



**31st Annual
Gene F. Anderson
Memorial CLE**

**Friday, April 30, 2021
8:00 a.m. - 5:00 p.m.**

**Saturday, May 1, 2021
8:00 a.m. - Noon**

www.elliscountyksbar.org

Email: elliscountyksbar@gmail.com

Program Schedule

Friday, April 30, 2021

8:00 – 8:50 am

Everyday Conflicts (Ethics)

The QUIZ – A Potpourri of the Hottest Topics

Christian Stiegemeyer, Director of Risk Management

The Bar Plan Mutual Insurance Company

9:00 – 9:50 am

Everyday Conflicts, Cont'd (Ethics)

(Rules 1.7, 1.8, 1.9, 1.10 & 1.18)

Christian Stiegemeyer, Director of Risk Management

The Bar Plan Mutual Insurance Company

10:00 – 10:50 am

Effective Cross-Examination of Expert Witnesses

Brian C. Wright, Attorney

Wright Law Office, Chtd.

11:00 – 11:50 am

Medicaid and VA Update

Jennifer D. Walters, Attorney

Clinkscales Elder Law Practice

12:00 – 12:50 pm

Lunch Break

1:00 – 1:50 pm

Medicare Liens in Personal Injury Cases

Todd D. Powell, Partner

Glassman Bird Powell, L.L.P.

2:00 – 2:50 pm

Child Support Guidelines

Amy Raymond, Director of Trial Court Programs

Office of Judicial Administration, Kansas Judicial Center

3:00 – 3:50 pm

2021 Legislative Review and Budget Update

Joseph Molina, Director, Legislative Services

Kansas Bar Association

4:00 – 4:50 pm

Getting Things Done: Overcoming Stress and Managing Productivity (Ethics)

Danielle Hall, Executive Director

Kansas Lawyers Assistance Program

Program Schedule

Saturday, May 1, 2021

8:00 – 8:50 am

Effective Legal Writing for the Digital Audience

Hon. Sarah E. Warner

Kansas Court of Appeals

9:00 – 9:50 am

Drug Court on the Prairie

Hon. Glenn Braun, Chief Judge, 23rd Judicial District, State of Kansas

Teresa Greenwood, Drug Court Coordinator, Ellis County Drug Court

10:00 – 10:50 am

Zoom Depositions—Practical Pointers

Pablo Mose, Attorney

Rebein Brothers PA

11:00 – 11:50 am

Country Lawyer: Abraham Lincoln and the Art of Persuasion

David J. Rebein, Attorney

Rebein Brothers PA

**Everyday Conflicts
The QUIZ –
A Potpourri of the Hottest Topics**

Presented By:

**Christian Stiegemeyer,
Director of Risk Management
The Bar Plan Mutual Insurance
Company**

**Everyday Conflicts, Cont'd
(Rules 1.7, 1.8, 1.9, 1.10 & 1.18)**

Presented By:

**Christian Stiegemeyer,
Director of Risk Management
The Bar Plan Mutual Insurance
Company**

**Effective Cross-Examination
of Expert Witnesses**

Presented By:

**Brian C. Wright, Attorney
Wright Law Office, Chtd.**

EFFECTIVE CROSS-EXAMINATION OF EXPERT WITNESSES

Brian C. Wright
WRIGHT LAW OFFICE, CHTD
117 E. 13th St.
Hays, Kansas 67601

Expert witnesses are everywhere. In every type of litigation, on both sides of a case, expert witnesses are called upon to explain and interpret the facts. Experts look back and tell the court what happened, look at the present and tell the court what is happening, and look into the future to tell the court what will happen. They do so with opinions that only they are qualified to give, telling courts about probabilities, possibilities, likelihoods, and certainties. Modern courts have embraced expert testimony, so no matter what kind of litigation, all lawyers need to be ready to find expert witnesses to help their clients, develop and present opinions helpful to their clients, and cross-examine the testimony of experts presented by the opposing side.

Cross-examination has been referred to as an “art,” but I contend it is also part science. There are tried and true methods and procedures that help every lawyer avoid cross-examination disasters, and sometimes, help advance your client’s cause. I will demonstrate a few of the methods I was taught, and continue to use, and some that I have developed on my own, with the hope that I can give you some things to consider and think about to improve on the skills you already have.

WHAT IS AN “EFFECTIVE” CROSS-EXAMINATION?

Cross-examination of an expert witness doesn’t always go well.

When I was a young lawyer, listening to the older lawyers talk about expert witnesses, I thought that every adverse expert was an opponent to be killed in battle. After a few years, I learned that trying to destroy every expert can backfire.

