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Negotiating Private Healthcare Liens and Insurance Subrogation Claims in Personal Injury Cases

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PRECISION RESOLUTION, LLC

Negotiating Private Healthcare Liens and Insurance Subrogation Claims in Personal Injury Cases

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Medicare Advantage Plans

A. MEDICARE ADVANTAGE GENERALLY—PART C OF THE MEDICARE ACT

In 1997, the Medicare Advantage Program (hereinafter "MA"), Part C of the Medicare Act, was created as an alternative to the government Medicare program. Under the Medicare Advantage Program, enrollees have the option of receiving their Medicare insurance from private insurers instead of direct benefits from the federal government.

Medicare Advantage acts as a total replacement to Medicare coverage. It is important to find out whether the plaintiff was enrolled in a MAP and through which insurance company. This can change from year to year during the open enrollment period.

B. STATUTES AND REGULATIONS

The Medicare Secondary Payer (MSP) Act provides that Medicare is secondary to other insurers, called primary plans: group health plans, workers compensation plans, liability insurance policies and plans, and no-fault insurance. See 42 U.S.C. § 1395y(b)(2)(A). Medicare makes conditional payments, i.e., it pays for services and if it later learns that those services are covered by a primary plan, the primary plan (or an entity that receives payment from a primary plan) must reimburse Medicare for those services. See 42 U.S.C. § 1395y(b)(2)(B).

1. The Medicare Advantage Secondary Payer Statute

2. The Medicare Advantage Secondary Payer Regulations

3. MSP Private Cause of Action for Double Damages

Medicare Advantage Plans

1. The Medicare Advantage Secondary Payer Statute: 42 USC Section 1396w-22(a)(4):

Notwithstanding any other provision of law, a Medicare+Choice organization may (in the case of the provision of items and services to an individual under a Medicare+Choice plan under circumstances in which payment under this subchapter is made secondary pursuant to section 1395y(b)(2) of this title) charge or authorize the provider of such services to 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.

2. The Medicare Advantage Secondary Payer Regulations: 42 CFR 422.108

(a) Basic rule. CMS does not pay for services to the extent that Medicare is not the primary payer under section 1825(b) of the Act and part 411 of this chapter.

(b) Responsibilities of the MA organization. The MA organization must, for each MA plan—

(1) Identify payers that are primary to Medicare . . . ;

(2) Identify the amounts payable by those payers; and

(3) Coordinate its benefits to Medicare enrollees with the benefits of the primary payers, including reporting, on an ongoing basis, information obtained related to requirements in paragraphs (b)(1) and (b)(2) of this section in accordance with CMS instructions.

(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.. . .

(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 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.**

3. MSP Private Cause of Action for Double Damages 42 USC Section 1395y(b)(3)(A)

"There is established a private cause of action for damages (which shall be in an amount double the amount otherwise provided) in the case of a primary plan which fails to provide for primary payment (or appropriate reimbursement) in accordance with paragraphs (1) and (2)(A)."

MEDICARE ADVANTAGE REIMBURSEMENT: CASE LAW

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

2. *Nott v. Aetna U.S. Healthcare, Inc.,* 303 F. Supp. 2d 565 (E.D. Pa. 2004)

3. *Primax Recoveries, Inc. v. Yarmosh,* Case No. 3: 03CV01931, 2006 U.S. Dist. LEXIS 98858 (D. Conn. 2006)

4. *Konig v. Yeshiva,* 12-CV-467, (E.D. N.Y. March 30, 2012)

5. *In re Avandia Marketing, Sales Practices and Products Liability Litigation*, 685 F.3d 353 (3d Cir. 2012)

MEDICARE ADVANTAGE REIMBURSEMENT: CASE LAW

6. Trezza v. Trezza, 2012 N.Y. Slip. Op. 09048 (N.Y. App. Div. 2d Dept. 2012)

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

8. Collins v. Wellcare Healthcare Plans, Inc., No. 13-6759 L(3) (E.D. LA 2014).

9. Humana Med. Plan, Inc. v. W. Heritage Ins. Co., No. 15-11436, 1:12-cv-20123-MCG (11th Cir. Aug. 8, 2016).

LIABILITY OF PLAINTIFF'S ATTORNEY

Medicare Advantage plans have also sued the plaintiff's attorney in these cases where the plan is not reimbursed. The Eastern District of Virginia, in Humana v. Paris Blank, LLP, 187 F.Supp.3d 676 (E.D. Va. 2016), held that "regulation dictates that MAOs 'exercise the same rights to recovery 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.' 42 C.F.R. § 422.108(f). CMS has promulgated regulations identifying attorneys as an entity from which recovery may be sought under the MSP law by the Secretary. See id. § 411.24(g). Accordingly, Plaintiff may maintain suit against Defendants for recovery of conditional payments."

