so that BCRC can contact the no-fault carrier, and a second for the liability case, so that BCRC can make a claim for reimbursement from the third-party lawsuit settlement. The same is true in workers compensation cases.

The Benefits Coordination and Recovery Center will do an investigation and will send Rights and Responsibilities Letter to the beneficiary and, if known, to the beneficiary's attorney. A Conditional Payment Letter containing a list of all accident related claims "conditionally" paid

by Medicare will automatically be generated within 65 days of the Rights and Responsibilities Letter and does not have to be requested.

The attorney should submit a Proof of Representation to Benefits Coordination and Recovery Center, by form which can be obtained online at http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Non-Group-Health-Plan-Recovery/Non-Group-Health-Plan-Recovery.html. The Procedure described by BCRC on its website.

The attorney and client should immediately thereafter register the client on the www.mymedicare.gov website. The beneficiary and his attorney simply create a user name and password on the website. After the initial investigation is completed by the BCRC and the Conditional Payments Letter issued all of the client's Medicare information should be readily available, including conditional payments. Those payments are updated weekly and can be reviewed, and, if any are incorrectly included, can be challenged.

Download Social Security Consent to Release form and send to plaintiff's social security office to obtain itemization of benefits client receiving. It can be provided to defendant who demands proof that plaintiff was not a Medicare beneficiary. It can be filled in on the fillable PDF form found at www.socialsecurity.gov/forms/ssa-3288.pdf

You should also utilize the BCRC Self-Service Information Line where you can now get your Conditional Payment amount even sooner. When you call BCRC and select the Self-Service option, you can automatically get Demand and Conditional Payment amounts as well as the dates those letters were issued without having to speak with a Customer Service Representative. You will also be able to request updated Conditional Payment amounts and copies of Conditional Payment letters without ever having to speak to a customer service representative.

The Self-Service Option is a means to obtain conditional payment information via telephone and without having to speak with a Customer Service Representative. To use this option, call 1-855-798-2627 and select the Self-Service option. When you use the Self-Service Option you will need the Case ID, your Medicare number, date of birth, and last name.

When calling the Self-Service Information Line, all you will need is the Case ID, Medicare number, date of birth, and last name of the beneficiary. All of this information can be found on your **Rights and Responsibilities Letter.**

On January 10, 2012, President Obama signed into law the SMART Act, which amended a number of provisions of the Medicare Secondary Payer Law, as follows:

Section 201 (Conditional Payment Final Demand and use of Website):

1. A claimant (or his/her representative) may at any time 120 days prior to the settlement, judgment or award notify the Secretary of the expected date and amount of the settlement, judgment or award.

2. The Secretary must provide conditional payment information through a website and update the information no later than 15 days after a payment is made.

3. If certain conditions are met, the last statement downloaded from the website can be considered the final demand (H.R. 1845 defines the "Protected Period" in section V, as 65 days from notice to the Secretary "except the Secretary may extend such period for an additional 30 days").

4. If there is a dispute over the conditional payment amount, the Secretary must respond/resolve the dispute within 11 business days or the proposed resolution by the claimant/representative will be deemed accepted.

5. This process will go into effect 90 days after the effective date of the Act (January 10, 2013). This section also provides that the Secretary create an appeals process for conditional payments.

Section 202 (Thresholds for Reporting and Conditional Payment Reimbursement):

By November 15th each year, the Secretary will have to publish a threshold, under which, reporting and conditional payment reimbursement will not apply. This will begin in the year 2014. The threshold amount will be based upon "the estimated cost of collection (including payments made to contractors)" for "physical trauma-based incidents." This threshold will not apply to "alleged ingestion, implantation, or exposure cases." The Limit is now $750.00

Section 203 (Discretionary Fines for Noncompliance with MIR):

Fines for noncompliance with MIR (Mandatory Insurer Reporting) will now be discretionary rather than mandatory; however, the guidelines for discretion are not yet created. Within 60 days of the effective date (January 10, 2013) CMS will seek comments on which actions should be subject to fine and which should not be subject to fine. The Secretary in conjunction with the Attorney General shall publish in the federal Register, those actions subject to and those actions not subject to, allowing for public comment during the 60 day period.

Section 205 (Statute of Limitations for conditional payment recovery):

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. This amendment shall be applicable to "actions brought and penalties sought on or after 6 months after the date of enactment."

Proposed Rules Issued by Medicare With Regard To SMART Act – Portal

Medicare has issued an interim final rule to implement its time frame for the expansion of the existing MSP Webb portal in order to comply with the Smart Act.

The existing MSP Webb portal currently permits authorize users and applicable plans to register to the Webb portal in order to access MSP conditional payment amounts electronically and update certain case specific information on line. Beneficiaries are able to lodge into the existing Webb portal by logging into their “MyMedicare.gov” accounts. Webb portal provides detailed data on claims that Medicare paid conditionally that are related to the beneficiary's liability insurance, no-fault insurance or worker's compensation settlement. This detailed claims data for each claim includes dates of service, total charges, conditional payment amounts and diagnosis codes. Beneficiaries’ attorneys or other representatives may also register through the Webb portal to access conditional payment information.

However, currently, in accordance with federal privacy and security requirements Medicare does not permit attorneys and other representatives to view certain aspects of the beneficiaries claim data via the Internet. That means that an attorney or other representative currently registered to use the Webb portal must submit proper proof of representation before he or she is able to access a beneficiary's case. Once the attorney or other representative is designated as an authorized user he or she may log into the Webb portal to view the conditional payment amount and perform certain actions which include addressing discrepancies, disputing claims and up-loading settlement information.

CMS has implemented a security feature known as a multifactor authentication to the Webb portal. When they implement multifactor authentication an authorized attorney will be able to view claims specific data.

In keeping with the requirements of the Smart Act, CMS has added functionality to the existing Webb portal that permits users, as of January of this year, to report the case to CMS in addition to other functions already available, such as notifying CMS when the specified cases approaching settlement, download or otherwise obtain time and date stamped final conditional payment summary forms and amounts before reaching settlement and insure that relatedness disputes in any of the discrepancies are addressed within 11 business days of receipt of dispute information. The beneficiary, his or her attorney or representative or an applicable plan is required to provide initial notice of pending liability insurance, no-fault insurance, worker's compensation, settlements judgments awards or other payment to the appropriate Medicare contractor at least 185 days before the anticipated date of settlement. The act permits CMS to extend its response time frame by an additional 30 days if it determines that additional time is required paragraph the beneficiary or his attorney may notify CMS, once and only once, via the Webb portal, of an impending settlement, any time after Medicare's contractor has posted its initial claims compilation, 65 days after initial notice to Medicare, and up to 120 days before the anticipated date of settlement.

It is important to note that the beneficiary or his attorney may request the claims be refreshed on the of the Webb portal any time after Medicare post-its initial claims compilation. If the beneficiary or his attorney believes the claims included in the most up-to-date conditional payment summary form are unrelated to the pending liability insurance settlement he or she may address discrepancies to a dispute process available for the Webb portal. A claim may be disputed once only once. Disputes submitted to the Webb portal will be resolved within 11 business days. After disputes have been fully resolved, and the beneficiary or his attorney have

executed a final claims refresh and obtained confirmation that the refresh his been performed, he or she may download or otherwise requested time and date stamped final conditional payment summary form for the Webb portal. This form constitutes the final conditional payment amount if settlement is reached within 3 days of the date of the conditional payment summary form.

Within 30 days of securing the settlement the beneficiary or his attorney must submit to the Webb portal settlement information specified by the Secretary that would CMS typically collects to calculate a final demand amount CMS will then apply a pro rata reduction to final conditional payment amount initial and issue a final MSP recovery demand letter> these changes will be implemented no later than January 1, 2016.

As of July 22, 2015, the Centers for Medicare & Medicaid Services (CMS) has implemented optional MFA services which are now available on the MSPRP. MFA is the use of two or more different authentication factors to verify the identity of a user. Verified users will now have access to view unmasked claims data on the MSPRP.

Non-beneficiaries will still need to have a verified Proof of Representation or Consent to Release authorization to perform actions on cases. Please note that MFA and the associated identity proofing process is optional for MSPRP users. Users may still use the MSPRP without going through the MFA process, but they will not have the benefit of viewing unmasked data.

User guides and training materials have been updated on CMS.gov and in the MSPRP to reflect the new MFA process.

As of January 1, 2016 the Portal has been modified to include Final CP process functionality. The Portal user can notify CMS that a case is 120 days or less from an anticipated settlement, ensure that relatedness disputes are addressed within 11 business day of receipt of dispute documentation, request a Final Conditional Payment Amount, and obtain a time and date stamped final conditional payment summary document before reaching settlement. The Final Conditional Payment calculation will not change so long as the case is settled within 3 calendar days of requesting the Final Conditional Amount and Settlement information is submitted through the Portal within 20 calendar days of requesting the Final Conditional Payment Amount.

With regard to an appeal process to be followed: Once a Final Demand, also known as an Initial Determination, has been issued by one of the Medicare contractors, beneficiaries, providers and suppliers have the right to appeal the recovery amount as outlined in Section 1869 of the Social Security Act and codified in 42 CFR 405, Subpart I.

There are five levels of appeal: Redetermination, Reconsideration, ALJ hearing, Council Review, and Federal District Court Action.

If a party to the Initial Determination does not agree with the Demand amount, that party has 120 days from the date of the Initial Determination to appeal directly with the contractor that issued the Determination (this is called a Redetermination). There is no threshold amount in controversy for the Redetermination to be reviewed. Any evidence to support the request for Redetermination will be reviewed by the contractor.

If the Redetermination is not favorable, the parties have 180 days from the date of the Redetermination to request a Reconsideration. The Request for Reconsideration is reviewed by a Qualified Independent Contractor (QIC), regardless of the amount in controversy. Any evidence that was submitted to the contractor will be reviewed by the QIC in addition to any new evidence the Parties include in the Request for Reconsideration.

If the Reconsideration is not favorable, the parties have 60 days after the receipt of the Reconsideration to request a Hearing in front of an Administrative Law Judge (ALJ), if it meets the amount in controversy requirements outlined in 42 CFR 405.1006. The current amount in controversy required to request an ALJ hearing is $160. The ALJ will review the evidence that is contained in the record of the previous two appeals. The ALJ will consider additional evidence if there is good reason the evidence was previously left out of the previous appeals.

If the decision by the ALJ is unfavorable, the parties have 60 days from the date of the decision to request a Council Review. There is no current amount in controversy needed to request a Council Review. The Council limits its review to the evidence contained in the record of the proceedings before the ALJ, unless the ALJ's decision included a new issue that the parties were not afforded an opportunity to address previously.

If the decision by the Council is unfavorable, the parties have 60 days from the date of the decision to file an action in Federal District Court, if the file meets the amount in controversy for the appeal. The current amount in controversy that must be met to file an action in Federal District Court is $1,600. This is the last Appeal a party has in the Medicare Appeals Process. The decision by the Federal District Court is final and binding on all parties.

Limitations on Medicare's Recovery:

Medicare Secondary Payer rules (42 USC § 1395y(b)(2), 42 CFR §§ 411.24, 28) limit recovery to medical expenses incurred by the decedent. Medicare recovery does not extend to state-created rights for the decedent's family to recover for his or her wrongful death, unless the NY statutes provide that medical expenses are recoverable by the beneficiaries as part of their claims under NY's wrongful death statute.