Sometimes it can be counterproductive to attempt to destroy the witness. Rest assured, when most of a jury laughs out loud at you during an expert cross-examination, you are likely to reassess your approach!

I learned that while I had been encouraged to think about going to war and winning every battle, that approach could hurt my client. The analogy to battle is seldom appropriate. Not every witness has to be attacked. Destruction is not always the best goal. Lesser goals can be useful with the right witnesses and the right issues.

Effective expert cross-examination requires preparation, planning, and flexibility. We need to:

- Identify a goal that we can meet.
- Use the best available means to meet the goal.

Finding the right goal is essential to making the cross-examination effective, because it requires us to think about what we can achieve, and what we can't do. Once we have a goal that can be achieved, we still need to apply the proven methods. Only then can we reasonably expect to change the trajectory established by the expert testimony on direct examination.

Effective cross-examination requires that the questioner is in control of the courtroom. The rules of evidence, combined with the reality of how most judges handle witness examination, allow us to use various means to achieve control of the testimony coming from that witness.

1. GOALS OF EXPERT CROSS-EXAMINATION

An unfocused cross without a specific goal will not be effective. Only when we know our goals can we begin to design an effective cross-examination. Thinking about your goal should be second nature, something you do every time you approach a hearing or trial where an expert will testify.

Defining the goal helps bring into focus:

- The best way to prepare for the specific issue
- The best way to prepare for the specific witness
- The best approach to take in cross-examination
- The most effective means to achieve the goal of the cross

Goals/purposes of Cross

There are only a few possible goals of cross-examination. They can include:

- Minimize damage done by the testimony of the witness
- Help our case
- Hurt the other side's case. There are two primary methods of doing this:
 - Repudiate the authority of the expert
 - Refute the conclusions of the witness

Defining Goals and Focusing the Preparation

The facts and circumstances of a specific expert testifying about a specific issue in our case helps us define the right questions.

We need to know for this case, for this issue, how much or how little we can expect to achieve, within the limitations of facts that have been or can be proven. We hope

to know something about the witness so the questions on cross-examination can be tailored to the witness' characteristics and habits.

We need to find out or figure out what kind of person this witness is, and we must consider what kind of opinion is being presented.

There is almost always something you can cross if you consider the type of witness and the type of opinion. All expert witnesses carry some baggage.

What can be accomplished with cross of this expert in this case?

We need make the decision whether it is more helpful to use the expert to prove our points or to attack the expert. It all depends on the specific issue and the specific person we are cross-examining. Think about:

- **Is the opinion obviously correct?** We aren't going to get anywhere attacking this opinion.
- **Is the opinion demonstrably incorrect?** We can undermine it with the right kind of information or facts.
- **If accepted, does the opinion prove something important or unimportant?** We may want to leave alone the unimportant stuff. We might want to attack it anyway, if it helps us attack credibility, so that we can impair the effect of a more important opinion.
- **Is the opinion filling a gap in the other side's case?** We might try to focus the cross on that gap of proof, to focus doubt on the whole case or claim.
- **Is the opinion creating an obstacle to your client's ability to prove a point?** Maybe we need to use our facts or our expert's opinions in the cross-examination of the adverse expert.

When defining goals, always be aware of your own expert's opinion. Will the adverse attorney be able to pick on your expert the same way you go after his? Are your expert's opinions honest and well-supported, or a carefully constructed house of cards?

We need to consider the context of the opinion, and the person giving it. We can choose to embrace the helpful aspects of the opinion, and/or to attack the unhelpful aspects of the opinion.

Generally, we do not want to attack an expert opinion and embrace the same expert's testimony within the same cross-exam. It may not look good to attack someone who is making points for your case. If you do that, be sure to separate these parts of the cross examination from each other in your outline, so they do not run into each other.

What kind of person is this witness?

Except for the rare witness whose interest is in providing a free public service to the court system, the parties, and/or the jury, the retained expert witness (and, often, a non-retained expert) has a *purpose* or a *motivation*. These are always the source of cross-examination material.

Common purposes and motivations

- Making money
 - The purpose of the expert may be to receive money in return for the time spent evaluating the facts, rendering a report and/or testifying.
- Fame
 - The expert may be motivated by notoriety.
- On a mission
 - The expert may be motivated by a sense of right and wrong, or strong personal beliefs in the opinions. This is often the case for defense experts in med mal cases. The expert may be on his or her own personal crusade.
- Ivory tower
 - The expert may be completely devoted to the field of study, and he or she may feel a corresponding strong sense of public duty.
- Doing a job
 - The expert may be a public employee whose job includes expressing opinions, like a coroner
 - The expert may be a treating physician of a patient whose condition is at issue in the litigation.

