

MEDICARE SECONDARY PAYER PROVISIONS AND MEDICAID AS PAYER OF LAST RESORT:

WHAT EVERY INSURER NEEDS TO KNOW

by

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I. INTRODUCTION

The primary focus of this outline are the Medicare and Medicaid secondary payer provisions from the perspective of liability insurers, workers' compensation insurers, no-fault insurers and self-insurers, as well as attorneys involved with the defense of claims brought by persons who are eligible for these Federal benefits. Claims of health insurers who also seek reimbursement from liability carriers, and other lien interests are also discussed.

It should be noted at the outset that these new provisions are still in the process of being implemented, and that everyone expects there will be "growing pains" and that the system and process will evolve, hopefully with some compassion and flexibility. While we have done our best to be thorough, and definitive, please understand that the following outline is intended solely as a guide, not as a substitute for thoughtful and careful handling by the professionals charged with the duty of defending personal injury claims, whether litigated or not.

II. MEDICARE

A. Background on Medicare Secondary Payer (MSP) Provisions

In 1980, Congress made Medicare the secondary payer to certain primary plans. The purpose was to shift cost from Medicare to private insurance providers. The provisions are known as the Medicare Secondary Payer (MSP) provisions. Medicare is administered by the Centers for Medicare & Medicaid Services (CMS), a component of the United States Department of Health and Human Services. See <http://www.cms.hhs.gov/>. Medicare handles claims on behalf of beneficiaries who have received medical items or services that are reviewed and paid by CMS contractors, traditionally known as Part A for hospitals and Part B for physicians. See 42 C.F.R. §421.1(b).

B. Eligibility for Medicare Benefits

An individual is eligible for Medicare if that individual or their spouse has worked for at least ten (10) years in Medicare-covered employment; are sixty-five (65) years or older; and are a citizen or permanent resident of the United States. See <http://www.medicare.gov/MedicareEligibility/Home.asp?dest=NAV|Home|GeneralEnrollment#TabTop>. See also 42 U.S.C. §426. An individual may also be eligible if they have not attained the age of 65, but they have a disabling physical or mental impairment on the basis of which the individual was found to be under a disability. See 42 U.S.C. §1395i-2a.

A disability is defined as the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment, which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. See 42 U.S.C. §423. If the individual has reached the age of 55 and is blind, the individual may qualify for Medicare. *Id.* The individual must be unable to engage in substantial gainful activity, requiring skills or abilities comparable to those of any gainful activity in which he has previously engaged with some regularity and over a substantial period of time. *Id.*

C. Applicability of MSP in instance of personal injury to the following “primary” payers:

(1) Liability and No-Fault Insurers

Liability insurance types, defined by regulation, include, but are not limited to, automobile liability insurance, uninsured motorist insurance, underinsured motorist insurance, homeowners' liability insurance, malpractice insurance, product liability insurance, and general casualty insurance. See 42 C.F.R. §411.50(b). Any payment made by a liability insurer, except payments under a no-fault clause in a non-automobile policy, constitutes a liability insurance payment whether there has been a determination of liability. See 42 C.F.R. §411.50(c) (except as provided under §411.52 and §411.53, Medicare will not pay for services which were made or reasonably will be made by automobile no-fault insurance.) Medicare is secondary payer to any liability insurance, such as automobile and malpractice insurance. See 42 U.S.C. 1395y(b)(2)(A)(ii).

Any business entity is considered self-insured to the extent that it has not purchased liability insurance. See 42 C.F.R. §411.50(b) (stating that “[a]n entity that engages in a business, trade, or profession is deemed to have a self-insured plan for purposes of liability insurance if it carries its own risk (whether by failure to obtain insurance, or otherwise) in whole or in part”).

(2) Workers' Compensation Carriers

Workers' compensation benefits in New York are governed by Workers' Compensation Law §29, which governs the rights and responsibilities of employers and their injured workers. Medicare is the secondary payer to workers' compensation plans. See 42 U.S.C. 1395y(b)(2)(A)(ii).

(3) Employer's Large Group Health Plans (LGHP)

Medicare is secondary payer to insurers and third party administrators of Group Health Plans and Large Group Health Plans and employers and employee organizations that sponsor or contribute to the plans. See 42 U.S.C. §1395y(B)(2)(A)(i) and 42 U.S.C. §1395y(B)(2)(A)(ii). See also 42 C.F.R. §411.101 and §5000(b)(1) of the Internal Revenue Code of 1986 for definitions of group health plan and large group health plan.

