2013 UPDATE ON
RESOLVING CASES WITH MEDICARE AND OTHER LIENS

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The reimbursement claims of medical services payers have changed personal injury litigation. The days of settling cases with a handshake and closing the file are long gone. Now, governments, private employers, and health and liability insurers jockey for a share of the injured plaintiff's settlement to recoup their medical payments.

To effectively resolve a case, the parties and the courts must understand these differing interests. We discuss them briefly below, and then focus on Medicare liens and how to manage them during the settlement process.

We list below some of the entities that commonly seek recovery of medical expenses in a personal injury action:

1. **Medicare**– a statutory right of recovery running to the United States Government for Medicare payments conditionally made to an injured party pending payment by a liability insurer, or other primary plan. *See* 42 U.S.C. §1395y (b). We discuss this further below.

2. **Medicaid** – a statutory right of recovery running to the states and administered through local districts for medical assistance and other services, asserted by notice of lien under SSL § 104-b and assignment of benefits by the Medicaid recipients as a condition of receiving payments and services. 42 U.S.C. § 1396a (a) (25) (H); *Lugo v. Beth Israel Medical Ctr.*, 13 Misc.3d 681, 683-684 (Sup. Ct. New York County 2006).

On March 20, 2013 the Supreme Court decided *WOS v. E.M.A*, ___ U.S. ___ , 133 S.Ct. 1391, 185 L.Ed.2d 471 (2013). It affirmed vacatur of a North Carolina statute that irrebuttably presumed that one third of any personal injury recovery was attributable to Medicaid medical expenses. This decision re-affirmed the proportionate approach to Medicaid lien repayments set forth in *Arkansas Dep't of Health and Human Services v. Ahlborn*, 547 U.S. 268 (2006). *See also Ka Yang v.*

Portage County, 2013 U.S. Dist. LEXIS 101521 (W.D. Wis. 7/19/2013)(holding that a hearing was necessary under *Wos* to determine the *Ahlborn* proportionate share owed to Medicaid when the state and the beneficiary could not agree on that allocation).

3. Health insurers – Historically these entities sought reimbursement for injury related medical payments provided through health insurance contracts. General Obligations Law § 5-335(a) bars these claims when a plaintiff settles with a tortfeasor. *See Rizzo v. Moseley*, 30 Misc.3d 773, 778 (Sup. Ct. Westchester County 2010); *J.A. v. Ja-Ru, Inc.*, 2011 U.S. Dist. LEXIS 27453 *12, 13 (S.D.N.Y 2011).

However GOL § 5-335 does not limit a health insurer's equitable or contractual subrogation rights at verdict. *Rizzo*, 30 Misc.3d at 777. This has sparked intervention motions by health insurance carriers in personal injury actions. While the appellate divisions remain split on this issue, the passage of GOL § 5-335 has prompted trial courts to grant motions to intervene. *See Mittenhall v. N.Y. Univ. School of Medicine.*, 2012 N.Y. Misc. LEXIS 1358, *7-9, 2012 NY Slip Op 30734(U) *7-8 (Sup. Ct. New York County 2012). In granting such a motion, a court of claims judge called the situation a quagmire further complicated by GOL § 5-335. *See Rink v. State*, 27 Misc.3d 1159, 1163 (Ct. Claims Fitzpatrick, J. 2010), *aff'd on opn below,* 87 AD3d 1372 (4th Dep't 2011).

GOL §5-335 does not apply to statutory rights of reimbursement, such as the Employer Retirement Income Security Act of 1974 ("ERISA"). *See Wurtz v. Rawlings*, 2013 U.S. Dist. LEXIS 45008 *42-45 (E.D.N.Y. 2013); *Kohl's v. Castelli*, 2013 U.S. Dist. LEXIS 111985 *14-17 (E.D.N.Y 2013).

4. ERISA Plans – These are self-funded private employer health plans that can recoup medical service payments to their private employees for injuries that are the subject of a recovery. This right of recovery arises under ERISA for all expenses irrespective of the recovery amount, or the equity of such recoupment from the injured plaintiff's recovery. *See Sereboff v. Mid Atlantic Medical Services, Inc.,* 547 U.S. 356 (2006); *Administrative Committee of Wal-Mart Stores, Inc. Associates Health and Welfare Plan v. Shank*, 500 F.3d 834 (8th Cir. 2007). Until 2013, some courts allowed use of the "make whole" and "common fund" equitable doctrines as affirmative defenses to full reimbursement of expenses under ERISA. *See U.S. Airways Inc. v. McCutchen*, 663 F.3d 671 (3rd Cir. 2011); *CGI Technologies and Solutions, Inc. v. Rose, 683 F.3d 1113 (9th Cir. 2012).*

However, on April 15, 2013, in *US Airways v. McCutchen*, ____ US ____, 133 S.Ct. 1537, 185 L.Ed.2d 654 (2013), the Supreme Court held that an injured party could not assert equity defenses such as the "make whole" doctrine against an ERISA recovery action based on an equitable lien by agreement, i.e. the Plan language. However, the Supreme Court did hold that due to gaps in the Plan

language at bar, traditional equity principles could fill those gaps. The gap pertained to whether the Plan had to share part of the fees and costs incurred in getting the recovery. Lower courts have followed *McCutchen* to uphold full recovery under ERISA plans. *See Makoul v. Prudential Ins. Co.*, 2012 U.S. Dist. LEXIS 104653 (N.D. Ill. 7/25/2013).

