Medicare Liens in Personal Injury Cases

Presented By:

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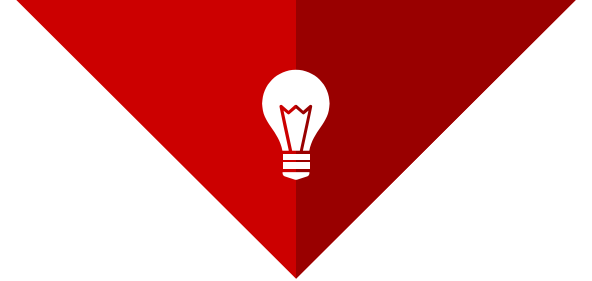

Medicare Liens in Personal Injury Cases

Todd D. Powell
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Why is this important to me?

- Medicare liens matter to you if:
  - You handle personal injury cases
  - You're ever in a position to refer personal injury cases
  - You discuss other legal issues facing clients
  - You represent or advise insurance companies or healthcare providers
  - You do NOT want to be liable to your client, the insurance company, and the U.S. Government for not ensuring Medicare's subrogation right is protected

Medicare as Secondary Payer

- Medicare Secondary Payer Act - *See* 42 USC 1395y- 1980
- In certain circumstances, the MSPA makes Medicare the "secondary payer" in relation to certain other sources, which are considered "primary payers." *Meek- Horton v. Trover Solutions, Inc.,* 915 F. Supp. 2d 486, 488 (2013).
- Medicare does not pay for items or services to the extent the payment has been, or may reasonably be expected to be made through a liability insurer, no- fault insurer or workers' compensation carrier
- Medicare beneficiary (Plaintiff) is required to reimburse Medicare for "conditional payments" to be repaid from settlement, judgment, award or other payment received by beneficiary

Authorizing Legislation and Implementing Regulation

42 USC 1395y(b)

Exclusions from coverage and Medicare as secondary payer

- Prohibition on payments to be made from no-fault, liability or workers' compensation carrier
- Authorizes conditional payment of such amounts

42 CFR 411.20(a)(2)

Medicare is precluded from paying for services to the extent payment is made under:

- Workers' compensation
- Liability insurance
- No-fault insurance

Authorizing Legislation and Implementing Regulation

- If Medicare makes payment, it has the right to reimbursement
- Can file action against anyone responsible. *See* 42 CFR 411.24
- Take special note of subsections (g)-(i)

Some Case Law Interpreting these Provisions

- Government has an independent right of recovery against any entity, including a beneficiary or an attorney, which has received a third - party payment. *U.S. v. Sosnowski,*822 F. Supp. 570 (W.D. Wis. 1993)
- This includes liability insurance carriers. If Medicare is not reimbursed within 60 days of the settlement payment, the primary payer must reimburse Medicare even though it has already reimbursed the beneficiary or other party. *See*42 CFR 411.24(i)(1) *and Humana Med. Plan, Inc. v. W. Heritage Ins. Co.,* 832 F.3d 1229, 1239 (11th cir, 2016)

Responsible Entities

Centers for Medicare & Medicaid Services (CMS)

- Federal agency which administers the nation's major healthcare programs such as Medicare & Medicaid
- Oversees many offices including the BCRC

Benefits Coordination & Recovery Center (BCRC)

Data Collections

- Collects information from multiple sources to research MSP situation

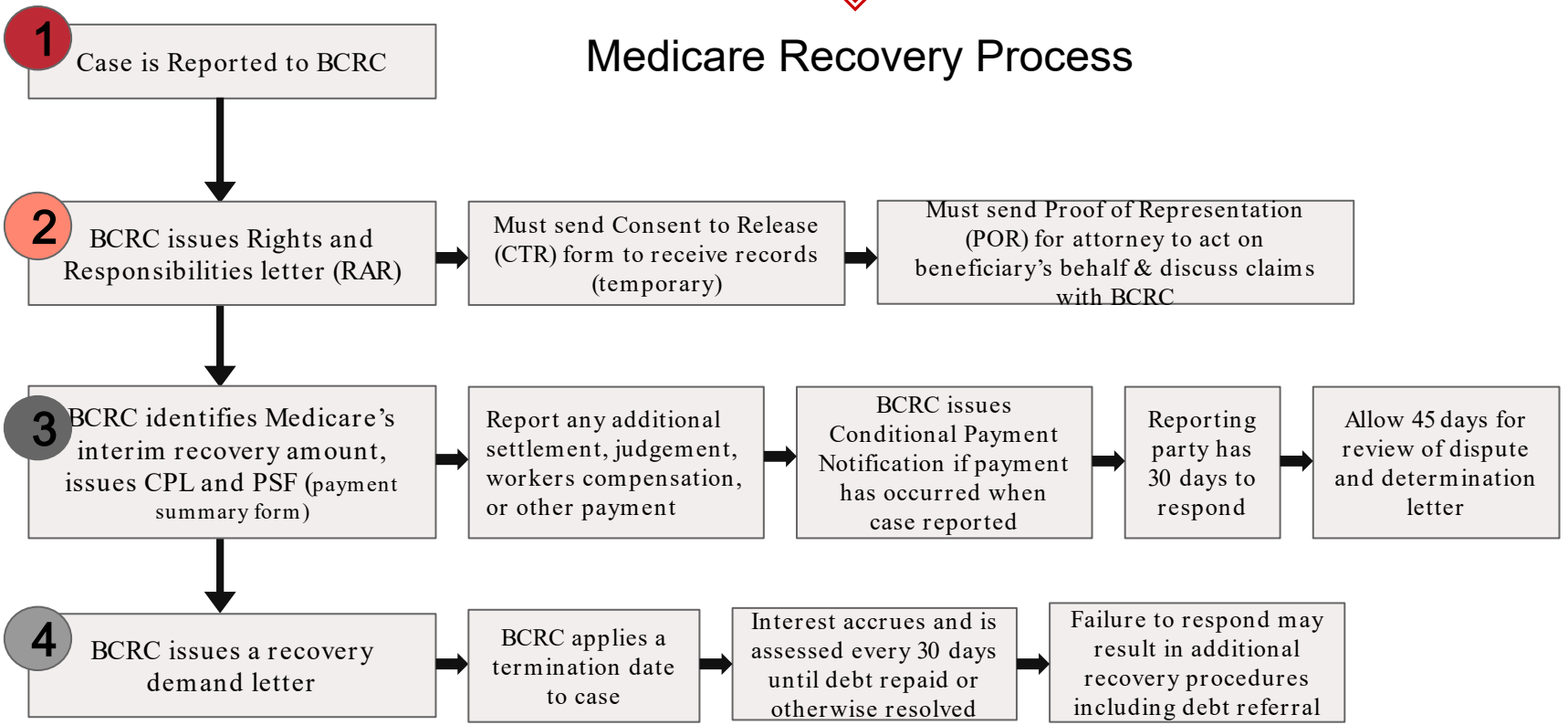
Recovery Center

- Responsible for identifying & recovering Medicare payments that should have been paid by another entity as the primary payer

Key Terms

- **BCRC - Benefits Coordination & Recovery Center** - Responsible for ensuring Medicare is reimbursed for conditional payments
- **NGHP - Non-Group Health Plan** - Encompasses no-fault, liability and workers' compensation carriers
- **RAR - Rights and Responsibilities Letter** - Issued by BCRC after receipt of notice of claim
- **CPL - Conditional Payment Letter** - Issued within 65 days of RAR itemizing *related* conditional payments
- **WCMSA - Workers' Compensation Medicare Set-Aside Arrangement** - Allocation of portion of work comp settlement for future medical expenses

Medicare Recovery Process



1 Reporting Case to the BCRC

- Beneficiary (or attorney) ultimately responsible
- NGHP entity: liability, no-fault, workers' compensation carrier
- BCRC harvests data from claims processors, workers compensation entities, etc.
- *See* 42 USC 1395y(b)(8)
- Civil penalty of $1,000 for each day of noncompliance against applicable plan

2 BCRC Issues Rights and Responsibilities Letter (RAR)

- Consent to release form **(CTR)** Required for attorney to receive copy of letter and to receive certain information from the BCRC - Lasts for limited time only
- Proof of Representation **(POR)** required if attorney acts on behalf of beneficiary - Must have in order for attorney to communicate with BCRC on behalf of beneficiary
- Example RAR Letter

3 BCRC identifies Medicare's interim recovery amount, issues CPL and PSF (Payment Summary Form)

- BCRC identifies claims Medicare has paid conditionally *that are related to the case*, based upon the type of incident, illness or injury alleged
- Medicare's recovery case runs from date of incident through date of settlement/award
- CPL explains how to dispute unrelated claims and includes BCRC's best estimate of reimbursement amount
- Current information can also be obtained through Medicare Secondary Payer Recovery Portal (MSPRP)

4 BCRC issues a Recovery Demand Letter

- After BCRC advised of settlement, a final demand is issued
- Settlement notification can be done using Final Settlement Detail document which informs BCRC of date of settlement, amount and fees and procurement costs
- Notifies beneficiary of demand amount and information on applicable waiver and administrative appeal rights

Assessment of Interest and Failure to Respond

- Interest accrues from date of demand letter, but not assessed unless reimbursement not made within time demanded - 60 days
- Interest accrues even if appeal or waiver is sought
- Failure to respond within specified time may result in referral to the Department of Justice for legal action
- Treasury Department for collection actions

Right to Appeal

- Only the person/entity that received demand may appeal
- Letter of appeal along with supporting documentation
- Can appeal either amount or existence of debt, or both

Right to Appeal (continued)

- Federal law permits a party to appeal Medicare's demand for reimbursement of a conditional payment through an administrative review process. *See* 42 U.S.C. § 405(g).
- The final decision for the Secretary of the Department of Health and Human Services is made by the Medicare Appeals Council (MAC). 42 C.F.R. §§ 405.1100, 405.1108(a).
- A beneficiary may seek review of a MAC decision in federal court. *Heckler v. Ringer*, 466 U.S. 602, 607 (1984).

Requirement to Exhaust Administrative Remedies

- Plaintiff's failure to exhaust administrative remedies leads to lack of subject matter jurisdiction if plaintiff pursues suit before receiving a final decision from Medicare
- *Wilson ex vel. Estate of Wilson v. United States* 405 F.3d 1002, 1013 (Fed. civ 2005)

Waiver Request

- For subrogation to be waived, requesting party must show:
  - The beneficiary is not at fault for Medicare making conditional payments
  - Paying back money would cause financial hardship or otherwise be unfair
- Waiver and appeal can be done at same time
- Example of Request for Waiver of Overpayment Recovery Form (SSA-632-BK)
- Example of Request for Change in Overpayment Recovery Rate Form (SSA-634)

Formulas for Reducing Lien for Procurement Costs

42 CFR 411.37

- When the settlement or award is greater than Medicare conditional payments the lien is reduced the product of procurement costs divided by settlement amount multiplied by demand
- Example: Settlement of $100,000 and Conditional Payments of $25,000. Attorney fees and expense of $40,000
- 40% or .40 x 25,000=Repayment amount of $15,000
- When the settlement or award is less than conditional payments, the repayment amount is total settlement minus procurement costs
- Example: Settlement of $20,000 and conditional payments of $25,000. Procurement costs of $8,000
- Repayment is $12,000

Workers' Compensation Medicare Set-Asides (WCMSA)

- Financial arrangement that allocates a portion of WC settlement to pay for future medical expenses
- Funds in a Set-Aside must be depleted before Medicare will pay for treatment related to the injury
- Amount of the WCMSA is determined on a case-by-case basis

Workers' Compensation Medicare Set-Asides (ctd)

- While not required, Medicare will review Set-Asides if:
  - The claimant is a Medicare beneficiary and the total settlement amount is greater than $25,000; or
  - The claimant has a reasonable expectation of Medicare enrollment within 30 months of settlement date and the anticipated settlement amount for future medical/ lost wages may be more than $250,000
- WCMSA may be funded by lump sum or may be structured

Workers' Compensation Medicare Set-Asides (WCMSA)

- If a lump-sum compensation award stipulates that the amount paid 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 payment. *See* 42 CFR 411.46(a)
- *See also Rood v. New York State Teamsters Conference Pension and Retirement Fund et al.* 39 F. supp. 3d. 241, 245 (N.D.N.Y. 2014)
- Goal of a WCMSA is to estimate the total cost that will be incurred for all medical expenses otherwise reimbursable by Medicare for work-related conditions during the course of the claimant's life and to set aside sufficient funds from the award to cover that cost

Set-Asides in Liability Cases

- Currently*, no requirement to establish a Set-Aside or seek CMS approval (except in extreme circumstances), but...
- Prudence dictates considering Medicare's interest in a third-party liability action where there will likely be the need for future medical treatment after the date of settlement/award
- CAUTION: CMS is authorized to bring an action for **double damages** "against any entity" that has received any portion of a third party payment if those funds, rather than Medicare, should have paid for the injury-related medical expense. *See* 42 U.S.C 1395y(b)(2)(B)(iii) *on the next slide.*

(iii) Action by United States

In order to recover payment made under this subchapter for an item or service, the United States may bring an action against 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 payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity. The United States may not recover from a third-party administrator under this clause in cases where the third-party administrator would not be able to recover the amount at issue from the employer or group health plan and is not employed by or under contract with the employer or group health plan at the time the action for recovery is initiated by the United States or for whom it provides administrative services due to the insolvency or bankruptcy of the employer or plan. An action may not be brought by the United States under this clause with respect to payment owed unless the complaint is filed not later than 3 years after the date of the receipt of notice of a settlement, judgment, award, or other payment made pursuant to paragraph (8) relating to such payment owed.

Web Portal


CMS
Medicare Secondary Payer Recovery Portal
Skip Navigation
About This Site
CMS Links
How To...
Reference Materials
Contact Us
Welcome to the MSPRP
The Medicare Secondary Payer Recovery Portal provides a quick and efficient way to request case information and provide information to assist in resolving Medicare's recovery claim. With the use of this portal, you may submit a valid authorization, request an update to the conditional payment amount, submit settlement information and dispute claims.
For information about the availability of auxiliary aids and services, please visit:
http://www.medicare.gov/about-us/nondiscrimination/nondiscrimination-notice.html
MSPRP Message
Quarterly updates have been made to the MSPRP. An updated MSPRP User Guide is now available via the Reference Materials link above. Please refer to Chapter 1 for a summary of updates.
Getting Started
If you are a Medicare Beneficiary and would like to use the MSPRP to request case information, please login to your MyMedicare account by visiting the MyMedicare.gov website at https://mymedicare.gov/.
For more information, refer to How To Get Started under the How To menu option. To begin the registration process, click the 'New Registration' button.
STEP 1
New Registration
STEP 2
Account Setup
(Account ID and PIN required)
Sign in to your account
User Name:
Forgot User Name
Password:
Forgot Password
Login
Clear
Privacy Policy | User Agreement | Adobe Acrobat

Practice Tips

- Wait… wait… wait… Medicare generally responds to requests within 30-45 days
- **BUT** CMS will answer phone calls
- When in doubt, recognize Medicare's interest and attempt to protect it

Thanks!

Any questions?

42 C.F.R. § 405.1100

(a) The appellant or any other party to an ALJ's or attorney adjudicator's decision or dismissal may request that the Council review the ALJ's or attorney adjudicator's decision or dismissal.

(b) Under circumstances set forth in §§ 405.1016 and 405.1108, the appellant may request that a case be escalated to the Council for a decision even if the ALJ or attorney adjudicator has not issued a decision, dismissal, or remand in his or her case.

(c) When the Council reviews an ALJ's or attorney adjudicator's decision, it undertakes a de novo review. The Council issues a final decision or dismissal order or remands a case to the ALJ or attorney adjudicator within 90 calendar days of receipt of the appellant's request for review, unless the 90 calendar day period is extended as provided in this subpart.

(d) When deciding an appeal that was escalated from the OMHA level to the Council, the Council will issue a final decision or dismissal order or remand the case to the OMHA Chief ALJ within 180 calendar days of receipt of the appellant's request for escalation, unless the 180 calendar day period is extended as provided in this subpart.

[82 FR 5122, Jan. 17, 2017]

42 CFR § 405.1108 - Council actions when request for review or escalation is filed.

§ 405.1108 Council actions when request for review or escalation is filed.

(a) Except as specified in paragraphs (c) and (d) of this section, when a party requests that the Council review an ALJ's or attorney adjudicator's decision, the Council will review the ALJ's or attorney adjudicator's decision *de novo.* The party requesting review does not have a right to a hearing before the Council. The Council will consider all of the evidence in the administrative record. Upon completion of its review, the Council may adopt, modify, or reverse the ALJ's or attorney adjudicator's decision or remand the case to an ALJ or attorney adjudicator for further proceedings.

(b) When a party requests that the Council review an ALJ's or attorney adjudicator's dismissal of a request for a hearing, the Council may deny review or vacate the dismissal and remand the case to the ALJ or attorney adjudicator for further proceedings.

(c) The Council will dismiss a request for review when the party requesting review does not have a right to a review by the Council, or will dismiss the request for a hearing for any reason that the ALJ or attorney adjudicator could have dismissed the request for hearing.

(d) When an appellant requests escalation of a case from the OMHA level to the Council, the Council may take any of the following actions:

(1) Issue a decision based on the record constructed at the QIC and any additional evidence, including oral testimony, entered in the record by the ALJ or attorney adjudicator before the case was escalated.

(2) Conduct any additional proceedings, including a hearing, that the Council determines are necessary to issue a decision.

(3) Remand the case to OMHA for further proceedings, including a hearing.

(4) Dismiss the request for Council review because the appellant does not have the right to escalate the appeal.

(5) Dismiss the request for a hearing for any reason that the ALJ or attorney adjudicator could have dismissed the request.

[70 FR 11472, Mar. 8, 2005, as amended at 82 FR 5122, Jan. 17, 2017]

42 CFR § 411.20 - Basis and scope.

§ 411.20 Basis and scope.

(a) ***Statutory basis.***

(1) Section 1862(b)(2)(A)(i) of the Act precludes Medicare payment for services to the extent that payment has been made or can reasonably be expected to be made under a group health plan with respect to -

(i) A beneficiary entitled to Medicare on the basis of ESRD during the first 18 months of that entitlement;

(ii) A beneficiary who is age 65 or over, entitled to Medicare on the basis of age, and covered under the plan by virtue of his or her current employment status or the current employment status of a spouse of any age; or

(iii) A beneficiary who is under age 65, entitled to Medicare on the basis of disability, and covered under the plan by virtue of his or her current employment status or the current employment status of a family member.

(2) Section 1862(b)(2)(A)(ii) of the Act precludes Medicare payment for services to the extent that payment has been made or can reasonably be expected to be made under any of the following:

(i) Workers' compensation.

(ii) Liability insurance.

(iii) No-fault insurance.

(b) ***Scope.*** This subpart sets forth general rules that apply to the types of insurance specified in paragraph (a) of this section. Other general rules that apply to group health plans are set forth in subpart E of this part.

[60 FR 45361, Aug. 31, 1995, as amended at 71 FR 9470, Feb. 24, 2006]

42 CFR § 411.24 - Recovery of conditional payments.

CFR

§ 411.24 Recovery of conditional payments.