Medicare's claim is not a statutory lien that follows the requirements of N.Y. Soc. Serv. L. § 104-b. Indeed, the MSP statute does not say that Medicare has a lien. Rather, the statute creates a statutory claim for reimbursement which may be pursued by a direct action or through the right of subrogation. Courts have recognized that the United States' right of reimbursement is paramount to any other claim. *U.S. v Geier*, 816 F.Supp. 1332, 1337 (W.D. Wis. 1993).

Currently, Medicare is paid back, in full, even if plaintiff has not been "made whole", unlike Medicaid, which is now subject to the *Ahlborn* analysis found in *Arkansas Dept. of Health and Human Services v. Ahlborn,* 547 U.S. 268, 126 S.Ct. 1752, 164 L.Ed.2d 459 [2006] . There is an appeals process that may be followed, however, to seek to reduce the amount to be repaid to Medicare based upon hardship. *Zinman v. Shalala,* 67 F.3d 841, (1995)

In *Zinman*, the Court held that the Medicare Secondary Payer law, 42 U.S.C.1395y(b)(2)(B)(i), permits Medicare to recover in full its expenditures when a Medicare beneficiary suffers an injury covered by a group health plan or liability, workers' compensation, automobile or no-fault insurance and the beneficiary receives a settlement from that insurer. The court held that Medicare will be paid back in full even if the plaintiff, Medicare recipient has not been "made whole" by a settlement insufficient to cover in full all of the plaintiff's damages such as pain and suffering, medical injuries and lost wages. The court did not permit any allocation of the recovery to determine what portion of the recovery, if any, was intended to reimburse the plaintiff for medical costs paid by Medicare.

An attempt to apply an *Ahlborn* type analysis to Medicare was rejected in *U.S. v. Hadden*, 2011 U.S. App. LEXIS 23289; 2011 FED App. 0293P (6th Cir, 2011). In *Hadden*, the court affirmed a district court ruling which held that Medicare was entitled to reimbursement of its entire claim although the plaintiff only recovered 10 percent of the full value of the case.

A case which permitted an allocation, in a probate court context was *Bradley v. Sebelius, 621 F.3d 1330 (*11th Cir., 2010*)*, where the Court reversed a district court ruling and upheld a probate court finding that Medicare was only entitled to 2% ($787.50) of its full Medicare Lien ($22,480.89) because the entire case settled for 2% ($52,500.00) of its full value ($2,538,875.08). This decision stems from a Florida wrongful death case where a nursing home settled for its liability policy limits of $52,500.00.

In *Bradley*, the plaintiff's father died while under the care of a nursing home in Gainesville, Florida. Plaintiff brought a wrongful death action against the nursing home on behalf of Burke's estate and his 10 surviving children.

The case settled for the facility's insurance limits of $52,500 before a lawsuit was filed. Bradley notified the Secretary of the settlement proceeds and associated legal fees and costs. The Secretary refused to recognize that the medical expense claim had been settled for less than 100%. She asserted that under the MSP, 42 U.S.C. § 1395y(b)(2)(B)(ii), and its attendant regulations, 42 C.F.R. 411.37(c), the Secretary had the authority to claim the total amount of medical expenses, $38,875.08, less procurement costs, or a net amount of $22,480.89. The Secretary gave the estate sixty (60) days to pay Medicare.

Counsel for the children and the estate filed with the probate court an application for the court to adjudicate the rights of the estate and the rights of the children in regard to the compromised sum received in settlement of their claims.

The probate court hearing to allocate the settlement was scheduled and HHS was given adequate notice and invited the Secretary's participation. The Secretary declined to appear or to participate. (This is not unusual, as generally HHS is of the opinion that it is not obligated to respond to notices for "non-Article III courts").

The probate court awarded took testimony and determined that each of the ten survivors' claims had a value of at least $250,000 and noted that Medicare had asserted a claim of lien based upon payments of $38,875.08. Therefore, the court found that the total, full value of the

case was $2,538,875.08, and based on principles of equity determined that the medical expense recovery in the case was $787.50 to HHS. The court did not prioritize the recovery of medical expenses over recovery on each of the respective survivors' claims.

HHS refused to accept the probate court's determination, relying on language in the "Medicare Secondary Payer Manual" which provides that "the only situation in which Medicare recognizes allocations of liability payments to non-medical losses is when payment is based on a court order on the merits of the case. The Secretary contended that the probate court's decision was merely "advisory in nature or superseded by federal law."

HHS then demanded that Bradley to pay the $22,480.89 within 60 days. Bradley paid under protest, perfected its administrative appeal, and exhausted its administrative remedies.

The district court adopted the report of the magistrate judge holding the Secretary's interpretation of the statute and regulations reasonable and relied "heavily" upon the language of the Medicare field manual and held that Medicare was entitled to $22,480.89.

The circuit court reversed, noted that the facts of the case were not in dispute and that "the issue of first impression was: 'Whose property is the settlement?'"

The circuit court stated that the deference given to the language in the field manual in this case by the Secretary and the district court was misplaced, and would lead to "an absurd Catch-22 result. Forcing counsel to file a lawsuit would incur additional costs, further diminishing the already paltry sum available for settlement. This flies in the fact of judicial and public policy."

Further, the court said that "the Secretary's position would have a chilling effect on settlement" because it would force all plaintiffs to bring their claims to trial.

In a decision out of the United States District Court for the District of Maryland, *Weiss v. Price*, 2018 U.S. Dist. LEXIS 35078 (District of Maryland, March 5, 2018), a Plaintiff widow sought a declaratory judgment that CMS did not have interest in the funds she received as part of a wrongful death settlement. The Plaintiff previously had appealed CMS' desired recovery of $26,404.20 that Medicare had paid conditionally for medical treatment on behalf of her deceased husband, after she had allocated her settlement funds between her deceased husband and the Estate. When the Plaintiff received an unfavorable outcome at the Medicare Appeals Council level determining that CMS did have a right to recover its conditional payments, she filed this action in Maryland District Court.

The court found that she did not have standing in her individual capacity because she was not a party to the administrative appeal and had not yet obtained a final judgment from the Agency. There are two important reminders regarding Medicare conditional payments from this decision: 1) Parties must fully exhaust administrative remedies in the conditional payment appeal process prior to seeking judicial intervention. 2) CMS is not bound by an allocation unless it is determined via an evidentiary hearing on the merits of the case. Because the allocation here between her deceased husband and the Estate was determined via settlement agreement, CMS

will likely continue to demand its conditional payment recovery as the Plaintiff continues through the administrative appeals process.

In the Surrogate's Court context, keep in mind that in New York, EPTL 5-4.3 limits wrongful death awards to fair and just compensation for the pecuniary injuries resulting from the decedent's death to the person for whose benefit the action is brought. In every such action, in addition to any other lawful element of recoverable damages, the reasonable expenses of medical aid, nursing and attention incident to the injury causing death and the reasonable funeral expenses of the decedent paid by the distributees, or for the payment of which any distributee is responsible, shall also be proper elements of damage." Thus, such expenses which were not paid by distributees or for which they are responsible, are not recoverable in wrongful death.

On the other hand, Medicare takes the position that a claim for personal injuries includes a claim for medical expenses and thus, if a plaintiff has asserted a claim for personal injuries in the complaint and alleged that the plaintiff incurred medical expenses then Medicare must be reimbursed from the personal injury allocation and recovery and its claim should not be denied because there is no pain and suffering.

Salveson v. Sebelius, 2012 WL 1665424, D.S.D. 2012 holds that Medicare has a claim of reimbursement for payment of any item that was included in a claim against the tortfeasor - even if that claim is arguably not included in the settlement.

Thus, if you include a claim in a bill of particulars in a medical malpractice case arising from delay in diagnosis of cancer for treatments (chemo, radiation, etc.) that would have been performed even without malpractice, you will not be able to claim later that those claims should not be part of Medicare's claim for reimbursement.

In *Weinstein v. Sebelius*, 2013 WL 1187052 (E.D. Pa, 2013) , the issues were to what extent a Medicare secondary payer claim attaches and whether the "court-approved" settlement allocation to Medicare's reimbursement was based on the merits (according to the Medicare Manual, it will accept an allocation made by a trier of fact - the jury or the court - on the merits). Medicare Manual 50-4.4. The appeals court concluded that the state Orphan Court decision was not on the merits and that Medicare was not bound by it.

If you appeal or request a waiver, the 60 day time period in which to pay Medicare does not apply to the contested amount, and attorneys are not liable for payment to Medicare of those sums.

In *Haro v. Sebelius*, 789 F. Supp. 2d 1179 (D. Ariz. 2011) suit was filed by two Medicare beneficiaries (both of whom settled auto accident claims and pursued appeals of the MSPRC's recovery amount), and by a lawyer who represented one of the two beneficiaries. The Medicare beneficiaries challenged the right of CMS to demand reimbursement within 60 days of receiving settlement proceeds in those situations where an appeal or waiver request remains unresolved, and the lawyer challenged CMS's ability to hold attorneys personally liable for their client's reimbursement claim, contending such collection practices exceeded the Secretary's authority under the Medicare statutes and violated due process.

The court held that CMS may not demand immediate payment from Medicare beneficiaries while the reimbursement amount is pending on appeal or a waiver request stating: "60-day reimbursement requirement to support immediate collection activities against beneficiaries when the reimbursement claim is in dispute is neither rational nor consistent with the statutory scheme providing for waiver and appeal rights . . . because it unnecessarily chills a beneficiary's right to seek a waiver or to dispute the reimbursement claim and reaches beyond the fiscal objectives and policies behind the 60-day reimbursement provision."

The court also held that Medicare cannot hold plaintiff attorneys financially responsible for MSP reimbursement and cannot require them to either turn the settlement awards over to Medicare or hold the settlement sums in trust. The *Haro v. Sebelius* court took issue with Medicare's position that it could pursue MSP recovery directly from plaintiff's counsel by characterizing the attorney as "*an entity that receives payment from a primary plan . . . .*" *Id.* at 17 (emphasis in original). Although the federal regulations define an "entity" to include "a beneficiary, provider, supplier, physician, attorney, State agency or private insurer that has received a primary payment" (see 42 C.F.R. §411.24(g) the *Haro* court noted Congress never expressly made attorneys responsible for reimbursement under 42 U.S.C. § 1395y(b)(2)(B)(ii), and the court found no statutory basis for such an expansive reading of the Medicare statute. *Id.* at 18-19. The *Haro* court reasoned that since attorneys did not have the right to appeal or apply for waiver of Medicare claims themselves, nor were attorneys included in the original scope of the statute, they could not be directly targeted for reimbursement simply because they received the settlement funds on behalf of their client. The *Haro* court ultimately held there was no statutory support, either expressly or in the legislative history, to support the Secretary's assertion that she has a direct cause of action, pursuant to 42 U.S.C. § 1395y(b)(2)(B)(ii), to recover a reimbursement claim from an attorney that has received payment from a primary plan and has passed it along to the beneficiary.