Employee health plans that are insured rather than self-funded are not true ERISA plans and do not hold the right of recovery of ERISA plans. *See Cagle v. Bruner*, 112 F.3d 1510, 1520-1521 (11th Cir. 1997).

Under a true ERISA plan with appropriate language, the Plan Administrator may recoup funds from a personal injury settlement disbursed as attorney's fees, *see Central States v. Lewis*, 871F.Supp.2d 771 (N.DIll. 2012), or sheltered in a supplemental needs trust, *see ACS Recovery Services, Inc. v. FKI Industries, Inc.*, 2013 U.S. App. LEXIS 9324, (5th Cir. 2013) *petition for certiorari filed* August 5, 2013 (No. 13-182).

A common problem for plaintiff's personal injury attorneys is determining whether a true ERISA plan exists. In this respect it is important to remember that claims administrators are not the Plan Administrator. Any failure of the claims administrator to provide Plan documents to a plaintiff's attorney cannot subject the Plan Administrator to liability under ERISA. *See Delprado v. Sedgewick Claims Management Serv., Inc.*, 2013 U.S. Dist LEXIS 38159 (N.D.N.Y. 3/20/13).

5. Medicare Advantage Policy ("MAP") contract providers. The MAP is a Medicare policy of insurance provided by a private insurer as an alternative to direct government Medicare. Some cases have held that MAP providers as private entities cannot assert Medicare's statutory right of recovery. *See Ferlazzo v. 18th Avenue Hardware, Inc.,* 33 Misc.3d 421, 425-426 (Sup. Ct. Kings County 2011); *Konig v. Yeshiva Imrei Chaim Viznitz of Boro Park Inc.,* 2012 U.S. Dist. LEXIS 45448 (E.D.N.Y. 2012). The Third Circuit, however, has reached the opposite conclusion. *See In Re Avandia Mktg. Sales Practices and Prod. Liab. Litig.*, 685 F.3d 353 (3d Cir. 2012). Other courts have found that the MPSA preempts GOL § 5-335. *See Trezza v. Trezza,* 104 A.D.3d 37, 48-49 (2d Dep't 2012)*; Potts v. The Rawlings Co.*, 897 F.Supp.2d 185 (S.D.N.Y. 2012); *Meek Horton v. Trover Solutions, Inc.,* 910 F.Supp.2d 690 (S.D.N.Y. 2013).

6. The State Insurance Fund or a workers' compensation carrier. They can recoup medical benefits pursuant to the statutory lien at WCL § 29(1).

7. **A no fault insurer based on the personal injury payment ("APIP") statutory lien.** This is for no fault benefits above the basic no-fault first party benefits. *See* 11 NYCRR §65-1.3; *Allstate Ins. Co. v. Stein*, 1 N.Y.3d 416 (2004).

8. A no fault insurer by lien under Ins. Law § 5104(b). This is for first party benefits paid or payable to an injured party suffering injury from a non-covered loss. The injured party cannot compromise the personal injury action without the written consent of the no-fault insurer, or with the approval of the court, or where the amount of the settlement exceeds $50,000. Ins. Law § 5104(b).

We focus here on the challenges that present when parties settle a case with conditional Medicare payments, or potential future Medicare covered payments.

1. *An overview of the Medicare Secondary Payer Act ("MSPA")*

In 1980 Congress made Medicare a "secondary payer" for medical expenses for which some other entity bears responsibility. *See* 42 U.S.C. § 1395y(b)(2). Congress also mandated that Medicare seek reimbursement from the injured party, i.e. "the beneficiary," or the responsible party. *Id.*; 42 U.S.C. § 1395 y (b)(2)(B)(ii)(iii); *Hadden v. United States*, 661 F.3d 298, 300 (6th Cir. 2012). Any doubt that liability insurers were a primary plan or payer ended in 2003 when Congress amended the MSPA to include them.

The injured party must pay back Medicare for all conditional payments that Medicare has made for injury related medical expenses. *See* 42 C.F.R. § 411.24(c). The injured party may offset payment with litigation procurement costs, generally consisting of a percentage of the Medicare lien based on attorneys' fees and disbursements. *See* 42 C.F.R. § 411.37. There is also a provision for hardship exceptions if recovery under the MSPA would be against equity and good conscience. *See* 42 U.S.C. § 1395gg (c).

If the injured party receives a settlement but does not repay Medicare, Medicare may bring an action directly against the injured party, and/or the liability insurer, for double the amount due under the Medicare lien, with interest. *See* 42 U.S.C. § 1395y(b)(2)(B)(iv). This means that a liability insurer could pay a Medicare lien once when settling the case by tendering a settlement check including the Medicare lien payment, and then a second and third time when Medicare pursued it directly after the injured party did not pay the Medicare lien. *See* 42 C.F.R. § 411.24(i); *Pollo Operations, Inc. v. Tripp*, 906 So.2d 1101, 1105-1106 (Fla. Ct. App. 3rd Dist. 2005).

