ERISA Trusts and Medicare Liens: Traps for Insurers

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Subrogation Issues Under ERISA

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ERISA Background

- The Employee Retirement Security Act ("ERISA")
  - Federal law which governs employer sponsored benefit plans, including pension plans and health insurance
  - Strict limitations on damages and lawsuits
  - Subrogation provisions are permitted, and may be drafted very broadly

ERISA Background

- Health Benefit Plans may be funded in one of three ways
  - Via a contract of insurance
    - Insurer is carrying risk of claims
  - "Self funding" via a trust or VEBA
    - Trust carries risk of claims. Trustee has a responsibility to preserve assets
  - "Self funding" via general assets of the employer/plan sponsor
    - Employer/plan sponsor carries risk of claims

Sample Subrogation Clause (for your amusement)

Subrogation and Reimbursement Rights

The Plan has a right to be reimbursed for the amount of any benefits it pays out to you if you receive, directly or indirectly, any money from a third party (such as a person responsible for an injury or an insurance company) on account of the same injury, illness or condition for which the Plan has paid benefits (any such money is referred to here as a "recovery"). Therefore, as a condition of receiving benefits from the plan for medical or other expenses, you agree that if you receive any recovery from a third party on account of an injury, illness, or condition for which the Plan has paid benefits, you will pay to the plan the amount of that recovery, up to the total amount of benefits paid to you by the plan. For example, if you are injured in an auto accident and either your insurance company or the other driver's insurance company settles with you, you must reimburse the plan for the benefits the plan provided to you for your medical expenses resulting from that accident, but only up to the amount of your settlement.

If you decide not to pursue a claim relating to any injury, illness or condition for which the Plan has paid benefits, the Plan shall be subrogated to your right to pursue such claim. The Plan may assert a claim, in its discretion, to collect a recovery directly from any third party against whom you have any rights in any court of competent jurisdiction, or in any tribunal or other proceeding. You agree not to object to the jurisdiction of any such court or venue and otherwise cooperate in pursuing the recovery.

In connection with the Plan's rights of subrogation and reimbursement, you are required to:

- notify the Plan within thirty (30) days of the date when any notice is given to any party, including an attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to any injury, illness, or condition for which the Plan has paid benefits;
- promptly notify the Plan of any recovery paid as a result of any injury, illness or condition for which the Plan has paid you benefits that you become aware of, by any person from any source;
- fully cooperate with the Plan's efforts to enforce its rights of subrogation and reimbursement;
- complete all forms and provide all information requested by the Plan, including completing and submitting any applications or other forms or statements the Plan may reasonably request;
- cooperate in all efforts to pursue the recovery, including in the preparation and execution of any case or otherwise, and by attendance or giving testimony at depositions and in court, or as otherwise may be necessary; and
- do nothing to prejudice or impede the Plan's rights of subrogation and reimbursement, including by making any settlement or recovery that attempts to reduce or exclude the full cost of the benefits provided by the Plan, except as reasonably agreed to by the Plan.

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ERISA Restrictions

- Plan may sue to enforce plan terms (essentially, a contract action)
  - But, enforcement of terms is suit under ERISA statutory provisions rather than contract law
  - ERISA Section 502(a)(3):
    - "*A civil action may be brought-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-*"
- ERISA does not permit lawsuits for "legal" damages. Only "appropriate equitable relief"

Equitable Relief

- Multiple Supreme Court Cases
  - Great West v. Knudson (2002)
    - General money damages are “legal” remedies, and unavailable under ERISA
  - Sereboff v. Mid Atlantic (2006)
    - Enforcing a subrogation clause is equitable
  - U.S. Airways v. McCutcheon (2013)
    - Plan terms govern over equitable principles (no “double recovery” or “unjust enrichment” defense)
  - Montanile v. National Elevator
    - Equity means you must seek specific money, and once that money is gone, no remedy is available.

Equitable Relief

- General rules for plans are as follows:
  - Cannot sue for general reimbursement of expenditures
  - Can only sue for “traceable” assets
  - Cannot sue for even traceable assets if they have been disbursed by recipient
  - Must prepare for equitable relief prior to disbursement

Equitable Relief

- Result of the rules:
  - Plan has very limited opportunity to enforce terms
  - *Vigilantibus non dormientibus aequitas subvenit*
  - Plan must demonstrate intent to enforce rights
- Plans have created methods to enforce:
  - Equitable Lien
  - Constructive Trust

Equitable Relief

- Plans have become more aggressive and active in enforcing subrogation clauses
- Plan will frequently put all parties on notice of subrogation claim
  - This is to establish a lien or constructive trust on assets PRIOR TO disbursal to the beneficiary
- Plan may attempt to establish itself as “personal representative” of insured
  - Very state-law dependent
  - Plan terms must authorize

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Equitable Relief

- Insurer can find themselves caught between competing claims
  - ERISA plan asserting trust on assets
  - Contract holder asserting insurance claim

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So…What do I do?