D. Medicare's Right to Reimbursement

Medicare's interest is not a lien; Medicare has an interest that has been characterized as superior to a lien. See *Zinman v. Shalala*, 67 F.3d 841, 845 (9 cir. 1995) (Appellate court affirming trial level decision, rejecting the beneficiary's argument that the "Coordination of Benefits" provision of the MSP legislation requires proportionate reduction of Medicare's recovery of conditional payments when a beneficiary receives a discounted settlement.) Medicare's interest is a statutorily created claim for reimbursement which may be pursued by a directed action or through the right of subrogation. See 42 U.S.C. §1395y(b)(2)(B)(iii). See also 42 U.S.C. §1395y(b)(2)(B)(iv).

(1) Medicare's Right to seek recovery from "any or all entities"

42 U.S.C. §1395y(b)(2)(B)(iii) states that Medicare may seek to recover from "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 a payment with respect to the same item or service (or any portion thereof) under a primary plan."

(2) Medicare's Right to Waive, Compromise, Terminate, or Suspend its Right of Recovery

The Center for Medicare & Medicaid Services (CMS) may waive, compromise, terminate, or suspend its right of recovery. See

42 U.S.C. §1395y(b)(2)(B)(v) (stating that Medicare may waive individual claims if the Secretary determines that the waiver is in the best interests of the program). See also 42 C.F.R. §405.376 for suspension and termination of collection conditions. It may compromise, suspend or terminate collection under the Federal Claims Collection Act (FCCA) of 1966. See 31 U.S.C. §3711. Medicare must waive recovery in cases where recovery would cause financial hardship to the beneficiary or otherwise be “against good conscience.” *Discussed in Zinman v. Shalala*, 67 f.3d at 843. See 42 C.F.R. §411.28 (stating that “CMS may waive recovery, in whole or in part, if the probability of recovery, or the amount involved, does not warrant pursuit of the claim.”)

E. Liability Insurer’s Right to Subrogation

An insurer who pays claims on the insured’s behalf for damages caused by a third-party tortfeasor is entitled to be subrogated to the rights which the insured would have had against such third party for its wrongdoing and to enforce these rights in an action in the insurer’s own name and without joining the insured as a party. *Group Health, Inc. v. Mid-Hudson Cablevision, Inc.*, 871 N.Y.S.2d 780, 781-782 (N.Y. 3rd Dept., 2009), *citing cases*. (holding that *if the tortfeasor was aware of the insurer’s subrogation rights before the settlement, then the settlement has no effect on the insurer’s subrogation rights from third party tortfeasor*). This doctrine of equitable subrogation is for the protection of insurers who are the intended beneficiaries. *Id.* at 782.

F. Duties and Procedures of Primary Payers leading up to Settlement or Judgment and Medicare Reimbursement

- (1) Duty to Report the Date of Loss and Insurance Carrier to the Coordination of Benefits Contractor

Reporting the date of loss and insurance carrier to the Coordination of Benefits Contractor (COBC) is an important preliminary step, as it triggers a record review by the Medicare Secondary Payer Recovery Contractor (MSPRC). Upon notifying the COBC of the date of loss and insurance carrier, the MSPRC will automatically search for all Medicare expenses paid out under the claim number and date of loss reported to the COBC. See <http://www.msprc.info/>. The MSPRC record search may take up to *45 days or more*. Pursuant to 42 C.F.R. §411.25, *primary payers must report to the COBC if it is brought to their attention that Medicare has paid primary when Medicare should be secondary payer.*

- (2) Obtain and Submit Consent to Release Information forms

In the event of litigation, attorneys and insurers should be reminded to obtain “consent to release information forms” from the MSPRC so that the attorney and insurer can automatically receive a conditional payment letter from the MSPRC upon completion of the MSPRC record search. See http://www.msprc.info/forms/Consent_to_Release.pdf. This step should be completed when the COBC is notified of the claim so that the attorney and insurance company can be authorized to speak with MSPRC.

(3) Importance of Timing: Issuance of Conditional Payment Letter and Recovery Demand Letter

Once the COBC is notified of a potential Medicare recovery, the MSPRC searches for Medicare-reimbursed claims and drafts a conditional payment amount. The conditional payment amount is *not* a lien, but should be used during settlement negotiations as an *approximation* of the Medicare lien.

