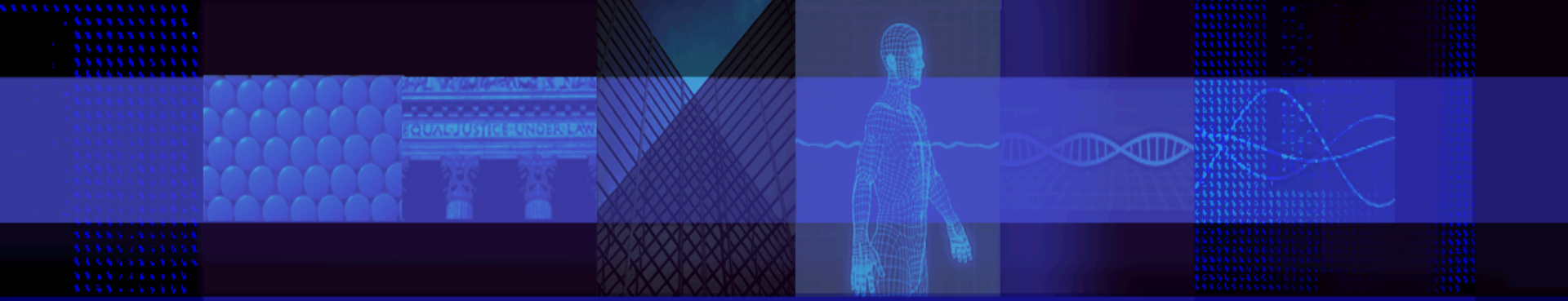
LIEN RESOULTION:

Managing Health Plan Claims Against Tort Settlements



LITIGATION CONFERENCES

Mass Tort Claims Administration with
Hon. Marina Corodemus (ret.)

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Speakers

Franklin P. Solomon, Esq.

Solomon Law Firm, LLC
Cherry Hill, NJ
fsolomon@franklinsolomonlaw.com
www.franklinsolomonlaw.com

Brett Newman

The Lien Resolution Group
West Nyack, NY
bnewman@helpwithliens.com
www.helpwithliens.com

About our Speakers

BRETT NEWMAN, LIEN RESOLUTION GROUP

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

About our Speakers

FRANKLIN P. SOLOMON, SOLOMON LAW FIRM LLC

A graduate of Rutgers University School of Law at Camden, Franklin Solomon is based in Cherry Hill, NJ, with a nationwide practice focused on evaluation, litigation and resolution of healthcare "lien" claims. Mr. Solomon represents personal injury victims and their attorneys in defending against claims by health plans and government benefits programs seeking payment out of tort recoveries, whether under ERISA, FEHBA, Medicare, Medicaid, Tricare/CHAMPVA, or other public or private health and disability programs.

Prior to opening his own firm, Mr. Solomon's practice included 20 years of litigating mass tort and individual personal injury claims on behalf of plaintiffs.

MEDICARE

Medicare Secondary Payer Act

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

MSP Liability

Repayment required

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

42 USC § 1395y(b)(2)(B)(ii)

MSP Liability

Action by United States

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

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

42 USC § 1395y(b)(2)(B)(iii)

MSP Liability: Claim Reduction

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

42 CFR § 411.37

MSP Liability: Recent Case Law

- ***Bradley v. Sebelius,***

  621 F.3d 1330 (11th Cir. 2010)

- ***Hadden v. United States,***

  661 F.3d 298 (6th Cir. 2012)

- ***Taransky v. Secty, U.S. Dept. of Health & Human Svcs.,***

  760 F.3d 307 (3d Cir. 2014)

MSP Liability: Recent Case Law

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

MSP Liability: Private Action

Private cause of action

- There is established a private cause of action for damages (in an amount double the amount otherwise provided) in the case of a primary plan which fails to provide for primary payment (or appropriate reimbursement).

42 USC § 1395y(b)(3)(A)

Pleading the MSP Cause of Action

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

Pleading the MSP Cause of Action

MSP Private Cause of Action is NOT a *qui tam* action.

Must be brought on behalf of a claimant who has actually suffered a loss.

Pleading the MSP Cause of Action

- No-Fault and Liability Insurers, as well a Self-Insured Entities, are Named Defendants
  - No-fault insurance coverage provided by defendant PIP CARRIER – or – liability insurance coverage provided by defendant LIABILITY CARRIER is a "primary plan" with respect to Medicare for payment of medical expense benefits on behalf of plaintiff

Pleading the MSP Cause of Action

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

MEDICARE SET-ASIDES

Considering Medicare's Interest

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

MEDICARE SUBSTITUTE PLANS

MEDICARE SUBSTITUTE PLANS (Medicare Advantage)

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

MAO as Secondary Payer

- Where payment would be secondary under the Medicare Secondary Payer Act, a Medicare Advantage organization may charge, in accordance with the charges allowed under a law, plan, or policy described in such section—
  - (A) the insurance carrier, employer, or other entity which under such law, plan, or policy is to pay for the provision of such services, or
  - (B) **such individual to the extent that the individual has been paid under such law, plan, or policy for such services.**