- Highly dependent on terms of subrogation provision
  - Don’t trust the parties. Ask for the plan.
- Review type of remedy authorized
  - Constructive trust? Lien?
- Review if equitable defenses are forbidden
  - Plan language must be specific
- Review any claims of “personal representation”
  - Dependent on state law and terms of insurance contract.
  - Also, must be authorized by plan language

So…What do I do?

- Only negative result is double recovery
- Have parties agree to distributions
- If all else fails, interpleader is an option

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The Medicare Secondary Payer Act March 28, 2019

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Background – History of MSP Act

- Medicare Program
  - Enacted in 1965
  - Federal program that provides government-sponsored health insurance for the following:
    - Individuals aged 65 or older
    - Recipient of Social Security Disability ("SSD") benefits for at least 24 months
    - End stage renal disease ("ESRD")
    - Recipient of Social Security benefits for ALS
  - Medicare Benefits
    - Part A (hospital)
    - Part B (physician and supplier items)
    - Part C/Medicare Advantage (private plans)

Background – History of MSP Act

- Medicare Secondary Payer Act - 1980
  - Codified at 42 U.S.C. §1395y(b). See also 42 C.F.R. Part 411
  - Beginning in 2001: CMS enforcement tightened through a series of memos (at least for Workers' Compensation)

- Medicare Modernization Act – 2003
  - MSP Act further expanded to include self-insurance

Background – History

- **Medicare, Medicaid and SCHIP Extension Act ("MMSEA") - 2007**
  - Section 111 of the MMSEA added reporting requirements for payments made to Medicare beneficiaries

- **Strengthening Medicare and Repaying Taxpayers Act ("SMART Act")**
  - Enacted January 10, 2013
  - Attempts to streamline the settlement process

Background – Goal of the MSP Act

- Goal: to reduce spending and preserve fiscal integrity of Medicare Program

- Principle: Medicare does not pay primary for treatment of an injury or illness when payment has been made or can reasonably be expected to be made by a "primary" payer. 42 U.S.C. 1395y(b)(2)(A)
  - See https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Medicare-Secondary-Payer/Medicare-Secondary-Payer.html

Primary Payers

- Medicare is secondary when payment can be reasonably expected to be made by a primary payer

- Primary payers include:
  - Liability insurance (including self-insurance)
  - No fault insurance
  - Workers' compensation

Primary Payers

- Primary payer's responsibility is demonstrated by:
  - Judgment
  - Payment conditioned on Medicare recipient's compromise, waiver or release
  - "Other means" which includes a settlement, award or other contractual obligation

Conditional Payments

- Medicare may issue a conditional payment for medical care if a primary payer did not pay or cannot reasonably be expected to issue payment promptly (120 days)
  - Avoids hardship on providers
  - Ensures beneficiaries receive care during litigation

Conditional Payments

- Medicare program expects to be reimbursed from proceeds of any subsequent settlement(s) less procurement costs

- Often referred to as "Medicare Liens"
  - However, Medicare's interest is not a lien. Medicare's right to reimbursement is paramount to any other claim. *United States v. Geier*, 816 F. Supp. 1332 (W.D. Wis. 1993)

Conditional Payments

- Conditional payments must be reimbursed to Medicare within 60 days of settlement
  - If not, the primary payer may have to reimburse Medicare "even though it has already reimbursed the beneficiary." 42 C.F.R. § 411.24(i)
- If conditional payment is not reimbursed, the United States may choose its target in an enforcement action

Conditional Payments

- Electronic conditional payment letters now available to beneficiaries

- Insurers can also get conditional payment information through the Medicare Secondary Payer Recovery portal

  - https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/MSPRP/Medicare-Secondary-Payer-Recovery-Portal.html

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Right of Recovery

- **Medicare's Direct Right of Action**
  - Against primary plans and any entity (beneficiary, provider, physician, attorney) receiving a third party payment
  - If successful, Medicare can obtain **double damages**

- **Medicare's Subrogation Right**
  - As claimant against the responsible party and primary plan
  - As a party to any claim by a beneficiary or other entity against alleged tortfeasor and/or his/her liability insurance
  - Can participate in settlement negotiations

Right of Recovery

- Private right of action:
  - Private litigant has private cause of action for damages against a primary payer that fails to provide primary payment or appropriate reimbursement of Medicare conditional payments
  - If successful, private litigant may recover double damages

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Medicare Advantage

- *In re Avandia Marketing*, 685 F.3d 353 (3d Cir. 2012): Medicare Advantage Plans have same right as the government

- *Parra v. PacifiCare of Arizona, Inc*., 715 F.3d 1146 (9th Cir. 2013): Medicare Advantage Plan's claim for reimbursement rejected because the private right of action only applies in case a primary plan fails to provide payment and the primary plan in this case *did* provide payment