**Note that there is no penalty for the MSPRC failure to issue a conditional payment letter.

G. Settlement/Judgment Recommendations and Procedures

Medicare has rights of subrogation and the right to intervene or join in actions involving events giving rise to the need for Medicare services to be paid. See 42 C.F.R. §411.26. Medicare is allowed full recovery of conditional payments even when the beneficiary’s settlement is for less than her total damages. See 42 C.F.R. §411.24(c). *Discussed in Zinman v. Shalala*, 67 F.3d 841, 843 (9th cir. 1995). Adequately considering Medicare’s interest is important; “if a settlement appears to shift to Medicare the responsibility for medical expenses for the treatment of the work-related condition, the settlement will not be recognized.” 42 C.F.R. §411.46(b)(2).

(1) Insured should be generally advised never to release tortfeasor during settlement

If the injured party and tortfeasor settle the case after the tortfeasor learned of the insurer’s (including but not limited to health insurers, automobile insurers, or homeowner insurers) subrogation right, but without the insurer’s consent, the settlement will *not* destroy the insurer’s right to proceed in a subrogation action against the tortfeasor. See *Group Health, Inc.*, 871 N.Y.S.2d at 782, *citing cases*. The insured plaintiff should generally be advised never to release the tortfeasor because it could potentially destroy the insurer’s subrogation rights. See *e.g., Weinberg v. Transamerica Ins. Co.*, 62 N.Y.2d 379 (1984) (holding that the general release prejudiced the subrogation rights of Transamerica Insurance Company, who was entitled to

summary judgment). See also Settlement Releases and Double Damages, *infra*.

(2) Lump-Sum Compromise Settlements vs. Lump-Sum Commutation Settlements in Workers' Compensation Cases

(a) Lump Sum Compromise Settlements

Lump sum compromise settlements are agreements between the workers' compensation carrier and injured individual to accept less than the injured individual would have received if he or she received full reimbursement for lost wages and life-long medical treatment. Compromise settlements are for current or past medical expenses, only. 42 C.F.R. §411.46(d)(1). Lump Sum Compromise Settlements generally occur when the workers' compensation carrier strongly disputes liability and has not voluntarily paid for all the bills from the accident.

(b) Lump-Sum Commutation Settlements

Commutation cases are settlement awards for *future* medical expenses required because of work-related injury. See 42 C.F.R. §411.46(a).

(c) Cases with both Lump-Sum Compromise Settlements and Lump-Sum Commutation Settlements

Lump sum settlement agreements can designate part of a settlement for an injured individual's future medical expenses and simultaneously designate another part of the settlement for all of the injured individual's medical expenses up to the date of settlement. See "Apportionment of a lump sum compromise settlement of a workers' compensation claim," 42 C.F.R. §411.47. Therefore, it is possible for a settlement agreement to be both a compromise and a commutation settlement.

(3) Preventing Double Recovery in Workers' Compensation and Medicare Settlements

The law seeks to prevent double-recovery, but permits an injured worker to bring a tort action in addition to receiving workers' compensation benefits. See Workers' Compensation Law §29. The law prevents double-recovery by creating a lien against third-party recovery. *Id.* This lien is statutory and does not require the carrier to inform the claimant of its existence. If the plaintiff recovers, workers'

compensation may suspend payments until the compensation benefits exceed the recovery; by suspending payments, the law prevents double recovery based upon future losses. This is similar to Medicare suspending payment following a lump sum commutation settlement. See Lump Sum Payments, 42 C.F.R. §411.46(a). However, the analogy between Medicare tort cases and workers' compensation is far from exact. See *Zinman v. Shalala* 67 F.3d 841, 846 (9 cir., 1995) (discussing how recovery in workers' compensation is generally based on rigid formula, whereas in tort cases, damages include non-economic damages not available in workers' compensation cases).

H. Post Settlement/Judgment Duties and Procedures

Once there is a settlement or judgment, MSPRC should be notified of the date of the settlement or judgment, the amount of the settlement or judgment, and attorney's fees or other costs borne by the beneficiary associated with the settlement or judgment. See 42 C.F.R. §411.24(h) (Medicare must be notified within 60 days of the settlement or judgment). MSPRC may request a copy of the settlement or judgment.