If a Medicare conditional payment is made, the following rules apply:

(a) ***Release of information.*** The filing of a Medicare claim by on or behalf of the beneficiary constitutes an express authorization for any entity, including State Medicaid and workers' compensation agencies, and data depositories, that possesses information pertinent to the Medicare claim to release that information to CMS. This information will be used only for Medicare claims processing and for coordination of benefits purposes.

(b) ***Right to initiate recovery.*** CMS may initiate recovery as soon as it learns that payment has been made or could be made under workers' compensation, any liability or no-fault insurance, or an employer group health plan.

(c) ***Amount of recovery.***

(1) If it is not necessary for CMS to take legal action to recover, CMS recovers the lesser of the following:

(i) The amount of the Medicare primary payment.

(ii) The full primary payment amount that the primary payer is obligated to pay under this part without regard to any payment, other than a full primary payment that the primary payer has paid or will make, or, in the case of a primary payment beneficiary, the amount of the primary payment.

(2) If it is necessary for CMS to take legal action to recover from the primary payer, CMS may recover twice the amount specified in paragraph (c)(1)(i) of this section.

(d) ***Methods of recovery.*** CMS may recover by direct collection or by offset against any monies CMS owes the entity responsible for refunding the conditional payment.

(e) ***Recovery from primary payers.*** CMS has a direct right of action to recover from any primary payer.

(f) ***Claims filing requirements.***

(1) CMS may recover without regard to any claims filing requirements that the insurance program or plan imposes on the beneficiary or other claimant such as a time limit for filing a claim or a time limit for notifying the plan or program about the need for or receipt of services.

(2) However, CMS will not recover its payment for particular services in the face of a claims filing requirement unless it has filed a claim for recovery by the end of the year following the year in which the Medicare intermediary or carrier that paid the claim has notice that the third party is a primary plan to Medicare for those particular services. (A notice received during the last three months of a year is considered received during the following year.)

(g) ***Recovery from parties that receive primary payments.*** CMS has a right of action to recover its payments from any entity, including a beneficiary, provider, supplier, physician, attorney, State agency or private insurer that has received a primary payment.

(h) ***Reimbursement to Medicare.*** If the beneficiary or other party receives a primary payment, the beneficiary or other party must reimburse Medicare within 60 days.

(i) ***Special rules.***

(1) In the case of liability insurance settlements and disputed claims under employer group health plans, workers' compensation insurance or plan, and no-fault insurance, the following rule applies: If Medicare is not reimbursed as required by paragraph (h) of this section, the primary payer must reimburse Medicare even though it has already reimbursed the beneficiary or other party.

(2) The provisions of paragraph (i)(1) of this section also apply if a primary payer makes its payment to an entity other than Medicare when it is, or should be, aware that Medicare has made a conditional primary payment.

(3) In situations that involve procurement costs, the rule of § 411.37(b) applies.

(j) ***Recovery against Medicaid agency.*** If a primary payment is made to a State Medicaid agency and that agency does not reimburse Medicare, CMS may reduce any Federal funds due the Medicaid agency (under title XIX of the Act) by an amount equal to the Medicare payment or the primary payment, whichever is less.

(k) ***Recovery against Medicare contractor.*** If a Medicare contractor, including an intermediary or carrier, also insures, underwrites, or administers as a third party administrator, a program or plan that is primary to Medicare, and does not reimburse Medicare, CMS may offset the amount owed against any funds due the intermediary or carrier under title XVIII of the Act or due the contractor under the contract.

(l) ***Recovery when there is failure to file a proper claim*** -

(1) ***Basic rule.*** If Medicare makes a conditional payment with respect to services for which the beneficiary or provider or supplier has not filed a proper claim with a primary payer, and Medicare is unable to recover from the primary payer, Medicare may recover from the beneficiary or provider or supplier that was responsible for the failure to file a proper claim.

(2) ***Exceptions.***

(i) This rule does not apply in the case of liability insurance nor when failure to file a proper claim is due to mental or physical incapacity of the beneficiary.

(ii) CMS will not recover from providers or suppliers that are in compliance with the requirements of § 489.20 of this chapter and can show that the reason they failed to file a proper claim is that the beneficiary, or someone acting on his or her behalf, failed to give, or gave erroneous, information regarding coverage that is primary to Medicare.

(m) ***Interest charges.***

(1) With respect to recovery of payments for items and services furnished before October 31, 1994, CMS charges interest, exercising common law authority in accordance with 45 CFR 30.13, consistent with the Federal Claims Collection Act (31 U.S.C. 3711).

(2) In addition to its common law authority with respect to recovery of payments for items and services furnished on or after October 31, 1994, CMS charges interest in accordance with section 1862(b)(2)(B)(i) of the Act. Under that provision -

(i) CMS may charge interest if reimbursement is not made to the appropriate trust fund before the expiration of the 60-day period that begins on the date on which notice or other information is received by CMS that payment has been or could be made under a primary plan;

(ii) Interest may accrue from the date when that notice or other information is received by CMS, is charged until reimbursement is made, and is applied for full 30-day periods; and

(iii) The rate of interest is that provided at § 405.378(d) of this chapter.

[54 FR 41734, Oct. 11, 1989, as amended at 55 FR 1820, Jan. 19, 1990; 60 FR 45361, 45362, Aug. 31, 1995; 69 FR 45607, July 30, 2004; 71 FR 9470, Feb. 24, 2006]

42 CFR § 411.46 - Lump-sum payments.

§ 411.46 Lump-sum payments.

(a) ***Lump-sum commutation of future benefits.*** If a lump-sum compensation award stipulates that the amount paid 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 payment.

(i) shall share information on entitlement under part A and enrollment under part B under this subchapter with entities, plan administrators, and fiduciaries described in subparagraph (A);

(ii) may share the entitlement and enrollment information described in clause (i) with entities and persons not described in such clause; and

(iii) may share information collected under this paragraph as necessary for purposes of the proper coordination of benefits.

(D) Implementation

Notwithstanding any other provision of law, the Secretary may implement this paragraph by program instruction or otherwise.

(8) Required submission of information by or on behalf of liability insurance (including self-insurance), no fault insurance, and workers' compensation laws and plans

(A) Requirement

On and after the first day of the first calendar quarter beginning after the date that is 18 months after December 29, 2007, an applicable plan shall—

(i) determine whether a claimant (including an individual whose claim is unresolved) is entitled to benefits under the program under this subchapter on any basis; and

(ii) if the claimant is determined to be so entitled, submit the information described in subparagraph (B) with respect to the claimant to the Secretary in a form and manner (including frequency) specified by the Secretary.

(B) Required information

The information described in this subparagraph is—

(i) the identity of the claimant for which the determination under subparagraph (A) was made; and

(ii) such other information as the Secretary shall specify in order to enable the Secretary to make an appropriate determination concerning coordination of benefits, including any applicable recovery claim.

Not later than 18 months after January 10, 2013, the Secretary shall modify the reporting requirements under this paragraph so that an applicable plan in complying with such requirements is permitted but not required to access or report to the Secretary beneficiary social security account numbers or health identification claim numbers, except that the deadline for such modification shall be extended by one or more periods (specified by the Secretary) of up to 1 year each if the Secretary notifies the committees of jurisdiction of the House of Representatives and of the Senate that the prior deadline for such modification, without such extension, threatens patient privacy or the integrity of the secondary payer program under this subsection. Any such deadline extension notice shall include information on the progress being made in implementing such modification and the anticipated implementation date for such modification.

(C) Timing

Information shall be submitted under subparagraph (A)(ii) within a time specified by the Secretary after the claim is resolved through a settlement, judgment, award, or other payment (regardless of whether or not there is a determination or admission of liability).

(D) Claimant

For purposes of subparagraph (A), the term "claimant" includes—

(i) an individual filing a claim directly against the applicable plan; and

(ii) an individual filing a claim against an individual or entity insured or covered by the applicable plan.

(E) Enforcement

(i) In general

An applicable plan that fails to comply with the requirements under subparagraph (A) with respect to any claimant may be subject to a civil money penalty of up to $1,000 for each day of noncompliance with respect to each claimant. The provisions of subsections (e) and (k) of section 1320a–7a of this title shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title. A civil money penalty under this clause shall be in addition to any other penalties prescribed by law and in addition to any Medicare secondary payer claim under this subchapter with respect to an individual.

(ii) Deposit of amounts collected

Any amounts collected pursuant to clause (i) shall be deposited in the Federal Hospital Insurance Trust Fund.

(F) Applicable plan

In this paragraph, the term "applicable plan" means the following laws, plans, or other arrangements, including the fiduciary or administrator for such law, plan, or arrangement:

(i) Liability insurance (including self-insurance).

(ii) No fault insurance.

(iii) Workers' compensation laws or plans.

(G) Sharing of information

(i) In general

The Secretary may share information collected under this paragraph as necessary for purposes of the proper coordination of benefits.

(ii) Specified information

In responding to any query made on or after the date that is 1 year after December 11, 2020, from an applicable plan related to a determination described in subparagraph (A)(i), the Secretary, notwithstanding any other provision of law, shall provide to such applicable plan—

(I) whether a claimant subject to the query is, or during the preceding 3-year period has been, entitled to benefits under the program under this subchapter on any basis; and

(II) to the extent applicable, the plan name and address of any Medicare Advantage plan under part C and any prescription drug plan under part D in which the claimant is enrolled or has been enrolled during such period.

(H) Implementation

Notwithstanding any other provision of law, the Secretary may implement this paragraph by program instruction or otherwise.

(I) Regulations

Not later than 60 days after January 10, 2013, the Secretary shall publish a notice in the Federal Register soliciting proposals, which will be accepted during a 60-day period, for the specification of practices for which sanctions will and will not be imposed under subparagraph (E), including not imposing sanctions for good faith efforts to identify a beneficiary pursuant to this paragraph under an applicable entity responsible for reporting information. After considering the proposals so submitted, the Secretary, in consultation with the Attorney General, shall publish in the Federal Register, including a 60-day period for comment, proposed specified practices for which such sanctions will and will not be imposed. After considering any public comments received during such period, the Secretary shall issue final rules specifying such practices.

42 U.S.C. § 405

Section 405 - Evidence, procedure, and certification for payments

(g) Judicial review

Any individual, after any final decision of the Commissioner of Social Security made after a hearing to which he was a party, irrespective of the amount in controversy, may obtain a review of such decision by a civil action commenced within sixty days after the mailing to him of notice of such decision or within such further time as the Commissioner of Social Security may allow. Such action shall be brought in the district court of the United States for the judicial district in which the plaintiff resides, or has his principal place of business, or, if he does not reside or have his principal place of business within any such judicial district, in the United States District Court for the District of Columbia. As part of the Commissioner's answer the Commissioner of Social Security shall file a certified copy of the transcript of the record including the evidence upon which the findings and decision complained of are based. The court shall have power to enter, upon the pleadings and transcript of the record, a judgment affirming, modifying, or reversing the decision of the Commissioner of Social Security, with or without remanding the cause for a rehearing. The findings of the Commissioner of Social Security as to any fact, if supported by substantial evidence, shall be conclusive, and where a claim has been denied by the Commissioner of Social Security or a decision is rendered under subsection (b) of this section which is adverse to an individual who was a party to the hearing before the Commissioner of Social Security, because of failure of the claimant or such individual to submit proof in conformity with any regulation prescribed under subsection (a) of this section, the court shall review only the question of conformity with such regulations and the validity of such regulations. The court may, on motion of the Commissioner of Social Security made for good cause shown before the Commissioner files the Commissioner's answer, remand the case to the Commissioner of Social Security for further action by the Commissioner of Social Security, and it may at any time order additional evidence to be taken before the Commissioner of Social Security, but only upon a showing that there is new evidence which

is material and that there is good cause for the failure to incorporate such evidence into the record in a prior proceeding; and the Commissioner of Social Security shall, after the case is remanded, and after hearing such additional evidence if so ordered, modify or affirm the Commissioner's findings of fact or the Commissioner's decision, or both, and shall file with the court any such additional and modified findings of fact and decision, and, in any case in which the Commissioner has not made a decision fully favorable to the individual, a transcript of the additional record and testimony upon which the Commissioner's action in modifying or affirming was based. Such additional or modified findings of fact and decision shall be reviewable only to the extent provided for review of the original findings of fact and decision. The judgment of the court shall be final except that it shall be subject to review in the same manner as a judgment in other civil actions. Any action instituted in accordance with this subsection shall survive notwithstanding any change in the person occupying the office of Commissioner of Social Security or any vacancy in such office.

42 U.S. Code § 1395y - Exclusions from coverage and medicare as secondary payer

U.S. Code Notes

(b) MEDICARE AS SECONDARY PAYER

(1) REQUIREMENTS OF GROUP HEALTH PLANS

(A) Working aged under group health plans

(i) In general

A group health plan—

(I) may not take into account that an individual (or the individual's spouse) who is covered under the plan by virtue of the individual's current employment status with an employer is entitled to benefits under this subchapter under section 426(a) of this title, and

(II) shall provide that any individual age 65 or older (and the spouse age 65 or older of any individual) who has current employment status with an employer shall be entitled to the same benefits under the plan under the same conditions as any such individual (or spouse) under age 65.

(ii) Exclusion of group health plan of a small employer

Clause (i) shall not apply to a group health plan unless the plan is a plan of, or contributed to by, an employer that has 20 or more employees for each working day in each of 20 or more calendar weeks in the current calendar year or the preceding calendar year.

(iii) Exception for small employers in multiemployer or multiple employer group health plans

Clause (i) also shall not apply with respect to individuals enrolled in a multiemployer or multiple employer group health plan if the coverage of the individuals under the plan is by virtue of current employment status with an employer that does not have 20 or more individuals in current employment status for each working day in each of 20 or more calendar weeks in the current calendar year and the preceding calendar year; except that the exception provided in this clause shall only apply if the plan elects treatment under this clause.

(iv) Exception for individuals with end stage renal disease

Subparagraph (C) shall apply instead of clause (i) to an item or service furnished in a month to an individual if for the month the individual is, or (without regard to entitlement under section 426 of this title) would upon application be, entitled to benefits under section 426–1 of this title.

(v) "Group health plan" defined

In this subparagraph, and subparagraph (C), the term "group health plan" has the meaning given such term in section 5000(b)(1) of the Internal Revenue Code of 1986, without regard to section 5000(d) of such Code.

(B) Disabled individuals in large group health plans

Heckler v. Ringer

U.S.

May 14, 1984

466 U.S. 602 (1984) Copy Citations

CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

No. 82-1772.

Argued February 27, 1984 Decided May 14, 1984

Part A of Title XVIII of the Social Security Act, commonly known as the Medicare Act, provides insurance for the cost of hospital and related posthospital expenses, but precludes reimbursement for services which are not "reasonable and necessary" for the diagnosis or treatment of illness or injury. Judicial review of a claim under the Medicare Act is available only after the Secretary of Health and Human Services renders a "final decision" on the claim in the same manner as is provided in 42 U.S.C. § 405(g) for old-age and disability claims arising under Title II of the Social Security Act. Title 42 U.S.C. § 405(h), to the exclusion of 28 U.S.C. § 1331 (federal-question jurisdiction), makes § 405(g) the sole avenue for judicial review of all "claim[s] arising under" the Medicare Act. Pursuant to her rulemaking authority, the Secretary has provided that a "final decision" is rendered on a Medicare claim only after the claimant has pressed the claim through all designated levels of administrative review. In January 1979, the Secretary issued an administrative instruction to all fiscal intermediaries that no payment is to be made for Medicare claims arising out of a surgical procedure known as bilateral carotid body resection (BCBR) when performed to relieve respiratory distress. Until October 1980, Administrative Law Judges (ALJs), who were not bound by the instruction, consistently ruled in favor of claimants whose BCBR claims had been denied by the intermediaries. The Appeals Council also authorized payment for BCBR Part A expenses in a case involving numerous claimants. On October 28, 1980, the Secretary issued a formal administrative ruling, intended to have a binding effect on the ALJs and the Appeals Council, prohibiting them from ordering Medicare payments for BCBR operations occurring after that date, the Secretary having concluded that the BCBR procedure was not "reasonable and necessary" within the meaning of the Medicare Act.

Without having exhausted their administrative remedies, respondents brought an action in Federal District Court challenging the Secretary's instruction and ruling, and relying on 28 U.S.C. § 1331, 28 U.S.C. § 1361 (mandamus against federal official), and 42 U.S.C. § 405(g) to establish jurisdiction. Respondents are four Medicare claimants for whom BCBR surgery was prescribed to relieve pulmonary problems. Three of the respondents (Holmes, Webster-Zieber, and Vescio) had the surgery before *procedure*

Pursuant to her rulemaking authority, see 42 U.S.C. § 1395hh, 1395ii (incorporating 42 U.S.C. § 405(a)), the Secretary has provided that a "final decision" is rendered on a Medicare claim only after the individual claimant has pressed his claim through all designated levels of administrative review.[2] First, the Medicare Act authorizes the Secretary to enter into contracts with fiscal intermediaries providing that the latter will determine whether a particular medical service is covered by Part A, and if so, the amount of the reimbursable expense for that service. 42 U.S.C. § 1395h; 42 C.F.R. § 405.702 (1983). If the intermediary determines that a particular service is not covered under Part A, the claimant can seek reconsideration by the Health Care Financing Administration (HCFA) in the Department of Health and Human Services. 42 C.F.R. § 405.710 — 42 C.F.R. § 405.716 (1983). If denial of the claim is affirmed after reconsideration and if the claim exceeds $100, the claimant is entitled to a hearing before an administrative law judge (ALJ) in the same manner as is provided for claimants under Title II of the Act. 42
607 U.S.C. § 1395ff(b)(1)(C), (b)(2); 42 C.F.R. § 405.720 (1983). *607 If the claim is again denied, the claimant may seek review in the Appeals Council. 42 C.F.R. § 405.701(c), 405.724 (1983) (incorporating 20 C.F.R. § 404.967 (1983)). If the Appeals Council also denies the claim and if the claim exceeds $1,000, only then may the claimant seek judicial review in federal district court of the "Secretary's final decision." 42 U.S.C. § 1395ff(b)(1)(C), (b)(2).

[2] The Secretary has recognized one exception which is not applicable here. She has provided by regulation that when the facts and her interpretation of the law are not in dispute and when the only factor precluding an award of benefits is a statutory provision which the claimant challenges as unconstitutional, the claimant need not exhaust his administrative remedies beyond the reconsideration stage. 42 C.F.R. § 405.718-405.718e (1983); 20 C.F.R. § 404.923 — 20 C.F.R. § 404.928 (1983).

In January 1979, the Secretary through the HCFA issued an administrative instruction to all fiscal intermediaries, instructing them that no payment is

to be made for Medicare claims arising out of the BCBR surgical procedure when performed to relieve respiratory distress. See 45 Fed. Reg. 71431-71432 (1980) (reproducing the instruction).[3] Relying on information from the Public Health Service and a special Task Force of the National Heart, Lung and Blood Institute of the National Institutes of Health, *id.*, at 71426, the HCFA explained that BCBR has been "shown to lack [the] general acceptance of the professional medical community" and that "controlled clinical studies establishing the safety and effectiveness of this procedure are needed." *Id.*, at 71431. It concluded that the procedure "must be considered investigational" and not "reasonable and necessary" within the meaning of the Medicare Act. *Ibid.*

3 BCBR, first performed in this country in the 1960's, involves the surgical removal of the carotid bodies, structures the size of a rice grain which are located in the neck and which control the diameter of the bronchial tubes. Proponents of the procedure claim that it reduces the symptoms of pulmonary diseases such as asthma, bronchitis, and emphysema. Although the Secretary concluded that BCBR for that purpose is not "reasonable and necessary" within the meaning of the Medicare Act, she did note that the medical community had accepted the procedure as effective for another purpose, the removal of a carotid body tumor in the neck. 45 Fed. Reg. 71431 (1980).