Such motivations are important to the cross-examiner, because for our purposes, the **motivation of the expert can be a source of the expert's vulnerability**.

Old evidence treatises recognized this fact. Lord Campbell wrote:

Skilled witnesses come with such a bias on their minds to support the cause in which they are embarked, that hardly any weight should be given to their evidence.

Taylor, "Law of Evidence":

Expert witnesses become so warped in their judgment by regarding the subject in one point of view, that, even when consciously disposed, they are incapable of expressing a candid opinion.

Compared to these old treatises, modern rules of evidence are far more tolerant of experts, but for cross examination we are always trying to show that those old evidence experts were right. The key is finding why they “are incapable of expressing a candid opinion” and why “hardly any weight should be given to their evidence.” If we know the motivation and purpose of the witness, we can find out whether the opinion is strongly or weakly held and whether the witness truly believes the opinion. Knowing these things helps us fashion an effective cross-examination.

What kind of opinion does this person have?

In developing goals for cross examination, we need to consider both the source and the nature of the opinion being delivered by the witness on direct examination. Is this an opinion that the witness truly believes? Why does the witness truly believe in this opinion? Is it likely or unlikely that the witness will have any doubt about the opinion? Is this opinion expressed as a matter of convenience?

The approach to a witness whose opinion is held and expressed “honestly” can be substantially different than the approach to a witness who has presented an opinion that is conveniently shaped to fit the facts of this case, or who selectively perceives the facts so the facts will fit the preconceived opinion. An opinion of convenience is not a legitimate opinion.

We often encounter a witness whose opinion is the same, regardless of the facts of the case. This is an “illegitimate” opinion because it isn’t a firmly held belief shaped by the unique circumstances of the case at hand. Though it has obvious vulnerabilities, it isn’t necessarily easier to cross-examine.

With professional witnesses and people who testify regularly, the opinions tend to fit themselves to facts in ways that may not make sense to the outside observer. Every expert, like all other people, has a set of filters (or blinders) that affect the way he or she sees and interprets facts from the perspective of that paradigm. The extent to which an expert is willing to adjust his or her opinion as the facts change, makes the witness more vulnerable to cross examination for this opinion that is poorly fitted to the facts.

We can encounter legitimate opinions expressed by legitimate experts; illegitimate opinions expressed by legitimate experts; legitimate opinions expressed by illegitimate experts; and illegitimate opinions expressed by illegitimate experts.

Each combination requires a different cross-examination approach. We want to attack, disparage, disprove, and expose the illegitimate opinion or expert. We want to be very careful attacking or disparaging legitimate opinions or experts. Far in advance of the testimony we need to do our best to identify which of these combinations applies. Legitimate, honestly held opinions are not likely to be abandoned, and they cannot be effectively attacked head-on.

In general, if the opinion is legitimately based on special expertise or science in which the witness truly believes, it is better to leave the complicated, specialized knowledge out of the cross-examination and focus the cross-examination on grounds where the expert has no natural advantage. In that case we need to focus on the grounds on which the cross-examiner has the natural advantage.

In contrast to strongly held, well-supported opinions that a witness truly believes, “illegitimate opinions” will be abandoned much more readily by the witness, and can be effectively attacked, even if they are not completely abandoned. An “illegitimate opinion” is one that:

- Has no basis in the facts of the case. This is easy to deal with.
- Is based on a selective choice of the facts to use as the basis for the opinion, or it emphasizes some facts over others. This kind of opinion ignores known facts; discounts or explains away inconvenient facts, and/or avoids mentioning inconvenient facts.
- Is based on a mistaken understanding of the facts. This opinion is illegitimate because we can prove that the expert must have been too busy to sweat the details, or just didn’t take the time to carefully review all the information, or was just sloppy, so the opinion is simply wrong. This might lead you to plan to use the cross-exam to draw a contrast between the amount of money paid to this expert, and the “careful, thorough” job the witness will say led to the opinion.
- Reflects a failure to know all the information at hand. This can mean the witness has not adequately prepared, despite being an honest, decent witness. This opinion might be perfectly legitimate, but just a little mistake can make a big difference, especially if we give it extra emphasis during cross-examination.
- Reflects a failure of the hiring attorney to provide key information
- Is malleable, and it may be readily changed or abandoned. We can identify this witness by the words at the end of his report, where he always says:

“I reserve the right to change my opinions in the event of”

This is a clear signal that a hypothetical question, assuming different facts, perhaps including your client’s version of the facts, can generate a potentially favorable answer on cross-examination. This witness wants to preserve his or her own credibility, often at the expense of the lawyer who hired him or her. The opinion can be effectively attacked, even if the opinion is not abandoned.