(1) Issuance of a Recovery Demand Letter

After settlement, the MSPRC will use the settlement/judgment amount and fees to calculate the total recovery claim amount. At this time, the MSPRC will officially provide counsel with the Recovery Demand Letter, which states how much Medicare is owed. Upon telephone inquiry with the MSPRC, the representative stated that when MSPRC receives notice of the settlement/judgment amount, the MSPRC has 10 days, plus mailing time, to issue a recovery demand letter. (Telephone inquiry to the MSPRC dated: August 28, 2009).

(2) The Right to Administrative Review of Medicare's Demanded Recovery Amount

The beneficiary has the right to administrative appeal the recovery amount demanded by Medicare. See 42 U.S.C. §1395y(b)(2)(B)(v) (stating that Medicare may waive individual claims if the Secretary determines that the waiver is in the best interests of the program). If the attorney believes that the client's case meets the criteria set forth in 42 C.F.R. §405.376, the attorney may request a compromise Medicare recovery form from the Regional CMS office. These compromise decisions are discretionary and not subject to administrative appeal. See Overview of Medicare Secondary payer Recovery Claim Process, <https://www.cms.hhs.gov/MSPRecovClaimPro>.

(3) Effect of Post-Settlement/Judgment Liens in Workers' Compensation Cases

The lien applies against any workers' compensation benefits paid to an injured claimant. Attorney's fees for the tort action "shall be equitably apportioned by the court between the employee and his dependents and the lienor." Workers' Compensation Law §29(1). Just as with Medicaid liens, workers' compensation liens cannot be avoided by characterizing the recovery as one for pain and suffering only.

I. **Attorney's Duties with Medicare**

The attorney handling the personal injury matter does not have a fiduciary relationship with Medicare; the attorney is representing a client who has a legal obligation to ensure that Medicare is reimbursed for conditional payments. Medicare is reimbursed for the conditional payments from any recovery against the tortfeasor. Medicare generally will reimburse attorneys for the cost of procurement of settlement or judgment. See 42 C.F.R. 411.37 (For conditions when Medicare reduces its recovery to take account of the cost of procuring the judgment or settlement.) See *also* Settlement Releases and Double Damages, *infra*.

Attorneys and injured claimants should proceed with caution with personal injury settlements, as Medicare can seek double damages if not reimbursed. See Settlement Releases and Double Damages, *infra*. Attorney's should also be advised that the statute of limitations on personal injury actions runs from the date of the injury. See State of Limitations, *infra*.

J. **Penalties and Limitations**

(1) Settlement Releases and Double Damages

Personal injury settlements often contain very broad releases, releasing all causes of action, sums of money, damages, claims, that a plaintiff ever had and further declares that the settlement constitutes payment for all damages and injuries arising from the incident. Medicare interprets these broad releases as including damages for medical expenses. *The impact of this interpretation is that Medicare, if not reimbursed for its conditional payments, could seek double damages from the primary liability insurer or could sue the beneficiary or the beneficiary's attorney, if appropriate and necessary.* See 42 C.F.R. §411.24(c)(2). See *also* Health Ins. Ass'n of Am., Inc. v. Shalala, 23 F.3d 412, 417-418 (D.C. Cir. 1994) (for a discussion of double damages). See *also* §1862(b)(2)(B)(ii) as amended in §1395y.

This would be a very costly, avoidable proposition for a liability insurance company; Federal court litigation is costly and time-consuming and the liability insurer's liability may be resolved in one action. Medicare will often share in the costs associated with prosecuting the injured plaintiff's case, which will be to no avail if subsequent litigation against the primary liability insurer becomes necessary. See 42 C.F.R. 411.37 (For conditions when Medicare reduces its recovery to take account of the cost of procuring the judgment or settlement.) Furthermore, Medicare regulations provide a mandatory duty of cooperation from the beneficiary to assist in the case against the liability insurance company. 42 U.S.C. §1395y(b)(2)(B)(iii). See also 42 C.F.R. §411.23(a).

(2) If Medicare is not reimbursed, the primary payer may be deemed 'nonconforming'

Employers are imposed a 25% excise tax equal to employer's or employee organization expenses paid in contribution to each large group health plan or group health plan. See 42 U.S.C. §1395y(b)(3)(B) and 42 C.F.R. §411.100 *et seq.* See also 26 U.S.C. §5000(c) (Internal Revenue Code provision imposing 25% tax via paragraph (a) of §5000 of Title 26. Liability and other insurance carriers are not subject to these provisions.