Future Medicals – General Principles

- Medicare's interests (both past and future) must be considered in the settlement
  - Avoid shifting burden of future Medicare-covered incident-related medical expenses
  - Medicare may deny payment for a beneficiary's future Medicare-covered incident-related medical care until the payment for future medical expenses (or the entire settlement) is exhausted
  - CMS has stated that Medicare remains the secondary payer until settlement proceeds are exhausted

Future Medicals – General Principles

- Medicare Set-Aside (MSA)
  - An administrative mechanism used to allocate a portion of a settlement, judgment or award for future medical and/or future prescription drug expenses
  - If used, an insurer is protected from having Medicare allege that its interests were not taken into account and that the insurer attempted to shift responsibility to Medicare
  - Once a MSA is exhausted, claimant may receive Medicare benefits
  - Formal approval process available for Workers Comp: guidance issued November 6, 2013

Section 111 Reporting Requirements

- Section 111 of the MMSEA
  - Amended MSP Act to help CMS enforce the MSP rules
  - Requires settlements to be reported to CMS
  - On May 1, 2013, CMS established an "ongoing, informal opportunity" for the public to comment on the Section 111 mandatory reporting requirements
- Information collected under Section 111 is used to ensure Medicare makes payment in proper order and pursues recovery actions as appropriate
- Penalties: Civil monetary penalty of up to $1,000 for each day of noncompliance for each individual ***may*** be imposed (as amended by SMART Act, previously mandatory)

Section 111 – Who must report?

- "Responsible Reporting Entities" ("RREs"):
  - Group Health Plans (not discussed in this presentation)
  - Non-GHPs
    - Liability (including self-insurance) insurers
      - including D&O policies
    - No-fault insurers
    - Workers' compensation
- Obligation for reporting rests on RRE and cannot be transferred to claimant or his/her attorney

Which Settlements must be reported?

- Claimants who are Medicare eligible
  - Individuals 65 and older
  - Individuals under age 65 on disability, ESRD, etc. – approximately 16% of all beneficiaries

- Until a claim is closed, the RRE must continue to check if claimant is a Medicare beneficiary

When is Reporting Triggered?

- The date when a claim is resolved through a signed settlement, judgment, or award
  - Regardless of whether there is an admission of liability
  - A statement that there are “no medicals” does not eliminate RRE’s reporting requirement

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Summary of a RRE's Responsibilities

- Determine if claimant is entitled to Medicare – as of date of settlement

- Reporting required only if claimant is actually a Medicare beneficiary at settlement. No safe harbor if RRE fails to properly determine if claimant is a Medicare beneficiary

Practical Steps on Receipt of a New Case

- Determine if claimant is a Medicare beneficiary, and document all efforts made to determine that
- Determine if there are any conditional payments and continue to monitor throughout
- Take past medicals (conditional payments) and future medicals (MSA) into account at settlement
- Carefully document efforts made to reimburse Medicare appropriately, and keep documentation for no less than 3 years
  - Should also determine if claimant is a Medicaid recipient (not discussed in this presentation)

Practical Steps on Receipt of a New Case

- If not currently a Medicare beneficiary, what is claimant's likelihood of becoming a Medicare beneficiary within thirty (30) months of settlement:
  - Claimant is age 62.5 or greater at the time of settlement (Claimant may be eligible for Medicare based on age within 30 months)
  - Claimant is receiving SSD benefits at the time of settlement

Practical Steps on Receipt of a New Case

– Claimant has applied for SSD benefits or has applied and been denied, but anticipates appealing the decision

– Claimant is in the process of appealing and/or re-filing for SSD benefits

– Claimant has ESRD or ALS, but does not yet qualify for Medicare based on ESRD or ALS

NOTE: Medicare coverage begins 24 months after entitlement to SSD benefits

Settlement Obligations

- If Claimant is a Medicare Beneficiary:
  - RRE initiates Section 111 reporting
  - Claimant Receives Final Demand Letter for repayment of conditional payments
  - Settlement terms must address payment of Medicare conditional payments
  - Consider Medicare's interests regarding Future Medicals