Humana Med. Plan, Inc. v. W. Heritage Ins. Co.

UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

Aug 8, 2016

832 F.3d 1229 (11th Cir. 2016) Copy Citation

No. 15-11436

08-08-2016

Humana Medical Plan, Inc., Plaintiff–Appellee, v. Western Heritage Insurance Company, Defendant–Appellant.

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BLACK, Circuit Judge

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Frank Carlos Quesada, MSP Law Firm, Miami, FL, for Amicus Curiae MSP Recovery, LLC.

Before WILLIAM PRYOR, BLACK and PARKER,[*] Circuit Judges.

[*] Honorable Barrington D. Parker, Jr., United States Circuit Judge for the Second Circuit, sitting by designation.

BLACK, Circuit Judge:

Defendant Western Heritage Insurance Co. (Western) appeals the district court's order granting summary judgment in favor of Plaintiff Humana Medical Plan, Inc. (Humana) on Humana's claims for double damages pursuant to the Medicare Secondary Payer Act (MSP) private cause of action, 42 U.S.C. § 1395y(b)(3)(A), and for a declaratory judgment regarding Western's obligation to reimburse Humana for Medicare benefits that Humana paid on behalf of its Medicare Advantage plan enrollee. This case requires the Court to decide as a matter of first impression in this circuit whether the MSP private cause of action permits a Medicare Advantage Organization (MAO) to sue a primary payer that refuses to reimburse the MAO for a secondary payment. The Third Circuit previously considered this issue and concluded that an MAO may sue a primary payer under the MSP private cause of action. *In re Avandia Mktg., Sales Practices & Prods. Liab. Litig.*, 685 F.3d 353, 367 (3d Cir. 2012). After review, we agree with the Third Circuit and affirm the order of the district court.

I. BACKGROUND

Humana operates as an MAO, providing Medicare Part C coverage (also known as a Medicare Advantage plan) to Medicare-
1232 *1232 eligible enrollees and receiving in return a per capita fee from the Centers for Medicare & Medicaid Services (CMS). In January 2009, Mary Reale, a Humana Medicare Advantage plan enrollee, was injured at Hamptons West Condominiums. Ms. Reale sought medical treatment for her injury, and her medical providers billed Humana. Humana paid $19,155.41.

In June 2009, Ms. Reale and her husband sued Hamptons West Condominium Association, Inc. (Hamptons West) in Florida state court for her injury. In March 2010, while the Reales' suit was pending and in light of a pending settlement between Hamptons West and the Reales, Humana issued to Ms. Reale an Organization Determination in the amount of $19,155.41. The basis for Humana's reimbursement request was the MSP, under which Medicare payments are secondary and reimbursable if any other insurer—even a tortfeasor's liability insurer—is liable. *See* 42 U.S.C. § 1395y(b)(2) ; *see also id.* § 1395w-22(a)(4). Although an administrative appeal process was available, no party appealed Humana's Organization Determination.

On April 20, 2010, in return for $115,000 from Hamptons West and its liability insurer, Western, the Reales released Hamptons West and Western. The Reales represented in the settlement agreement that there was no Medicare or other lien or right to subrogation. The Reales also agreed to indemnify Hamptons West and Western against any Medicare or other lien or right to subrogation.

On May 7, 2010, Humana sued the Reales and their attorney in the Southern District of Florida seeking reimbursement of the $19,155.41. On the defendants' motion, the district court dismissed Humana's complaint for lack of subject matter jurisdiction, holding that an MAO does not have a private cause of action to recover reimbursement from a beneficiary under the MSP. The district court later vacated its order after Humana moved the district court to correct or amend the order. The district court scheduled a hearing to consider Humana's motion. On the date of the hearing, Humana voluntarily dismissed its action against the Reales and their attorney.

Perhaps in response Humana's suit, Western and Hamptons West attempted to make Humana a payee on the settlement draft to the Reales. The Reales refused and on May 25, 2010 sought sanctions against Hamptons West for failing to comply with the settlement agreement. Thereafter, Hamptons West agreed to a stipulated order under which Humana would not be a payee on the check, but the Reales' attorney would hold $19,155.41 in trust pending resolution of the Reales' litigation. Hamptons West and Western tendered the $115,000.

On June 4, 2010, the Reales sued Humana in state court seeking a declaration as to the amount they owed Humana. Applying Florida law regarding collateral indemnity and subrogation, the trial court held that Humana was entitled to $3,685.03. *See Humana Med. Plan, Inc. v. Reale* , 180 So.3d 195, 199 (Fla. 3d DCA 2015). Humana appealed, and in December 2015, Florida's Third District Court of Appeal reversed for lack of jurisdiction. *Id.* at 197, 199. The court held that the Medicare Act creates an exclusive federal administrative process under which a Medicare Advantage plan enrollee appeals through CMS an MAO's denial of benefits or request for reimbursement. *Id.* at 204–05. Upon exhaustion of the administrative process, the Medicare Act provides for federal judicial review and expressly preempts state law. *Id* . Therefore, according to the court, Florida courts lack jurisdiction to adjudicate the dispute between Humana and Ms. Reale
1233 regarding her Medicare Advantage plan benefits. *Id.* at 209.*1233 Having failed to secure reimbursement from Ms. Reale, in December 2011, Humana demanded that Western reimburse Humana's secondary payment. On January 11, 2011, Humana sued Western in the action upon which this appeal proceeds. Humana pled three counts: Count One sought double damages under the MSP private cause of action, 42 U.S.C. § 1395y(b)(3)(A) ; Count Two sought declaratory relief under the Medicare statutory and regulatory scheme; and Count Three sought damages under several state law theories including unjust enrichment and a contract implied by law. Western moved to dismiss, arguing among other things that the MSP does not permit an MAO to bring a private cause of action. In an endorsed order, the district court denied Western's motion in part, dismissing the state law claims but finding that Humana had adequately pled a question regarding whether the MSP private cause of action is available to an MAO.

On December 29, 2014, Humana moved for summary judgment. On March 16, 2015, the district court granted summary judgment in favor of Humana, finding that the MSP private cause of action is available to an MAO and that Humana is entitled to double damages, $38,310.82. *Humana Med. Plan, Inc. v.*

W. Heritage Ins. Co. , 94 F.Supp.3d 1285 (S.D. Fla. 2015). The district court entered judgment in favor of Humana, and Western appealed.

II. STANDARD OF REVIEW

We review *de novo* a grant or denial of summary judgment, viewing all facts and reasonable inferences in the light most favorable to the nonmoving party. *Bridge Capital Inv'rs, II v. Susquehanna Radio Corp.* , 458 F.3d 1212, 1215 (11th Cir. 2006). "Summary judgment is appropriate only if there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law." *Hallmark Developers, Inc. v. Fulton Cty., Ga.* , 466 F.3d 1276, 1283 (11th Cir. 2006) ; *see also* Fed. R. Civ. P. 56(a).

III. DISCUSSION

Before considering whether the MSP private cause of action is available to an MAO on these facts and, if so, whether Humana was entitled to summary judgment, we first introduce the Medicare Act, the MSP, the Medicare Advantage program, and pertinent CMS regulations.

A. Statutory and Regulatory Background

Traditional Medicare consists of Parts A and B of the Medicare Act. These are the fee-for-service provisions entitling eligible persons to have CMS directly pay medical providers for their hospital and outpatient care. Part C is the Medicare Advantage program under which Medicare-eligible persons may elect to have an MAO (rather than CMS) provide Medicare benefits. Part D provides for prescription drug coverage, and Part E contains generally applicable definitions and exclusions. One such exclusion is the MSP.

1. The MSP

Frequently, more than one insurer is liable for an individual's medical costs. For example, a car accident victim may be entitled to recover medical expenses from both her health insurer and a tortfeasor's liability insurer. To address such situations, the MSP allocates liability between Medicare and other insurers, known as "primary plans."[1] *1234 Before 1980, "Medicare paid for all medical treatment within its scope and left private insurers merely to pick up whatever expenses remained." *Bio – Med. Applications of Tenn., Inc. v. Cent. States Se. & Sw. Areas Health & Welfare Fund* , 656 F.3d 277, 278 (6th Cir. 2011). In effect, when Medicare and a private insurer were both liable for the same expenses, Medicare satisfied or partially satisfied the private insurer's obligation. In 1980, in an effort to curb the rising costs of Medicare, Congress enacted the MSP, which "inverted that system; it made private insurers covering the same treatment the 'primary' payers and Medicare the 'secondary' payer." *Id.* Medicare benefits became an entitlement of last resort, available only if no private insurer was liable.

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[1] A "primary plan" is a group health plan, worker's compensation plan or law, automobile or other liability insurance policy or plan, no-fault insurance, or self-insured plan that has made or can reasonably be expected to make payment for an item or service. 42 U.S.C. § 1395y(b)(2)(A).

The MSP, 42 U.S.C. § 1395y(b), is located in Part E of the Medicare Act. Paragraph (1) creates rules regarding group health plans. *Id.* § 1395y(b)(1). Paragraph (2) establishes Medicare's status as a secondary payer to a primary plan. Paragraph (2)(A) is a general prohibition against making Medicare payments for items or services for which a primary plan has paid or can reasonably be expected to pay. *Id.* § 1395y(b)(2)(A). Paragraph (2)(B), entitled "Conditional payment" and cross-referenced as the sole exception to paragraph (2)(A), describes the circumstances and procedures under which Medicare can make a conditional payment notwithstanding its status as secondary payer. *Id.* § 1395y(b)(2)(B).

Under paragraph (2)(B), when the primary plan does not fulfill its duties, the Secretary of Health & Human Services may make a payment conditioned on reimbursement. *Id.* § 1395y(b)(2)(B)(i). If the Secretary makes a conditional payment, the primary plan must reimburse the Secretary. *Id.* § 1395y(b)(2)(B)(ii). Paragraph (2)(B) also establishes and defines a Government cause of action to recover from a primary plan. *Id.* § 1395y(b)(2)(B)(iii) ; *see also* 42 C.F.R. § 411.24 (describing a Government cause of action against a primary plan or any other person that received a primary payment). The remaining portions of paragraph (2)(B) establish the United States' subrogation rights in the event of a secondary payment, § 1395y(b)(2)(B)(iv), permit the Secretary to waive the conditional payment rules under some circumstances, § 1395y(b)(2)(B)(v), establish a limitations period, § 1395y(b)(2)(B)(vi), and create a disclosure mechanism to help primary plans determine whether they owe a reimbursement, § 1395y(b)(2)(B)(vii). Paragraph (2)(B) does not mention MAOs and refers almost exclusively to the Secretary, the United States, and the Medicare trust fund.

Paragraph (3)(A), entitled "Private cause of action," states as follows:

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

42 U.S.C. § 1395y(b)(3)(A). The MSP private cause of action is not a *qui tam* statute but is available to a Medicare beneficiary whose primary plan has not paid Medicare or the beneficiary's healthcare provider. *Stalley ex rel. United States v. Orlando Reg'l Healthcare Sys., Inc.* , 524 F.3d 1229, 1234 (11th Cir. 2009) ; *see also Glover v. Liggett Grp., Inc.* , 459 F.3d 1304, 1310 (11th Cir. 2006) (explaining that the MSP private cause of action is available "against a primary plan that pays a judgment or settlement to a Medicare beneficiary, but fails to pay Medicare its share"). The Sixth Circuit holds that the MSP private cause of action is also available to a healthcare provider who has not
1235 been paid *1235 by a primary plan. *Mich. Spine & Brain Surgeons, PLLC v. State Farm Mut. Auto. Ins. Co.* , 758 F.3d 787, 790 (6th Cir. 2014). Although we have not explicitly addressed the issue, our case law implicitly supports the proposition. *Cf. Glover* , 459 F.3d at 1307 (suggesting the MSP private cause of action was intended "to encourage private parties who are aware of non-payment by primary plans to bring actions to enforce Medicare's rights").

2. The Medicare Advantage program

Part C, also known as the Medicare Advantage program,[2] was enacted in 1997, 17 years after the MSP and 11 years after the MSP private cause of action.[3] "Congress's goal in creating the Medicare Advantage program was to harness the power of private sector competition to stimulate experimentation and innovation that would ultimately create a more efficient and less expensive Medicare system." *In re Avandia* , 685 F.3d at 363 (citing H.R. Rep. No. 105-217, at 585 (1997), 1997 U.S.C.C.A.N. 176, 205-06 (Conf. Rep.)). Under the Medicare Advantage program, a private insurance company, operating as an MAO, administers the provision of Medicare benefits pursuant to a contract with CMS. CMS pays the MAO a fixed fee per enrollee, and the MAO provides at least the same benefits as an enrollee would receive under traditional Medicare. *See* 42 U.S.C. §§ 1395w-22(a), 1395w-23. In 2015, 31% of Medicare-eligible individuals were enrolled in a Medicare Advantage program. *Medicare Advantage Enrollees as a Percent of Total Medicare Population* , Henry J. Kaiser Family Foundation, http://kff.org/medicare/state-indicator/enrollees-as-a-of-total-medicare-population (last visited August 8, 2016). This percentage has risen every year since 2004. *See id* .

[2] The Medicare Advantage program was originally called Medicare+Choice.

[3] *See* Pub. L. No. 105–33, § 4001, 111 Stat. 251 (codified as amended at 42 U.S.C. §§ 1395w–21 –1395ww-28); Pub. L. No. 99–509, § 9319, 100 Stat. 1874 (codified as amended at 42 U.S.C. § 1395y(b)); Pub. L. No. 96–499, § 953, 94 Stat. 2599 (codified as amended at 42 U.S.C. § 1395y(b)).

Part C includes a reference to the MSP, entitled "Organization as secondary payer," which states as follows:

> Notwithstanding any other provision of law, a Medicare+Choice organization may (in the case of the provision of items and services to an individual under a Medicare+Choice plan under circumstances in which payment under this subchapter is made secondary pursuant to section 1395y(b)(2) of this title) charge or authorize the provider of such services to charge, in accordance with the charges allowed under a law, plan, or policy described in such section—
>
> (A) the insurance carrier, employer, or other entity which under such law, plan, or policy is to pay for the provision of such services, or
>
> (B) such individual to the extent that the individual has been paid under such law, plan, or policy for such services.

42 U.S.C. § 1395w-22(a)(4). In several cases, an MAO has contended that § 1395w-22(a)(4), sometimes called the MAO "right-to-charge" provision, creates an implied federal cause of action for an MAO to recover secondary payments, but courts have rejected this argument. *See, e.g.* , *Parra v. PacifiCare of Ariz., Inc.* , 715 F.3d 1146, 1153, 1154 (9th Cir. 2013) (explaining

that the MAO right-to-charge provision "describes when MAO coverage is secondary to other insurance, and permits (but does not require) a[n] MAO to include in its plan provisions allowing recovery against a primary plan.... [It] does not create a federal cause of action in favor of a[n] MAO"; *1236 *Care Choices HMO v. Eng strom* , 330 F.3d 786, 790 (6th Cir. 2003) (reaching a similar conclusion as to 42 U.S.C. § 1395mm(e)(4), which addresses secondary payment by Medicare-substitute HMOs); *Nott v. Aetna U.S. Healthcare, Inc.* , 303 F.Supp.2d 565, 571–72 (E.D. Pa. 2004) (concurring with *Care Choices HMO* as to both the HMO and the MAO provision).

B. An MAO's Rights Under the MSP

In this case, Humana contends that an MAO can sue a primary plan under the MSP private cause of action, which is available "in the case of a primary plan which fails to provide for primary payment (or appropriate reimbursement) in accordance with paragraphs (1) and (2)(A)." 42 U.S.C. § 1395y(b)(3)(A). Humana's contention appears to comport with CMS regulations, which provide that an MAO "will exercise the same rights to recover from a primary plan, entity, or individual that the Secretary exercises under the MSP regulations in subparts B through D of part 411 of this chapter." 42 C.F.R. § 422.108(f). Under subpart B of part 411 of chapter 42, CMS regulations identify two causes of action available to the Secretary: one against a primary payer and one against any entity (including a beneficiary) that receives a primary payment. 42 C.F.R. §§ 411.24(e), 411.24(g). Thus, according to CMS, an MAO may sue a primary plan or an MAO beneficiary (among others) under the MSP.

Although the Secretary believes MAOs may sue in federal court to recover reimbursement from a primary plan, MAOs have no cause of action absent a statutory basis. *See Alexander v. Sandoval* , 532 U.S. 275, 286–87, 121 S.Ct. 1511, 1519–20, 149 L.Ed.2d 517 (2001). Humana does not contend that the MAO right-to-charge provision creates an implied cause of action. Nor does Humana contend that an MAO may avail itself of § 1395y(b)(2)(B)(iii), the Government's cause of action. Rather, Humana argues that the MSP private cause of action is unambiguous and broadly permits any private party with standing (including an MAO) to sue a primary plan. The district court concurred with the Third Circuit's analysis of the MSP private cause of action and held that "[t]he statutory text of the MSP Act clearly indicates that MAOs are included within the purview of parties who may bring a private cause of action." We agree.

The United States Supreme Court recently described our threshold analysis in statutory interpretation as follows:

> If the statutory language is plain, we must enforce it according to its terms. But oftentimes the meaning—or ambiguity—of certain words or phrases may only become evident when placed in context. So when deciding whether the language is plain, we must read the words in their context and with a view to their place in the overall statutory scheme. Our duty, after all, is to construe statutes, not isolated provisions.

King v. Burwell , ––– U.S. ––––, 135 S.Ct. 2480, 2489, 192 L.Ed.2d 483 (2015) (quotation marks and citations omitted). We therefore read the MSP private cause of action in the context of the broader Medicare Act.

The MSP private cause of action is available "in the case of a primary plan which fails to provide for primary payment (or appropriate reimbursement) in accordance with paragraphs (1) and (2)(A)." 42 U.S.C. § 1395y(b)(3)(A). Paragraph (1) regulates group health plans and is not at issue in this case. *See id.* § 1395y(b)(1). Paragraph (2)(A) defines "primary plan" and bars any Medicare payment—including an MAO payment—when there is a primary plan. *See id.* § 1395y(b)(2)(A). The sole exception to the prohibition in paragraph (2)(A) is the conditional payment scheme in paragraph (2)(B). *See*
1237 *id* .*1237 Although paragraph (2)(A) does not expressly obligate primary plans to make payments, the defined term "primary plan" presupposes an existing obligation (whether by statute or contract) to pay for covered items or services. *See id* . Therefore, a primary plan "fails to provide for primary payment (or appropriate reimbursement) in accordance with paragraph[ ] ... (2) (A)," when it fails to honor the underlying statutory or contractual obligation.

Thus, the three paragraphs work together to establish a comprehensive MSP scheme. Paragraph (2)(A) alters the priority among already-obligated entities and contemplates primary plans fulfilling their payment obligation. Paragraph (2)(B) addresses the Secretary's options when a primary plan fails to fulfill its payment obligation. Paragraph (3)(A), the MSP private cause of action, grants private actors a federal remedy when a primary plan fails to fulfill its payment obligation, thereby undermining the secondary-payer scheme created by paragraph (2)(A).