Plaintiff's attorney has been sued by Medicare Advantage plans in cases throughout the country. See, e.g., Humana Health Benefit Plan of Louisiana, Inc. v. Falcon, 3:17-cv-00596-JWD-EWD (M.D. La., Complaint filed August 30, 2017); Humana Ins. Co. v. Pelham, 4:17-cv-00374-RH-CAS (N.D. Fla., Complaint filed August 18, 2017); United Healthcare Ins. Co. v. Kardoulias, 1:16-cv-735 (E.D.N.Y., Complaint filed February 11, 2016).

BUT SEE: *Aetna Life Ins. Co. v. Guerrera*, 2018 US Dist. LEXIS 41450 (D. Conn. 2018): holding that the MSP Private Cause of Action permits only actions against primary plans, not beneficiaries and their attorneys.

VETERAN'S ADMINISTRATION CLAIMS

Federal Medical Care Recovery Act

The Federal Medical Care Recovery Act (FMCRA), 42 USC § 2651, authorizes the right of recovery by the United States for medical treatment paid by the federal government in situations where there is "tort liability."

Relevant Case Law

***United States v. Trammel*, 899 F. 2d 1483 (6th Cir. 1990).**

***Holbrook v. Anderson Corp.,* 996 F. 2d 1339 (1th Cir. 1993).**

***Mosey v. United States*, 3 F. Supp. 2d 1133 (D. NV. 1998).**

***Cockerham v. Garvin,* 768 F. 2d 784 (6th Cir. 1985).**

FEDERAL EMPLOYEES

Most federal employees are provided health benefits through the Federal Employee Health Benefits Act. Benefits are provided through private insurance carriers, and the federal government, along with employees, pay a premium to the carriers. Benefits are administered through the Office of Personnel Management (OPM). There is no statutory right of FEHB plans to assert reimbursement rights. However, there is a provision which states that the terms of any FEHB contract which relate to the coverage of benefits preempt state law related to health insurance.

FEHBA Preemption clause 5 U.S.C. §8902(m)(1):
(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.

The relevant question became: does contract language in these types of plans, which relate to subrogation and reimbursement, “relate to the nature, provision, or extent of coverage or benefits” and thus preempt state law.

The answer had a long and tortured history which was finally resolved by the United States Supreme Court in Coventry Health Care of Missouri, Inc. v. Nevils, 581 U.S. ___ (April 18, 2017. The Court explained that there is an expansive view of Congress' use of the phrase "relate to." The purpose of the statute also supported the Court's view, reasoning that there is a strong federal interest in uniform administration of the Federal Employee Health Benefits program, free from interference by the individual states.

Contract terms would therefore govern the scope of reimbursement rights in cases involving federal employees.

SELF- FUNDED HEALTH BENEFIT PLANS: ERISA

Self Funded Health Plans vs. Insured Plans

A. The distinction between self-funded ERISA plans and those that are insured ERISA plans is a significant one, as it is part of the determination of whether ERISA preempts state law.

B. Self-funded plans are often created by large employers that are better able to fund a group health and pension plan. The employer uses its own assets, usually in combination with contributions from the employees, to fund the plan.

C. By contrast, an insured ERISA plan is one where the employer purchases insurance from a commercial insurer to cover the risk of loss should any benefits be paid out. Here, the employer (and employee through a contribution) pay a premium to the insurance company, which is on the risk for payment of benefits.

ERISA PREEMPTION

1. The Preemption Clause

Except as provided in subsection (b) *of this section, the provisions of [ERISA] shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan* described in section 1003(a) of this title and not exempt under section 1003(b) of this title.

29 U.S.C. § 1144(a) (emphasis added).

2. The Savings Clause

Except as provided in subparagraph (B), *nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance*, banking, or securities.

29 U.S.C. § 1144(b)(2)(A) (emphasis added).

2. The Deemer Clause

Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), 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.

29 U.S.C. 1144(b)(2)(B) (emphasis added).

SELF- FUNDED HEALTH BENEFIT PLANS: ERISA

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

This Supreme Court case decided in 1990 involved a state anti-subrogation statute from Pennsylvania and a self-funded ERISA plan.

The Court held that FMC created the preemption distinction between self-funded plans, and insured plans. If a plan is self-funded, state laws regulating insurance are preempted, and ERISA applies.

For insured plans, any state law which regulates insurance is applicable.

EQUITABLE RELIEF UNDER ERISA

Under the provisions of ERISA, a civil action may be brought by a member of the plan, or by a fiduciary who administers the plan, to enforce certain rights under ERISA and/or the terms of the benefit plan. ERISA dictates which courts have jurisdiction to hear these actions, and what specific relief may be sought.