(3) Statute of Limitations

The statute of limitations for bringing a personal injury action in New York State is three (3) years. See N.Y. C.P.L.R. §214. The statute of limitations runs from the date of the accident, rather than the date that benefits were first paid. See *Group Health, Inc.*, 871 N.Y.S.2d at 782, *citing Allstate Ins. Co. v. Stein*, 775 N.Y.S.2d 219 (2004). In *Allstate*, plaintiff's automobile insurer brought a subrogation to recover APIP benefits. *Allstate Ins. Co.* 775 N.Y.S.2d at 220. The Court of Appeals held that the statute of limitations period runs from the date of the accident. *Id.* at 223.

In cases involving liability insurance (including self-insurance) or no-fault insurance with primary payer responsibility, the statute of limitations is six years under the False Claims Act. Under the False Claims Act, the primary payer may be sued within six (6) years if Medicare was the primary payer when it should have been the secondary payer. See *Manning v. Utilities Mut. Ins. Co., Inc.*, 254 F.3d 387, 397-98 (2d Cir. 2001). (holding that the six-year statute of limitations applicable to private rights of action under the False Claims Act should be applied to private rights of action under the Medicare Secondary Payer (MSP) provision, and therefore plaintiff's MSP claim

was not time barred). See also 28 U.S.C. 2415(a) (stating that actions for money damages brought by the United States based on a express or implied contract are barred unless filed within six years after the right of action accrues).

The primary payer assumes the risk that the claim may be time-barred before the right of subrogation exists; *Winkelman v. Excelsior Ins. Co.*, 85 N.Y.2d 577 (1995) (holding that the insurance carrier who paid their insured the full amount under a policy, but less than the insured's actual loss, may proceed against the third-party tortfeasor before the injured is made whole by the tortfeasor). In such a case, the insurance carrier's remedy is against the injured party, because their conduct has prejudiced the insurance carrier's subrogation rights. See *Group Health, Inc.*, 871 N.Y.S.2d at 782, *citing cases*. See also *Allstate Ins. Co.*, N.Y.S.2d at 223 (Court of Appeals stated that in such a case the subrogee's remedy is against the subrogor, for conduct that has prejudiced the subrogee's right).

K. Recommendations

(1) Register

- Final day for registration is 9/30/2009

(2) Test to Make Sure System is Operable

- Do internal tests for filling out questionnaire.

(3) Report...Report...Report

- When in doubt, report
- "Medicare Eligible?" Why not answer "yes"?
- See **TIPS 1-4**, *infra*.

(4) Conditional Payment Letter Review

- Medicare reimbursement only for related-injuries
- Allocate payment amount as part of reserves and settlement
- See **TIP 5**, *infra*.

(5) Advise Medicare of Settlement

- Plaintiff's attorney should do with copy to carrier/primary payer
- Letter should be specific as to amounts being paid for various components of settlement; in particular, the Medicare piece(s)
- See **TIP 6**, *infra* on lump sum commutation settlements

(6) Recovery Demand Letter Review

- Verify amount being sought; do not rely on Conditional Payment Letter amount
- Carrier's check to be made payable directly to "MSPRC"

(7) Payment by Primary Payer to Medicare

- Enclose remittance slip with address information. See attached remittance slip. Post Office box varies depending on the type of case (liability, workers compensation, group health plan).
- Payment directly to MSPRC by carrier? If not, claimant's attorney to transmit to Medicare, with copy to carrier. See remittance slip, Recommendation 6, *supra*.
- Verify receipt by contacting MSPRC???

(8) Miscellaneous Tips:

TIP 1: General Inquiries to the Coordination of Benefits Contractor (COBC) can be directed to:

Medicare Coordination of Benefits
P.O. Box 33847
Detroit, Michigan 48232

TIP 2: COBC can be contacted directly, M-F from 8am to 8pm EST at 1-800-999-1118. Call them during off-peak hours to avoid long wait times. A phone call is all that is needed to alert them to the Medicare claim and to request a copy of 'consent to release information' form;

TIP 3: The MSPRC can be contacted directly at 1-866-677-7220. Call them during off peak hours to avoid long wait times.