We must now consider how an MAO fits within the MSP scheme and whether an MAO may avail itself of the MSP private cause of action in paragraph (3)(A). Western suggests that the MSP does not govern MAOs at all and that the MAO right-to-charge provision instead governs when and whether an MAO is a secondary payer. According to Western, because an MAO derives secondary payer status from the MAO right-to-charge provision rather than the MSP, an MAO may not sue under the MSP private cause of action.

We reject Western's reading as contrary to the plain language of the pertinent provisions. First, paragraph (2)(A) unambiguously refers to all Medicare payments, which include both traditional Medicare and Medicare Advantage plans. *See In re Avandia* , 685 F.3d at 360 ; 42 U.S.C. § 1395y(b)(2)(A) (regulating "[p]ayment under this subchapter"). Second, the MAO right-to-charge provision parenthetically refers to circumstances under which MAO payments are "made secondary *pursuant to* section 1395y(b)(2)." 42 U.S.C. § 1395w-22(a)(4) (emphasis added). A plain reading of paragraph (2)(A) and the MAO right-to-charge provision therefore reveals that MAO payments are made secondary to primary payments pursuant to the MSP, not the MAO right-to-charge provision. This alone suggests that the MSP does not limit the cause of action in paragraph (3)(A) to cases in which traditional Medicare is the secondary payer.

The fact that paragraph (2)(B), the sole exception to paragraph (2)(A), refers to the Secretary does not alter our analysis. *See id.* § 1395y(b)(2)(B) (authorizing the Secretary to make conditional payment when a primary plan "has not made or cannot reasonably be expected to make [prompt] payment"). Even if paragraph (2)(B) does not apply to MAOs,[4] neither paragraph (2)(A) nor paragraph (3)(A) contain the limiting language found in paragraph (2)(B). Paragraph (2)(A) establishes secondary payer status for all Medicare and defines "primary plan" with reference to pre-existing
1238 obligations. Thus, a primary plan that fails to make primary payment *1238
has failed to do so "in accordance with paragraphs (1) and (2)(A)," regardless of whether the secondary payer is the Secretary or an MAO. *Id.* § 1395y(b)(3)(A).

[4] The parties do not argue and we do not consider whether the Government cause of action described in paragraph (2)(B) was intended to be available to MAOs. *See In re Avandia* , 685 F.3d at 364 n.18 ("Because Congress clearly intended there to be parity between MAOs and traditional Medicare, we find additional support for our decision in § 1395y(b)(2)(B)(iii), the government's cause of action for recovery from primary payers, which also provides for double damages."); 42 C.F.R. § 411.108(f) ("The [MAO] will exercise the same rights to recover from a primary plan, entity, or individual that the Secretary exercises under the MSP regulations....").

Western Heritage does not dispute that an MAO may make a secondary payment. The MAO right-to-charge provision confirms this right. *See id.* § 1395w-22(a)(4) (establishing an MAO's right to charge a plan "under circumstances in which payment under this subchapter is made secondary pursuant to section 1395y(b)(2) "). Fulfilling our duty to "read the words in their context and with a view to their place in the overall statutory scheme" and to "construe statutes, not isolated provisions," *King* , 135 S.Ct. at 2489, we note that other aspects of the Medicare Act indicate an MAO *must* make a secondary payment any time the Secretary would do so. An MAO's payment obligation under Part C is coextensive with that of the Secretary under Parts A and B. *See* 42 U.S.C. § 1395w–22(a)(1)(A) (An MAO "shall provide" its enrollees with the benefits to which they would be entitled under traditional Medicare.); *id.* § 1395w–22(a)(2)(A) (An MAO satisfies § 1395w–22(a)(1)(A) if it "provides payment in an amount ... equal to at least the total dollar amount of payment ... as would otherwise be authorized under parts A and B...."). In other words, if the Secretary would pay "X" amount for covered service "Y," then an MAO must also pay "X" amount for covered service "Y." *See id* . Thus, Part C of the Medicare Act prohibits an MAO's avoiding paying benefits whenever the Secretary would pay under traditional Medicare. Collectively, these provisions clarify that Congress empowered (and perhaps obligated) MAOs to make secondary payments under the same circumstances as the Secretary. *See id.* §§ 1395w–22(a)(1)(A), 1395w–22(a)(2)(A), 1395w–22(a)(4). Thus, an MAO both has secondary payer status and can make reimbursable secondary payments.

We conclude that paragraph (3)(A), the MSP private cause of action, permits an MAO to sue a primary plan that fails to reimburse an MAO's secondary payment. Paragraph (3)(A) is broadly available "in the case of a primary plan

which fails to provide for primary payment (or appropriate reimbursement) in accordance with paragraphs (1) and (2)(A)." 42 U.S.C. § 1395y(b)(3)(A). We have held that paragraph (3)(A) is not a *qui tam* statute but is instead available only when the plaintiff has suffered an injury in fact. *See Stalley* , 524 F.3d at 1234. Neither the MSP nor our case law places any other restriction on the class of plaintiffs to whom the MSP private cause of action is available. *But see Harris Corp. v. Humana Health Ins. Co. of Fla., Inc.* , 253 F.3d 598, 605–06 n.5 (11th Cir. 2001) (affirming dismissal of a claim under § 1395y(b)(3)(A) because the dispute involved priority between two non-Medicare health insurance plans).

We see no basis to exclude MAOs from a broadly worded provision that enables a plaintiff to vindicate harm caused by a primary plan's failure to meet its MSP primary payment or reimbursement obligations. As stated above, the MSP applies to MAOs. An MAO has a statutory right to charge a primary plan when an MAO payment is made secondary pursuant to the MSP. 42 U.S.C. § 1395w-22(a)(4) ; *see also* 42 C.F.R. § 422.108 (elaborating upon an MAO's right to charge a primary plan and means of recovering a secondary payment). In such a case, the primary plan's failure to make primary payment or to reimburse the MAO causes the MAO an injury in fact. Therefore, an MAO may avail itself of the MSP private cause of action when a primary plan fails to make primary payment or to reimburse the
1239 MAO's secondary payment.*1239 *C. Humana's Entitlement to Summary Judgment*

Having found that Humana may bring its claim under the MSP private cause of action, we must decide whether Humana was entitled to summary judgment in its favor on the claim. The MSP private cause of action permits an award of double damages when a primary plan fails to provide for primary payment or appropriate reimbursement. 42 U.S.C. § 1395y(b)(3)(A). Thus, a plaintiff is entitled to summary judgment on a § 1395y(b)(3)(A) claim when there is no genuine issue of material fact regarding (1) the defendant's status as a primary plan; (2) the defendant's failure to provide for primary payment or appropriate reimbursement; and (3) the damages amount. We agree with the district court that Western is a primary plan under § 1395y(b)(2)(A) because it is a liability insurer that, under a settlement agreement, paid Ms. Reale, a Medicare Advantage plan enrollee, for covered medical expenses. We discuss the second and third elements in turn below.

Western argues that it did not fail to provide for payment or appropriate reimbursement because Western (1) lacked constructive knowledge that Medicare made a payment; and (2) attempted to make Humana a payee on the settlement check but was ordered instead to pay $19,155.41 into trust pending resolution of a dispute regarding the amount of Humana's entitlement. As the district court noted, Western's second argument forecloses its first. Western's attempt to list Humana as a payee on the settlement check indicates that Western knew of Humana's lien. Western seeks to evade this conclusion by asserting its ignorance of Humana's status as an MAO. We see no value in this distinction. Western had actual knowledge of Humana's claim, and as a settling party in tort litigation, Western had the ability to discern the precise nature of Ms. Reale's health insurance coverage. *See* Fla. R. Civ. P. 1.280(b)(2) ("A party may obtain

discovery of the existence and contents of any agreement under which any person may be liable to satisfy part or all of a judgment that may be entered in the action or to indemnify or to reimburse a party for payments made to satisfy the judgment."); 42 C.F.R. § 422.108(b)(3) (requiring MAOs to coordinate benefits with primary payers); *cf. United States v. Baxter Int'l, Inc.* , 345 F.3d 866, 901 (11th Cir. 2003) ("[W]hen the primary insurer later pays, Medicare's prior payment will normally be a matter of ascertainable fact."). Western therefore had constructive knowledge of Humana's Medicare payment.

We reject Western's contention that it provided for appropriate reimbursement by placing $19,155.41 into trust pending resolution of the dispute between Ms. Reale and Humana. The MSP private cause of action does not describe what constitutes "appropriate reimbursement." We therefore seek guidance from the CMS regulations. *See Chevron, U.S.A., Inc. v. Nat. Res. Def. Council, Inc.* , 467 U.S. 837, 844, 104 S.Ct. 2778, 2782, 81 L.Ed.2d 694 (1984) (When "the legislative delegation to an agency on a particular question is implicit rather than explicit," we "may not substitute [our] own construction of a statutory provision for a reasonable interpretation made by the administrator of an agency.").

If a beneficiary or other party fails to reimburse Medicare within 60 days of receiving a primary payment, the primary plan "must reimburse Medicare even though it has already reimbursed the beneficiary or other party." 42 C.F.R. § 411.24(i)(1). This regulation applies equally to an MAO. *See id.* § 422.108(f). Thus, Western's payment to Ms. Reale or any other party is
1240 insufficient to extinguish *1240 its prospective reimbursement obligation to Humana. Sixty days after Western tendered the settlement to the Reales and their attorney, because no party reimbursed Humana, Western became obligated to directly reimburse Humana. *See id.* § 411.24(i)(1). Even after receiving Humana's demand for reimbursement, Western has declined to do so. Therefore, Western failed to provide for "appropriate reimbursement" as defined by the CMS regulations.

Western also disputes the damages amount, contesting both the amount of Humana's reimbursement entitlement and the appropriateness of double damages. Before Western settled with the Reales, Humana issued to Ms. Reale an Organization Determination for $19,155.41. Ms. Reale was entitled to administratively appeal that amount but did not. *See* 42 U.S.C. § 1395w-22(g). The amount that Humana may recover is therefore fixed, at least as to Ms. Reale. *See* 42 C.F.R. § 422.576. Even if Western retains the right to dispute the amount, its argument regarding Ms. Reale's procurement costs lacks merit. A beneficiary's procurement costs do not offset an MAO's recovery if the MAO must litigate to secure repayment. *See* 42 C.F.R. §§ 411.37(e), 422.108(f). This is the third lawsuit in which Humana has attempted to recover its $19,155.41 secondary payment. Therefore, Humana may recover the full amount.

Finally, we agree with the district court that double damages are required by statute. Unlike the Government's cause of action, the private cause of action uses the mandatory language "shall" to describe the damages amount. *Compare* 42 U.S.C. § 1395y(b)(2)(B)(iii) ("The United States *may* ... collect

[Print Date]

Insert name
Insert address 1
Insert address 2
Insert city, state, zip code

SUBJECT: Medicare Secondary Payer Rights and Responsibilities Letter for:
Beneficiary Name:
Medicare Number:
Case Identification Number:
Insurer Claim Number:
Insurer Policy Number:
Date of Incident:

Dear [Addressee Name]

You are receiving this letter because we were notified that you filed a liability insurance (including self-insurance), no-fault insurance, or workers' compensation claim. This is confirmation that a Medicare Secondary Payer (MSP) recovery case has been established in our system.

If we know that you have a lawyer or other person representing you, we have sent him or her a courtesy copy of this letter and you will see him or her listed as a "cc" at the end of this letter.

This letter gives you information on the following:

1. What happens when you have Medicare and file an insurance or workers' compensation claim;
2. What information we need from you;
3. What information you can expect from us and when;
4. How and when you are able to elect a simple, fixed percentage option for repayment; and,
5. How to contact us.

What Happens When You Have Medicare and You file a Liability Insurance (including Self-Insurance), No-Fault Insurance, or Workers' Compensation Claim

Applicable Medicare law says that liability insurance (including self-insurance), no-fault insurance, and workers' compensation must pay for medical items and services before Medicare pays. This law can be found at 42 U.S.C. Section 1395y(b)(2)(A) and (B).

However, Medicare makes "conditional payments" while your insurance or workers' compensation claim is being processed to make sure you get the medical services you need when you need them. If you get a(n) insurance or workers' compensation settlement, judgment, award, or other payment, Medicare is entitled to be repaid for the items and services it paid for conditionally.

If you receive a settlement, judgment, award, or other payment related to this claim and Medicare determines that it has made conditional payments that must be repaid, you will get a demand letter. The demand letter explains how Medicare calculated the amount it needs to be repaid and it also explains your appeal and waiver rights. *If you decide to appeal or request a waiver of recovery, Medicare will not take any collection action while your appeal or waiver of recovery request is being processed.*

What Information We Need From You

- ***Do you have a lawyer or other person representing you?***

  Medicare works to protect your privacy. We are not allowed to communicate with anyone other than you about your MSP case unless you tell us to do so. If you have a lawyer or other person representing you, please see the enclosed brochure. It explains what type of information we need from you in order to work directly with your lawyer or representative.

- ***Is the information we have on your claim correct?***

  If the information at the top of this letter is incorrect or if you filed a no-fault insurance or workers' compensation claim and do not see the insurer/carrier listed as a "cc" at the end of this letter, please contact the Benefits Coordination & Recovery Center (BCRC) immediately at 1-855-798-2627 (TTY/TDD for the hearing or speech impaired: 1-855-797-2627)..

- ***Has your insurance or workers' compensation claim already been resolved?***

  If you already got a settlement, judgment, award, or other payment, we need the following information:

  - The date and total amount of your settlement, judgment, award, or other payment.
  - A list of the attorney fees and other costs that you had to pay in order to get your settlement, judgment, award, or other payment.

  If your insurance or workers' compensation claim was dismissed or otherwise closed, we need documentation of that so that we are able to close your MSP case.

What Information Can You Expect From Us and When

- *Medicare's Conditional Payment Amount*

  Our system will automatically send you a Conditional Payment Letter within 65 days of the date on this letter. It includes a Payment Summary Form, which lists medical items and services Medicare has paid for that we believe are related to your claim. Keep in mind that this list is not final or complete until your insurance or workers' compensation claim is resolved.

  If you would like the most up-to-date claims information, please visit www.MyMedicare.gov. Once your letter is issued, you will be able to access conditional payment amount information through the MyMSP tab, as well as current claims information using the MyMedicare.gov "blue button."

How to Elect a Simple, Fixed Percentage Option For Repayment If You Have Experienced a Physical Trauma-Based Injury

If you experienced a physical trauma-based injury and you get a liability insurance settlement, judgment, award, or other payment of $5,000 or less, Medicare offers the option to pay 25% of your gross settlement, judgment, award, or other payment, instead of the amount that Medicare would otherwise calculate.

If you wish to choose this option, you must formally elect it at the same time that you send us information on your settlement, judgment, award, or other payment. Please visit the Beneficiary or Attorney Toolkit sections of the BCRC website (http://go.cms.gov/cobro) for all of the additional details. You will find model language that can be used to elect this option, as well as a special mailing address to ensure efficient processing.

How You Can Contact Us

Please mail any documents to: [BCRC Fixed Percentage Option, P.O. Box 138880, Oklahoma City, OK 73113 or fax documents to: [BCRC 405-869-3309.

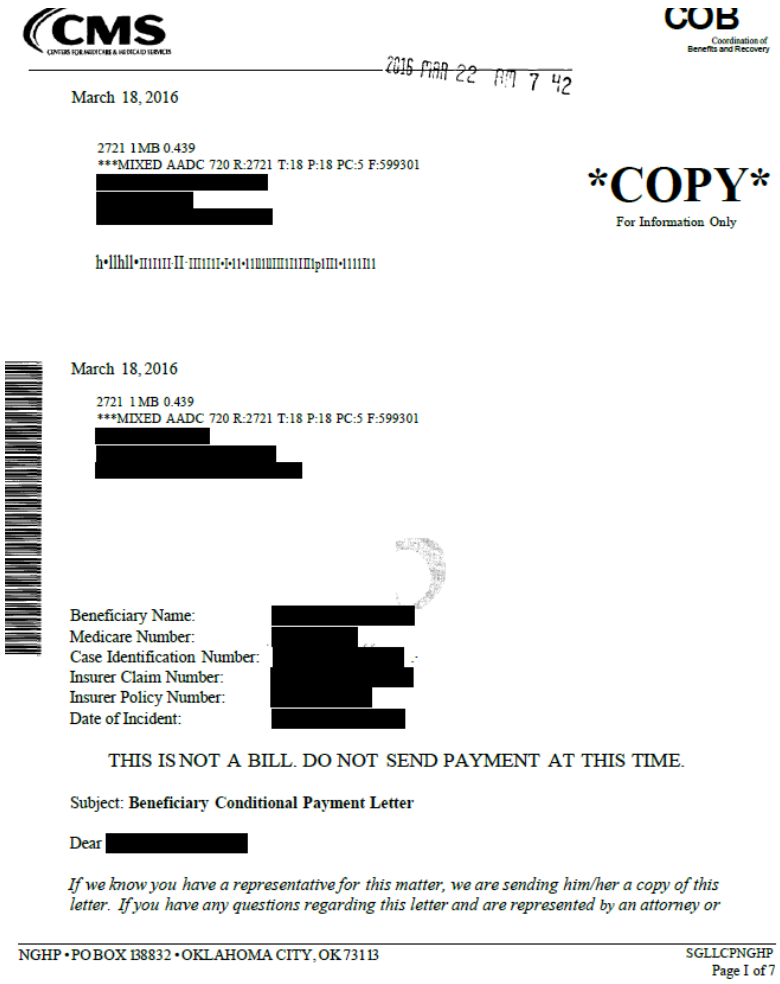
For more information, please visit http://go.cms.gov/cobro or call 1-855-798-2627 (TTY/TDD for the hearing or speech impaired: 1-855-797-2627).

Sincerely,
BCRC

Enclosure:
BCRC Brochure

CC:

Beneficiary Conditional Payment Letter from BCRC



CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

COB
Coordination of Benefits and Recovery

2016 MAR 22 AM 7 42

March 18, 2016

2721 1MB 0.439
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[redacted]

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For Information Only

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March 18, 2016

2721 1MB 0.439
***MIXED AADC 720 R:2721 T:18 P:18 PC:5 F:599301
[redacted]

Beneficiary Name: [redacted]
Medicare Number:
Case Identification Number:
Insurer Claim Number:
Insurer Policy Number:
Date of Incident:

THIS IS NOT A BILL. DO NOT SEND PAYMENT AT THIS TIME.

Subject: **Beneficiary Conditional Payment Letter**

Dear [redacted]

If we know you have a representative for this matter, we are sending him/her a copy of this letter. If you have any questions regarding this letter and are represented by an attorney or

NGHP • PO BOX 138832 • OKLAHOMA CITY, OK 73113

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Page 1 of 7

other individual in this matter, you may wish to talk to your representative before contacting us.

This letter follows a previous letter notifying you/your attorney of Medicare's priority right of recovery as defined under the Medicare Secondary Payer provisions. Conditional Medicare payments for Medicare Part A and Part B Fee-for-Service claims have been made that we believe are related to your case for the Date of Incident listed above. These conditional payments are subject to reimbursement to Medicare from proceeds you may receive pursuant to a settlement, judgment, award, or other payment.