Section 502(a)(3), 29 U.C.S. §1132(a)(3):

A civil action may be brought—
(3) by a participant, beneficiary, or fiduciary
(A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or

(B) to obtain other ***appropriate equitable relief***
(i) to redress such violations or
(ii) to enforce any provisions of this subchapter or the terms of the plan.

EQUITABLE RELIEF UNDER ERISA

RELEVANT CASE LAW

Great-West Life & Annuity Insurance Co. v. Knudson, **534 U.S. 204 (2002)**

Sereboff v. Mid-Atlantic Services, Inc., **547 U.S. 356 (2006)**

U.S. Airways v. McCutchen, **133 S.Ct. 1537 (April 16, 2013)**

Montanile v. Bd. of Trustees of the Nat'l Elevator Industry Health Benefit Plan**, 136 S.Ct. 651 (January 20, 2016)**

EQUITABLE RELIEF UNDER ERISA

WHAT IS THE "AGREEMENT" IN "EQUITABLE LIEN BY AGREEMENT?"

29 U.S.C. § 1024(b)(4) under ERISA mandates that upon written request by the plan member, to the plan administrator, certain plan documents must be furnished to the plan member. Among these documents are the Summary Plan Description (SPD) and the plan document. Under ERISA, these are two different documents, both requirements for a plan.

However, in some cases, the terms of the SPD differ from the terms of the plan document. Therefore, it is important to have all documents related to the plan at your disposal when analyzing any claim for reimbursement.

EQUITABLE RELIEF UNDER ERISA

RELEVANT CASE LAW

Cigna v. Amara, 131 S.Ct. 1866 (May 16, 2011)

We cannot agree that the terms of statutorily required plan summaries (or summaries of plan modifications) necessarily may be enforced (under § 502(a)(1)(B)) as the terms of the plan itself.

***

Summary documents, important as they are, provide communication with beneficiaries about the plan, but that their statements do not themselves constitute the terms of the plan for purposes of §502(a)(1)(B).

McCutchen Continued: Remand to the Western District of Pennsylvania:

When the case was remanded, McCutchen's attorneys moved to amend their Answer, six years after the fact, to add causes of action for breach of the plan's fiduciary duty for failure to disclose the plan document. The motion was granted.

"In *Amara*, the Court found it improper to enforce the terms of the SPD over the plan language reasoning that the syntax of another section of ERISA, § 102(a), which obliges the plan administrators to furnish SPDs and requires that participants and beneficiaries "be advised of their rights and obligations 'under the plan,'" suggests that the information about the Plan provided by the SPDs "is not itself part of the plan." Since *Amara*, courts have agreed that the summary plan provisions, including stipulations not present in the plan certificate, are unenforceable."

The district court enforced the terms of the plan that were contained in the Plan Document, which severely limited U.S. Airways' claim, and disregarded the SPD.

SELF- FUNDED HEALTH BENEFIT PLANS: ERISA

REQUESTING AND REVIEWING PLAN DOCUMENTS

ERISA requires certain documents to be furnished to the plan member upon written request to the designated plan administrator. 29 U.S.C. § 1024(b)(4). Failure by the plan administrator to furnish the requested documents within 30 days of receipt of the request can result in a penalty of $110.00 per day that the administrator is in breach. 29 U.S.C. § 1132(c)(1) and 29 CFR § 2575.502c-1.

***Popowski v. Parrott,* 461 F.3d 1367 (11th Cir. 2006).**

REQUESTING PLAN DOCUMENTS

Sent directly to Plan Administrator;

Certified Mail;

Signed by The Plan Participant or Beneficiary;

Request the following documents effective for date of injury through current year:

- **Plan Document**
- **Summary Plan Description**
- **Administrative Services Contract between Employer and Claims Administrator**
- **Stop loss Contracts**
- **Health insurance policies/contracts**
- **Amendments to the Plan Document**
- **Trust Agreement**
- **Summaries of Material Modifications**
- **Form 5500s filed with the Department of Labor**

SELF- FUNDED HEALTH BENEFIT PLANS: ERISA

JURISDICTION

In re *Boisseau*, 2017 U.S. Dist. LEXIS at *2-3. The Northern District then applied the probate exception to federal jurisdiction, noting that the exception has two purposes, as outlined by the United States Supreme Court:

(1) it "reserves to state probate courts the probate or annulment of a will and the administration of a decedent's estate" and (2) it "precludes federal courts from endeavoring to dispose of property that is in the custody of a state probate court." This case falls squarely within the scope of the second application of the probate exception because it necessarily involves the Court's interference with a res in the custody of the state probate court. As Petitioner makes clear, "[t]he res of Mr. Boisseau is subject exclusively to the jurisdiction of the Oswego County Surrogate's Court. . . . Any claim against the settlement proceeds is a claim against his estate."

Id. at *8 (internal citations omitted).

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Please do not hesitate to reach out to Precision Resolution with any questions regarding the content covered in this program or with your own case-specific questions.

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