Medicare may also bring a direct action for the same double damages against an attorney who has received a payment. 42 C.F.R. § 411.24 (g), 411.26(a); 42 U.S.C. §1395y (b)(2)(B)(iii). In an action against the insurer, the exhaustion of the policy limits is not a defense. *Id.*; *Porter v. Farmers Ins. Co.*, 2012 U.S. Dist. LEXIS 9862 *56-57 (N.D. Okl. 2012).

Medicare's rights are automatic. It need not serve a notice of lien. 42 C.F.R. § 411.21. Its right to recover triggers when a case settles or goes to verdict. *Id.* An injured party must pay the Medicare lien within sixty days of receiving Medicare's final demand letter. *See* 42 C.F.R. § 411.24 (h).

In 2007 the Medicare, Medicaid and SCHIP Extension Act of 2007, Pub. L. No. 110-173, 121 Stat. 2492 ("MMSEA") became law. Section 111 of MMSEA mandates that insurers determine the Medicare status of claimants and report information about claimants to the government. The reporting trigger is when the insurer accepts responsibility for medical payments, or when it settles a case, or a verdict is rendered. The reporting requirement applies only to injured parties who were Medicare beneficiaries at the time of settlement or verdict.

The insurer may be liable to the government for $1,000 per day penalties if it violates this provision. Section 111 of MMSEA helped Medicare match an injured party's monies from settlements or verdicts with that party's conditional payment record from Medicare for the same injury.

Medicare also requires that the primary plans and the beneficiaries consider Medicare's interests when future Medicare services are expected, and the settlement or verdict is or may include payments for these future services. Medicare has the right to not pay for these future medical services otherwise covered by Medicare. *See* 42 C.F.R. § 411.46 (d). Therefore, in cases involving continuing medical care, the parties may need to discuss or consider a Medicare Set Aside ("MSA"). This involves consideration of whether Medicare related services are reasonably anticipated in the future for the injured party. If so, the cost of these services is reduced to present value, and that amount is generally deposited into a earmarked fund to pay for those services. Currently, however, there is no legal requirement to create and fund an MSA in liability cases. *See Bruton v. Carnival Corp.*, 2012 U.S. Dist. LEXIS 64416, * 7 (S.D. Fla. 2012). Medicare does enforce such MSA regulations in workers compensation cases.

Specifically, in workers compensation cases, Medicare determines if the injured party might need an MSA by the following criteria:

1. The injured party is either enrolled in Medicare or possesses a reasonable expectation of Medicare enrollment within 30 months of settlement;

2. The settlement forecloses payment of future medical expenses by the insurer, effectively shifting the burden of future injury related care from the insurer to Medicare;

3. The injured party requires future injury related care that would otherwise be covered by Medicare.

Reasonable expectation of Medicare enrollment includes but is not limited to: (a) the injured party has applied for Social Security Disability Benefits, (b) the injured party has been denied Social Security Disability Benefits but expects to appeal that decision; (c) the injured party is appealing and/or re-filing for Social Security Benefits; (d) the injured party is 62 years and six months old; and (e) the injured party has end stage renal disease (ESRD) but does not yet qualify for Medicare based on that condition. *See* April 22, 2003 Memorandum from Thomas L. Grisson, Regional Director of CMS, at p.2.

On June 15, 2012 Medicare issued an advanced notice of proposed rulemaking ("ANPR") for new rules and guidelines for MSAs in liability cases. They are still pending as of September 24, 2013.

2. Law on Medicare issues in settlements

The parties and the courts can minimize the impact of a Medicare lien on settlement if they know the relevant law and prepare accordingly.

a. Ambiguities about liens in settlement records

A settlement on the record which was "subject to any outstanding liens" broke apart and required an evidentiary hearing when the full amount of liens became known. *See Ostman v. St. John's Episcopal Church*, 918 F.Supp. 635 (E.D.N.Y. 1996).

Ostman is a cautionary tale. It shows how liens can derail a settlement, or damage a party. The plaintiff suffered quadriplegia from a late diagnosed cervical spine abscess. He sued a range of defendants for medical malpractice, including the United States, in the Eastern District of New York. The parties settled the case for $2,000,000 on the record. The settlement was "subject to any outstanding liens." *Id.* at 639. The plaintiff's attorney knew of a $111,000 New York City Medicaid lien. He also knew, however, from the plaintiff's injuries that the medical bills were probably higher than such an amount. He discussed this with a defense counsel before placing the settlement on the record. The plaintiff's attorney warned plaintiff that the social services liens could reach $300,000.

After the settlement, the state and city asserted Medicaid liens totaling $411,000.00. The United States also asserted a $253,000 Medicare lien against the settlement. Plaintiff moved to vacate the settlement.