As of the date of this letter, and based upon the available information, Medicare has identified $2,775.69 in conditional payments that we believe are associated with your case. A listing of Part A and Part B Fee-for-Service claims that comprise this total is enclosed with this letter; please review this listing carefully and let us know as soon as possible if this list is incorrect or inaccurate.

If you believe the enclosed itemization of conditional payments is incomplete, inaccurate, or that you are not responsible for repaying Medicare for these payments, please provide written documentation along with an explanation to support your dispute/rebuttal, to the address listed below. Please include a description of the injury with your response. The following is a list of documents (not all inclusive) that could assist in processing your dispute/rebuttal request:

- Statute of limitations submitted by insurer
- Physicians statement or discharge summary
- Independent medical exams
- Medical records
- Written statement defining similar injuries or pre-existing conditions

Please also be advised that we are still investigating this case file to obtain any other outstanding Medicare conditional payments; therefore, the enclosed listing of current conditional payments is not final. We request that you/your attorney refrain from sending any monies to Medicare prior to submission of settlement information and receipt of a demand/recovery calculation letter from our office. This will eliminate underpayments, overpayments, and/or associated delays. Once the case settles, please furnish our office with the information requested on the attached "Final Settlement Detail Document".

We have posted this conditional payment information under the "MyMSP" tab of the www.mymedicare.gov website. The information at www.mymedicare.gov will be updated weekly with any changes or newly processed claims. If you wish, you may track the medical expenses that were paid by Medicare, and if you have an attorney or other representative, provide him/her with this information. This may help you with finalizing your settlement.

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COB
Coordination of Benefits and Recovery

If you have any questions concerning this matter, please contact the Benefits Coordination & Recovery Center (BCRC) by phone at 1-855-798-2627 (TTYffDD: 1-855-797-2627 for the hearing and speech impaired), in writing at the address below, or by fax to 405-869-3309. When sending correspondence, please include the Beneficiary Name along with the Medicare and Case Identification Numbers (shown above).

Sincerely,

BCRC

CC: [redacted]

Enclosures: Final Settlement Detail Document
Payment Summary Form

Final Settlement Detail Document

Beneficiary Name: [redacted]
Medicare Number:
Date of Incident:
Case Identification Number:

Please supply the information outlined below to help Medicare to properly calculate the amount it is due. This information will also be used to update your records.

Total Amount of the Settlement: _____

Total Amount of Med-Pay or PIP: _____
** *only if paid directly to the beneficiary or the beneficiary's representative*

Attorney Fee Amount Paid by the Beneficiary: _____

Additional Procurement Expenses Paid by the Beneficiary: _____
(Please submit an itemized listing of these expenses)

Date the Case Was Settled: ____/____/____

Description of Injuries: _____

Name of person who is providing this information: _____

Relationship with the Beneficiary: _____

This information should be submitted to:

NGHP
PO BOX 138832
OKLAHOMA CITY, OK 73113

If you have any questions concerning this matter, please contact the Benefits Coordination & Recovery Center (BCRC) by phone at 1-855-798-2627 (TTY/TDD: 1-855-797-2627 for the hearing and speech impaired), in writing at the address below, or by fax to 405-869-3309. When sending correspondence, please include the Beneficiary Name along with the Medicare and Case Identification Numbers (shown above).

Payment Summary Form

umber: [redacted]

r: NGHP

Date:: [redacted]

Time: 06:22:19

ry Name: [redacted]

ry HICN: [redacted]

Case ID: [redacted]

Case Type: E -Workers

Date of Incident: [redacted]

ICN	Line #	Processing Contractor	Provider Name	ICD Indicator	Diagnosis Codes	From Date	To Date	Total Charges	Reimburse Amount	Conditional Payment
33200130207CAA	0	01011	[redacted]	ICD-9	3441, V5883, V7283, 40210	05/01/2013	05/01/2013	$733.58	$99.89	$99.89
504700574807CAA	0	01011	[redacted]	ICD-9	7242	01112/2015	01/27/2015	$3,150.50	$360.93	$360.93
506501991907CAA	0	01011	[redacted]	ICD-9	7242, 7244	02/02/2015	02/23/2015	$1,691.00	$175.29	$175.29
0213141798980	002	01102	[redacted]	ICD-9	40210, V7283, 3441	04/29/2013	04/29/2013	$87.00	$16.78	$16.78
0213136882570	001	01102	[redacted]	ICD-9	72251	05/07/2013	05/07/2013	$1,723.00	$370.79	$370.79
0213142628060	001	01102	[redacted]	ICD-9	7224	05/07/2013	05/07/2013	$1,576.00	$201.55	$201.55

CMS

CENTERS FOR MEDICARE & MEDICAID SERVICES

March 23, 2016

RE: Beneficiary Name: [redacted]
Medicare Number: [redacted]
Case Identification Number: [redacted]
Insurer Claim Number: [redacted]
Insurer Policy Number: [redacted]
Date of Incident: [redacted]
Demand Amount: $8,323.72

D<;ar [redacted]

Our records indicate that you are the responsible primary payer for services Medicare paid conditionally as a result of the accident/incidentwhich occurred on July 04, 2003. Medicare has a claim and is seeking recovery in the amount of $8,323.72.

Pursuant to the Medicare Secondary Payer (MSP) provisions of the Social Security Act, liability insurance (including self-insurance), no-fault insurance, and workers' compensation coverage are primary to Medicare (Section 1862(b)(2) of the Act; 42 U.S.C. 1395y(b)(2). We have researched our records and identified those items and services related to the beneficiary' sinsurance/workers' compensation case for which Medicare has made payment. Medicare made conditional payments totaling $8,323.72. A list of the individual payments used to arrive at this total is enclosed.

Please provide a check or money order made payable to Medicare in the amount of $8,323.72. If the amount payable under your coverage as primary payer is less than the demand amount, please provide documentation that explains the lesser payment with your check or money order. The amount requested in this letter may not include payments received prior to the issuance of this demand letter dated March 23, 2016. Please deduct previous payments, if any, made to Medicare for this debt.

NGHP • PO BOX 138832 • OKLAHOMA CITY, OK 73113 SGLDIWNGHP

Initial Determination letter to insurer / formerly known as "demand letter"

Mail all correspondence to:

NGHP
PO BOX 138832
OKLAHOMA C11Y, OK 731B

Right to Appeal- If you believe the amount or existence of the debt is in error, you may file an appeal. To file an appeal, send a letter explaining why the amount or existence of the debt is incorrect. Please include supporting documentation, if applicable. Medicare will continue collection efforts unless and until an appeal is requested. Medicare will suspend any recovery action while an appeal is pending; however, interest will continue to accrue on any outstanding balance from the date of this letter.

You have 120 days from receipt of this lctter to file an appeal. We must assume that you received this letter within five (5) days of the date of the letter unless you provide proof to the contrary. This means the appeal must be filed no later than Jnly 26, 2016.

If we issue a decision that is not fully favorable to you and you wish to appeal our decision, our letter will provide information on the next steps to request an appeal at the next level.

If you are the agent acting on behalf of the above referenced entity, you must provide proper proof of representation in order to file an appeal. ·IT you have already provided such documentation, you are not required to submit it again. Please note that appeals filed without proper proof of representation will be dismissed.

Interest will accrue ou any unpaid portion of this debt from the date of this letter. Interest will be assessed *if* this debt is not fully resolved within 60 days of the date of this letter at an annual rate of 9.750% and *is* payable for each full 30 day period the debt remains unresolved. By law, all payments are applied to interest first, principal secorid. For provisions specific to interest on MSP debts, see 42 C.F.R. 411.24(m)

The provisions of the Debt Collection Improvement Act of 1996 apply to Medicare debt, and your failure to respond as requested within sixty (60) days of the date of this letter may result in the initiation of additional recovery procedures without further notice. You should be aware that the Debt Collection Improvement Act of 1996 (DCIA) requires Federal Agencies to refer debts to the Department of the Treasury or *its* designated debt collection center for recovery actions, which can include collection by offset against any monies otherwise payable to the debtor by any agency of the United States and other collection methods. For example, the Internal Revenue Service may collect this debt by offset against tax refunds owed to individuals or other entities. DCIA also allows Medicare to refer delinquent debtors to the Department of Justice for legal

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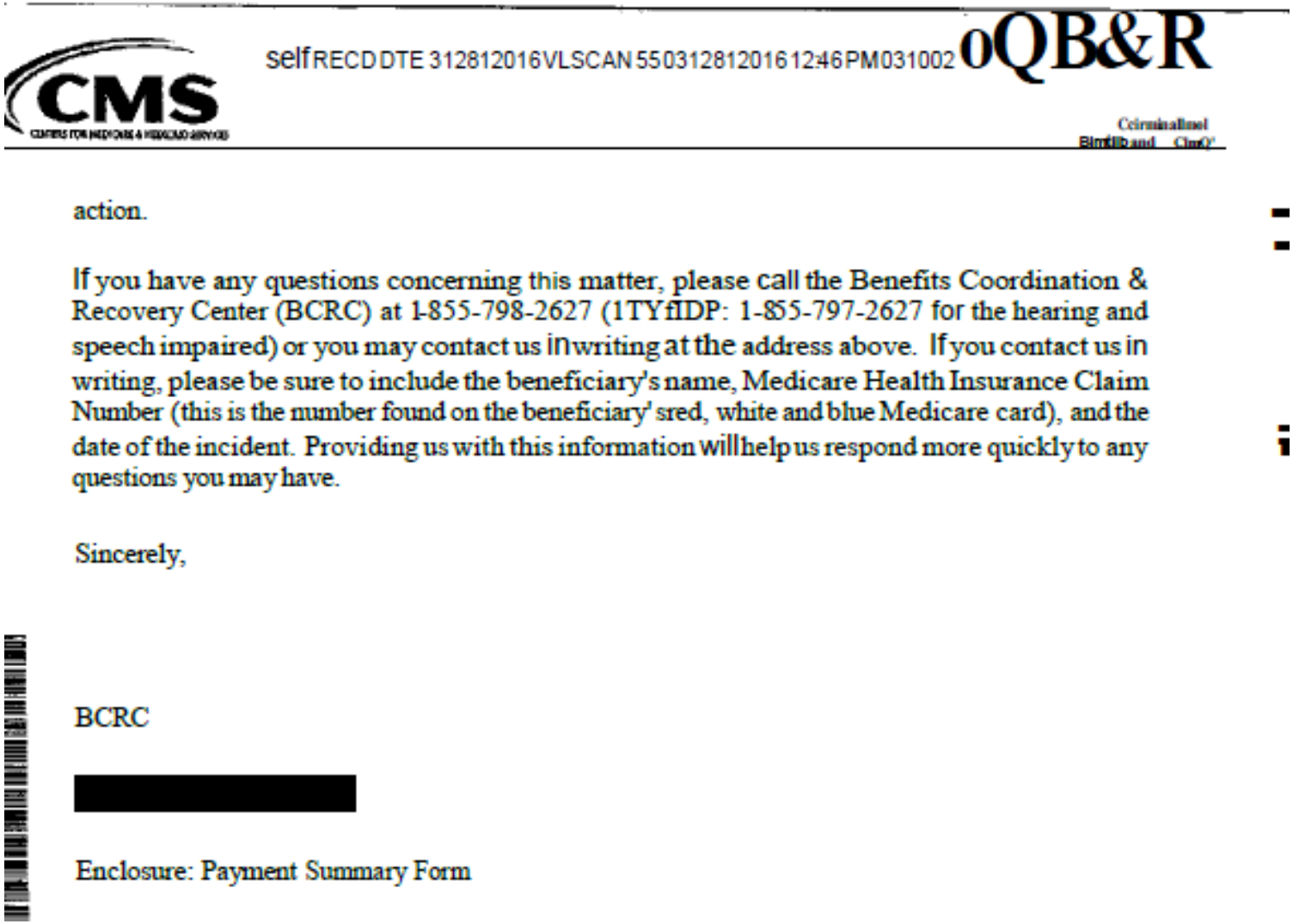
Page 2 of 7

Initial Determination letter to insurer / formerly known as "demand letter"



CMS

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action.

If you have any questions concerning this matter, please call the Benefits Coordination & Recovery Center (BCRC) at 1-855-798-2627 (1TYflDP: 1-855-797-2627 for the hearing and speech impaired) or you may contact us inwriting at the address above. If you contact us in writing, please be sure to include the beneficiary's name, Medicare Health Insurance Claim Number (this is the number found on the beneficiary' sred, white and blue Medicare card), and the date of the incident. Providing us with this information willhelp us respond more quickly to any questions you may have.

Sincerely,

BCRC

[redacted]

Enclosure: Payment Summary Form

Date

Insert name
Insert address 1
Insert address 2
Insert city, state, zip code

SUBJECT: Medicare Secondary Payer Rights and Responsibilities
Beneficiary Name:
Medicare ID:
Case Identification Number:
Insurer Claim Number:
Insurer Policy Number:
Date of Incident:

Dear [Addressee Name]

You are receiving this letter because we were notified that you filed a liability insurance (including self-insurance), no-fault insurance, or workers' compensation claim. This is confirmation that a Medicare Secondary Payer (MSP) recovery case has been established in our system. The enclosed brochure will provide information pertinent to the Medicare recovery process. Please retain this brochure for your future reference.

You can also keep track of your Recovery case by visiting the Medicare Secondary Payer Recovery Portal (MSPRP). To access your Recovery case, please log into your account on http://www.MyMedicare.gov or visit http://go.cms.gov/msprp to learn more about the MSPRP.

If we know that you have a lawyer or other person representing you, we have sent him or her a courtesy copy of this letter and you will see him or her listed as a "cc" at the end of this letter.

What Happens When You Have Medicare and You file a Liability Insurance (including Self- Insurance), No-Fault Insurance, or Workers' Compensation Claim

Applicable Medicare law says that liability insurance (including self-insurance), no-fault insurance, and workers' compensation must pay for medical items and services before Medicare pays. This law can be found at 42 U.S.C. Section 1395y(b)(2)(A) and (B). However, Medicare makes "conditional payments" (payments made to make sure you get the medical services you need while your insurance or workers' compensation claim is being processed).

Later, if you get a(n) insurance or workers' compensation settlement, judgment, award, or other payment, Medicare is entitled to be repaid for the items and services for whit it made these conditional payments. If Medicare determines it must be reimbursed for conditional payment, you will get a demand letter. The demand letter explains how Medicare calculated the amount it

needs to be repaid and it also explains your appeal and waiver rights. If you decide to appeal or request a waiver of recovery. Medicare will **not** take any collection action while your appeal or waiver of recovery request is being processed at any level of review. Please note, however, that interest will continue to accrue on any unpaid balance.

The enclosed brochure explains Medicare's recovery process in more detail and what information we need to work with your attorney or other representative, if you have one. There are also two special, streamlined recovery processes outlined below.

1. **Fixed Percentage Option for Repayment:** If you experienced a physical trauma-based injury and you get a liability insurance settlement, judgement, award, or other payment of $5,000 or less, Medicare offers the option to pay 25.000% of your gross settlement, judgement, award, or other payment, instead of the amount that Medicare would otherwise calculate.

   If you wish to choose this option, you must formally, elect it at the same time that you send us information on your settlement, judgement, award, or other payment. Please visit the Beneficiary (http://go.cms.gov/beneficary) or Attorney (http://go.cms.gov/attorney) sections of the BCRC website for all of the additional details. You will find model language that can be used to elect this option, as well as a special mailing address to ensure efficient processing.

2. **Self-Calculation Option for Medicare's Final Conditional Payment Amount:** if you experienced a physical trauma-based injury, can demonstrate that treatment has been completed, and you expect to get a settlement of $25,000 or less, you may calculate Medicare's Conditional Payment Amount to help us expedite resolution of your case. Please visit the Beneficiary (http://go.cms.gov/beneficary) or Attorney (http://go.cms.gov/attorney) sections of the BCRC website for all of the additional details.

If you have any questions concerning this matter, please contact the Benefits Coordination & Recovery Center (BCRC) by phone at 1-855-798-2627 (TTY/TDD: 1-855-797-2627 for the hearing and speech impaired), in writing at the address below, or by fax to 405-869-3309.

Sincerely,
BCRC

Enclosure: Correspondence Cover Sheet
Benefits Coordination & Recovery Center Brochure

CC:

Rood v. N.Y. State Teamsters Conference Pension & Ret. Fund

No. 5:13–CV–0435 LEK/ATB.

08-20-2014

Paul J. ROOD, Plaintiff, v. NEW YORK STATE TEAMSTERS CONFERENCE PENSION AND RETIREMENT FUND; and The Board of Trustees of the New York State Teamsters Conference Pension and Retirement Fund, Defendants.

Carla N. McKain, McKain Law, PLLC, Ithaca, NY, for Plaintiff. Donald L. Havermann, Morgan, Lewis Law Firm, Washington, DC, Sean K. McMahan, Alston, Bird Law Firm, Atlanta, GA, Vincent M. Debella, Paravati, Karl Law Firm, Utica, NY, for Defendants.

LAWRENCE E. KAHN, Senior District Judge.

I. INTRODUCTION

Plaintiff Paul J. Rood ("Plaintiff") commenced this action on April 19, 2013, alleging a claim for disability pension benefits under the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. §§ 1001 –1461. Dkt. No. 1 ("Complaint"). Plaintiff's Complaint names the New York State Teamsters Conference Pension and Retirement Fund (the "Fund") and its Board of Trustees ("the Board") (collectively, "Defendants") as Defendants. *Id.* Presently before the Court are the parties' Motions for summary judgment. Dkt. Nos. 15 ("Defendants Motion"); 16 ("Plaintiff Motion"). For the following reasons, Defendants' Motion is denied and Plaintiff's Motion is granted.

II. BACKGROUND [1]

[1] Ordinarily, on a motion for summary judgment, a court must resolve all ambiguities and draw all reasonable inferences in favor of the nonmoving party. *Reeves v. Sanderson Plumbing Prods., Inc.*, 530 U.S. 133, 150, 120 S.Ct. 2097, 147 L.Ed.2d 105 (2000) ; *Nora Beverages, Inc. v. Perrier Grp. of Am., Inc.*,

164 F.3d 736, 742 (2d Cir.1998). Where both parties have moved for summary judgment, it may thus be necessary to distinguish their factual assertions accordingly. *See id.* However, in this case, the facts are, in large part, not in dispute, and therefore the Court has consolidated the parties' factual statements for purposes of this section.

A. The Fund

The Fund is a multi-employer plan that provides pension and disability
245 benefits to *245 employees covered by collective bargaining agreements between contributing employers and various local unions of the International Brotherhood of Teamsters. Dkt. Nos. 15–5 ("Defendants SMF") ¶ 1; 18–1 ("Response to Defendants SMF") ¶ 1. The Fund pays pension and disability benefits to eligible participants and beneficiaries pursuant to a written pension plan. Defs. SMF ¶ 3; Resp. to Defs. SMF ¶ 3; Dkt. No. 15–8 Ex. 2 (the "Plan").

B. Disability Benefits Under the Plan

Under the Plan, a participant who becomes "disabled" is eligible for a disability benefit ("Fund Disability Benefit" or "FDB") if he has earned ten years of Future Service Credit. Plan § 7.03(a); Defs. SMF ¶ 7; Resp. to Defs. SMF ¶ 7. A participant is considered "disabled" if he satisfies the requirements for a Social Security disability award. Plan § 2.15; Defs. SMF ¶ 8; Resp. to Defs. SMF ¶ 8. The participant's disability benefit ends when the participant reaches normal retirement age under the Plan. Plan § 7.03(b); Defs. SMF ¶ 9; Resp. to Defs. SMF ¶ 9.