MEDICARE ADVANTAGE PLANS

A Medicare beneficiary may choose to receive his/her Medicare from a Medicare Advantage Plan (Part C) 42 U.S.C. § 1395 w-21 et seq; 1395w-22(a)(4) and 1395mm(e)(4).

Until quite recently, the determination of whether MA plans had a right of recovery was based on an analysis of the MA's statutory provisions, which indicated that Congress did not create a federal scheme under the Medicare Act for the civil enforcement of a Medicare-substitute HMO's subrogation claims. Rather, the few courts which construed the statute found that it merely permitted MAs to include a right of subrogation or reimbursement in its contracts with Medicare beneficiaries.

In *Nott v. Aetna U.S. Healthcare, Inc*., 303 F. Supp. 2d 565 (E.D. Pa. 2004) the court held that the Medicare Act merely permitted HMOs to include a right of subrogation in those contracts, enforceable in the state courts subject to the laws of the state where such action is brought. "We conclude that the Medicare Act permits, but does not mandate, HMO insurers to contract for subrogation rights".

The *Nott* court specifically found that the Medicare Act did not completely preempt state law contract actions dealing with an HMO's subrogation rights. "Although the Medicare Act permits HMOs to contract with their insureds for subrogation, it does not provide a mechanism for them to enforce their private contractual rights."

The court in *Care Choices HMO v. Engstrom* 330 F.3d 786 (6th Circuit, 2003) rejects the notion that the Medicare Act "equates Medicare+Choice plans's subrogation/reimbursement rights to the recovery rights available to the federal government under the so-called Medicare Secondary Payer (MSP) statute." To the contrary, the court specifically said that "Reading the statute as a whole, it is clear that Section 1395mm(e)(4) is intended to permit Medicare-substitute HMOs to create a right of reimbursement for themselves in the context of their own insurance agreements with Medicare beneficiaries. The statute does not confer any affirmative rights to reimbursement, much less contain an implied private right of action." The court specifically did not equate Medicare HMOs rights with Medicare Secondary Payers: "Congress did not intend to imply a private right of action in the latter statute. Where the HMO provision uses permissive language (i.e., the HMO 'may' obtain reimbursement) the MSP provision uses mandatory language (i.e., Medicare payments "shall" be conditioned on reimbursement by the primary insurer). This is a fairly clear indication that Congress intended the Medicare program to have more extensive rights than Medicare-substitute HMOs."

In *Konig v. Yeshiva Imrei Chaim Viznitz of Boro Park Incl*, No. 12 Civ. 467, 2012 WL 1078633 (E.D.N.Y., Mar 30, 2012), the plaintiff sought to extinguish an MA plan claim for subrogation. The MA removed the action to the federal court which sought to enforce

> Here, Oxford and Rawlings ask me to find that the state court order to show cause constitutes a claim to extinguish Oxford's subrogation rights with respect to Konig's settlement proceeds, and that such a claim—because it seeks a determination with respect to the subrogation rights of a MAP provider—is completely preempted by the federal Medicare laws. But no such claim may be brought under the Medicare laws. Even if the Medicare laws could be read to create a right to subrogation for MAP providers—an interpretation rejected by many courts, who have instead held that the Medicare statute simply authorizes MAP providers to contractually create subrogation rights, *see, e.g., Nott v. Aetna U.S. Healthcare, Inc.*, 303 F.Supp.2d 565, 567 (E.D.Pa.2004); *Ferlazzo v. 18th Avenue Hardware, Inc.*, 33 Misc.3d 421, 929 N.Y.S.2d 690, 692 (N.Y.Sup.Ct.2011)—no provision expressly extends such providers a private right of action to sue upon their subrogation rights. Although the Medicare statute clearly authorizes the government to bring an action to enforce its subrogation rights under its own Medicare insurance contracts, *see* 42 U.S.C. § 1395y(b)(2)(B)(iii), the statute does not expressly accord private MAP providers the same right.[FN2] Every court to address the issue has found that the laws also fail to create an implied cause of action. *See Care Choices HMO v. Engstrom*, 330 F.3d 786 (6th Cir.2003); *Parra v. PacifiCare of Ariz.*, No. 10 Civ. 8, 2011 WL 1119736 (D.Ariz. Mar. 28,

2011); *Nott*, 303 F.Supp.2d 565; *Ferlazzo*, 33 Misc.3d 421, 929 N.Y.S.2d 690. I agree and conclude that the Medicare laws offer no private right of action—express or implied—to MAP providers to enforce any claimed subrogation rights. Accordingly, the Medicare laws do not completely preempt any claims raised in the order to show cause.

FN2. Oxford and Rawlings argue that 42 C.F.R. § 422.108(f), which provides that MAP providers "will exercise the same rights to recover from a primary plan, entity, or individual that the Secretary exercises," places MAP providers in the same shoes as the government, thereby granting them the power to bring a private right of action. This reasoning is faulty. "Language in a regulation may invoke a private right of action that Congress through statutory text created, but it may not create a right that Congress has not." *Alexander v. Sandoval*, 532 U.S. 275, 291, 121 S.Ct. 1511, 149 L.Ed.2d 517 (2001). Nothing in the Medicare statute itself creates a cause of action, and the parties cannot fashion one by invoking the regulations.

In *Parra v. PacifiCare of Arizona*, No. 11-16069 (9th Cir., April 19, 2013 yet another Federal Circuit Court of Appeals held that a Medicare Advantage Plan does not have a private cause of action against its insureds.

PacifiCare contends that because the MAO Statute allows a MAO to charge a primary plan for conditional payments made on behalf of a plan participant, that statute grants it a private right of action to recover those payments as well. We find the argument unavailing.

On its face, the MAO Statute does not purport to create a cause of action. Rather, it simply describes when MAO coverage is secondary to other insurance, and permits (but does not require) a MAO to include in its plan provisions allowing recovery against a primary plan, as PacifiCare did here. In considering 42 U.S.C. § 1395mm(e)(4), a provision virtually identical to the MAO Statute governing privately run health maintenance organizations ("HMOs"), the courts have consistently concluded that Congress did not intend to create a federal cause of action thereby. *Care Choices HMO v. Engstrom*, 330 F.3d 786 (6th Cir. 2003), is particularly instructive. In *Care Choices*, the Sixth Circuit unanimously rejected an HMO's invocation of federal question jurisdiction in a suit against one of its insureds, holding that § 1395mm(e)(4) merely permitted HMOs to create a contractual right of reimbursement. *Id*. at 788–90; *accord Nott v. Aetna U.S. Healthcare, Inc*., 303 F. Supp. 2d 565, 571 (E.D. Pa. 2004) ("[W]hile granting statutory permission to include recovery provisions in their contracts, Congress did not create a mechanism for the private enforcement of subrogation rights of Medicare substitute[s].").
We agree. The MAO Statute simply allows PacifiCare to provide via its contracts that its insurance is secondary to other available plans and allows

> recovery from a primary plan that refuses to reimburse the MAO for payments made on behalf of a participant. In the end, the MAO's claim thus arises by virtue of its decision to include provisions allowing such recovery in its contract with plan participants.

Thus it appeared that without a reimbursement provision in an MA plan, there was no right of reimbursement.

However, in the Third Circuit case of *In re Avandia Mktg*., 2012 U.S. App. LEXIS 13230 (3rd Cir. Pa) the MA plan took a different tack, claiming that it could bring a private right of action, under section 1395(b)(3)(A) of the Medicare Law for reimbursement, as a health benefit provider, against a primary payer (the tortfeasor).

It was generally understood that Section 1395(b)(3)(A) was a provision available to beneficiaries to bring a private right of action, and collect double damages, where a primary plan failed to provide primary payment.

The United States is specifically authorized under Section 1395(b)(2)(B)(iii) to bring an action under Section 1395(b)(3)(A).

> **(iii)** Action by United States In order to recover payment made under this subchapter for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity.

Notwithstanding the distinction made between Medicare and Medicare Advantage in the Medicare Law, the court in *In Re Avandia* held that a Medicare Advantage plan had the same rights as the United States to bring a private cause of action, at least against a primary payer.

In Re Avandia was not granted certiorari and remains the basis of claims by subrogation agents where there is no reimbursement provision. The claims can be settled by a negotiated settlement. It must be stressed that *In re Avandia* involved a claim against the tortfeasor, clearly a primary payer, and not against the plaintiff.

In *Michigan Spine & Brain Surgeons, PLLC v. State Farm Mut. Auto. Ins Co.,* 785 F.3d 787 (6th Cir. 2014) the court permitted the plaintiffs which had provided $26,000 in neurological treatment to the plaintiff which State Farm denied and which a Medicare Advantage Plan paid for to sue State Farm in a private cause of action and collect double damages. Again, this is a suit against a primary payer. Under the same circumstances the injured enrollee could sue, as could

the MAP. But does this case give the MAP the right to sue the enrollee who one could argue is not a primary payer.

In *Collins v. Wellcare Healthcare Plans, Inc.*, 2014 WL 7239426 (E.D.La., 2014) the enrollee had settled a personal injury case after the MAP had paid out approximately $180,000 in medicals. The plaintiff did not respond to the MAP's questionnaire and when the case was settled, put the disputed amount in a trust account and sued to extinguish the lien.

The court held that the plaintiff had not exhausted her administrative remedies and had failed to sue the Secretary as opposed to the MAP.

The plan counter claimed as a private cause of action. The court held that the MAP could bring a private cause of action claim and that the plaintiff was, in effect, a primary payer.

This year, in *Aetna Life Ins. Co. v. Guerrera*, 2018 U.S. Dist. LEXIS 41450, the court permitted a private cause of action to be asserted against a tortfeasor but not the victim or her attorney.

Plaintiff, Guerrera, a Medicare beneficiary, was allegedly injured on February 20, 2015 at a Big Y Grocery store. She received medical treatment that was paid for by Aetna, a Medicare Advantage Plan. The total charges are $9,854.16. Guerrera retained Carter Mario and Attorneys Hammil and/or Wisniowski to represent her against Big Y. Aetna informs Big Y of its lien a year in advance of any settlement discussions. Big Y settled Guerrera's claim for $30,000 and advised her that the Aetna lien amount will be held back to be paid directly. However, for reasons that are unclear from the opinion, Big Y issues the entire amount to Guerrera and her attorneys on September 15, 2016.

Aetna filed this action in Federal District Court for reimbursement pursuant to the Medicare Secondary Payer Act, and in particular the private cause of action provisions of that law which would entitled it to double damages. The claim was brought against Big Y, Guerrera and Guerrera's attorneys. Defendants moved to dismiss the action for failure of subject matter jurisdiction, believing that no Federal question was involved in the case. The Court dismissed Aetna's claims against Guerrera and Guerrera's attorneys due to its determination that the MSP private cause of applies only to primary plans or payers. The decision to do so was based on the Court's determination that the Congressional intent was for double damages only to be applied to primary plans or payers. However, it refused to dismiss the claim against Big Y.