The District Court held an evidentiary hearing. *Id.* at 643. The attorneys testified, and findings of fact issued. The District Court denied plaintiff's motion to vacate the settlement. It found a binding agreement. The plaintiff in the settlement had agreed to satisfy any non-federal liens outstanding at settlement. The District Court found no such agreement on the Medicare lien. It therefore denied the government's application to order the Medicare lien withheld from the government's share of the settlement. It also held, however, that the settlement did not preclude the government from bringing an independent action against the plaintiff on that lien. *Id.* at 645-646.

The injured plaintiff therefore was potentially responsible for an additional $300,000 in Medicaid liens, and $253,000 in Medicare liens, before allowance for recoupment costs. It seems unlikely that the case would have settled at $2,000,000 if all liens were known.

b. The Catch 22 of the need for a binding settlement before Medicare issues its final demand letter.

The parties require a final, complete settlement on the record, *see* CPLR 2104, but until January 10, 2013 Medicare only provided a final lien payment amount after receiving the final settlement documents. This has caused problems across the country requiring court intervention to rule on disputes related to the final demand letters. *See Carty v. Clark*, 2012 U.S. Dist. LEXIS 98318 (E.D. Pa. 2012) *recommendation adopted Carty v. Clark*, 2012 U.S. Dist. LEXIS 98314 (E.D. Pa 2012)(compelling defendant to release the settlement funds from escrow when plaintiff served the required MSPRC final demand letter post settlement, even though certain medical bills were not included in the MSPRC final demand letter amount).

On January 10, 2013 the SMART Act[1] became law, effective April 1, 2013. Among other things, it establishes a Medicare electronic portal for litigants. They can now notify CMS four months before an expected settlement. Within sixty five days of that notice, CMS must post on its portal the final amount that the injured party owes Medicare. With this system, litigants can now more quickly secure a final Medicare lien amount. It also established a three year period for Medicare to

[1] Strengthening Medicare and Repaying Taxpayers Act of 2011 H.R. 1845.

seek reimbursement of covered medical expenses. A full reading of all provisions in the Smart Act is recommended.

c. *Medicare as a co-payee on the settlement check*

Courts may enforce a settlement that omits Medicare as a co-payee on a settlement check where the plaintiff by release acknowledges her responsibility to pay any Medicare claim and agrees to indemnify the released parties. *See Hearn v. Dollar Rent A Car, Inc.* 2012 Ga. App. LEXIS 338 (Ct. Appeals Ga. 2012); *Wright v. Liberty Medical Supply*, 2011 U.S. Dist. LEXIS 81621 (D.S.C 2011); *Riccardi v. Strunk*, 2010 Conn. Super. LEXIS 186 (D. New London, Case No. CV085008671, decided January 22, 2010); *Tomlinson v. Landers*, 2009 U.S. Dist. LEXIS 38683 *16 (M.D. Fla. 2009)(denying defendant's motion to enforce a settlement where defendant's insurer had insisted on putting Medicare on a settlement check as a co-payee and plaintiff rejected the check and sued the defendant on the underlying cause of action).

Private parties do not have the standing to assert the government's Medicare interest in the litigation. *See Zeleppa v. Seiell*, 2010 PA Super 208 (Pa. Sup. Ct. 2010); *see also McBride v. Brown*, 2011 Conn. Super. LEXIS 830 (D. New Haven, Case No. CV085012165, decided April 4, 2011)(stating that no authority existed for insurer to insist that Medicare be placed on a settlement check as a co-payee, when ruling on a settlement involving a Texas child support lien).

One court has held that an insurer's insistence that Medicare be listed as a payee on a settlement check evidenced bad faith. The plaintiff had already indemnified the carrier and defendant against any Medicare claims. *See Wisinski v. American Commerce Group*, 2011 U.S. Dist. LEXIS 320 (N.D. Pa. 2011). Another court has found that it is a breach of contract for an uninsured motorist insurer to issue a check to the insured with Medicare as a co-payee when the insurer had no reason to believe that Medicare paid for any injury related medicals. *See Texas Farmers Ins. Co. v. Fruge*, 13 S.W.3d 509, 511 (Tex. App. Beaumont 2000).

The issue remains unsettled, as other courts have found it proper to name Medicare as a co-payee on a settlement check. In *Wilson v. State Farm*, 795 F.Supp.2d 604 (W.D. Ky. 2011) plaintiff settled a case with State Farm on an uninsured motorist claim. State Farm held back the settlement check after plaintiff refused to accept a check with Medicare as a co-payee. During this time, State Farm did not know the amount of the Medicare lien. Two months later, State Farm learned the amount, and paid the plaintiff and Medicare a day later, apparently by separate checks. On this record, the Kentucky federal district court granted summary judgment dismissing the plaintiff's motion for bad faith against State

Farm. It found State Farm's actions reasonable to protect against overpayment in light of Medicare's requirements. *Id.* at 607.