The monthly Fund Disability Benefit amount is equal to the normal pension benefit the participant would be entitled to if he had attained the age requirement for a normal pension. Plan § 7.03(c); Defs. SMF ¶ 11; Resp. to Defs. SMF ¶ 11. However, the Plan further provides that, if a participant is also receiving workers' compensation ("WC") benefits due to an occupational disability, the monthly amount of the Fund Disability Benefit will be reduced by the amount of monthly WC benefits received. Plan § 7.03(i); Defs. SMF ¶¶ 12–13; Resp. to Defs. SMF ¶¶ 12–13. But if part of the participant's WC benefit is "used to offset other payment sources (*i.e.*, Social Security disability awards, long-term disability, etc.)" to which the participant may be entitled, that portion of the WC benefit is not included in the reduction of the participant's monthly Fund Disability Benefit. Plan § 7.03(i); Defs. SMF ¶¶ 14–16; Resp. to Defs. SMF ¶¶ 14–16.

C. Workers' Compensation Medicare Set–Aside Arrangements

Medicare is a federally funded program that covers health care costs for certain individuals, including those who have received Social Security disability benefits for at least twenty-four months. *See* 42 U.S.C. § 1395c. Medicare Parts A and B provide hospital and medical care benefits to individuals by making payments on their behalf directly to health care providers, or, in some cases, to individual beneficiaries. *See generally* 42 U.S.C. §§ 1395c, 1395d, 1395g, 1395j –1395k.

SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0037

Request For Waiver Of Overpayment Recovery Or Change In Repayment Rate

We will use your answers on this form to decide if we can waive collection of the overpayment or change the amount you must pay us back each month. If we can't waive collection, we may use this form to decide how you should repay the money.

Please answer the questions on this form as completely as you can. We will help you fill out the form if you want. If you are filling out this form for someone else, answer the questions as they apply to that person.

FOR SSA USE ONLY	
ROAR Input	☐ Yes ☐ No
Input Date	
Waiver	☐ Approval ☐ Denial
SSI	☐ Yes ☐ No
AMT OF OP $	
PERIOD (DATES) OF OP	

1. A. Name of person on whose record the overpayment occurred:

_____

B. Social Security Number

☐☐☐—☐☐—☐☐☐☐

C. Name of overpaid person(s) making this request and his/her Social Security Number(s):

_____ ☐☐☐—☐☐—☐☐☐☐

_____ ☐☐☐—☐☐—☐☐☐☐

_____ ☐☐☐—☐☐—☐☐☐☐

_____ ☐☐☐—☐☐—☐☐☐☐

2. Check any of the following that apply. (Also, Fill in the dollar amount in B, C, or D.)

A. ☐ The overpayment was not my fault and I cannot afford to pay the money back and/or it is unfair for some other reasons.

B. ☐ I cannot afford to use all of my monthly benefit to pay back the overpayment. However I can afford to have $ _____ withheld each month

C. ☐ I am no longer receiving Supplement Security Income (SSI) payments. I want to pay back $ _____ each month instead of paying all of the money at once.

D. ☐ I am receiving SSI payments. I want to pay back $ _____ each month instead of paying 10% of my total income.

SECTION I-INFORMATION ABOUT RECEIVING THE OVERPAYMENT

3. A. Did you, as representative payee, receive the overpaid benefits to use for the beneficiary?

☐ Yes ☐ No (Skip to Question 4)

B. Name and address of the beneficiary

C. How were the overpaid benefits used?

4. If we are asking you to repay someone else's overpayment:

A. Was the overpaid person living with you when he/she was overpaid? ☐ Yes ☐ No

B. Did you receive any of the overpaid money? ☐ Yes ☐ No

C. Explain what you know about the overpayment AND why it was not your fault.

5. Why did you think you were due the overpaid money and why do you think you were not at fault in causing the overpayment or accepting the money?

6. A. Did you tell us about the change or event that made you overpaid? ☐ Yes ☐ No
If no, why didn't you tell us?

B. If yes, how, when and where did you tell us? If you told us by phone or in person, who did you talk with and what was said?

C. If you did not hear from us after your report, and/or your benefits did not change, did you contact us again? ☐ Yes ☐ No

7. A. Have we ever overpaid you before? ☐ Yes ☐ No

If yes, on what Social Security number? ☐☐☐—☐☐—☐☐☐☐

B. Why were you overpaid before? If the reason is similar to why you are overpaid now, explain what you did to try to prevent the present overpayment.

FOR SSA USE ONLY

NAME:

SSN:

SECTION II-YOUR FINANCIAL STATEMENT

You need to complete this section if you are asking us either to waive the collection of the overpayment or to change the rate at which we asked you to repay it. Please answer all questions as fully and as carefully as possible. We may ask to see some documents to support your statements, so you should have them with you when you visit our office.

EXAMPLES ARE:

- Current Rent or Mortgage Books
- Savings Passbooks
- Pay Stubs
- Your most recent Tax Return
- 2 or 3 recent utility, medical, charge card, and insurance bills
- Cancelled checks
- Similar documents for your spouse or dependent family members

Please write only whole dollar amounts-Round any cents to the nearest dollar. If you need more space for answers, use the "Remarks" section at the bottom of page 7.

9. A. Do you now have any of the overpaid checks or money in your possession (or in a savings or other type of account)?

☐ Yes Amount:$ _____
Return this amount to SSA
☐ No

B. Did you have any of the overpaid checks or money in your possession (or in a savings or other type of account) at the time you received the overpayment notice?

☐ Yes Amount:$ _____
Answer Question 10.
☐ No

10. Explain why you believe you should not have to return this amount.

_____

_____

ANSWER 11 AND 12 ONLY IF THE OVERPAYMENT IS SUPPLEMENTAL SECURITY INCOME PAYMENTS (SSI). IF NOT, SKIP TO 13.

11. A. Did you lend or give away any property or cash after notification of the overpayment?

☐ Yes (Answer Part B)
☐ No (Go to question 12.)

B. Who received it, relationship (if any), description and value:

_____

12. A. Did you receive or sell any property or receive any cash (other than earnings) after notification of this overpayment?

☐ Yes (Answer Part B)
☐ No (Go to Question 13.)

B. Describe property and sale price or amount of cash received:

_____

13. A. Are you now receiving cash public assistance such as Supplemental Security Income (SSI) payments?

☐ Yes (Answer B and C and See note below)
☐ No

B. Name or kind of public assistance

_____

C. Claim Number

_____

IMPORTANT: If you answered "YES" to question 13, DO NOT answer any more questions on this form. Go to page 8, sign and date the form, and give your address and phone number(s). Bring or mail any papers that show you receive public assistance to your local Social Security office as soon as possible.

Members Of Household

14. List any person (child, parent, friend, etc.) who depends on you for support AND who lives with you.

NAME	AGE	RELATIONSHIP (If none, explain why the person is dependent on you)

Assets-Things You Have And Own

15. A. How much money do you and any person(s) listed in question 14 above have as cash on hand, in a checking account, or otherwise readily available?

$

B. Does your name, or that of any other member of your household appear, either alone or with any other person, on any of the following?

TYPE OF ASSET	OWNER	BALANCE OR VALUE	PER MONTH	SHOW THE INCOME (Interest, dividends) EARNED EACH MONTH. (If none explain in spaces below) If paid quarterly, divide by 3.
SAVINGS (Bank, Savings and Loan, Credit Union)		$	$	
		$	$	
CERTIFICATES OF DEPOSIT (CD)		$	$	
INDIVIDUAL RETIREMENT ACCOUNT (IRA)		$	$	
MONEY OR MUTUAL FUNDS		$	$	
BONDS, STOCKS		$	$	
TRUST FUND		$	$	
CHECKING ACCOUNT		$	$	
OTHER (EXPLAIN)		$	$	
TOTALS →		$	$	Enter the "Per Month" total on line (k) of question 19.

16. A. If you or a member of your household own a car, (other than the family vehicle), van, truck, camper, motorcycle, or any other vehicle or a boat, list below.

OWNER	YEAR, MAKE/MODEL	PRESENT VALUE	LOAN BALANCE (if any)	MAIN PURPOSE FOR USE
		$	$	
		$	$	
		$	$	

B. If you or a member of your household own any real estate (buildings or land), OTHER than where you live, or own or have an interest in, any business, property, or valuables, describe below.

OWNER	DESCRIPTION	MARKET VALUE	LOAN BALANCE (if any)	USAGE-INCOME (rent etc.)
		$	$	
		$	$	
		$	$	
		$	$	

Monthly Household Income

If paid weekly, multiply by 4.33 (4 1/3) to figure monthly pay. If paid every 2 weeks, multiply by 2.166 (2 1/6) If self-employed, enter 1/12 of net earnings. Enter monthly TAKE HOME amounts on line A of question 19 also.

17. A. Are you employed? ☐ YES (Provide information below) ☐ NO (Skip to B)

Employer name, address, and phone: (Write "self" if self-employed) | Monthly pay before deduction (Gross) $

| | Monthly TAKE-HOME pay (NET) $

B. Is your spouse employed? ☐ YES (Provide information below) ☐ NO (Skip to C)

Employer(s) name, address, and phone: (Write "self" if self-employed) | Monthly pay before deduction (Gross) $

| | Monthly TAKE-HOME pay (NET) $

C. Is any other person listed in Question 14 employed? ☐ YES ☐ NO (Go to Question 18) Name(s)

Employer(s) name, address, and phone: (Write "self" if self-employed) | Monthly pay before deduction (Gross) $

| | Monthly TAKE-HOME pay (NET) $

18. A. Do you, your spouse or any dependent member of your household receive support or contributions from any person or organization? ☐ YES (Answer B) ☐ NO (Go to question 19)

B. How much money is received each month? (Show this amount on line (J) of question 19) $ | SOURCE

BE SURE TO SHOW **MONTHLY** AMOUNTS BELOW - If received weekly or every 2 weeks, read the instruction at the top of this page.

19.

INCOME FROM #17 AND #18 ABOVE AND OTHER INCOME TO YOUR HOUSEHOLD		YOURS	V	SPOUSE'S	V	OTHER HOUSEHOLD MEMBERS	V	SSA USE ONLY
A. TAKE HOME Pay (Net) (From #17 A, B, C, above)		$	☐	$	☐	$	☐	
B. Social Security Benefits			☐		☐		☐	
C. Supplemental Security Income (SSI)			☐		☐		☐	
D. Pension(s) (VA, Military, Civil Service, Railroad, etc.)	TYPE		☐		☐		☐	
	TYPE		☐		☐		☐	
E. Public Assistance (Other than SSI)	TYPE		☐		☐		☐	
F. Food Stamps (Show full face value of stamps received)			☐		☐		☐	
G. Income from real estate (rent, etc.) (From question 16B)			☐		☐		☐	
H. Room and/or Board Payments (Explain in remarks below)			☐		☐		☐	
I. Child Support/Alimony			☐		☐		☐	
J. Other Support (From #18 (B) above)			☐		☐		☐	
K. Income From Assets (From question 15)			☐		☐		☐	
L. Other (From any source, explain below)			☐		☐		☐	
REMARKS	TOTALS	$		$		$		

GRAND TOTAL $
(Add 3 total blocks above)

MONTHLY HOUSEHOLD EXPENSES

If the expense is paid weekly or every 2 weeks, read the instruction at top of Page 5. Do NOT list an expense that is withheld from income (Such as Medical Insurance). Only take home pay is used to figure income.

Show "CC" as the expense amount if the expense (such as clothing) is part of CREDIT CARD EXPENSE SHOWN ON LINE (F).

20.		$ PER MONTH	SSA USE ONLY
	A. Rent or Mortgage (If mortgage payment includes property or other local taxes, insurance, etc. DO NOT list again below.		
	B. Food (Groceries (include the value of food stamps) and food at restaurants, work, etc.)		
	C. Utilities (Gas, electric, telephone)		
	D. Other Heating/Cooking Fuel (Oil, propane, coal, wood, etc.)		
	E. Clothing		
	F. Credit Card Payments (show minimum monthly payment allowed)		
	G. Property Tax (State and local)		
	H. Other taxes or fees related to your home (trash collection, water-sewer fees)		
	I. Insurance (Life, health, fire, homeowner, renter, car, and any other casualty or liability policies)		
	J. Medical-Dental (After amount, if any, paid by insurance)		
	K. Car operation and maintenance (Show any car loan payment in (N) below)		
	L. Other transportation		
	M. Church-charity cash donations		
	N. Loan, credit, lay-away payments (If payment amount is optional, show minimum)		
	O. Support to someone NOT in household (Show name, age, relationship (if any) and address)		
	P. Any expense not shown above (Specify)		
	EXPENSE REMARKS Also explain any unusual or very large expenses, such as medical, college, etc.)	TOTAL	$

INCOME AND EXPENSES COMPARISON

21. A. Monthly income
(Write the amount here from the "Grand Total" of #19. → $

B. Monthly Expenses
Write the amount here from the "Total" of #20. → $

C. Adjusted Household Expenses → + $25

D. Adjusted Monthly Expenses (Add (B) and (C)) → $

22. If your expenses (D) are more than your income (A), explain how you are paying your bills.

FOR SSA USE ONLY	
☐ INC. **EXCEEDS** ADJ EXPENSE	$ +
☐ INC **LESS THAN** ADJ EXPENSE	$ -

FINANCIAL EXPECTATION AND FUNDS AVAILABILITY

23. A. Do you, your spouse or any dependent member of your household expect your or their financial situation to change (for the better or worse) in the next 6 months? (For example: a tax refund, pay raise or full repayment of a current bill for the better-major house repairs for the worse).

☐ YES (Explain on line below)
☐ NO

B. If there is an amount of cash on hand or in checking accounts shown in item 15A, is it being held for a special purpose?

☐ No amount on hand
☐ NO (Money available for any use)
☐ YES (Explain on line below)

C. Is there any reason you CANNOT convert to cash the "Balance or Value" of any financial asset shown in item 15B.

☐ YES (Explain on line below)
☐ NO

D. Is there any reason you CANNOT SELL or otherwise convert to cash any of the assets shown in items 16A and B?

☐ YES (Explain on line below)
☐ NO

REMARKS SPACE – If you are continuing an answer to a question, please write the number (and letter, if any) of the question first.

(MORE SPACE ON NEXT PAGE)

(REMARKS SPACE (Continued)

PENALTY CLAUSE, CERTIFICATION AND PRIVACY ACT STATEMENT

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

SIGNATURE OF OVERPAID PERSON OR REPRESENTATIVE PAYEE

SIGNATURE (First name, middle initial, last name) (Write ink)	DATE (Month, Day, Year)
	HOME TELEPHONE NUMBER (Include area code) ( ) –
SIGN HERE ▶	WORK TELEPHONE NUMBER IF WE MAY CALL YOU AT WORK (Include area code) ( ) –

MAILING ADDRESS (Number and street, Apt. No., P.O. Box, or Rural Route)

CITY AND STATE	ZIP CODE –	ENTER NAME OF COUNTY (IF ANY) IN WHICH YOU NOW LIVE

Witnesses are required ONLY if this statement has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the individual must sign below, giving their full addresses.

SIGNATURE OF WITNESS	SIGNATURE OF WITNESS
ADDRESS (Number and street, City, State, and ZIP Code)	ADDRESS (Number and street, City, State, and ZIP Code)

About the Privacy Act

The Social Security Act (Sections 204, 1631(b), and 1870) and the Federal Coal Mine Health and Safety Act of 1969 allow us to collect the facts on this form. This form is voluntary. However, if you do not give us the facts we ask for, we may not be able to approve your waiver request. If we cannot collect the overpayment, we may ask the Justice Department to collect it.

Sometimes the law requires us to give out the facts on this form without your consent. We must give these facts to another person or government agency if Federal law requires that we do so or to do the research and audits needed to monitor and improve the programs we manage.

We may also give these facts to the Justice Department to investigate and prosecute violations of the Social Security Act or we may use the facts in computer matching programs. Matching programs compare our records with those of other Federal, State, or local government agencies. All the Agencies may use matching programs to find or prove that a person qualifies for benefits paid for or managed by the Federal government. Another use is to identify and collect overpayments or to collect overdue loans under these benefits programs.

Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 2 hours to read the instructions, gather the facts, and answer the questions. SEND **OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is listed underU. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213.** You may send comments on our time estimate above to: SSA, 6401 Security Blvd.,Baltimore,MD21235-6401. ***Send only comments relating to our time estimate to this address, not the completed form.***

(i) In general

A large group health plan (as defined in clause (iii)) may not take into account that an individual (or a member of the individual's family) who is covered under the plan by virtue of the individual's current employment status with an employer is entitled to benefits under this subchapter under section 426(b) of this title.

(ii) Exception for individuals with end stage renal disease

Subparagraph (C) shall apply instead of clause (i) to an item or service furnished in a month to an individual if for the month the individual is, or (without regard to entitlement under section 426 of this title) would upon application be, entitled to benefits under section 426–1 of this title.

(iii) "Large group health plan" defined

In this subparagraph, the term "large group health plan" has the meaning given such term in section 5000(b)(2) of the Internal Revenue Code of 1986, without regard to section 5000(d) of such Code.

(C) Individuals with end stage renal disease

A group health plan (as defined in subparagraph (A)(v))—

(i) may not take into account that an individual is entitled to or eligible for benefits under this subchapter under section 426–1 of this title during the 12-month period which begins with the first month in which the individual becomes entitled to benefits under part A under the provisions of section 426–1 of this title, or, if earlier, the first month in which the individual would have been entitled to benefits under such part under the provisions of section 426–1 of this title if the individual had filed an application for such benefits; and

(ii) may not differentiate in the benefits it provides between individuals having end stage renal disease and other individuals covered by such plan on the basis of the existence of end stage renal disease, the need for renal dialysis, or in any other manner;

except that clause (ii) shall not prohibit a plan from paying benefits secondary to this subchapter when an individual is entitled to or eligible for benefits under this subchapter under section 426–1 of this title after the end of the 12-month period described in clause (i). Effective for items and services furnished on or after February 1, 1991, and before August 5, 1997,[2] (with respect to periods beginning on or after February 1, 1990), this subparagraph shall be applied by substituting "18-month" for "12-month" each place it appears. Effective for items and services furnished on or after August 5, 1997,[2] (with respect to periods beginning on or after the date that is 18 months prior to August 5, 1997), clauses (i) and (ii) shall be applied by substituting "30-month" for "12-month" each place it appears.

(D) Treatment of certain members of religious orders

In this subsection, an individual shall not be considered to be employed, or an employee, with respect to the performance of services as a member of a religious order which are considered employment only by virtue of an election made by the religious order under section 3121(r) of the Internal Revenue Code of 1986.

(E) General provisions

For purposes of this subsection:

(i) Aggregation rules

(I) All employers treated as a single employer under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 shall be treated as a single employer.

(II) All employees of the members of an affiliated service group (as defined in section 414(m) of such Code) shall be treated as employed by a single employer.

(III) Leased employees (as defined in section 414(n)(2) of such Code) shall be treated as employees of the person for whom they perform services to the extent they are so treated under section 414(n) of such Code.