TIP 4: When calling the COBC or MSPRC, be prepared with:

- (1) A Medicare Health Insurance Claim Number (HSICN), if this is an existing claim;
- (2) The name of the insurer (if you are an attorney),

(3) The date of the incident and a brief description of the incident (if this is the first reporting of the incident)

(4) The full name, date of birth, address, and SSN of the Medicare beneficiary

TIP 5: A conditional payment letter will be sent to the attorney after the MSPRC does a record review and obtains consent to release information form; the MSPRC will not send a notice of lien because out of pocket expenses and attorney fees will ultimately be deducted from the conditional payment amount. The conditional payment letter is often required by attorneys when settling personal injury cases so that a portion of the settlement may be allocated to Medicare.

TIP 6: If a lump-sum commutation settlement is “intended to compensate the individual for all future medical expenses required because of the work-related injury or disease, Medicare payments for such services are excluded until medical expenses related to the injury or disease equal the amount of the lump sum.” 42 C.F.R. §411.46(a).

Medicare will not pay for any items or medical services related to the injury until the beneficiary presents medical bills related to the injury *equal* to or in *excess of* the total amount of the lump-sum settlement allocated to future medical treatment.

III. MEDICAID

A. Background on Medicaid

Medicaid is a jointly funded federal and state medical assistance program, which was signed into law in July 1965. Medicaid is governed by 42 U.S.C. §1396 *et seq* (effective July 1, 2009). The purpose of the Medicaid program was to pay for the necessary medical care for eligible individuals whose income and resources are insufficient to cover their medical care costs; Medicaid is the payer of last resort. 42 U.S.C. §1396; Social Services Law §363.

B. Eligibility for Medicaid Benefits

An individual may qualify for Medicaid benefits if they have high medical bills, the individual receives Supplemental Security Income (SSI), and the

individual meets income, resource, age, or disability requirements. See http://www.health.state.ny.us/health_care/medicaid/#qualify (for an outline of income and resource requirements, for contact information, and for a list of services covered by Medicaid). See also 42 U.S.C. §1396a.

C. Applicability in instance of personal injury to same Primary Payers

Medicaid liens apply to all of the primary payers referred to under the Medicare section. See “Applicability of MSP in instance of personal injury to the following “primary” payers: *supra*.”

D. Medicare’s Right to Reimbursement

If Medicaid payments have been made under the State plan, the State is “considered to have acquired the rights of such individual to payment by any other party for such healthcare items or services.” 42 U.S.C. §1396a(a)(10)(G)(25)(H). To be reimbursed, the State may take “all reasonable measures to ascertain the legal liability of third parties to pay for care and services available under the plan.” 42 U.S.C. §1396a(a)(10)(G)(25)(A). Third parties, defined in regulation, include liability insurance companies. See 42 C.F.R. §433.136 for definition of private insurance company. Without Medicaid’s right to recovery, it would not remain the payer of last resort.

(1) Medicaid Beneficiaries Assign DSS Rights to Reimbursement

Applicants for Medicaid must “assign to DSS any rights he or she has to seek reimbursement from any third party up to the amount of medical assistance paid.” 42 U.S.C. §1396k(a)(1)(A); Discussed in *Cricchio v. Pennisi*, 683 N.E.2d 301, 304-305 (N.Y., 1997). (DSS obtains “all of the rights that the recipient has as against the third party to recover for medical expenses, including the ability to immediately pursue those claims against the third party. Because the injured Medicaid recipient has assigned its recovery rights to DSS, and DSS is subrogated to the rights of the beneficiary, the settlement proceeds are resources of the third-party tortfeasor that are owed to DSS.”)

(2) Medicaid Subrogation Rights

Not only does Medicaid have a right of reimbursement, they additionally have subrogation rights up to the Medicaid program’s expenditures for medical care. Social Services Law §367a(2)(b). Federal law obliges the states to pursue third parties legally liable for the expended Medicaid funds. See 42 U.S.C. §1396a(a)(10)(G)(25)(A). See also 42 U.S.C. §1396a(a)(10)(G)(25)(B). Medicaid is able to pursue claims against third parties once the injured Medicaid recipient assigns their rights to the State. The Medicaid recipient, in turn, is

obligated to assist in identifying the responsible third parties. See 42 U.S.C. §1396k(a)(1)(c). See *also* 42 C.F.R. §433.145(a)(3).