42 USC § 1395w-22(a)(4)

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

- Part C **statute does not create a private cause of action** to enforce reimbursement claims.
- Part C statute **does not confer any affirmative right** to reimbursement; any reimbursement claim must be based on contract provision.
  - See *also* ***Nott v. Aetna,*** 303 F.Supp.2d 565 (EDPA 2004)

- *Comment: To the extent MA plan contract may require reimbursement, it is limited by the Part C Secondary Payer provision.*

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

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

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

- *Cert. denied,* 133 S.Ct. 1800, *sub nom GlaxoSmithKline, LLC v. Humana Medical Plans, Inc.* (2013).
- **Allows MAOs to access "private cause of action"** provision under MSPA, 42 U.S.C. § 1395y(b)(3)(A).
- By its terms, private cause of action is exercisable only against a "primary plan" that has failed to make payment.
  - *But see* ***Collins v. Wellcare***, 73 F.Supp.3d. 653 (E.D. La. 2014)

Cases to Watch

- ***Emblem Health v. Yi*** (SDNY)
  - Includes claims against plaintiff's attorney and liability carrier
- ***United Healthcare v. Kardoulias*** (EDNY)

MEDICAID

Statute and Interpretation

- 42 U.S.C. § 1396p(a)
- ***Arkansas Dept. of Health and Human Svcs. v. Ahlborn,*** *547* U.S. 268 (2006)
- ***Wos v. E.M.A.,*** *568* U.S. ___, 133 S.Ct. 1391 (2013)
- Bipartisan Budget Act of 2013
  - HR 4302, signed into law Apr. 1, 2014, delays implementation until Oct. 1, 2016 (Section 211)

ERISA

Employee Retirement Income Security Act of 1974

ERISA Liens?

THERE IS NO SUCH THING AS AN "ERISA LIEN"

- ERISA is silent on liens and creates no reimbursement rights for employee benefits plans
- Almost every health plan issued as an employee benefit is subject to ERISA – ***but some are not.***

Know what ERISA means and when it applies!

ERISA Coverage

ERISA applies to:

- any employee benefit plan if it is established or maintained--

(1) by any employer engaged in commerce or in any industry or activity affecting commerce; or

(2) by any employee organization or organizations representing employees engaged in commerce or in any industry or activity affecting commerce; or

(3) by both.

29 USC Sec. 1003(a)

ERISA Exclusions

ERISA specifically excludes from coverage:

- any employee benefit plan if--

  (1) such plan is **a governmental plan** ....

  (2) such plan is **a church plan** ....

  (3) such plan is maintained solely for the purpose of complying with applicable workmen's compensation laws or unemployment compensation or disability insurance laws;

  (4) such plan is maintained outside of the United States primarily for the benefit of persons substantially all of whom are nonresident aliens; or

  (5) such plan is an excess benefit plan and is unfunded.

  29 USC Sec. 1003(b)

"Governmental Plan"

- Federal government (e.g., FEHBA, Tri-Care)
- State & municipal government
- Railroad Retirement Act
- Indian tribal government
  - where substantially all work is in essential governmental functions, not in commercial activities

29 USC Sec. 1002 (32)

"Church Plan"

- "Church plan" is a plan maintained by an organization to provide employee benefits if such organization is controlled by or associated with a church.
- "Employee of a church" includes an employee of an organization which is exempt from tax under section 501 of the IRC and which is controlled by or associated with a church.

  29 USC Sec. 1002 (33)

May include hospitals, nursing homes, schools, colleges, etc.

ERISA PREEMPTION

EXPRESS PREEMPTION: §514

~~**COMPLETE PREEMPTION: §502**~~

ERISA § 514(a): **Preemption clause**

... [T]he provisions of this subchapter and subchapter III of this chapter **shall supersede any and all State laws insofar as they** may now or hereafter **relate to any employee benefit plan** ...

ERISA § 514(b)(A): **"Savings" clause**

... [N]othing in this subchapter shall be construed to exempt or relieve any person from any law of any State which **regulates insurance, banking, or securities**

ERISA § 514(b)(B): **"Deemer" clause**

Neither an employee benefit plan ... nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be **engaged in the business of insurance** or banking **for purposes of any law of any State purporting to regulate insurance** companies, insurance contracts, banks, trust companies, or investment companies.

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

- Insured plans indirectly regulated by state law regulating the plans' insurers
- Self-funded plans exempt from state insurance regulation; not altered by state law

What's a self-funded plan?

- Look at each plan component
- Stop-loss insurance?