> In its Complaint, **Aetna** brings claims pursuant to the MSP Private Cause of Action provision against three categories of defendant: (1) a Medicare beneficiary, **Guerrera**; (2) the law firm, Carter Mario, and the lawyers, Hammil and Wisniowski, who represented **Guerrera** in her personal injury settlement with Big Y; and (3) a tortfeasor, Big Y. In their Motion to Dismiss, the defendants argue that the Private Cause of Action provision permits suits only against a "primary plan," and that **Aetna** has failed to allege that any of the defendants—Big Y, **Guerrera**, or her attorneys—constitute a "primary plan." In response, **Aetna** argues that other federal courts have upheld the right of MAOs to sue all three types

of defendants at issue here pursuant to the Private Cause of Action provision, and urges this court to follow suit. **Aetna** further argues that, although its Complaint does not use the term "primary plan," that deficiency "elevates form over substance" because "[t]he Complaint clearly identifies the MSP Act and its Private Cause of Action Provision as the federal statutes pursuant to which **Aetna** has filed suit, and Defendants are obviously on notice of same."

1. Suit may only be brought against a primary plan.

In order to determine against whom suit may be brought, the court turns first to the language of the Private Cause of Action provision. Unfortunately, as with the question of who may sue, the express language of the Private Cause of Action provision does not specify who may be sued. Instead, the Private Cause of Action provision states that suit may be brought "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)." 42 U.S.C. § 1395y(b)(3)(A). Thus, the language of the provision itself does not clarify against whom suit is proper.

When interpreting the MSP Private Cause of Action, the Second Circuit has clearly concluded that suit may be brought against the primary plan itself. See Manning v. Utils. Mut. **Ins**. **Co**., Inc., 254 F.3d 387, 391–92 (2d Cir. 2001) ("Congress has authorized a private cause of action and double damages against entities designated as primary payers that fail to pay for medical costs for which they were responsible, which are borne in fact by Medicare." (emphasis added)); Woods v. Empire Health Choice, Inc., 574 F.3d 92, 95–96 (2d Cir. 2009) (describing the Private Cause of Action provision as one which allows private parties to "recover amounts owed by a primary plan"); Mason v. Amer. Tobacco Co., 346 F.3d 36, 42–43 (2d Cir. 2003) ("[P]ursuant to [the Private Cause of Action provision] individuals may be awarded double damages against a primary plan that has wrongfully denied them payment ..."); see also Parra, 715 F.3d at 1154 (affirming dismissal of claim in part because it was not brought against the primary plan). In short, the Second Circuit has concluded that, at a minimum, primary payers may be sued pursuant to the Private Cause of Action provision.

Aetna urges the court to find that beneficiaries and their attorneys may also be sued pursuant to the Private Cause of Action. The court concludes, however, that the MSP and interpreting regulations do not give MAOs the right to sue beneficiaries or their attorneys. The court reaches this conclusion for several reasons. First, the plain language of the Private Cause of Action provision, while admittedly vague, suggests that Congress intended suit against only primary plans. The provision is triggered when "a primary plan ... fails to provide for primary payment (or appropriate reimbursement)." 42 U.S.C. § 1395y(b)(3)(A). Had Congress intended to create a cause of action for double damages against

beneficiaries who received payment from a primary plan, Congress could simply have created a cause of action when "any entity or person" failed to reimburse an MAO.

In support of its interpretation, **Aetna** cites the court to a CMS regulation section 411.24(g) of title 42 of the Code of Federal Regulations ("section 411.24(g)"), which states that "CMS has a right of action to recover its payments from any entity, including a beneficiary, ... that has received a primary payment." 42 C.F.R. § 411.24(g). **Aetna** further cites the court to the government's cause of action in the MSP, subsection (2)(B)(iii), which states that "the United States may recover under this clause 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 U.S.C. § 1395y(b)(2)(B)(iii). Far from conflicting with the court's interpretation, however, this authority supports a reading of the Private Cause of Action provision that permits suit only against primary plans. This is because the government's cause of action permits only recovery from beneficiaries, while providing that the government may "collect double damages against" entities including "any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan." 42 U.S.C. § 1395y(b)(2)(B)(iii). In other words, the government's cause of action provides only for recovery of payment against beneficiaries or their attorneys, while allowing the government to sue primary plans for double damages. See Mason, 346 F.3d at 38 ("The [MSP] provides for the government to receive double damages in successful actions against primary payers."). Notably, the government's cause of action, subsection (2)(B)(iii), references the Private Cause of Action provision, paragraph (3)(A), in the course of allowing for double damages "against any such entity," where "such entity" describes primary plans. 42 U.S.C. § 1395y(b)(2)(B)(iii). This cross-reference suggests that the Private Cause of Action, like the government's cause of action, allows for double damages only against primary plans.

Aetna also directs the court to a Ruling by a court in the Eastern District of Louisiana, which held that beneficiaries who had received a settlement from a tortfeasor were, in effect, converted into primary plans. Collins, 73 F.Supp.3d at 667–68. The Collins court concluded that the settlement itself—as opposed to the entity that funded the settlement—was the "primary plan" because "there is no real distinction between a claim against a tortfeasor or his insurer to obtain reimbursement and a claim against a beneficiary to obtain reimbursement from a settlement funded by a tortfeasor or his insurer." Id. at 667.

The court declines to follow the lead of the Collins court, however, as its interpretation of the Private Cause of Action provision cannot be reconciled with the text of the MSP. Unlike much of the language at issue in the MSP, "primary plan" has a clear definition that does not include beneficiaries who have received benefits or settlement funds. The MSP defines "primary plan" as "a group health plan or large group health plan ... and a workmen's compensation law or plan, an automobile or liability insurance policy or plan (including a self-insured plan) or no fault insurance...." 42 U.S.C. § 1395y(b)(1)(A)(ii). In addition, elsewhere the MSP repeatedly distinguishes between primary plans and other entities. See, e.g., id. at (b)(2)(B)(vii)(I) (governing notice of settlement by "the claimant or applicable plan"); id. at (b)(8)(D) (defining "claimant" as "an individual filing a claim directly against the applicable plan" or "an individual filing a claim against an individual or entity insured or covered by the applicable plan"); id. at (b)(8)(F) (defining "applicable plan" as "[l]iability insurance (including self-insurance)," "[n]o fault insurance," or "[w]orkers' compensation laws or plans").

In the alternative, the Collins court concluded that, even if the Private Cause of Action provision did not unambiguously allow for suit against beneficiaries, proper deference to CMS regulations would direct the same result. Collins, 73 F.Supp.3d at 667–68. However, what the CMS regulations provide is that MAOs will have the "same rights to recover" as the Secretary. 42 C.F.R. § 422.108(f). As analyzed above, the government's cause of action allows for double damages only against primary plans, who do not include beneficiaries or their attorneys. In fact, this distinction is spelled out even more explicitly in another CMS regulation, section 411.24. See 42 C.F.R. §411.24. Section 411.24(c) states, "If it is necessary for CMS to take legal action to recover from a primary payer, CMS may recover twice the amount [of the Medicare primary payment]." 42 U.S.C. § 411.24(c)(2) (emphasis added). In contrast, section 411.24(g), which governs recovery of payments "from parties that receive primary payments," including "a beneficiary, provider, supplier, physician, attorney, State agency or private insurer that has received a primary payment," includes no double-damages provision, permitting CMS only to "recover its payments." 42 U.S.C. § 411.24(g) (emphasis added). Thus, the CMS regulations do not suggest that the Private Cause of Action provision allows collection of double damages from beneficiaries or their attorneys, but only from primary plans.

In Collins, the Medicare beneficiary had already received medical expenses from a tortfeasor, and the Collins court observed that precluding suit against beneficiaries would "produce[ ] an odd result, as that interpretation would encourage beneficiaries to hide their settlements from the MAOs and provide no recourse to the MAOs against the beneficiaries

for such action." Collins, 73 F.Supp.3d at 667. However, both the Collins court and the parties in this case have overlooked another provision in section 411.24, which provides "[s]pecial rules" in circumstances including "liability insurance settlements." 42 C.F.R. § 411.24(i). Section 411.24(i)states, "If Medicare is not reimbursed as required by paragraph (h)[8] of this section, the primary payer must reimburse Medicare even though it has already reimbursed the beneficiary or other party." 42 C.F.R. § 411.24(i)(1) (emphasis added). In short, section 411.24(i) explicitly addresses the situation with which the Collins court was concerned, and addresses the issue not by treating beneficiaries and primary plans alike, as **Aetna** urges the court to do here, but by clarifying that primary plans could not evade their obligations to Medicare simply through settlement with beneficiaries. See Glover v. Liggett Group, Inc., 459 F.3d 1304 (11th Cir. 2006) ("The MSP authorizes a private cause of action against a primary plan that pays a judgment or settlement to a Medicare beneficiary, but fails to pay Medicare its share." (citing section 411.24(i))).

Aetna also cites the court to a decision from the Eastern District of Virginia, Humana Insurance Company v. Paris Blank LLP, in which the court held that the plaintiff, a MAO, could pursue a claim under the Private Cause of Action provision against a beneficiary and her attorneys. 187 F.Supp.3d 676, 681. As in Collins, the Paris Blank holding relied on section 422.108(f), which equates the rights of recovery for MAOs to the rights of recovery for the government, in combination with section 411.24, which permits recovery against beneficiaries and their attorneys, as the court has just described. Id. at 681–82. However, section 411.24 does not provide for double damages recovery against beneficiaries and their attorneys, consistent with the text of the government's cause of action, subsection (2)(B)(iii). Thus, to conclude that beneficiaries and their attorneys may be sued under the Private Cause of Action provision would mean that MAOs would not have rights equal to those of the government, but rather rights greater than those of the government, because the Private Cause of Action provision only provides for double damages.

Relevant to this issue, the court notes that the Collins court interpreted the Private Cause of Action provision to allow for either single or double recovery, depending on whether a primary plan (which, for the Collins court, includes beneficiaries who have received settlement payments) "intentionally withh[e]ld payment." Collins, 73 F.Supp.3d at 669–70. The text of the Private Cause of Action provision does not, however, provide for single recovery. As described above, the Private Cause of Action provision creates "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 payment (or appropriate reimbursement)." 42 U.S.C. § 1395y(b)(3)(A) (emphasis added).

The Collins court reached its conclusion that the provision allowed for either single or double damages, depending on the circumstances, by effectively shifting the second parenthesis to include another clause, converting the clause "which shall be in an amount double the amount otherwise provided" to say, instead, "which shall be in an amount double the amount otherwise provided in the case of a primary plan which fails to provide payment." Collins, 73 F.Supp.3d at 670. In the view of this court, however, such a reading is explicitly precluded by the way Congress wrote this sentence, which unambiguously defines the damages available under the Private Cause of Action provision as double damages. See W. Heritage Inc. Co., 832 F.3d at 1240 (holding that the Private Cause of Action provision requires double damages because, "[u]nlike the Government's cause of action, the private cause of action uses the mandatory language 'shall' to describe the damages amount"); see also Mason, 346 F.3d at 38 (describing the Private Cause of Action provision as providing for "double damages against a primary plan").