The district court in *Wilson* cited two cases that also found it reasonable for a defendant or its insurer to include Medicare on a settlement check: *Lewis v. Allstate Ins. Co.*, 2006 Tex. App. LEXIS 2055 *5-8 (Tex. App. 2006) (holding that insurer did not breach its insurance contract by issuing a settlement check with Medicare as a co-payee as the record showed no prior agreement as to how the settlement check would be issued), and *Wall v. Leavitt*, 2008 U.S. Dist. LEXIS 89880 (E.D. Cal. 2008).

Other cases have also found it proper for a liability insurer to issue a settlement check naming Medicare as a co-payee. *See Pollo Operations, Inc., 906 So.2d at 1105 (*expressing concern over insurer's exposure if plaintiff did not pay Medicare its share of settlement check); *Porter,* 2012 U.S. Dist. LEXIS 9862 at *53-57 (finding no bad faith on insurer's conduct in issuing a check with Medicare as a co-payee given the course of conduct and the harsh penalties that could be assessed by Medicare against the insurer).

d. Medicare issues impacting settlement enforcement

Over defendant's objections, a federal district court in Missouri enforced a settlement agreement in which the plaintiff agreed to satisfy all liens. The defendant's fear of potential unknown liens was irrelevant. *Baker v. Truckstop Distributors,* 2010 U.S. Dist. LEXIS 118114 (W.D. Mo. 2010). In *Snook v. Oakland County Deputy Sheriff*, 2009 U.S. Dist. LEXIS 75435 (E.D. Mich. 2009) the Court enforced a settlement despite a plaintiff's resistance to the settlement because the final Medicare amount was not known by final demand letter. *Id.* at * 9-10.

In *Hensley v. Marion*, 2011 U.S. Dist. LEXIS 14420 (W.D. Va. 2011), a defendant's insurer refused to tender a settlement check until Medicare issued its final payment letter.

Plaintiff moved in Virginia state court to enforce the settlement and compel payment, less money estimated for the Medicare lien. The defendant removed the case to the Virginia federal district court. It claimed that Medicare regulations preempted the issue of Medicare payment. The Virginia federal district court disagreed. It held that Medicare regulations did not completely preempt Virginia state law on enforcement of settlement agreements. Medicare's right of recovery against one of the parties to the agreement did not sway the court. *Id.* at *9. It remanded the case back to Virginia state court. *Id.* at *10.

In *Hackley v. Garofano*, 2010 Conn. Super. LEXIS 1669 (D. New Haven, Case No. CV095031940S, decided July 1, 2010), the parties settled a personal injury case for $7,500. The defendant's insurer would not tender the settlement funds until the plaintiff provided his social security number. The plaintiff was 16 years old, and not Medicare eligible. The plaintiff refused to provide the social security number, and sued defendant for default. The Court denied the motion. It found that the plaintiff had never agreed to provide the social security number. Neither, however, had the defendant agreed to settle the case without getting the social security number. *Id.* at *14-15. The parties had discussed but never resolved this issue. This open term showed that the parties had not agreed on a settlement. *Id.* at *15.

In 2013, a court found that a plaintiff's failure to tender his social security number to allow Medicare verification as part of a settlement breached a term of the settlement to exchange necessary closing documents. As such, the 90 day time period applicable to municipalities in CPLR 5003-a(e) did not begin to run until plaintiff tendered this information. *See Sekou v. City of New York*, 2013 U.S. Dist. LEXIS 15597 (E.D.N.Y. 2013).

e. New York cases involving Medicare releases, forms, and W-9's

In *Klee v. America's Best Bottling Co.*, 76 A.D.3d 544 (2d Dep't 2010) plaintiff settled an action and tendered a stipulation of discontinuance and a release to the defendants' attorney. Defendants' insurer requested a W-9 from the plaintiff's attorney. Plaintiff's attorney initially declined. The settlement checks did not arrive in twenty one days. Plaintiff entered judgment under CPLR 5003-a. Defendants below successfully vacated the judgment.

The Second Department reversed. It disagreed with the First Department's decision in *Liss v. Brigham Park Cooperative Apts.*, 264 A.D.2d 717 (1st Dep't 1999). Neither CPLR 5003-a nor the parties' stipulation of settlement, imposed additional requirements on the plaintiff or his attorney. *Id.* at 546. There was no statutory authority for elevating the completion of the W-9 to a condition precedent for payment of the sum due to settle a personal injury claim. *Id.*

The Fourth Department in 2011 reached the same result. In *Tencza v. St. Elizabeth Medical Ctr.*, 87 A.D.3d 1375 (4th Dep't 2011) the plaintiff in a medical malpractice case tendered a general release and a stipulation of discontinuance to defendant. The general release acknowledged the Medicare lien and stated that plaintiff would pay part of the settlement to satisfy the Medicare lien. The parties later agreed that the plaintiff would only withhold $50,000 from the settlement. Citing *Klee*, the Court held that neither CPLR 5003-a nor the stipulation imposed additional requirements on the plaintiff or his attorney. *Id.* at 1376. The Court

affirmed the lower court's decision that denied defendant's motion to vacate plaintiff's CPLR 5003-a judgment.