(3) Medicaid Authority to Place a Lien on Personal Injury Claims

Medicaid is also authorized to place a lien on personal injury claims and suits against third parties to the extent of Medicaid's expenditures for medical care. See Social Services Law §104-b (providing that "if a recipient of public assistance and care shall have a right of action, suit, claim, counter-claim or demand against another on account of any personal injuries suffered by such recipient, then the public welfare official for the public welfare district providing such assistance and care shall have a lien for such amount as may be fixed by the public welfare official not exceeding, however, the total amount of such assistance and care furnished by the public welfare official on and after the date when such injuries were incurred.") See *also* Effective Date of Lien, *infra*.

E. Duties and Procedures leading up to Settlement or Judgment and Medicaid Reimbursement

The United States Supreme Court found in *Arkansas Dept. of Health and Human Services v. Ahlborn*, 547 U.S. 268 (2006) that the Arkansas statute at issue violated federal law by allowing the State to be reimbursed for the entire amount of the recovery, and not just the amount allocated for past medical expenses. Prior to this decision, the entire amount of the settlement or judgment was available to satisfy the Medicaid lien. The Court relied on 42 U.S.C. §1396a(A)(25)(H) to limit the Department of Social Service's recovery amount to the amounts allocated to *past* medical expenses.

The *Ahlborn* case was discussed in a subsequent New York County Supreme Court case, *Lugo v. Beth Israel Medical Center*, which held that the Court should determine the ratio between the settlement amount and the actual value of the case, and then apply that same ratio to medical expenses. *Lugo v. Beth Israel Medical Center*, 819 N.Y.S.2d 892, 896-897 (2006). This precedent was followed in *Homan v. County of Cattaraugus Department of Social Services*, where the Cattaraugus County Supreme Court held that a hearing must be held to determine the full value of the case. See *Homan v. County of Cattaraugus Dept. of Social Services*, 2009 WL 2781070 (2009).

Subsequent to *Ahlborn*, Medicaid directed local directors that any portion of the settlement or judgment allocated to compensate the plaintiff Medicaid recipient for pain and suffering, lost wages, and other non-medical damages was *not* available to satisfy a 104-b lien. See 2006 memorandum http://www.health.state.ny.us/health_care/medicaid/publications/docs/gis/06ma02_2.pdf.

F. Settlement/Judgment Recommendations and Procedures

Pursuant to 42 U.S.C. §1396p, Medicaid will impose a lien on account of medical assistance provided under the State Medicaid plan pursuant to the judgment of a court on account of benefits *incorrectly* paid of the individuals behalf. However, pursuant to §1396p, the federal Medicaid statute prohibits the imposition of liens against the assets of Medicaid recipients during their lifetimes if Medicaid has been correctly provided. A lien may also be imposed on any settlement or judgment proceeds from a lawsuit. If the individual is a Medicaid recipient:

(1) Contact Medicaid to Verify the Amount Paid

Attorneys should be advised to contact their client's local Department of Social Services to obtain an itemized report detailing the amount paid by Medicaid.

(2) Only those Medicaid benefits related to the lawsuit should be subjected to the lien

The itemized report provided from the Department of Social Services should be used to determine if the benefits listed on the itemized report are related to the lawsuit. If there are benefits listed that are not related to the lawsuit, these benefits should be challenged, as they are not subjected to the lien. See Challenging the Medicaid Lien, *infra*.

(3) Involve Medicaid in Settlement Negotiation

Medicaid relies on private attorneys for their compensation in personal injury cases. They should be involved in the settlement negotiation process and should be forced to pay their equitable share of attorney's fees out of the settlement or judgment amount.

G. Challenging the Medicaid Lien

Medicaid should be challenged if a lien is imposed for expenses paid by the Medicaid program for pre-existing conditions. However, in cases where there is a large Medicaid lien, the plaintiff may have a negotiating dilemma because the Medicaid lien must be paid prior to the plaintiff recovering for pain and suffering, future needs, and past economic and future losses.

H. Supplemental Needs Trust in Medicaid Cases

(1) Overview

The supplemental needs trust is a “discretionary trust established for the benefit of a person with a severe and chronic or persistent disability.” New York Estates, Powers and Trusts Law §7-1.12(a)(5). The creation of the trust is authorized by statute. See NY Est. Powers & Trusts Law 7-1.12(a)(5) (discussing supplemental needs trusts). A supplemental needs trust should always be considered if the client currently needs, or may need government-sponsored medical, educational, vocational, or rehabilitation-type program assistance, including Medicare, Medicaid, or Social Security.