Admittedly, this interpretation of the Private Cause of Action provision—that it allows for double damages against primary plans, but does not allow for recovery of payment from beneficiaries or their attorneys—conflicts with the intention of CMS that MAOs be accorded the same rights to recover as the government, see section 411.108(f), because the government's cause of action grants the United States the ***383*** authority to sue beneficiaries and their attorneys for recovery of payment. 42 U.S.C. § 1395y(b)(2)(B)(iii)("[T]he United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity."). CMS regulations, however, are only entitled to deference where they interpret ambiguous statutory language. See Digital Realty Trust, Inc. v. Somers, —— U.S. ——–, 138 S.Ct. 767, 781-82, 200 L.Ed.2d 15 (2018) (declining to defer to an agency regulation where "Congress has directly spoken to the precise question at issue" (quoting Chevron, 467 U.S. at 842, 104 S.Ct. 2778)). With respect to the damages available, the language of the Private Cause of Action provision is unambiguous.

For the foregoing reasons, the court concludes that the Private Cause of Action provision permits suits for double damages against primary plans, as defined in the MSP, see title 42, section 1395y(b)(1)(2)(A)(ii), which excludes beneficiaries and their attorneys. The court therefore grants the defendants' Motion to Dismiss the Medicare Act claims with respect to **Guerrera**, Carter Mario, Himmel, and Wisniowski.

For the reasons set forth in Guerrera, defendants may refuse to release funds to the plaintiff Medicare beneficiary or their attorney, without making certain that both traditional Medicare and Private Medicare such as MAPs and Part D plans are promptly reimbursed.

In *Humana Medical Plans, Inc., v Western Heritage Insurance Company,* 2015 U.S. Dist. LEXIS 31875, the court permitted the MAP to sue the tortfeasor's insurance carrier which had settled with and had paid the plaintiff a settlement to recover the MAP's lien. This is a mind field for the plaintiff who holds a defendant harmless.

A new decision was handed down from the U.S. Court of Appeals for the 11th Circuit in *Barbara J. Harvey v. Florida Health Sciences Center, Inc.* 2018 WL 1388523 (11th Cir., 2018) Here, the Plaintiff pursued a medical malpractice claim against a hospital for her husband's death. The hospital agreed to binding arbitration on the sole issue of damages to avoid a lawsuit.

The plaintiff then decided to add to her claim the Medicare Secondary Payer (MSP) private cause of action against the hospital. She now believed she was entitled to double damages because the hospital was a primary payer that "failed" to reimburse Medicare, once it agreed to move forward on the issue of damages only. The arbitration panel that had jurisdiction over the hearing denied the private cause of action claim, and rather than reserving her right to pursue the issue later, she took another tactic. She instructed her attorney to write the U.S. Government advising her MSP claim was denied, and demanding that it now pursue hospital directly for any medical expense under that law. She then had her attorney advise the arbitration panel that it would not pursue or present any evidence on medical expense.

Plaintiff was awarded $700,050.73, but the decision was clear that <u>none</u> of it was for past and/or future medical, but only applied to damages funeral expense, Lost Accumulations, Non-economic damages and Loss of household damages. To satisfy the award, hospital issued three checks made payable as follows: 1) $619,115.82 to Plaintiff and Medicare representing the outstanding Medicare conditional payment obligation; 2) $80,934.91 to Plaintiff and 3) $105,008.00 to Plaintiff attorney for his fees. Instead of objecting to the draft that was issued payable to plaintiff and Medicare, she accepted it, endorsed it and then sent it to Medicare. Medicare applied the check to the outstanding conditional payment obligation, but refunded her $401,222.33, for her procurement costs.

Ultimately, the Court ruled against her various claims, because she decided to forego her claim for medical expenses at arbitration

<u>EFFECT OF GOL 5-335:</u>

It was felt by some that if the MA's contract had a subrogation provision its interpretation would be subject to the laws of the State of New York. However, two cases have now held the opposite. *Potts v. The Rawlings Company,* 2012 WL4364451 (S.D.N.Y, 2012) in federal court and *Trezza v. Trezza*, 822 N.Y.S.2d 121, 2012 WL 685525 (2nd Dept., 2012) in state court. Both held that the Medicare Act, as extended to Medicare Advantage, specifically preempts state laws which attempt to limit the MA's rights of recovery from a primary payer.

The trial held that the Medicare Act did not preempt General Obligations Law §5-335 in that the act did not create a private cause of action and because it did not, it does not create a statutory right of reimbursement, citing *Care Choices HMO v. Engstrom* and *Nott v. Aetna.*

On appeal Appellate Division agreed that there was no statutory right of reimbursement but that the statute was preempted:

> It is clear that Part C permits, but does not require, Medicare Advantage organizations to create a right of reimbursement for themselves in their insurance agreements with insureds covered under Medicare. This conclusion is reinforced by considering other provisions of the Medicare Act which provide for mandatory reimbursement in other contexts (*see* 42 USC § 1395y[b][2] [B]). Thus, there is no statutory right to reimbursement in favor of Medicare Advantage insurers such as Oxford. Instead, Part C only furnishes statutory authorization for insurers such as Oxford to include reimbursement provisions in their agreements with enrollees. In the absence of a statutory right of reimbursement, General Obligations Law § 5–335 would seem to apply and effectively bar Oxford from recovering any part of the funds the plaintiff received in settling her personal injury claims with the defendants as reimbursement for the cost of health care services paid for by Oxford.
>
> However, as did the Supreme Court, we must consider any preemptive effect the Medicare Act may have on General Obligations Law § 5–335. This is an issue of first impression before this Court.
>
> * * *
>
> In the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Congress replaced the limited preemption provision with the following comprehensive preemption provision: "The standards established under [Part C] shall supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency) with respect to [Medicare Advantage] plans which are offered by [Medicare Advantage] organizations under [Part C]" (42 USC § 1395w–26[b][3]). This provision took effect on the date of the enactment of the Act, December 8, 2003.
>
> According to the House of Representatives Report which accompanied the 2003 legislation, Congress intended the amendment to "clarif[y] that the [Medicare Advantage] program is a federal program operated under Federal rules" (HR Rep 391, 108th Cong, 1st Sess at 557). The report continued, "State laws, do not, and should not apply, with the exception of state licensing laws or state laws related to plan solvency. There has been some confusion in recent court cases" (*id.* at 557, 107 Cal.Rptr.3d 767).
>
> * * *

Under 42 USC § 1395w–26(b)(1), "[t]he Secretary shall establish by regulation other standards (not described in subsection (a) of this section) for Medicare+Choice organizations and plans consistent with, and to carry out, this part [Part C]. The Secretary shall publish such regulations by June 1, 1998." This enabling provision authorized the Secretary to promulgate regulations to carry out Part C, and to publish them in the CFR.

At 42 CFR 422.108, entitled "Medicare secondary payer (MSP) procedures," regulations of the Centers for Medicare & Medicaid Services promulgated pursuant to the foregoing enabling provision describe the procedures to be employed by Medicare Advantage organizations in billing for covered Medicare services for which Medicare is not the primary payer. Under 42 CFR 422.108(f): "Consistent with § 422.402 concerning the Federal preemption of State law, the rules established under this section supersede any State laws, regulations, contract requirements, or other standards that would otherwise apply to [Medicare Advantage] plans." That subsection further states, "A State cannot take away [a Medicare Advantage] organization's right under Federal law and the MSP regulations to bill, or to authorize providers and suppliers to bill, for services for which Medicare is not the primary payer" (42 CFR 422.108[f]).

Indeed, Part C itself states that, "[n]otwithstanding any other provision of law," Medicare Advantage organizations may charge "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]).

Thus, the Medicare Act provides that Medicare Advantage organizations may create a right of reimbursement for themselves in their insurance agreements with Medicare insureds. Moreover, "[t]he standards established under [Part C] shall supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency) with respect to [Medicare Advantage] plans which are offered by [Medicare Advantage] organizations under [Part C]" (42 USC § 1395w–26[b][3]), and "[a] State cannot take away [a Medicare Advantage] organization's right under Federal law and the MSP regulations to bill, or to authorize providers and suppliers to bill, for services for which Medicare is not the primary payer" (42 CFR 422.108[f]).

Based on the express preemption provision set forth in 42 USC § 1395w–26(b)(3), as well as the regulations set forth in 42 CFR 422.108(f), we hold that General Obligations Law § 5–335, insofar as applied to Medicare Advantage organizations under Part C, is preempted by federal law since it would impermissibly constrain contractual reimbursement rights authorized under the "Organization as secondary payer" provisions of the Medicare Act (*see* 42 USC § 1395w–26[b][3]; 42 CFR 422.108[f];

> *v. Rawlings Co., LLC,* 2012 WL 4364451, 2012 U.S. Dist LEXIS 137802 [SD N.Y. 2012]; *see also Phillips v. Kaiser Found. Health Plan, Inc.,* 2011 WL 3047475, 2011 U.S. Dist LEXIS 80456, 20–21 [ND Cal] ["The Medicare Act contains an expansive express preemption provision [and] prohibits states from limiting [secondary payer] rights" (citation omitted)]; *cf. Do Sung Uhm v. Humana, Inc.,* 620 F.3d at 1148–1153 [in considering the preemption provision of Medicare Part D, which incorporates the express preemption provision in Part C, the Ninth Circuit concluded that the statute preempted state consumer protection claims and fraud common law claims]). Moreover, we agree with the conclusion expressed most recently in a case from the United States District Court for the Southern District of New York that this is so "[w]hether or not there is a private right of action for [Medicare Advantage] organizations" (*Potts v. Rawlings Co., LLC,* 2012 WL 4364451, 10, 2012 U.S. Dist LEXIS 137802,).

Similarly, in *Potts*, which was a class action seeking a declaratory judgment that pursuant to GOL 5-335 the Medicare Advantage organizations and their agents do not have a right to seek reimbursement from monies that plaintiffs received in settlements, the Court held that the statute was preempted.

The district court reviewed the Medicare statutes which the court said were incorporated into the Medicare Advantage statutes, including the portion that provides that "Notwithstanding any other provision of law, a [MA] organization may charge an insurance carrier or such individual (the beneficiary) to the extent that the individual has been paid under such law, plan or policy (by the defendant)".

The district court noted that plaintiffs had not disputed the allegation that they had not exhausted their administrative remedies nor that they had not presented their claims to the Secretary of Health and Human Services. Rather they claimed that they did not have to exhaust remedies because there were not bringing a claim under the Medicare Act by requesting a determination of nor a challenge to the denial of benefits.

The court found that claims concerning reimbursement are inextricably intertwined with claims for benefits and thus is a claim for benefits and that exhaustion applies.

The court also found that the Medicare Law contains a very broad, express preemption clause, and that the statute provides that "[t]he Secretary shall establish by regulation other standards … for [MA organizations] and plans… The statute further provides … "Relation to State Laws": "The standards established under this part shall supersede any State law or regulation (other than State licensing laws or state laws relating to plan solvency) with respect to MA plans."

The court also pointed to the regulation 42 C.F.R. SS 422.108(f) The rules established under this section supersede any State laws, regulations, contract requirements, or other standards that would otherwise apply to MA plans. A State cannot take away an MA's

organization's right under Federal law and the MSP regulations to bill, or to authorize providers and suppliers to bill, for services for which Medicare is not the primary payer.

The court reviewed *Nott*, *Care Choices* and *Konig* and noted that the issue in those cases was whether there was an (express or implied) private right of action for MA organizations, which is immaterial for the determination of whether GOL 5-335 was preempted where the MA plan contained a reimbursement provision.