The First Department has a different view. In *Liss v. Brigham Park Cooperative Apts.*, 264 A.D.2d 717 (1st Dep't 1999) it reversed a trial court order that had granted the plaintiff's motion for costs, disbursements, and CPLR 5003-a interest. After the parties settled the case, the plaintiff tendered general releases and a stipulation of discontinuance to defendants. The First Department found the releases "defective" because they did not release the plaintiff's Medicare lien. *Id.* at 718. Because Medicare could collect the lien from defendants, the plaintiff had to provide for the release of the lien in the general release and stipulation of settlement. *Id.*

The First Department cited *Liss* with approval in *Cely v. O'Brien & Kreitzberg*, 45 A.D.3d 368 (1st Dep't 2007). It held that the lower court properly denied plaintiff's request for CPLR 5003-a relief. Plaintiff had not provided the defendant with a hold harmless stipulation and W-9 form. The open court stipulation and CPLR 5003-a did not require this, but the court relied on IRC provisions and *Liss*. *See also Brown v. City of New York*, 2012 U.S. Dist. LEXIS 24365, *3, 12 (E.D.N.Y. 2012)(citing *Liss* to hold that a release was defective when it did not release child support liens); *White v. New York City Hous. Auth.,* 16 Misc.3d 598, 600-601 (Sup. Ct. Kings Co. 2007)(reaching the same holding on a workers' compensation lien).

In *Panella v. CBS Broadcasting, Inc.*, 2011 N.Y. Misc. LEXIS 4271, 2011 N.Y. Slip Op. 32349U (New York Co. Sup. Ct. 2011) the Court vacated plaintiff's CPLR 5003-a judgment. The Court found that the parties had not resolved Medicare lien issues. The unpaid lien rendered the general release not duly executed. Therefore, CPLR 5003-a would not trigger until a valid release incorporating the Medicare payment issued. That valid release according to the Court did not occur until the Medicare issues were resolved by the plaintiff's tender of Medicare conditional payment letters. *Id.* at *6.

In 2012 the Second Department in *Torres v. Hirsch Park, LLC*, 91 A.D.3d 942, 943 (2d Dep't 2012) affirmed a lower court order directing the defendant to pay the settlement proceeds into court, and to stay entry of a CPLR 5003-a judgment, until plaintiff provided authorizations to defendants to secure the plaintiff's Medicare records. The lower court had ordered those authorizations produced before or close to the settlement. The plaintiff's release and stipulation of settlement were defective because they did not release and hold defendant harmless from potential Medicare and Medicaid liens, or acknowledge that such liens would condition precedent for entry of a CPLR 5003-a judgment. The Second Department also held that the Medicare and Medicaid authorizations were necessary to allow defendant to comply with its statutory duty to report the identity of plaintiffs

entitled to Medicare benefits, and to determine the existence of potential subrogation claims. *Id.*

In 2013, the Second Department held that a general release provided by a plaintiff was defective since it expressly excluded potential subrogation claims against the defendant. Therefore, the release did not trigger the 21 day payment requirement of CPLR 5003-a or its interest penalties. *See Pitt v. New York Hous. Auth.*, 106 A.D.3d 797 (2d Dep't 2013).

f. Medicare and Wrongful Death/Conscious Pain and Suffering Allocations

The law in this area is also unsettled. Under the Florida state wrongful death statute, the survivor's allocated loss of companionship and consortium recoveries were not property of Health and Human Services. They were not subject to lien for Medicare services provided to the decedent. The Medicare lien attached only to the decedent's action for conscious pain and suffering. *See Bradley v. Sebelius, 621 F.3d 1330, 1337* (6th Cir. 2010).

A different result occurred in *Benson v. Sebelius*, 771 F.Supp.2d 68 (D. D.C. 2011). Plaintiff's mother fell and died ten days later. She incurred Medicare bills for related and unrelated medical treatment. Plaintiff sued and recovered a $90,000 settlement. The parties with court approval allocated eighty percent of the settlement to wrongful death, and twenty percent to conscious pain and suffering. *Id.* at 71. Before the settlement, Medicare had issued a conditional payment letter for $40,213.74 in hospital payments. Plaintiff paid under protest, exhausted administrative remedies and sued in federal district court for the funds. *Id.*

The district court granted summary judgment dismissing plaintiff's case. It held that the government could recover Medicare payments from the plaintiff's wrongful death proceeds. It distinguished *Bradley*. The survivors in *Bradley* did not seek recovery of the decedent's medical expenses in their wrongful death action. *Id.* at 74-75. The plaintiff in *Benson* did. The district court also found that the plaintiff's decedent's medical expenses were contemplated by the parties in negotiating the settlement. *Id.* at 75. No cases *per se* limited Medicare from recovering from a survivor's wrongful death settlement. *Id.*

g. What is a related Medicare conditional medical payment

In many cases, the plaintiff alleges an aggravation or exacerbation of an existing condition, or claims that defendant's negligence precipitated the onset of a latent condition. These claims rest on the New York's Pattern Jury Instructions, and well established case law. Medicare does not follow state law. It seeks reimbursement for medical payments for which it has a responsibility to pay arising out of the items or service. *See* 42 U.S.C. § 1395y (b)(2)(B)(ii).