(2) Liens must be Satisfied before Settlement Proceeds can be put into Supplemental Needs Trust

Any lien must be satisfied before settlement proceeds can be put into the trust. *Cricchio v. Pennisi*, 683 N.E.2d 301,302 (N.Y. 1997) (Court of Appeals held that the Department of Social Services was entitled to satisfy the lien from the settlement proceeds, leaving the remainder for the supplemental needs trust). See also *Arkansas Dept. of Health and Human Services v. Ahlborn*, 547 U.S. 268 (2006) (holding that DSS has a right to satisfy a lien prior to the settlement proceeds being put into trust, rather than satisfying the lien with the trust assets after the beneficiary is deceased. Plaintiff also settled for less than the full value of the case; the parties stipulated that the settlement was one-sixth the value of the case, and the Court relied on this stipulation to reduce the lien to one-sixth the full amount).

The New York State Court of Appeals has held that Medicaid agencies have reviewable discretion to determine the amount of settlement funds that were to be paid to satisfy a Medicaid lien prior to the establishment of the trust. See *Calvanese v. Calvanese*, 93 N.Y.2d 111 (1999). (Establishing that the entire amount of a personal injury recovery is available to satisfy a Medicaid lien prior to any other damages being paid and a supplemental needs trust being created.)

(3) Advantage of Supplemental Needs Trust

The advantage for the beneficiary is that the trust is not considered an asset for eligibility purposes for Medicare, Medicaid, or Social Security programs. New York Estates, Powers and Trusts Law §7-1.12(a)(6) (for definition of beneficiary in context of supplemental needs trust) See also NY Social Services Law §104(3) (stating that

the trustee “shall not be deemed to be holding assets for the benefit of a beneficiary who may otherwise be subject of a claim under this section and no action may be brought against either the trust or the trustee to recover the cost of assistance or care provided to such person, or anyone for whose support such person is or was liable”).

Once the trust is funded, the money is protected against any future lien claims during the client’s lifetime and it will not have adverse Medicaid consequences. The trust was designed to provide for special needs without duplicating services covered by Medicaid or destroying Medicaid eligibility.

The trust should supplement the government benefits or assistance. NY Est. Powers & Trusts Law 7-1.12(a)(5)(i). The trust should prohibit the trustee from distributing assets that may impair the beneficiary’s entitlement to government benefits. NY Est. Powers & Trusts Law 7-1.12(a)(5)(ii). The trust must also prohibit the beneficiary of the trust from authorizing distributions from the trust. NY Est. Powers & Trusts Law 7-1.12(a)(5)(iii). Upon the death of the beneficiary, the state receives all amounts remaining in the trust up to the total value of all medical assistance paid by Medicaid. See NY Social Services Law §366.

I. Limitations and Effective Date of Lien

Medicaid lien’s are statutorily created, but are effective only if a written notice containing the name and address of the injured Medicaid recipient, the date and place of the accident, and the name of the person, firm, or corporation alleged to be liable to the injured party for such injuries, together with a brief statement of the nature of the lien, the amount claimed that a lien is claimed upon the said right of action, be served upon the person, firm, or corporation and his or her attorney, if known, and upon any insurance carrier which insures individual, firm, or corporation against such liability. Social Services Law §104-b(2).

It is the welfare commissioner’s responsibility to ascertain whether the person, firm, or corporation alleged to be responsible for the injuries is insured with a liability insurance company, and the name thereof. See Social Services Law §104-b(1).

IV. MEDICAL PAYMENTS COVERAGE

Med-pay coverage in liability policies pays medical expenses to a “person” for necessary medical expenses caused by an accident without regard to fault of the insured. It has generally been accepted in the Insurance Industry that this

entitlement is unique to the injured person and is not assignable to a third party such as a health insurer, Medicaid or Medicare.

Medicare is attempting to change this past practice. In addition to the seeking recovery of its payments from the liability portion of the policy, Medicare is now attempting to seek recovery from the med-pay provisions of liability policies. The regulations address the “automobile medical” payments, but there is no similar mention to the medical payments provisions in a liability policy.

Primary payers are listed as “workers’ compensation, **automobile medical**, no fault or liability insurance...” See, 42 C.F.R. §412.120. While Medicare is attempting to expand the recovery pool, there is presently no rule or regulation that supports this expansion to med-pay provisions in liability policies other than the auto policy. We have also found no case law that provides any guidance to this issue.