Between *Trezza* and *Potts* it is pretty clear that it will be an uphill battle to defeat a Medicare Advantage Plan that has a reimbursement provision. Could an argument be made that GOL 5-335 is preempted only as to Medicare Advantage Plan, but not as to the plaintiff, so that one could argue that the plaintiff did not recover the past medical expenses by operation of GOL 5-335 and then cite the Medicare regulation 42 CFR §422.108 that provides that the Medicare Advantage Plan "may bill, or authorize a provider to bill any of the following: . . . (2) The Medicare enrollee, to the extent that he or she has been paid by the carrier, employer, or entity for covered medical expenses.

42 C.F.R. § 422.108 provides at subsection c as follows:

> c) *Collecting from other entities.* The MA organization may bill, or authorize a provider to bill, other individuals or entities for covered Medicare services for which Medicare is not the primary payer, as specified in paragraphs (d) and (e) of this section.
>
> (d) *Collecting from other insurers or the enrollee.* If a Medicare enrollee receives from an MA organization covered services that are also covered under State or Federal workers' compensation, any no-fault insurance, or any liability insurance policy or plan, including a self-insured plan, the MA organization **may** bill, or authorize a provider to bill any of the following—
>
> (1) The insurance carrier, the employer, or any other entity that is liable for payment for the services under section 1862(b) of the Act and part 411 of this chapter.
>
> (2) The Medicare enrollee, **to the extent that he or she has been paid** by the carrier, employer, or entity for covered medical expenses.

It is worth noting that right of recovery is limited "to the extent that he or she has been paid for covered medical expenses" the Advantage plan must look at what has actually been recovered by the Medicare enrollee.

The preemption created by the regulations would act to prohibit the state from enacting a law which takes away the Advantage Plans' right under federal law to bill, as set forth above.

> *(f) MSP rules and State laws.* Consistent with §422.402 concerning the Federal preemption of State law, the rules established under this section supersede any State laws, regulations, contract requirements, or other standards that would otherwise apply to MA plans. A State cannot take away an MA organization's right under Federal law and the MSP regulations to bill, or to authorize providers and suppliers to bill, for services for which Medicare is not the primary payer. The MA organization will exercise the same rights to recover from a primary plan, entity, or individual that the Secretary exercises under the MSP regulations in subparts B through D of part 411 of this chapter.

The *Humana Medical Plan, Inc. v. Reale*, 2011 U.S. Dist. LEXIS 8909 (S.D. Fla, 2011), the court held that 42 U.S.C. 1395y(b)(2) when read with 42 C.F.R. §422.108(f) does not entitle a Medicare Advantage Plan to reimbursement because the only the United States can sue for reimbursement, not the Secretary of Health and Human Services, where regulations give the Medicare Advantage plan the same rights of recovery as the Secretary.

> A Medicare Advantage organization, such as Humana, "will exercise the same rights to recover from a primary plan, entity, or individual that the Secretary exercises under the MSP regulations…" However, under 42 U.S.C. 1395y(b)(2)(B)(i), the Secretary's authority is limited to making payments "conditioned on reimbursement to the appropriate Trust Fund." *Id*. The United States is vested with full authority to bring an action for reimbursement, not the Secretary. 42 U.S.C. 1395y(b)(2)(B)(iii). Therefore, because the Secretary does not have the authority to bring an action for reimbursement, Humana cannot claim such a right under 42 C.F.R. §422.108(f). Accordingly, Humana has failed to bring a claim arising under federal law.

In a footnote, the court further stated that no right of action exists under 42 U.S.C. §1395mm(e)(4).

> Defendants (plaintiffs in tort action) also argue that this action must be dismissed because no right of action exists under 42 U.S.C. §1395mm(e)(4). ... (ECF No. 14 at p.3). Humana clearly states that it is relying on 42 U.S.C. 1395y(b)(2), not U.S.C. §1395mm(e)(4). Even if this action had been brought under U.S.C. §1395mm(e)(4), however, a dismissal would still be warranted because U.S.C. §1395mm(e)(4) does not confer a private right of action. See *Care Choices HMO v. Engstrom*, 330 F.3rd 786, 789 (6th Cir. 2003)(noting that under U.S.C. §1395mm(e)(4) "there is no evidence that Congress intended to create an affirmative right to reimbursement that is enforceable in federal court.

In December 2011, CMS issued a letter reiterating its position that Medicare Advantage Plans "will exercise the same rights to recover from a primary plan, entity, or individual that the Secretary exercises under the MSP regulations…" As stated in *Reale*, that right is limited to making payments "conditioned on reimbursement to the appropriate Trust Fund." Since Medicare Advantage Plans do not pay from the trust fund, how can there be repayment to the trust fund?

"Language in a regulation may invoke a private right of action that Congress through statutory text created, but it may not create a right that Congress has not." *Alexander v. Sandoval*, 532 U.S. 275, 291, 121 S.Ct. 1511, 149 L.Ed.2d 517 (2001). Nothing in the Medicare statute itself creates a cause of action, and the parties cannot fashion one by invoking the regulations.

Medicare Set-Aside (MSA)

As discussed earlier, the Medicare Secondary Payer Law provides that where Medicare has made a conditional payment, as a secondary payer, which rightfully should have been paid by a primary payer, Medicare must be reimbursed for the payments made. Tortfeasors and their liability carriers are now considered primary payers.

Recognizing that Medicare had been paying billions of dollars in post-settlement medical bills that should reasonably have been paid by someone else, the Medicare Secondary Payer Law was also amended to provide that in addition to paying Medicare back for past medical bills paid as a secondary payer the plaintiff also must consider Medicare interest with regard to future medical expenses. Medicare is not responsible to pay a medical bill that has already been paid, whether in a workers compensation settlement or a liability settlement.

Workers Compensation:

The first area where Medicare has asserted itself in this regard is in workers compensation cases. Although in workers compensation situation the workers compensation carrier should pay all accident related medical bills, there are times when a work related accident medical bill is submitted, often erroneously, to Medicare. Medicare pays the bill as submitted and then learns there is workers compensation. When the workers compensation case is settled, The Secondary Payer Statute requires that Medicare has to be paid back for past medical bills paid by Medicare and that Medicare be considered regarding future accident related medical bills. If the worker is Medicare eligible, a provision has to be made for future medical bills to be paid by the injured worker from his workers compensation recovery. This provision is called a Medicare Set Aside. As the name suggests, a sum of money, determined by considering past medical expenses incurred, is set aside into an account from which future medicals are paid.

There is a detailed process to be followed in submitting a set aside plan to Medicare in order to get Medicare's agreement to the set aside plan. I refer you to the CMS website, http://www.cms.hhs.gov for details of the process. Once the set aside amount is agreed to, if and when the set aside is exhausted the claimant can submit bills for medical treatment to Medicare.

The situation above exists where the only recovery is from workers compensation. For the most part the only people who have to concern themselves with this are workers compensation attorneys.

The rule of thumb is if the workers compensation case is settled (as opposed to merely closed) a set-aside has to be created. The future medicals are paid from that fund until they are exhausted. After that bills can be submitted to Medicare.

In the area that we are concerned with, handling a third party personal injury action, the important thing to remember is that if the workers compensation claim is not settled, as is usually the case where there is a third party negligence action, then there is no need for a set aside. That is because when the third-party case is settled, the workers compensation carrier is reimbursed for the moneys paid by it, pursuant to its workers compensation lien. In addition, the worker ceases to receive workers compensation benefits, until the plaintiff's net personal injury recovery is spent, after which he can reapply to workers compensation. This is known as workers compensation credit or "holiday".

The holiday continues until full credit has been taken by the workers compensation carrier for lost earnings and medical expenses until the plaintiff's share of the recovery is used up. During the holiday medical bills are supposed to be paid by the plaintiff from the settlement after which workers compensation will again be the primary payer. Thus, there should never be a reason to submit a work accident related bill to Medicare and thus no need for a set aside.

In the past, when the workers compensation carrier stopped paying the medical bills, the worker, if otherwise eligible to receive Medicare, would often submit the bills to Medicare, which generally paid them. This is where Medicare has recently begun enforcing its right not to absorb workers compensation medical costs. It is up to the client to keep track of how much credit the workers compensation carrier has taken for medicals and loss of earnings to know when the holiday is over and to reapply for workers compensation. Be sure to advise your clients never submit a work accident medical bill to Medicare.

Non-Workers Compensation:

Authority exists for Medicare's interest to be considered in all cases. §1862(b)(1) of the Social Security Act says, in effect, that if you have already been paid for future medical expenses, Medicare will not pay for them again. However, as of now, Medicare is only requiring submission of Medicare set aside proposals where there has been a settlement of a workers compensation case.

But things appear to be changing.

In classic putting the cart before the horse, the Centers for Medicare and Medicaid Services (CMS) released a "CMS Manual System" "One-Time Notification" regarding Liability Medicare Set Asides and enforcement of the Medicare Secondary Payer statute (MSP). Although CMS has indicated that it may start to review LMSAs in July 2018, as of October 1, 2017 CMS will deny payments for beneficiaries with MSAs.

According to the CMS release, starting October 1, 2017, Medicare and their contractors will reject medical claims submitted post-resolution of a liability settlement on the ground that those claims "should be paid from a Liability Medicare Set Aside (LMSA)". The notice also states that "Liability and No-Fault MSP claims that do not have a MSA will continue to be processed under current MSP claims processing instructions".

What does that mean? It suggests that if there is an MSA all bills must be paid from it until it is exhausted, and on the other hand states that if there is no MSA liability claims will be handled as currently handled.

To me that says: "Don't do an MSA unless your settlement has sufficient recovery to fully fund an MSA. Otherwise do an MSA type analysis and have your client pay their medical expenses until that amount runs out. In this way you have considered Medicare with regard to future accident related medical expenses.

"Consider" means that provision has to be made for future accident related medical bills to be paid from a source other than Medicare. A reasonable evaluation should be made of how much money will be required for future accident related medical bills, based upon an evaluation of past expenses and funds utilized to pay those bills.

Medicare is interested in a settlement where at the time of the settlement the injured person is eligible to receive Medicare benefits and the total settlement amount is $25,000.00 or more, 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**.** Eligibility exists if the individual is (1) 65 years of age or older; or (2) has been receiving Social Security benefits for at least twenty-four months; or (3) has end-stage renal disease.

On June 8, 2016 Medicare issued the following announcement:

- Consideration for Expansion of Medicare Set-Aside Arrangements (MSA)

> The Centers for Medicare and Medicaid Services (CMS) is considering expanding its voluntary Medicare Set-Aside Arrangements (MSA) amount review process to include the review of proposed liability insurance (including self-insurance) and no-fault insurance MSA amounts. CMS plans to work closely with the stakeholder community to identify how best to implement this potential expansion. CMS will provide future announcements of the proposal and expects to schedule town hall meetings this year. Please continue to monitor this website for additional updates.

This statement reinforces to me, the understanding that MSAs are not required in liability cases, notwithstanding suggestions from defendants and the counsel, to the contrary.

However, plaintiffs' attorneys may want to consider doing a future benefits analysis and having a portion of the settlement structured to provide funds for future medical needs, or having a sum of money put into a separate bank account and paying medical bills from that fund, until exhausted.