In *Salveson v. Sebelius*, 2012 U.S. Dist. LEXIS 66293 (D.S.D. 2012) the plaintiff settled a medical malpractice case, and paid the Medicare lien. She then sought a ruling that she had overpaid the entire amount. She claimed that some medical payments were unrelated to the malpractice. She further alleged that Medicare could not apportion between the malpractice generated Medicare payments, and the other non-malpractice related Medicare payments. The defendant's insurers therefore were not "responsible" to make such unrelated payments under the MSP and no lien could attach. *Id.* at * 16, 19-22.

The District Court rejected the plaintiff's argument. It held that Medicare was entitled to the full lien amount. *Id.* at 23-26. This was so even though the plaintiff had alleged that she entered the hospital on December 20, 2004 and that the malpractice did not begin until December 30, 2004. The key, according to the District Court, were the 2003 amendments to the MSPA. *Id.* at 24-25. Those amendments defined a primary plan (i.e. insurer's) "responsibility"' under the MSPA. A Medicare lien arose if the primary plan had responsibility to make a payment with respect to any item or service paid by Medicare. Under the 2003 amendments, "responsibility" was demonstrated by a liability insurer issuing a settlement payment to a Medicare beneficiary (i.e. plaintiff) conditioned on that beneficiary's release of payment for items or services included in a claim against the defendant insured. *Id.* at 25-26.

Salveson relied heavily on *Hadden v. United States,* 661 F.3d 298, 302 (6th Cir. 2011). The Sixth Circuit in that case held that the scope of the plaintiff's claims against the defendant defined the scope of repayment for Medicare's conditional payment for medical items and services. To put it simply, if the plaintiff claimed that the defendant was responsible for medical bills associated with the injury, then Medicare could recoup those amounts. *Hadden*, 661 F.3d at 302-303.

Both decisions reject any *Ahlborn* style proportionality approach in Medicare recovery of conditional payments. Another case in agreement is *Mason v. Sebelius*, 2012 WL 3133801, at * 3 (D. N.J. 2012).

h. Confidentiality Orders

Portions of settlements involving confidentiality orders have been taxed as not representing damages received on account of personal injuries or sickness under 26 U.S.C. § 104(a)(2). *See Amos v. Commissioner*, 86 T.C.M. (CCH) 663 (Tax Ct. 2003).

In *Amos*, the plaintiff settled his case for assault against Dennis Rodman for $200,000. The Tax Court held that $80,000 of that settlement was paid for the confidentiality agreement. It held that amount taxable because the plaintiff did not receive the $80,000 for personal injury or sickness under 26 U.S.C. § 104(a)(2). *Id.* at *15-16. The Court found that Dennis Rodman paid the remaining $120,000 for personal injury. It therefore excluded that amount from taxable income.

i. Indemnity by plaintiff's counsel is not appropriate

A plaintiff's counsel may not agree to hold defendant harmless from claims arising out of defendant's payment of settlement consideration. Defendant's counsel may not ask plaintiff's counsel to provide such financial assistance. It violates ethical rules for the defendant's attorney to request such indemnity, and for the plaintiff's counsel to agree to such indemnity. NYC Bar Ass'n Comm. on Professional and Judicial Ethics, Formal Op. 2010-3 (2010)(Settlement agreements requiring the Financial Assistance of Counsel); Florida Bar Staff Informal Op. 30310 (2011)(finding that a plaintiff's counsel could not indemnify a defendant for payment by the client of a Medicare lien); Ohio Bd. Commissioners on Grievances and Discipline Informal Op. 2011-1 (2011); State Bar of Arizona Formal Op. 03-05 (2003); Ill. State Bar Ass'n Advisory Op. 06-01 (2006).

This prohibition includes a defendant's insurance carrier, the defendant's attorney, and the defendant. *See* Indiana State Bar Ass'n Advisory Op.1 (2005); Kansas Bar Ass'n Op. 01-5 (2001); Missouri Sup. Ct Adv. Comm. Formal Op. 125 (2008); North Carolina State Bar Ass'n Op. RPC 228 (1996); South Carolina Bar Op. 08-07 (2008); Tennessee Sup. Ct. Board Prof. Responsibility Formal Op. 2010 F-154 (2010); State Bar of Wisconsin O. E-87-11.

3. How to reach a binding settlement when Medicare is involved

Studying the above cases highlights areas where attention can be focused in future cases. In some of the studied cases:

a. Neither party knew the Medicare lien amount and therefore they settled the case based on faulty assumptions of overall case value, resulting in the settlement breaking apart when the full lien amounts became known;

b. The parties simply did not consider the Medicare lien and therefore material terms of the settlement remained open and unresolved;

c. The parties discussed the Medicare lien and agreed on some issues but not enough of them;

d. Before settlement, the parties did not speak to their stakeholders such as the insurers, the injured person, and the state Medicare compliance arm, and therefore did not know the additional terms that these stakeholders required.

e. The parties put an ambiguous settlement on the record.