Settlement Obligations

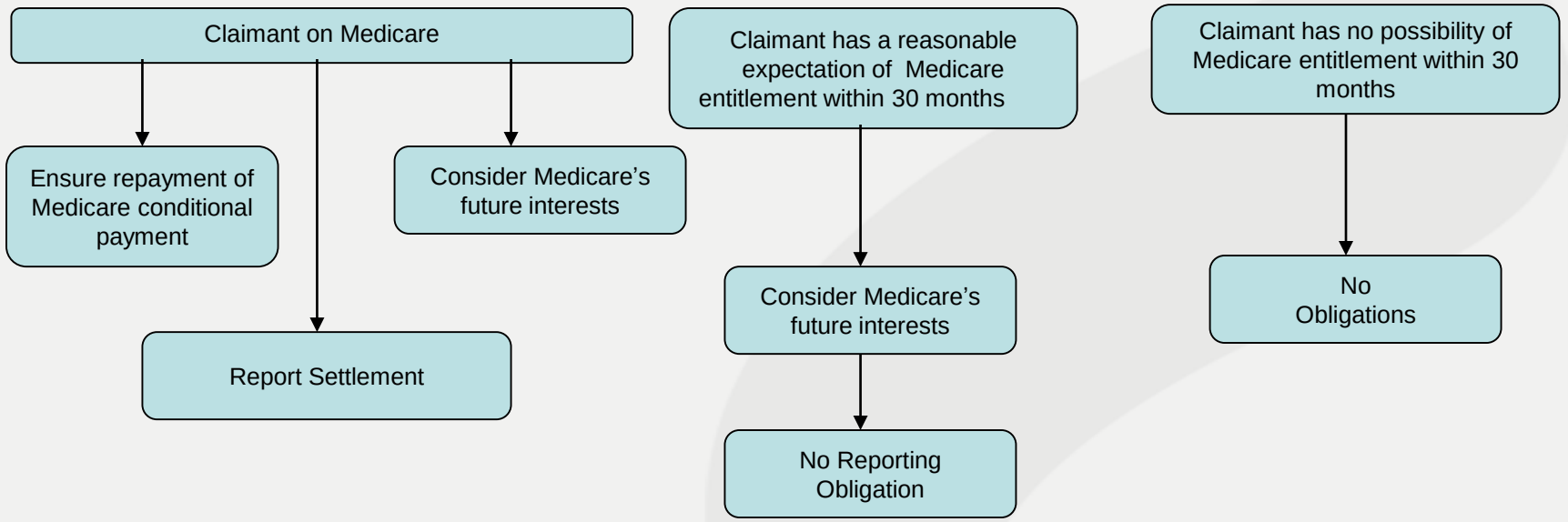
- Possible options include:
  - Settlement check made payable to the beneficiary after insurer receives confirmation that the conditional payments have been satisfied
  - Portion of the settlement proceeds estimating the amount of conditional payment due will be issued to the claimant's attorney to be placed in attorney trust account pending receipt of the Final Demand Letter
  - Defendant pays Medicare directly for the amount of the reasonably confirmed Medicare conditional payments (preferred method is to wait for the issuance of the Final Demand Letter to obtain final amount of the conditional payments) at the same time it pays claimant
- Must be negotiated and settlement agreement must demonstrate how the conditional payments have been satisfied

Settlement Obligations

- If Claimant is not a Medicare Beneficiary:
  - No need to reimburse conditional payments
  - Determine whether Medicare's interests in future medicals must be addressed
    - Is there a reasonable expectation of claimant's Medicare entitlement within 30 months and the settlement is $250,000 or greater and will involve continued incident-related medical treatment?
    - If so, an MSA or other allocation should be considered
    - Coordinate with insurer and claimant's counsel on process
  - No Section 111 reporting requirement
    - Exception: If responsibility for ORM is part of the settlement, continue to monitor claimant's status and report if claimant becomes a Medicare beneficiary

Settlement Obligations

Attorney Obligations at Settlement Lump Sum Settlements: a/k/a Total Payment Obligation to Claimants (TPOC)



Settlement Agreement

- Settlement Agreements should have a separate section dealing with the Medicare, including:
  - A general statement about Medicare
    - "The parties have attempted to resolve this matter in compliance with both state and federal law, and it is believed that the settlement terms adequately consider and protect Medicare's interests and do not reflect any attempt to shift responsibility of past or future medical treatment to Medicare in contravention of 42 U.S.C. § 1395y(b)
  - A section on conditional payments
    - If claimant is a Medicare beneficiary, clearly document how the conditional payments are being satisfied and claimant's overall responsibility for Medicare conditional payments and any other liens

Settlement Agreement

- Medicare's interest in future medicals
  - Document how the parties have considered/addressed Medicare's interest in future incident-related medical treatment
- Section 111 Reporting
  - Claimant acknowledges his/her duty to cooperate with defendant by providing all information that is necessary for defendant to comply with the Section 111 reporting requirements
- Indemnification/Hold Harmless
  - Recommend strong indemnification/hold harmless language and a waiver of any and all future actions against defendant including private right of action

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Final Thoughts

- A cooperative approach among claimant/Medicare beneficiary, attorneys and the insurer will limit risks to all
- Start the process at the beginning of the claim - don't wait until settlement
- Determine and satisfy CMS's interests prior to disbursement of settlement proceeds to a claimant who is Medicare beneficiary
  - Repay conditional payments
  - Consider Medicare's interest in future medicals
  - Report settlement

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