CMS has recently issued a letter regarding Medicare Set-Asides in liability cases in which it stated that if the beneficiary obtains a letter from the plaintiff's treating doctor stating that no future medical treatment is required that Medicare will consider that its future interest has been considered.

Although the notice is written in such a way that it might appear to be a follow up to other such notices, in fact, it is not. Medicare has still not issued any rule or regulation requiring a formal set aside and CMS will not review Set Asides submitted as a preventive measure.

Obviously, in any case involving a Medicare beneficiary who has completed treatment, it is a no-brainer to get a letter from the treating doctor stating the no future medical treatment is needed.

A number of cases have ruled on the issue of whether parties to a settlement can agree on the amount of a set-aside in a liability case and have that set-aside amount be held to be enforceable against Medicare. *Schexnayder v. Scottsdale Ins. Co.*, 2011 U.S. Dist. LEXIS 83687 (W.D. La, 2011) and *Smith v. Marine Terminals of Arkansas*, 2011 U.S. Dist. LEXIS 90428 (E.D. Ark, 2011).

It must be remembered that these are cases where the parties voluntarily entered into Medicare Set-Aside arrangements in liability cases, and in each case the court recognized that Medicare does not require or approve of set-asides submitted for review.

The only legal requirement with regard to future Medicare is that Medicare's interests be considered.

That can be done informally or more formally as the case requires.

These issues raise havoc at settlement conferences and even post-settlement. The trial attorney would be wise to discuss matters of lien resolution and appropriate settlement documentation prior to marking the case "settled".

In *Tomlinson v. Landers*, 2009 WL 1117399 (M.D., Florida) the court held that post-settlement demands for Medicare to be a payee on a settlement check would not be enforced because there was not a meeting of the minds that Medicare be a payee at the time of settlement.

In *Sipler v. Trans Am Trucking, Inc*., 881 F. Supp. 2d 635, 637 (D.N.J. 2012) the federal district court in New Jersey enforced a settlement where the defendant, after settlement, demanded that the plaintiff, who was a Medicare beneficiary but who had no medical bills paid by Medicare and planned to continue to receive primary medical benefits from private insurance, acknowledge that he would not seek future medical payments from Medicare and set up a Medicare Set-Aside.

The court held that no federal law required the creation of a Medicare Set-Aside in a liability case and that CMS opinion letters and the like lack the force of law. The court enforced the settlement stating that the plaintiff had no obligation to create a Medicare Set-Aside and no amount of the settlement had to be allocated to future damages.

In *Duhamell v. Renal Care Group*, No. L-871-09, Superior Court of New Jersey Law Division, Atlantic County (Dec. 11, 2012) both plaintiffs submitted expert reports determining the proposed set-aside amounts for future medical expenses. Both reports were submitted to CMS for review, and CMS responded that they did not have resources to review the proposed set-asides. CMS does not provide any other policy or procedure for determining the adequacy of protecting Medicare's interests for future medical expenses in conjunction with the settlement of plaintiffs' claims.

The Court held that "In light of the foregoing, and given the letters issued to plaintiffs lack the force of law, to require plaintiffs to force their case to trial when they have reached an amicable resolution outside of court, runs contrary to New Jersey's strong public policy interests in encouraging settlements" and "The court has thoroughly reviewed the sworn testimony of plaintiffs' expert regarding the proposed set-aside amounts for future medical expenses relating to the underlying accidents/incidents, which would otherwise be covered or reimbursable by Medicare. The court finds that the proposed set-aside amount in each case fairly takes Medicare's interests into account in that the figures are both reasonable and reliable. Therefore, the court is satisfied that Medicare's interests have been adequately protected pursuant to the MSP. Plaintiffs shall set aside the proposed sums in self-administered interest-bearing accounts to be used solely for the purpose of satisfying future medical expenses related to the underlying accidents/incidents. For all the foregoing reasons, plaintiffs' motion to enforce the settlement is granted.

Three other cases touch on the subject on the general topic of set asides and are worth mentioning.

None of these cases changes the fact that Medicare Set-Asides are not required in liability cases (yet). Rules are in the process of being made, but from what I understand, the sticking point is what you do with a case that settles for less than full value - due either to questionable liability or lack of coverage.

In *Early v. Carnival Corporation*, 2013 WL 462580 (S.D. Fla, 2013) the court said that it would not fill in missing pieces of a settlement agreement that the parties could not agree on and wanted the court to fill in. The Court correctly refused. The issue of whether or not to do a Medicare Set Aside was discussed by the parties and they could not agree, and thus, the issue was left open. In Early, the Court said:

> [T]he parties' request here is essentially for the Court to offer an advisory opinion on the legal requirements of the MSP or to draft a term into the parties' potential settlement agreement. The parties' request fails because the Court may not write-in the terms of parties' private settlement agreements or render advisory opinions. *See Holmes,* 706 F.2d at 1160; *R.T. Vanderbilt Co. v. Occupational Safety & Health Review Com'n,* 708 F.2d 570, 574 (11th Cir. 1983). Therefore, as District Judge Cecilia Altonaga persuasively noted in *Wilson,* in a strikingly similar situation, "[t]he Court declines the parties' invitations" to offer an advisory opinion

> on the legal requirements of the MSP, "or to rewrite the settlement agreement." *Wilson,* No. 07-60879, slip op. at 3.
>
> In addition, as the *Wilson* court found, the parties' very submission of this critical term of their purported settlement to the Court for its decision indicates that the parties do not in fact have a settlement. *Id.* at 4. Indeed, the situation here goes even farther than that in *Wilson.* Carnival and Early admit that they have agreed on only 4 of the 5 terms that are supposed to constitute the terms of a future settlement agreement. Thus, like in *Wilson,* this Court also finds that the parties do not in fact have a settlement agreement and this case will remain on the Court's trial docket."

The United States District Court for the District of New Mexico has issued an interesting decision involving the uncertainty for the need of a Liability Medicare Set-Aside (LMSA) in a medical malpractice settlement involving a Medicare beneficiary. The case is captioned *Silva v. Burwell*, 2017 U.S. Dist. LEXIS 195032 (November 28, 2017).

A plaintiff in a medical malpractice action settled his claim with defendant hospital and physician that had provided him medical treatment in December 1015. Because Medicare had made payments for his medical treatment, Medicare sought recovery for its conditional payments, which Plaintiff reimbursed Medicare in full. Although past payments were resolved, the parties were unclear on what obligations would be present to protect Medicare's interests for future treatment.

Defendants asserted that the Plaintiff must create an LMSA from the settlement funds for future medical expenses because of a concern that Medicare could come back after Defendants for future medical expenses. Defendants brought about this concern due to the regulations and guidelines created for the review and approval for Workers' Compensation Medicare Set-Asides (WCMSAs).

However, Plaintiff argued that there is no legal support for Medicare to request an LMSA, because the guidelines relate to workers' compensation settlements do not relate to liability or personal injury settlements. Plaintiff requested CMS to state its position as to whether funds must be "set-aside" from the settlement of a personal injury claim to cover unknown, unspecific future medical expenses. CMS did not respond to Plaintiff's inquiry and refused to take a position regarding 1) the legal basis of their claim for repayment or future medical care; and 2) whether a set-aside is required with respect to Plaintiff's future medical care.

Defendants at this point agreed that they would release the money in trust to Plaintiff's Trustee for his health and welfare if Plaintiff obtained a federal court order containing a finding that no federal law or CMS regulation requires the creation of a Medicare "set-aside" from Plaintiff's personal injury settlement. During the state-court approval of the settlement, it was determined that a certain amount of the settlement would be kept in trust to meet any Medicare "set-aside," while Plaintiff pursued the instant federal court action.

Consequently, Plaintiff filed a Declaratory Action in federal court seeking a declaration that no "set-aside" is required in Plaintiff's state court settlement to pay for his future medical expenses, that Defendant CMS may not in the future decrease or refuse to pay for medical bills

Mr. Silva may incur or otherwise penalize Plaintiff or his trust, and that MSAs are not required under the law for personal injury or medical malpractice damages. Defendants filed a motion to dismiss for lack of subject matter jurisdiction arguing that (i) there is no justiciable case or controversy because the Secretary has no duty under the law to take a position on the controversy; (ii) the United States is immune from suit; and (iii) Plaintiff has failed to exhaust his administrative remedies under the Medicare Secondary Payer Act.

The District Court upon reviewing the action for Declaratory Relief reviewed the Medicare Secondary Payer Act, the regulations governing WCMSAs, and also noted that CMS had previously issued a Proposed Notice of Rulemaking in 2012 which would have enacted a process for considering Medicare's future interest in liability claims, but that CMS took no further action on the Notice.

The District Court ultimately granted Defendants Motion to Dismiss for lack of subject matter jurisdiction and would not determine whether an LMSA was required. Its reasoning was that the Plaintiff had not shown that CMS has ever sought to recover funds not placed in an LMSA in other similar personal injury settlements. Further, Plaintiff has not demonstrated that CMS is likely to seek reimbursement from either Plaintiff or Defendants if they do not create an LMSA.

Lastly, the District Court was not required to opine on whether an LMSA should be created in this case, as there is no law or regulation currently in place that requires CMS to decide whether Plaintiff is required

As final commentary, the District Court state that it concurred with the decision in *Sipler,* 881 F.Supp. 2d at 638 concern that "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." More interesting was the District Court's commentary that "the uncertainty created by CMS' repeated failure to clarify its position on requiring MSAs in personal injury settlements generally and in specific cases is also proving burdensome to the settlement process."

I take the position that there is no requirement of a Medicare Set-Aside in liability cases. (*Sipler v. Trans Am Trucking, Inc*. U.S.D.C., District of New Jersey, 2012) "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. The parties need not include language in the settlement documents noting Mr. Sipler's obligations to Medicare or fashion a Medicare set-aside for future medical expenses").

Rather, Medicare must be considered in arriving at a settlement. There are many ways to consider Medicare: Arrange for other coverage from a private insurer, show that there is no-fault coverage, show that no future treatment is anticipated, doing an informal set aside analysis and putting some money away.

In *Benoit v. Neustrom* (W.D. La. 2013), the United States District Court for the Western District of Louisiana rendered an unprecedented decision. In a case where a limited recovery was achieved due to complicated liability issues with the case, the Court reduced a liability Medicare Set Aside allocation by applying a reduction methodology.

The *Benoit* case was settled in October of 2012, conditioned upon a full release by Mr. Benoit and his assumption of sole responsibility for "protecting and satisfying the interests of Medicare and Medicaid." To that end, a Medicare Set Aside allocation was prepared by an MSA vendor. The MSA cost projections gave a range of future Medicare covered injury related care of $277,758 to $333,267. The gross settlement amount was $100,000.00. Medicaid agreed to waive its lien. Medicare asserted a reimbursement right for its conditional payments of $2,777.88. After payment of fees, costs and the Medicare conditional payment, Mr. Benoit was left with net proceeds of $55,707.98. Mr. Benoit filed a motion for Declaratory Judgment confirming the terms of the settlement agreement, calculating the future potential medical expenses for treatment of his injuries in compliance with the Medicare Secondary Payer Act and representing to the court that the settlement amount was insufficient to provide a set aside totaling 100% of the MSA.