In applying sections of the Internal Revenue Code of 1986 under this clause, the Secretary shall rely upon regulations and decisions of the Secretary of the Treasury respecting such sections.

(ii) "Current employment status" defined
An individual has "current employment status" with an employer if the individual is an employee, is the employer, or is associated with the employer in a business relationship.

(iii) Treatment of self-employed persons as employers
The term "employer" includes a self-employed person.

(F) Limitation on beneficiary liability
An individual who is entitled to benefits under this subchapter and is furnished an item or service for which such benefits are incorrectly paid is not liable for repayment of such benefits under this paragraph unless payment of such benefits was made to the individual.

(2) Medicare secondary payer

(A) In general

Payment under this subchapter may not be made, except as provided in subparagraph (B), with respect to any item or service to the extent that—

(i) payment has been made, or can reasonably be expected to be made, with respect to the item or service as required under paragraph (1), or

(ii) payment has been made[3] or can reasonably be expected to be made[3] under a workmen's compensation law or plan of the United States or a State or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance.

In this subsection, the term "primary plan" means a group health plan or large group health plan, to the extent that clause (i) applies, and a workmen's compensation law or plan, an automobile or liability insurance policy or plan (including a self-insured plan) or no fault insurance, to the extent that clause (ii) applies. An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.

(B) Conditional payment

(i) Authority to make conditional payment
The Secretary may make payment under this subchapter with respect to an item or service if a primary plan described in subparagraph (A)(ii)[4] has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.

(ii) Repayment required
Subject to paragraph (9), a primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this subchapter with respect to an item or service if it is demonstrated that such primary plan

has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means. If reimbursement is not made to the appropriate Trust Fund before the expiration of the 60-day period that begins on the date notice of, or information related to, a primary plan's responsibility for such payment or other information is received, the Secretary may charge interest (beginning with the date on which the notice or other information is received) on the amount of the reimbursement until reimbursement is made (at a rate determined by the Secretary in accordance with regulations of the Secretary of the Treasury applicable to charges for late payments).

(iii) Action by United States

In order to recover payment made under this subchapter for an item or service, the United States may bring an action against 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 payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity. The United States may not recover from a third-party administrator under this clause in cases where the third-party administrator would not be able to recover the amount at issue from the employer or group health plan and is not employed by or under contract with the employer or group health plan at the time the action for recovery is initiated by the United States or for whom it provides administrative services due to the insolvency or bankruptcy of the employer or plan. An action may not be brought by the United States under this clause with respect to payment owed unless the complaint is filed not later than 3 years after the date of the receipt of notice of a settlement, judgment, award, or other payment made pursuant to paragraph (8) relating to such payment owed.

(iv) Subrogation rights

The United States shall be subrogated (to the extent of payment made under this subchapter for such an item or service) to any right under this subsection of an individual or any other entity to payment with respect to such item or service under a primary plan.

(v) Waiver of rights

The Secretary may waive (in whole or in part) the provisions of this subparagraph in the case of an individual claim if the Secretary determines that the waiver is in the best interests of the program established under this subchapter.

(vi) Claims-filing period

Notwithstanding any other time limits that may exist for filing a claim under an employer group health plan, the United States may seek to recover conditional payments in accordance with this subparagraph where the request for payment is submitted to the entity required or responsible under this subsection to pay with respect to the item or service (or any portion thereof) under a primary plan within the 3-year period beginning on the date on which the item or service was furnished.

(vii) Use of website to determine final conditional reimbursement amount

(I) Notice to Secretary of expected date of a settlement, judgment, etc.

In the case of a payment made by the Secretary pursuant to clause (i) for items and services provided to the claimant, the claimant or applicable plan (as defined in paragraph (8)(F)) may at any time beginning 120 days before the reasonably expected date of a settlement, judgment, award, or other payment, notify the Secretary that a payment is reasonably expected and the expected date of such payment.

(II) Secretarial providing access to claims information through a website

The Secretary shall maintain and make available to individuals to whom items and services are furnished under this subchapter (and to authorized family or other representatives recognized under regulations and to an applicable plan which has obtained the consent of the individual) access to information on the claims for such items and services (including payment amounts for such claims), including those claims that relate to a potential settlement, judgment, award, or other payment. Such access shall be provided to an individual, representative, or plan through a website that requires a password to gain access to the information. The Secretary shall update the information on claims and payments on such website in as timely a manner as possible but not later than 15 days after the date that payment is made. Information related to claims and payments subject to the notice under subclause (I) shall be maintained and made available consistent with the following:

(aa) The information shall be as complete as possible and shall include provider or supplier name, diagnosis codes (if any), dates of service, and conditional payment amounts.

(bb) The information accurately identifies those claims and payments that are related to a potential settlement, judgment, award, or other payment to which the provisions of this subsection apply.

(cc) The website provides a method for the receipt of secure electronic communications with the individual, representative, or plan involved.

(dd) The website provides that information is transmitted from the website in a form that includes an official time and date that the information is transmitted.

(ee) The website shall permit the individual, representative, or plan to download a statement of reimbursement amounts (in this clause referred to as a "statement of reimbursement amount") on payments for claims under this subchapter relating to a potential settlement, judgment, award, or other payment.

(III) Use of timely web download as basis for final conditional amount

If an individual (or other claimant or applicable plan with the consent of the individual) obtains a statement of reimbursement amount from the website during the protected period as defined in subclause (V) and the related settlement, judgment, award or other payment is made during such period, then the last statement of reimbursement amount that is downloaded during such period and within 3 business days before the date of the settlement, judgment, award, or other payment shall constitute the final conditional amount subject to recovery under clause (ii) related to such settlement, judgment, award, or other payment.

(IV) Resolution of discrepancies

If the individual (or authorized representative) believes there is a discrepancy with the statement of reimbursement amount, the Secretary shall provide a timely process to resolve the discrepancy. Under such process the individual (or representative) must provide documentation explaining the discrepancy and a proposal to resolve such discrepancy. Within 11 business days after the date of receipt of such documentation, the Secretary shall determine whether there is a reasonable basis to include or remove claims on the

statement of reimbursement. If the Secretary does not make such determination within the 11 business-day period, then the proposal to resolve the discrepancy shall be accepted. If the Secretary determines within such period that there is not a reasonable basis to include or remove claims on the statement of reimbursement, the proposal shall be rejected. If the Secretary determines within such period that there is a reasonable basis to conclude there is a discrepancy, the Secretary must respond in a timely manner by agreeing to the proposal to resolve the discrepancy or by providing documentation showing with good cause why the Secretary is not agreeing to such proposal and establishing an alternate discrepancy resolution. In no case shall the process under this subclause be treated as an appeals process or as establishing a right of appeal for a statement of reimbursement amount and there shall be no administrative or judicial review of the Secretary's determinations under this subclause.

(V) Protected period

In subclause (III), the term "protected period" means, with respect to a settlement, judgment, award or other payment relating to an injury or incident, the portion (if any) of the period beginning on the date of notice under subclause (I) with respect to such settlement, judgment, award, or other payment that is after the end of a Secretarial response period beginning on the date of such notice to the Secretary. Such Secretarial response period shall be a period of 65 days, except that such period may be extended by the Secretary for a period of an additional 30 days if the Secretary determines that additional time is required to address claims for which payment has been made. Such Secretarial response period shall be extended and shall not include any days for any part of which the Secretary determines (in accordance with regulations) that there was a failure in the claims and payment posting system and the failure was justified due to exceptional circumstances (as defined in such regulations). Such regulations shall define exceptional circumstances in a manner so that not more than 1 percent of the repayment obligations under this subclause would qualify as exceptional circumstances.

(VI) Effective date

The Secretary shall promulgate final regulations to carry out this clause not later than 9 months after January 10, 2013.

(VII) Website including successor technology

In this clause, the term "website" includes any successor technology.

(viii) Right of appeal for secondary payer determinations relating to liability insurance (including self-insurance), no fault insurance, and workers' compensation laws and plans

The Secretary shall promulgate regulations establishing a right of appeal and appeals process, with respect to any determination under this subsection for a payment made under this subchapter for an item or service for which the Secretary is seeking to recover conditional payments from an applicable plan (as defined in paragraph (8)(F)) that is a primary plan under subsection (A)(ii),[5] under which the applicable plan involved, or an attorney, agent, or third party administrator on behalf of such plan, may appeal such determination. The individual furnished such an item or service shall be notified of the plan's intent to appeal such determination[6]

(C) Treatment of questionnaires

The Secretary may not fail to make payment under subparagraph (A) solely on the ground that an individual failed to complete a questionnaire concerning the existence of a primary plan.

(3) Enforcement

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

(B) Reference to excise tax with respect to nonconforming group health plans
For provision imposing an excise tax with respect to nonconforming group health plans, see section 5000 of the Internal Revenue Code of 1986.

(C) Prohibition of financial incentives not to enroll in a group health plan or a large group health plan
It is unlawful for an employer or other entity to offer any financial or other incentive for an individual entitled to benefits under this subchapter not to enroll (or to terminate enrollment) under a group health plan or a large group health plan which would (in the case of such enrollment) be a primary plan (as defined in paragraph (2)(A)). Any entity that violates the previous sentence is subject to a civil money penalty of not to exceed $5,000 for each such violation. The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(4) Coordination of benefits

Where payment for an item or service by a primary plan is less than the amount of the charge for such item or service and is not payment in full, payment may be made under this subchapter (without regard to deductibles and coinsurance under this subchapter) for the remainder of such charge, but—

(A) payment under this subchapter may not exceed an amount which would be payable under this subchapter for such item or service if paragraph (2)(A) did not apply; and

(B) payment under this subchapter, when combined with the amount payable under the primary plan, may not exceed—

(i) in the case of an item or service payment for which is determined under this subchapter on the basis of reasonable cost (or other cost-related basis) or under section 1395ww of this title, the amount which would be payable under this subchapter on such basis, and

(ii) in the case of an item or service for which payment is authorized under this subchapter on another basis—

(I) the amount which would be payable under the primary plan (without regard to deductibles and coinsurance under such plan), or

(II) the reasonable charge or other amount which would be payable under this subchapter (without regard to deductibles and coinsurance under this subchapter),

whichever is greater.

(5) Identification of secondary payer situations

(A) Requesting matching information

(i) Commissioner of Social Security
The Commissioner of Social Security shall, not less often than annually, transmit to the Secretary of the Treasury a list of the names and TINs of medicare beneficiaries (as defined in section 6103(l)(12) of the Internal Revenue Code of 1986) and request that the Secretary disclose to the Commissioner the information described in subparagraph (A) of such section.

(ii) Administrator

The Administrator of the Centers for Medicare & Medicaid Services shall request, not less often than annually, the Commissioner of the Social Security Administration to disclose to the Administrator the information described in subparagraph (B) of section 6103(l)(12) of the Internal Revenue Code of 1986.

(B) Disclosure to fiscal intermediaries and carriers

In addition to any other information provided under this subchapter to fiscal intermediaries and carriers, the Administrator shall disclose to such intermediaries and carriers (or to such a single intermediary or carrier as the Secretary may designate) the information received under subparagraph (A) for purposes of carrying out this subsection.

(C) Contacting employers

(i) In general

With respect to each individual (in this subparagraph referred to as an "employee") who was furnished a written statement under section 6051 of the Internal Revenue Code of 1986 by a qualified employer (as defined in section 6103(l)(12)(E)(iii) of such Code), as disclosed under subparagraph (B), the appropriate fiscal intermediary or carrier shall contact the employer in order to determine during what period the employee or employee's spouse may be (or have been) covered under a group health plan of the employer and the nature of the coverage that is or was provided under the plan (including the name, address, and identifying number of the plan).

(ii) Employer response

Within 30 days of the date of receipt of the inquiry, the employer shall notify the intermediary or carrier making the inquiry as to the determinations described in clause (i). An employer (other than a Federal or other governmental entity) who willfully or repeatedly fails to provide timely and accurate notice in accordance with the previous sentence shall be subject to a civil money penalty of not to exceed $1,000 for each individual with respect to which such an inquiry is made. The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(D) Obtaining information from beneficiaries

Before an individual applies for benefits under part A or enrolls under part B, the Administrator shall mail the individual a questionnaire to obtain information on whether the individual is covered under a primary plan and the nature of the coverage provided under the plan, including the name, address, and identifying number of the plan.

(E) End date

The provisions of this paragraph shall not apply to information required to be provided on or after July 1, 2016.

(6) Screening requirements for providers and suppliers

(A) In general

Notwithstanding any other provision of this subchapter, no payment may be made for any item or service furnished under part B unless the entity furnishing such item or service completes (to the best of its knowledge and on the basis of information obtained from the individual to whom the item or service is furnished) the portion of the claim form relating to the availability of other health benefit plans.

(B) Penalties

An entity that knowingly, willfully, and repeatedly fails to complete a claim form in accordance with subparagraph (A) or provides inaccurate information relating to the availability of other health benefit plans on a claim form under such subparagraph shall be subject to a civil money penalty of not to exceed $2,000 for each such incident. The provisions of section 1320a–7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title.

(7) Required submission of information by group health plans

(A) Requirement

On and after the first day of the first calendar quarter beginning after the date that is 1 year after December 29, 2007, an entity serving as an insurer or third party administrator for a group health plan, as defined in paragraph (1)(A)(v), and, in the case of a group health plan that is self-insured and self-administered, a plan administrator or fiduciary, shall—

(i) secure from the plan sponsor and plan participants such information as the Secretary shall specify for the purpose of identifying situations where the group health plan is or has been—

(I) a primary plan to the program under this subchapter; or

(II) for calendar quarters beginning on or after January 1, 2020, a primary payer with respect to benefits relating to prescription drug coverage under part D; and

(ii) submit such information to the Secretary in a form and manner (including frequency) specified by the Secretary.

(B) Enforcement

(i) In general

An entity, a plan administrator, or a fiduciary described in subparagraph (A) that fails to comply with the requirements under such subparagraph shall be subject to a civil money penalty of $1,000 for each day of noncompliance for each individual for which the information under such subparagraph should have been submitted. The provisions of subsections (e) and (k) of section 1320a–7a of this title shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title. A civil money penalty under this clause shall be in addition to any other penalties prescribed by law and in addition to any Medicare secondary payer claim under this subchapter with respect to an individual.

(ii) Deposit of amounts collected

Any amounts collected pursuant to clause (i) shall be deposited in the Federal Hospital Insurance Trust Fund under section 1395i of this title.

(C) Sharing of information

Notwithstanding any other provision of law, under terms and conditions established by the Secretary, the Secretary—

(i) shall share information on entitlement under part A and enrollment under part B under this subchapter with entities, plan administrators, and fiduciaries described in subparagraph (A);

(ii) may share the entitlement and enrollment information described in clause (i) with entities and persons not described in such clause; and

(iii) may share information collected under this paragraph as necessary for purposes of the proper coordination of benefits.

(D) Implementation

Notwithstanding any other provision of law, the Secretary may implement this paragraph by program instruction or otherwise.

(8) Required submission of information by or on behalf of liability insurance (including self-insurance), no fault insurance, and workers' compensation laws and plans

(A) Requirement

On and after the first day of the first calendar quarter beginning after the date that is 18 months after December 29, 2007, an applicable plan shall—

(i) determine whether a claimant (including an individual whose claim is unresolved) is entitled to benefits under the program under this subchapter on any basis; and

(ii) if the claimant is determined to be so entitled, submit the information described in subparagraph (B) with respect to the claimant to the Secretary in a form and manner (including frequency) specified by the Secretary.

(B) Required information

The information described in this subparagraph is—

(i) the identity of the claimant for which the determination under subparagraph (A) was made; and

(ii) such other information as the Secretary shall specify in order to enable the Secretary to make an appropriate determination concerning coordination of benefits, including any applicable recovery claim.

Not later than 18 months after January 10, 2013, the Secretary shall modify the reporting requirements under this paragraph so that an applicable plan in complying with such requirements is permitted but not required to access or report to the Secretary beneficiary social security account numbers or health identification claim numbers, except that the deadline for such modification shall be extended by one or more periods (specified by the Secretary) of up to 1 year each if the Secretary notifies the committees of jurisdiction of the House of Representatives and of the Senate that the prior deadline for such modification, without such extension, threatens patient privacy or the integrity of the secondary payer program under this subsection. Any such deadline extension notice shall include information on the progress being made in implementing such modification and the anticipated implementation date for such modification.

(C) Timing

Information shall be submitted under subparagraph (A)(ii) within a time specified by the Secretary after the claim is resolved through a settlement, judgment, award, or other payment (regardless of whether or not there is a determination or admission of liability).

(D) Claimant

For purposes of subparagraph (A), the term "claimant" includes—

(i) an individual filing a claim directly against the applicable plan; and

(ii) an individual filing a claim against an individual or entity insured or covered by the applicable plan.

(E) Enforcement

(i) In general

An applicable plan that fails to comply with the requirements under subparagraph (A) with respect to any claimant may be subject to a civil money penalty of up to $1,000 for each day of noncompliance with respect to each claimant. The provisions of subsections (e) and (k) of section 1320a–7a of this title shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a–7a(a) of this title. A civil money penalty under this clause shall be in addition to any other penalties prescribed by law and in addition to any Medicare secondary payer claim under this subchapter with respect to an individual.

(ii) Deposit of amounts collected

Any amounts collected pursuant to clause (i) shall be deposited in the Federal Hospital Insurance Trust Fund.

(F) Applicable plan

In this paragraph, the term "applicable plan" means the following laws, plans, or other arrangements, including the fiduciary or administrator for such law, plan, or arrangement:

(i) Liability insurance (including self-insurance).

(ii) No fault insurance.

(iii) Workers' compensation laws or plans.

(G) Sharing of information

(i) In general

The Secretary may share information collected under this paragraph as necessary for purposes of the proper coordination of benefits.

(ii) Specified information

In responding to any query made on or after the date that is 1 year after December 11, 2020, from an applicable plan related to a determination described in subparagraph (A)(i), the Secretary, notwithstanding any other provision of law, shall provide to such applicable plan—

(I) whether a claimant subject to the query is, or during the preceding 3-year period has been, entitled to benefits under the program under this subchapter on any basis; and

(II) to the extent applicable, the plan name and address of any Medicare Advantage plan under part C and any prescription drug plan under part D in which the claimant is enrolled or has been enrolled during such period.

(H) Implementation

Notwithstanding any other provision of law, the Secretary may implement this paragraph by program instruction or otherwise.

(I) Regulations

Not later than 60 days after January 10, 2013, the Secretary shall publish a notice in the Federal Register soliciting proposals, which will be accepted during a 60-day period, for the specification of practices for which sanctions will and will not be imposed under subparagraph (E), including not imposing sanctions for good faith efforts to identify a beneficiary pursuant to this paragraph under an applicable entity responsible for reporting information. After considering the proposals so submitted, the Secretary, in consultation with the Attorney General, shall publish in the Federal Register, including a 60-day period for comment, proposed specified practices for which such sanctions will and will not be imposed. After considering any public comments received during such period, the Secretary shall issue final rules specifying such practices.

(9) Exception

(A) In general

Clause (ii) of paragraph (2)(B) and any reporting required by paragraph (8) shall not apply with respect to any settlement, judgment, award, or other payment by an applicable plan arising from liability insurance (including self-insurance) and from alleged physical trauma-based incidents (excluding alleged ingestion, implantation, or exposure cases) constituting a total payment obligation to a claimant of not more than the single threshold amount calculated by the Secretary under subparagraph (B) for the year involved.