To avoid these issues in future cases, we suggest: First, the earlier the parties focus on liens, particularly Medicare liens, the better. Second, the plaintiff and the defendant have similar interests in resolving the Medicare lien. Both parties therefore should possess equal information required to manage the Medicare liens. Third, given the unsettled law on Medicare related settlements, the parties should fully discuss all Medicare related issues before they declare the case settled. This includes exchanging and agreeing to all final settlement documents, attaching those documents as exhibits to the settlement transcript, and confirming that counsel have conferred with their principals (clients, insurers and any related Medicare compliance entities) and all Medicare terms and conditions have been fully discussed, agreed to, and incorporated into the agreement to be placed on the record.

If unaddressed issues remain, the court might give the parties a few days to negotiate the outstanding issues, and then order the parties back to court, to place a complete settlement on the record. We suggest below questions and practices at each stage of a personal injury case to focus the parties on Medicare lien issues.

a. The preliminary conference – questions for the parties

i. Who is paying for the plaintiff's medical bills?

ii. Is the plaintiff on Medicare, or is likely to go on Medicare?

iii. Has the plaintiff's attorney notified Medicare of the case and requested a conditional payment letter?

iv. Has the plaintiff's attorney secured the medical bills showing the amount of medical treatment and who paid for it?

vi. Do the defense attorney and the insurer/state have the conditional payment letter and the most up to date medical bills, and authorizations to get Medicare records?

vii. If the conditional payment letter has been sent and a response received from Medicare, has Medicare correctly identified only related conditional payments with correct dates of treatment? If not, has the plaintiff's attorney timely sent back a response to Medicare to correct the conditional payment letter ?

b. Following up on the preliminary conference

i. If a plaintiff's counsel does not know if Medicare is conditionally paying medical bills, the amount of Medicare payments, the conditional payment amounts as set by Medicare, or whether the plaintiff has notified Medicare of the litigation, request a follow-up status report from her on these issues.

ii. Confirm that authorizations for medical records, bills, and Medicare payments have been, or will be served in a short time, that if served defense counsel has sent those out, and if defense counsel has served a SCHIP demand, that the plaintiff has responded.

iii. Consider whether the parties should file a status report before the filing of the note of issue confirming that all medical records, bills and Medicare authorizations have been exchanged, and bringing to the Court's attention any unresolved issues relating to the Medicare lien (or any other lien).

c. The early pre-trial conference

1. Status of Medicare lien – amount, receipt of conditional payment letter, contested Medicare payments, and how current is information;

2. Has the plaintiff's Medicare status changed?

3. Do the parties know enough to evaluate the Medicare lien? What else is needed? Do the parties agree on the estimated amount of the Medicare lien?

4. Are Medicare payments continuing past the settlement date? Does the plaintiff need an MSA? How are the parties considering and protecting Medicare's interests to recoup future conditional payments ?

d. Final negotiations and settlement

a. The settlement should bind the parties under CPLR 2104, preferably in open court so that the parties and the court can resolve issues;

b. Do the parties agree on the estimated Medicare lien, before procurement costs, and is that estimate current and accurate?

c. Has the plaintiff/claimant agreed to pay the Medicare lien out of the settlement funds and indemnify the defendant on the Medicare lien?

d. Have the parties exchanged all final settling documents that they expect the opposing side to execute, have they been reviewed, and are they acceptable to all parties? And does the defense attorney know whether his insurer or the state's Medicare compliance arm require more documents or terms than have been discussed at the settlement conference? Examples include confidentiality agreements, and settlement agreements other than a stipulation of discontinuance and release.

e. Are there any additional documents that the defendant expects or is requesting that the plaintiff/claimant sign related to Medicare such as a W-9, authorization for HICN and SSN, and proof that plaintiff is not on Medicare at the time of settlement? Has this been discussed with the plaintiff's counsel?

f. Is payment of some or all of the settlement funds going to be held back until defendant receives a final demand letter from Medicare? Will the Medicare funds be escrowed, and if so, who will hold the escrow?

g. Will or will not Medicare be a payee on the settlement check? How many settlement checks will issue and to who?

h. Will the settlement funds issue according to the time frames of CPLR 5003-a? Is the defendant requiring that payment be delayed until it receives a Medicare final demand letter ?

i. What happens if the plaintiff controverts the Medicare final demand letter?

j. Will there be an MSA, and how have Medicare's interests been considered and protected? If no MSA, how will the parties document that they have considered and protected Medicare's interest in recouping future conditional payments.

k. Is a confidentiality agreement part of the settlement, or not? Does the plaintiff understand the possible tax ramifications?

l. Do the attorneys appearing at the time of final settlement have the full authority and knowledge to bind their principals on Medicare issues such as what closing or settlement agreements will be required by the insurer or the state's Medicare compliance arm? If not, what needs to be done to get the right parties at the table, or provide counsel with additional authority to resolve outstanding issues.

CONCLUSION

No one wants to upset a settlement. However, raising these issues early in the negotiations -- before the parties agree on a settlement amount -- may save that settlement by ensuring a true meeting of the minds.

A well vetted, workable settlement resolving Medicare issues also makes sense given the unsettled and fluid law in this area.

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