The matter was set for hearing and Medicare was put on notice of the hearing. Medicare responded with a written letter asserting its demand for repayment of the conditional payment in the amount of $2,777.88 but didn't address the set aside. Having heard testimony, the court rendered its opinion in April of 2013. The court made its findings of fact and conclusions of law which were not worthy of mention aside from the bombshell finding that the net settlement was 18.2% of the mid-point range of the MSA projection and using that percentage as applied to the net settlement, the sum to be set aside was $10,138 and not $305,512. The court found that $10,138 adequately protected Medicare's interests.

In its conclusions of law, the court first found it had jurisdiction to decide the motion because there was "an actual controversy and the parties seek a declaration as to their rights and obligations in order to comply with the MSP and its attendant regulations in the context of a third party settlement for which there is no procedure in place by CMS." The court then found that the sum of $10,138 "reasonably and fairly takes Medicare's interests into account." Lastly, the court found that since CMS provides no procedure to determine the adequacy of protecting Medicare's interests for future medical needs in third party claims and since there is a strong public policy interest in resolving lawsuits through settlement, Medicare's interests were "adequately protected in this settlement within the meaning of the MSP." The court ordered that the MSA be funded out of the settlement proceeds and be deposited into an interest-bearing account to be self-administered by Mr. Benoit's wife.

Starrett v Klebart, 2013 Conn. Super. Lexis 245 (unreported 2013) is a Connecticut trial leverl court case (which Medicare would not be bound by) but does use some of the arguments and tactics that are often employed in doing an informal Medicare Set-Aside analysis that will call for a reasonably small amount of money being set aside. Here, unfortunately, the Court appears to have bitten off more than it should have by saying that there was no future medicals in the settlement. Should Medicare chose to it can cause a lot of problems for the plaintiff by the parties' and the court's overreaching.

The concept in *Starrett* is that when you look at a whole settlement, including the fact that you sometimes have to take less than full value for a case because there is limited insurance or questionable liability, you can come to the valid conclusion that the settlement did not include all of the past and future damages paid at their full value. In *Starrett* the parties got the Court to

go along with their conclusion that the settlement did not include ANY money for future medical expenses, when the decision itself makes is clear that there had been $14,448.30 in past medical expenses and it was "contemplated that Sterrett will incur medical bills payable by Medicare in the foreseeable future."

I think this decision, while well intentioned and is based on a valid theory, will backfire if Medicare is sent bills to pay and realizes that it was "cut out" of the settlement apportionment. Then, in that situation, Medicare can say that it is paying NOTHING until the ENTIRE settlement is used up.

We don't ever want to get into that situation.

What I have done, and suggest as a reasonable approach, is to do a Medicare Set-Aside analysis that recognizes that there has to be some future medicals in the settlement, but when that is considered along with all of the past medicals, the pain and suffering, the loss of earnings, etc., that the amount of the settlement fairly allocated to future medicals is a relatively small amount of money. We then put that money "aside" and spend it down and submit subsequent bills to Medicare.

If Medicare asks any questions about the bills we submit after using up the allocation we came up with we show that we did a professional set-aside analysis and came up with that relatively small amount of money.

These situations are quite different from cases seeking to enforce a settlement where the matter of a Medicare claim had not been dealt with or resolved. Two New York Supreme Court cases have held that the plaintiff cannot enter a judgment against a defendant for failing to pay a settlement within the time limited for payment pursuant to the CPLR because the issue of Medicare reimbursement had not been resolved between the parties.

In *Liss v. Brigham Park Coop. Apts. Sec. No. 3*, 264 AD2d 717 (2nd Dept, 1999) the Supreme Court granted plaintiff's motion for costs, disbursements and interest pursuant to CPLR 5003-a(e) for failure to timely tender a stipulated payment, and *sua sponte* awarded attorneys' fees to the plaintiff.

The Appellate Division reversed and held that the General Release and Stipulation of Discontinuance were defective as they did not provide for the release of the plaintiff's Medicare lien. "Since the Federal Government has a right of subrogation and may collect the amount of the lien directly from the defendant (*see,* 42 CFR 411.24), it was incumbent upon the plaintiff to provide for the release of the lien in the general release and stipulation of settlement."

In *Panella v. CBS Broadcasting, Inc.,* 2011 WL 4017990 (N.Y. Sup, 2011) the parties participated in a court-order mediation in May, 2010 where the defendant made a settlement offer of $1.1 million. Numerous conversations followed with regard to whether the plaintiffs had received Medicare benefits and if so, to what extent. In October the plaintiff's attorney served a general release and a hold harmless agreement in the form drafted by the defendant. Approximately two months later, on December 2, plaintiff's attorney provided the Medicare lien

information for one plaintiff and on January 10, 2011 for the other. Also on December 2, the attorneys agreed to have the plaintiff's attorney hold money in escrow pending receipt of a Conditional Payment Letter from Medicare. On December 16, 2010 plaintiffs entered judgment for defendant's share of the settlement plus interest and costs. On December 17 and 21 defendant paid the settlement amounts and thereafter moved to vacate the portion of the judgment awarding interest and costs and disbursements.

The issue in the case is when the defendant's 21 days within which to pay began to run. Plaintiff argued the October date, defendants argued December 2 and January 10, when the defendant received the Medicare Conditional Payment Letters.

The court held that it was not until December 2 and January 10 that defendant received the Medicare Conditional Payment Letters and until then it was premature for plaintiff to move to enter judgment.

> Microtech should not be penalized for failing to disburse settlement funds within twenty-one days of the October 2010 release, when it had spent months trying to get information from the plaintiffs as to any Medicare liens that they may have against them. Microtech was taking the steps necessary to protect itself from liability for any potential failure by the plaintiffs to pay outstanding Medicare liens. There is no showing of bad faith here. * * * Microtech was clear that it would not complete the settlement without adequate assurance that any Medicare lien would be satisfied, and it was not until December 2, 2010 and January 10, 2011 that Microtech received the CMS letters. *** [T]his action was not settled within the purview of CPLR 5003-a(a) until the Medicare issues were **resolved by the CMS letters.**

The Second Department reiterated its *Liss* holding in *Torres v. Hirsch Park, LLC,* 91 AD3d 942 (2nd Dept, 2012) where the Court affirmed the Supreme Court which had permitted the defendant to pay the settlement proceeds into court and stay the entry of a judgment and directing plaintiff to provide defendant with authorizations to obtain his Medicare and Medicaid records. it said:

> The general release and stipulation of settlement tendered by the plaintiff to the defendant were defective because they failed to include any provisions releasing and holding the defendant harmless from potential Medicare and Medicaid liens. [Citations omitted] or acknowledging that any such liens would be satisfied from the settlement proceeds. Thus the plaintiff did not satisfy a condition precedent to the entry of judgment pursuant to CPLR 5003-a. Further, the authorizations that the Supreme Court directed the plaintiff to provide are necessary for the defendant to comply with its statutory duty to report the identity of a claimant who is entitled to Medicare benefits (*see* 42 USC § 1395y [b] [8]), and to determine the existence of potential subrogation claims

The Appellate Division, First Department followed the Second Department's *Liss* and *Torres* holding in *Torres v. Visto Realty*, 2015 NY Slip Op 03255, 2015, affirming the Supreme Court which had vacated a judgment enter pursuant to CPLR 5003-a and directed plaintiff to submit an affidavit that he is not and was not a Medicare recipient at the time of the accident.

> Contrary to plaintiff's contention, the court properly found that plaintiff did not satisfy his obligations under CPLR 5003-a, since he failed to provide defendant with the information relating to his Medicare status that defendant requires to comply with its reporting obligations under 42 USC § 1395y

I believe that best practices would have plaintiff notify Medicare at the time of retainer of the case, get a case number and periodically follow up, and then, at the time of settlement, to notify Medicare that the case is settled and obtain a Final Demand Letter. In settlement papers, counsel can provide a screen shot of the portal showing the amount of Conditional Payments, if any, and agree to hold that amount in escrow pending receipt of the Final Demand Letter. At worst, an agreement can be made for the defendant to hold back the amount of Conditional Payments and then issue a check to Medicare for the Final Demand Letter and the balance to the plaintiff, with all checks sent to plaintiff's counsel.

As an aside, should we ever agree to provide defendant with a "Final Demand Letter" for Medicaid or an ERISA Plan where no lien has been claimed, and thereby wake up a sleeping potential lien holder?

Proposed Rules Issued by Medicare Regarding Future Medicals

Medicare issued an ANPRM (Advanced Notice of Proposed Rulemaking) to solicit comments on standardized options that beneficiaries and their attorneys will be able to use to resolve MSP obligations related to settlements, judgments, awards or other payments involving future medical care while protecting Medicare's interest. The ANPRM gave a concise historical perspective on the application of Medicare secondary payer, Noting: "Medicare he is prohibited from making payment when payment has been made (that is, if the beneficiary obtains a settlement). Medicare remains a secondary payer until the settlement proceeds are **appropriately** exhausted. It is important to note that the designation future medical care or future medicals is a term specifically used to reference medical items and services provided after the date of settlement.

The ANPRM's primary purpose was to respond to affected parties requests for guidance on future medicals MSP obligations.

In October, 2014 Centers for Medicare & Medicaid Services (CMS) withdrew the Notice of Proposed Rulemaking (NPRM) it submitted to the Office of Management and Budget back on August 1, 2013 relating to CMS' intent in addressing future medical costs in workers' compensation, automobile, liability insurance (including self-insurance) and no-fault claims.

Currently, individuals involved in certain Worker's Compensation situations are available to use Medicare's formal, if voluntary, Medicare Set Aside arrangement (MSA) review process in order to determine if a proposed set aside amount is sufficient to meet their MSP obligations related to future medicals. To date Medicare has not established a similar process the individual/beneficiaries to use to meet their MSP obligations with respect to future medicals and liability insurance situations. "**We are soliciting comments on whether and how Medicare should implement such a similar process and liability insurance situations, as well as comment on the proposed definitions and additional options outlined later in this section".**

But, as previously noted, the Proposed Rule Making was withdrawn but CMS has indicated that it intends to reintroduce plans to create rules for MSAs in liability cases in the near future.

The Office of Information and Regulatory Affairs (OIRA) recently issued a notice entitled Miscellaneous Medicare Secondary Payer Clarifications and Updates (CMS-6047-P). This notice indicates that the Centers for Medicare and Medicaid Services (CMS) plans on issuing proposed rules regarding options to address future medicals in relation to liability, workers' compensation and no-fault cases.

The full text of the OIRA notice reads as follows:

> This proposed rule would ensure that beneficiaries are making the best health care choices possible by providing them and their representatives with the opportunity to select an option for meeting future medical obligations that fits their individual circumstances, while also protecting the Medicare Trust Fund. Currently, Medicare does not provide its beneficiaries with guidance to help them make choices regarding their future medical care expenses when they receive automobile and liability insurance (including self-insurance), no fault insurance, and workers' compensation settlements, judgments, awards, or payments, and need to satisfy their Medicare Secondary Payer (MSP) obligations.

This notice further indicates that a Notice of Proposed Rulemaking (NPRM) on this matter is targeted for release is by September 2019. Recall that CMS issued proposed regulations for liability cases back in 2012, but then withdrew them in 2014.