(B) Annual computation of threshold

(i) In general

Not later than November 15 before each year, the Secretary shall calculate and publish a single threshold amount for settlements, judgments, awards, or other payments for obligations arising from liability insurance (including self-insurance) and for alleged physical trauma-based incidents (excluding alleged ingestion, implantation, or exposure cases) subject to this section for that year. The annual single threshold amount for a year shall be set such that the estimated average amount to be credited to the Medicare trust funds of collections of conditional payments from such settlements, judgments, awards, or other payments arising from liability insurance (including self-insurance) and for such alleged incidents subject to this section shall equal the estimated cost of collection incurred by the United States (including payments made to contractors) for a conditional payment arising from liability insurance (including self-insurance) and for such alleged incidents subject to this section for the year. At the time of calculating, but before publishing, the single threshold amount for 2014, the Secretary shall inform, and seek review of, the Comptroller General of the United States with regard to such amount.

(ii) Publication

The Secretary shall include, as part of such publication for a year—

(I) the estimated cost of collection incurred by the United States (including payments made to contractors) for a conditional payment arising from liability insurance (including self-insurance) and for such alleged incidents; and

(II) a summary of the methodology and data used by the Secretary in computing such threshold amount and such cost of collection.

(C) Exclusion of ongoing expenses

For purposes of this paragraph and with respect to a settlement, judgment, award, or other payment not otherwise addressed in clause (ii) of paragraph (2)(B) that includes ongoing responsibility for medical payments (excluding settlements, judgments, awards, or other payments made by a workers' compensation law or plan or no fault insurance), the amount utilized for calculation of the threshold described in subparagraph (A) shall include only the cumulative value of the medical payments made under this subchapter.

(D) Report to Congress

Not later than November 15 before each year, the Secretary shall submit to the Congress a report on the single threshold amount for settlements, judgments, awards, or other payments for conditional payment obligations arising from liability insurance (including self-insurance) and alleged incidents described in subparagraph (A) for that year and on the establishment and application of similar thresholds for such payments for conditional payment obligations arising from worker compensation cases and from no fault insurance cases subject to this section for the year. For each such report, the Secretary shall—

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US District Court for the Western District of Wisconsin - 822 F. Supp. 570 (W.D. Wis. 1993)
February 5, 1993

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822 F. Supp. 570 (1993)

UNITED STATES of America, Plaintiff,
v.
Henry L. SOSNOWSKI, D.J. Weis, and Home Mutual Insurance Company, Defendants.

No. 92-C-598-S.

United States District Court, W.D. Wisconsin.

February 5, 1993.

***571** Mark A. Cameli, Asst. U.S. Atty., Madison, WI, for plaintiff.

D.J. Weis, Johnson, Weis, Paulson & Priebe, Rhinelander, WI, for defendants Sosnowski and Weiss.

Ward I. Richter, Bell, Metzner, Gierhart & Moore, Madison, WI, for defendant Home Mut. Ins. Co.

MEMORANDUM AND ORDER

SHABAZ, District Judge.

Plaintiff commenced this action against defendants Henry L. Sosnowski, D.J. Weis, Home Mutual Insurance Company ("Home Mutual") and George A. Richards for reimbursement

of Medicare payments pursuant to 42 U.S.C. § 1395y(b) (2) and related regulations. The parties have stipulated to the dismissal of defendant Richards.

The matter is currently before the Court on plaintiff's motion for judgment on the pleadings against defendants Sosnowski and Weis pursuant to Rule 12(c) of the Federal Rules of Civil Procedure. Defendants have submitted matters outside the pleadings and request the Court to treat the motion as one for summary judgment. Plaintiff joins defendants in this request. Accordingly, the Court will treat this motion as one for summary judgment.

A summary of the procedural background and other relevant facts follows. The facts necessary to resolve this motion are undisputed.

***572 BACKGROUND**

On about September 11, 1986 defendant Sosnowski sustained injuries in a car accident.

Sosnowski was eligible for benefits through the federal Medicare program, 42 U.S.C. §§ 1395 *et seq.,* administered by the Health Care Financing Administration ("HCFA"), an agency of the Department of Health and Human Services ("HHS"). As of November 15, 1990 HCFA paid $15,066.68 in claims submitted on behalf of Sosnowski for medical services provided as a result of the accident.

Sosnowski commenced an action in the Circuit Court for Lincoln County, Wisconsin against Gerald J. Kurth and his insurer, Home Mutual, alleging that Kurth's negligence caused the accident and Sosnowski's injuries. The nominal defendants listed included Wisconsin Physicians Services Ins. Corp. ("WPS") and Blue Cross & Blue Shield United of Wisconsin ("BCBS").

The Circuit Court issued findings of facts and conclusions of law on June 15, 1988. The Circuit Court found that nominal defendants WPS and BCBS had been properly served but failed to make an appearance and were in default. The Circuit Court concluded: "That because these nominal defendants have been placed on notice of this lawsuit and have failed to assert any claims which they may have against any parties to this lawsuit relating to contractual and/or statutory rights of subrogation, such rights are hereby extinguished."

Sosnowski and Home Mutual, by their respective attorneys, Weis and Richards, stipulated to the entry of judgment for Sosnowski in the amount of $25,000, the limit of the policy,

without costs and attorney's fees. Home Mutual paid this amount to Sosnowski and his attorney Weis who provided a satisfaction of judgment and a release of all liabilities concerning the accident.

Neither Sosnowski nor Weis has reimbursed HCFA from the settlement proceeds pursuant to 42 U.S.C. § 1395y(b) (2) and related regulations. The government filed this action on August 14, 1992.

MEMORANDUM

Plaintiff requests that the Court enter judgment against defendants Sosnowski and Weis, jointly and severally, for $15,066.68 plus double damages and costs. Defendants Sosnowski and Weis seek to have the Court extinguish the Medicare lien and grant summary judgment in their favor. Primarily at issue is whether the government is entitled to reimbursement under 42 U.S.C. § 1395y(b) (2) and related regulations from the settlement proceeds received by defendants Sosnowski and Weis regardless of the default judgment against WPS and BCBS in the third party action.

Summary judgment is appropriate when, after both parties have the opportunity to submit evidence in support of their respective positions and the court has reviewed such evidence in the light most favorable to the nonmovant, there remains no genuine issue of material fact and the moving party is entitled to judgment as a matter of law. Fed.R.Civ.P. 56(c).

A factual dispute is material only if its resolution might affect the outcome of the suit under governing law. *Anderson v. Liberty Lobby, Inc.,* 477 U.S. 242, 248, 106 S. Ct. 2505, 2510, 91 L. Ed. 2d 202 (1986). A factual dispute is genuine only if a reasonable factfinder could return a verdict for the nonmoving party. *Id.* The nonmoving party has the obligation to set forth specific facts showing that there is a genuine issue for trial. Fed. R.Civ.P. 56(e).

Generally the government is granted a direct right of action to recover conditional payments from entities which are required to make payments under a primary plan, or from other entities which have received payment from such entities. 42 U.S.C. § 1395y(b) (2) (B) (ii). Payment by Medicare is conditional when payment has been or can reasonably be expected to be made under an automobile or liability insurance policy. 42 U.S.C. § 1395y(b) (2). Regulation 42 C.F.R. § 411.24, entitled "Recovery of conditional payments," provides in part:

> (g) Recovery from parties that receive third party payments. *HCFA has a right of action to recover its payments from any* ***573** entity, including a beneficiary,* provider, supplier, physician, *attorney,* State agency or private insurer *that has received a third party payment.*
>
> (h) Reimbursement to Medicare. If the beneficiary or other party receives a third party payment, the beneficiary or other party must reimburse Medicare within 60 days.
>
> (i) Special rules. (1) In the case of liability insurance settlements and disputed claims under employer group health plans and no-fault insurance, the following rule applies: If Medicare is not reimbursed as required by paragraph (h) of this section, the third party payer must reimburse Medicare even though it has already reimbursed the beneficiary or other party.
>
> (2) The provisions of paragraph (i) (1) of this section also apply if a third party payer makes its payment to an entity other than Medicare when it is, or should be, aware that Medicare has made a conditional primary payment.

(Emphasis added.)

In this case Sosnowski and his attorney Weis received a third party settlement payment of $25,000. They admit that they did not reimburse HCFA from the settlement proceeds pursuant to 42 U.S.C. § 1395y(b) (2) and related regulations. The government has an independent right of recovery against any entity, including a beneficiary or an attorney, which has received a third party payment. 42 C.F.R. § 411.24(g). Therefore, plaintiff is entitled to bring this action against defendants Sosnowski and his attorney Weis for reimbursement of Medicare payments.

Defendants Sosnowski and Weis do not contest the requirements of the above statutes and regulations. In fact they do not even address the applicable statutes or regulations in their brief. They seek to extinguish the Medicare lien solely on two grounds: default and equitable estoppel.

Sosnowski and Weis generally contend that plaintiff's right to reimbursement was extinguished by the default judgment in the state court action against WPS and BCBS, agents of the government. Regardless of whether WPS and BCBS acted as agents of the government, they remain private entities and are not federal agencies. Neither the United States nor any of its federal agencies or officers were named in the state action. It appears that the real party in interest in litigation involving the administration of the Medicare Act is the HCFA. 42 C.F.R. § 421.5(b). However, in his official capacity, the Secretary of HHS can also be substituted. Defendants acknowledge that they did not name or make proper service upon the HCFA or the Secretary of HHS.

Defendants further claim that the government had actual notice of the state action and that this suffices to meet the requirements of Rule 4(d) of the Federal Rules of Civil Procedure. Correspondence between Weis and Assistant U.S. Attorney David C. Sarnacki indicates that Sarnacki knew of the state action. Weis also sent Sarnacki an authenticated copy of the amended summons and the amended complaint. However, regardless of whether the government was properly served in the state court action, neither it nor any federal agencies were named in the state action and therefore no default judgment exists against them.

Further, it is clear from the applicable statutes and regulations that the government has an independent right of action in this instance. Once Sosnowski and Weis received the settlement proceeds, they were required to reimburse Medicare within sixty days. *See* 42 C.F.R. § 411.24(h). When they did not the government could, and did, commence an action against them for reimbursement. *See* 42 C.F.R. § 411.24(g). The intent of the Medicare Secondary Payer Statute enacted in 1981 and the subsequently promulgated regulations was to reduce the cost of the Medicare program by requiring Medicare to pay "secondary" to alternate sources. *Blue Cross & Blue Shield Ass'n v. Sullivan,* 794 F. Supp. 1166, 1168-70 (D.D.C. 1992).

Defendants Sosnowski and Weis argue that the plaintiff should be equitably estopped from pursuing the Medicare lien. Estoppel against the government has been ***574** recognized only in "certain narrow circumstances." *United States v. Lindberg Corp.,* 882 F.2d 1158, 1163 (7th Cir. 1989) (quoting *Woodstock/Kenosha Health Center v. Schweiker,* 713 F.2d 285, 290 (7th Cir.1983)). These circumstances exist when:

> First, the party to be estopped must know the facts. Second, this party must intend that his conduct shall be acted upon, or must so act that the party

> asserting estoppel has a right to believe it is so intended. Third, the party asserting estoppel must have been ignorant of the facts. Finally, the party asserting estoppel must reasonably rely on the other's conduct to his substantial injury.

Id.

Sosnowski and Weis claim that despite the government's actual notice of the state action, it did nothing. Defendants assert that the inaction of the government and its agents "induced the defendants to proceed in the [state] action, seek a default judgment against WPS and BCBS, stipulate to judgment and disburse the proceeds of that judgment, without further contact with the United States of America and its agents." As previously noted, the government or its officers or agencies were not named as nominal defendants in the state action. Further, it appears that Weis did not notify Sarnacki of the default of the nominal defendants or the subsequent entry of judgment in the state action until sometime after the judgment had been entered. In a letter to Sarnacki dated July 28, 1987, Weis acknowledged that he had notification of the Medicare lien and he was required to notify Sarnacki of any settlement. However, the Circuit Court entered judgment on June 15, 1988, and Sarnacki's October 5, 1988 letter to Weis inquiring about the status of the case indicates that Weis had not notified Sarnacki. The Court finds defendants' arguments without merit and accordingly concludes that the government is not equitably estopped from pursuing this action to recover the Medicare payments.

The relevant section of title 42 of the Code of Federal Regulations provides:

> § 411.37 Amount of Medicare recovery when a third party payment is made as a result of a judgment or settlement.
>
> * * * * * *
>
> (e) HCFA incurs procurement costs because of opposition to its recovery. If HCFA must bring suit against the party that received payment because that party opposes HCFA's recovery, the recovery amount is the lower of the following:

(1) Medicare payment.

(2) The total judgment or settlement amount, minus the party's total procurement cost.

The government asserts that pursuant to 42 C.F.R. § 411.37(e) (1) it should recover the amount of the Medicare payment, $15,066.68. The Court agrees.

Plaintiff also argues that it is entitled to double the amount of damages, or $30,133.36. Double the amount of damages is available when a primary plan fails to provide for primary payment or appropriate reimbursement under 42 U.S.C. § 1395y(b) (1) and (2) (A). 42 U.S.C. § 1395y(b) (3) (A); *see also* 42 U.S.C. § 1395y(b) (2) (B) (ii). Defendants do not address this issue. The Court finds double damages are not appropriate in this instance, because neither defendant Sosnowski nor defendant Weis is a primary plan. Pursuant to 42 U.S.C. § 1395y(b) (3) (A), double damages only appear to be available when the primary plan fails.

As previously discussed, there is no default judgment against plaintiff in the state court action as neither the United States nor any federal agencies were named in that action. Accordingly, the arguments of defendant Weis in his letter to this Court dated January 27, 1993 are without merit.

ORDER

IT IS ORDERED that plaintiff's motion for summary judgment is PARTIALLY GRANTED concerning the amount of $15,066.68.

***575** IT IS FURTHER ORDERED that the motion for summary judgment of defendants Sosnowski and Weis is DENIED.

Wilson v. United States

UNITED STATES DISTRICT COURT EASTERN DISTRICT OF NEW YORK

Nov 17, 2019

19-cv-5037 (BMC) (E.D.N.Y. Nov. 17, 2019)

19-cv-5037 (BMC)

11-17-2019

EMILY S. WILSON, as Executrix of the Estate of Joseph A. Wilson, and the ESTATE OF JOSEPH A. WILSON, Plaintiffs, v. THE UNITED STATES OF AMERICA, Defendant.

COGAN, District Judge.

MEMORANDUM DECISION AND ORDER **COGAN**, District Judge.

Following a six-month period after filing an Amended Claim for Refund with the IRS, plaintiffs bring the present action for the return of $3,221,183. The Government moves for partial dismissal and plaintiffs cross-move for partial summary judgment and judgment on the pleadings. For the reasons discussed below, the Government's partial motion to dismiss is denied. Furthermore, plaintiffs' motion for partial summary judgment is granted and plaintiffs' motion for judgment on the pleadings is denied as premature.

BACKGROUND

As alleged in the complaint, Joseph Wilson established an overseas trust in 2003. Wilson named himself the grantor of the trust and was its sole owner and beneficiary. The singular purpose of the trust was to "place assets beyond the reach of his then-wife, who he had reason to believe was preparing to file a divorce action against him." (She did.) Wilson funded the trust with approximately $9 million in U.S. Treasury bills, accruing annual interest of 5% or less. All principal had previously been taxed in the United States. *2

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From 2003-2007, Wilson filed "various income tax and information returns" with the IRS, reporting the trust's assets and the interest it accrued. In 2007, upon conclusion of the divorce proceedings, Wilson terminated the trust

and transferred the assets - at that point $9,203,381 - back to his bank accounts in the United States.

Despite general compliance with IRS requirements, Wilson was late in filing his Form 3520 for calendar year 2007. Form 3520 is an annual report disclosing distributions from a foreign trust, with different requirements for trust grantors/owners and for trust beneficiaries. After Wilson filed his 2007 Form 3520, the IRS assessed a late penalty of $3,221,183, representing 35% of the distributions from the trust during the 2007 calendar year. Because Wilson had transferred 100% of his trust's funds back to his own domestic accounts during 2007, the penalty also amounted to 35% of his total trust assets.

Wilson had apparently suspected from the beginning that the IRS over-assessed his penalty, as he paid the full $3,221,183 (plus $268,651.52 statutory interest) directly to the IRS Appeals office in Fort Lauderdale. Less than two months later, Wilson submitted a Claim for Refund to the IRS, seeking the entire $3,221,183 plus interest. After waiting the statutorily-required period of six months without word from the IRS, Wilson filed a complaint in the United States Court of Federal Claims. In the complaint, Wilson alleged, *inter alia*, that the IRS erroneously assessed a 35% tax under I.R.C. (hereinafter "26 U.S.C.") § 6048(c), which applies to trust beneficiaries, when it should have assessed a 5% tax under 26 U.S.C. § 6048(b), which applies to a trust grantor/owner.

But that would be the case if the Government got its way. Because the gross reportable amount for an owner's untimely filing Form 3520 under § 6677(c)(2) is "the gross value of the portion of the trust's assets at the close of the year," Wilson's $0 in trust assets at the end of 2007 yields a $0 gross reportable amount. Any additional penalty resulting from the same "failure" would violate the statute. The Government seeks $3,221,183 above $0, which violates the statute.[2] *13

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[2] This conclusion would appear to result from any joint owner/beneficiary's transfer to himself of more than roughly 75% of his foreign trust's assets in a given year. In such cases, the assessment for a beneficiary of 35% of his distributions would always exceed the "gross value . . . of the trust's assets" remaining at the close of the year. The same is true for an owner/beneficiary's transfer to himself of less than 4% of his trust's assets during a given year. In that case, the assessment for a trust owner of 5% of the remaining trust assets would always exceed the "gross amount of the distributions." See 26 U.S.C. § 6677(c)(1). --------

Beyond the statutory text, certain aspects of Form 3520 itself imply that a foreign trust owner who receives distributions from his own trust should be treated as an owner - and not as a beneficiary - for failures related to the Form's filing. For example, Part III of the instructions for the 2007 Form 3520 states:

> If you received an amount from a portion of a foreign trust of which you are treated as the owner and you have correctly reported any information required on Part II and the trust has filed a Form 3520-A with the IRS, do not separately disclose distributions again in Part III.

Part II of Form 3520 is only to be filled out by the "U.S. Owner of a Foreign Trust" and Form 3520-A is the "Annual Information Return of Foreign Trust With a U.S. Owner." Thus, if a trust owner has received a distribution from his trust and thereafter reported the distribution in his 3250-A filing, he is not required to otherwise report the distribution on Form 3520. From this, it would appear that Form 3520 disregards the beneficiary status of the trust owner in favor of his owner status, at least for the limited purpose of tracking distributions to the owner.

The IRS can therefore assess *only* the 5% penalty under 26 U.S.C. § 6677 - not *both* or *either* the 5% and/or 35% penalty - for Wilson's untimely filing of his 2007 Form 3520.

SSA-634

Request for Change in Overpayment Recovery Rate:

https://www.ssa.gov/forms/ssa-634.pdf

SSA-632-BK

Request for Waiver of Overpayment Recovery:

https://www.ssa.gov/forms/ssa-632-bk.pdf