PLAN SUBROGATION & REIMBURSEMENT RIGHTS

The Insured Plan

- Most states have adopted anti-subrogation rules or doctrines precluding reimbursement
- Extent of prohibitions varies state to state
  - MT constitutional protection
  - NJ prohibited as a function of collateral source statute
  - NY statute prohibits claims by insurers
  - PA presumes settlement is full recovery
  - Many states allow for contracting out of anti-subro doctrines
- A few states have not adopted made-whole or other anti-subrogation law

The Self-Funded Plan

- Form 5500 and Schedule A
- Plan Document v. SPD
  - *Cigna v. Amara*, 563 U.S. ___, 131 S.Ct. 1866 (2011)
- Subrogation v. Reimbursement
- Interpreting the contract clause
  - Plan year and date of injury
  - Conditional language
  - Abrogating the made-whole doctrine
    - 6th, 9th & 11th Circuits require explicit language

The Plan's Claim: ERISA 502(a)(3)

- Federal jurisdiction is exclusive
- Allows only "appropriate equitable relief" to enforce plan terms
- *US Airways v. McCutchen*, 133 S.Ct. 1537 (2013)
  - Unjust enrichment not a defense to plan contract term
  - "Background equitable rules" apply if not expressly contradicted by contract term
    - Made-whole doctrine
    - Common-fund doctrine

"Appropriate equitable relief"

- *Montanile v. Bd. of Trustees, Nat'l. Elevator Industry Health Benefit Plan*, 577 U.S. ___ (2016)
  - Equitable claim *and* equitable relief
  - Equitable liens enforceable only against a specifically identified fund in the defendant's possession
    - Expenditure of identifiable fund on non-traceable items destroys equitable lien.

What public policy is promoted?

What are the practical consequences?

Requesting Plan Documents

- Request must be to Plan Administrator/Sponsor
  - Statutory responsibility to provide within 30 days
  - $110/day civil penalty available for non-compliance

29 U.S.C. § 1024(b)(4); 29 CFR § 2575.502c-3

What to request?

- Plan Document (written instrument pursuant to 29 U.S.C. § 1102) in effect on date of injury;
  - Any document amending, supplementing, or otherwise modifying the Plan Document;
- Summary Plan Description and employee benefits booklet in effect at the time of injury
  - All documents issued subsequently during any year in which benefits were paid
- SPD Wrap Documents
- Bargaining Agreement, Trust Agreement, Contract etc. under which Health Plan is established
- Trust Agreement or other document establishing funding for the Plan
- Annual Return/Report (IRS/DOL Form 5500), including all attached Financial Schedules
- Administrative Services Agreement with any Third-Party Administrator for the Plan
- An affidavit from the Plan Administrator attesting to self-funded status of the Plan
- Complete statement of benefits paid to or on behalf of claimant/beneficiary
- Specific plan component(s) paying benefits (e.g., health, dental, vision, AD&D, disability, etc.)
- "Stop-loss" or excess/re-insurance coverage (insurer, policy numbers and attachment points)

SPD as Plan Document?

- Named fiduciary/ies with authority to control and manage operation and administration of the plan
- Procedure for establishing and carrying out a funding policy and method
- Procedure for allocation of responsibilities for the operation and administration of the plan
- Procedure for amending the plan, and for identifying persons who have authority to amend
- Basis on which payments are made to and from the plan

29 USC § 1102 - ERISA § 402

Issues

- Can SPD function as a § 402 Plan Document?
- Can SPD include enforceable "terms of the plan"?
- Can a Plan Document delegate authority to claims administrator or SPD?
- Do plan amendments affect subro/reimbursement?

Third-Party Recovery Clause

- subrogation right
- reimbursement right
- first-priority claim
- first-dollar recovery
- lien
- constructive trust
- identified fund/amount
- abrogate made-whole
- abrogate common fund
- conditional language

FEDERAL EMPLOYEES

Federal Employees Health Benefits Act

FEDERAL EMPLOYEES HEALTH BENEFITS (FEHB)

Federal OPM contracts with 38 Plans, including:

American Postal Workers Union (APWU)

National Association of Letter Carriers (NALC)

Mail Handlers Benefit Plan (MHBP)

SAMBA

GEHA

BCBS

UHC

CareFirst

EXPRESS PREEMPTION:

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

***

(m)(1) The terms of any contract under this chapter which relate to **the nature, provision, or extent of coverage or benefits** (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.

FEHBA Case Law - Recent Decisions

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

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

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

- ***Nevils*** and ***Kobold*** both vacated by the U.S. Supreme Court and remanded for consideration in light of new agency rule

Final Rule 890.106

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

- ***Helfrich v. BCBSA***, __ F.3d __, 2015 WL 6535140 (10th Cir., Oct. 29, 2015)
  - FEHBA preempts state anti-subrogation law
  - *Chevron* deference to OPM rule
  - Declined to address constitutional issue as not raised below

FEDERAL MEDICAL CARE RECOVERY

FEDERAL MEDICAL CARE RECOVERY ACT (FMCRA)

- FMCRA provides the statutory authority for US government subrogation claims against tortfeasors
  - Includes:
    - Military personnel and dependents/survivors
    - Veterans and dependents/survivors
    - Any case in which the United States is authorized or required by law to furnish or pay for hospital, medical, surgical, or dental care and treatment.

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

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

42 U.S.C. § 2651(d)

Veterans Administration

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

TriCare & CHAMPVA

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

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

10 USC § 1095