- Has no basis or a limited acceptance in the field of expertise. A legitimate expert witness can have an illegitimate opinion. The expert might be well qualified, but the opinion is outside of the accepted parameters of the field of expertise. This presents a classic Daubert problem. This kind of opinion is hard to attack on cross, and it is probably better to deal with it by filing pretrial motions.

2. PLANNING FOR EFFECTIVE CROSS-EXAMINATION

Know your material

The jury will assess your depth of knowledge and commitment to the case by your demonstrated ability to handle the details of cross-examination.

When you appear vague on the details, the jurors may conclude that you are unconcerned about the finer points of the case. Thorough preparation also will ensure that the witness appreciates your competence, which can be very helpful in establishing control over the witness. But your most important audience is the jury. That jury should never doubt your commitment to the details.

Discovery

Pretrial preparation involves discovery methods and background investigation. We must focus on what is needed and what we are willing to do to get it. We must ask: what are the weapons that can be used? Are those weapons worth the effort? How do I get the information?

Essential Information

Our preparation must include at least some of these key areas of knowledge or inquiry:

- Knowing the facts of the case is most important. This is one advantage the lawyer can most easily gain over the expert.
- Research the background of the expert
- Review depositions of the expert taken in other cases
- Contact lawyers who have encountered the expert
- Check for advertisements or expert listings
- Carefully review all aspects of the expert's curriculum vitae to ensure that it is accurate in every material respect
- Search the internet
- Look at the expert's own web pages
- Look for their participation in online discussions
- Learn about the substantive field of expertise that underlies the opinions in the disclosure or report of the expert

- Figure out the substantive basis for the opinion itself
- Obtain the communications between the expert and the attorneys (but keep in mind the limitations on discovery of these communications)

Rules of Evidence

Keep in mind that what you are ultimately going to do is to present evidence. Much of cross-examination is style and technique, but the substantive content that holds the case together is evidence.

Anticipate problems with the authenticity and admissibility of documents needed for cross-examination.

Prepare trial briefs or motions in limine. You want the cross-examination to move as seamlessly as possible.

With expert witnesses, first and foremost, it is important to master the report and/or deposition taken in the case at hand because they represent the greatest opportunity for impeachment. But other items can be equally effective if handled properly.

Decide what points to make

You have to know the points that can be made with the witness. Before trial, *write them down*, because it is critical to make a list of what should be accomplished on cross. Then figure out *exactly* how you are going to make the points. There is no substitute for taking the time to think about this case, this witness, and nothing else. Review the deposition, your notes, and the documents, again. I often get my best ideas after working through everything more than once.

Now we must figure out how to make these points and how to package them to enable effective communication of the points to the jury.

Outline

In developing the cross-examination outline, ask yourself what you want the jury to remember about the expert during closing argument. Do you want the jury to remember that the expert was dishonest, exaggerating? Do you want the jury to remember the expert was a little too eager to give the critical opinions?

I find it helpful to use the points that are going to be made in the closing argument as a starting point for the development of an outline for the cross examination of the expert witness. There ought to be several points that I want to make during the closing argument, and there ought to be at least one or two of them that can be made through the expert witness. Of course, PIK 102.4 contains this admonition:

Statements and arguments of counsel are not evidence, but they may help you understand the evidence and apply the law. However, you should disregard any comments of counsel that are not supported by the evidence.

My closing argument is not evidence, at least according to the PIK instruction. But when I am in control, and while cross-examining an expert, my statements and arguments are evidence, *if the witness adopts them, endorses them, blesses them, or is hoisted on his own petard by them.*

So, I want to formulate questions and topics for the cross using my best arguments so they will be supported by the evidence.

Knowing the goals and the points that *can* be made, the next step is determining the best points you *should* make.

Finally, put them in order from best to worst.

The outline should *always start with the strongest point first.* The next best point should be the last point in the outline. Take these two points and separate them. When you stand up to start the cross-examination, you want a guaranteed winner to start, and a guaranteed winner to finish your cross examination. If those two points are handled well, everything else is of secondary importance.

In between the very best point and the second-best point are all the other points that need to be made with the expert. These can follow any logical progression that fits the circumstances of your case best. It can be a chronological list. It can be a list that goes from one topic to the next, or issues that are important in the case. It can deal with facts. It can deal with opinions. It may relate to your own expert's opinion. It can deal with learned treatises.

If a point is worth making on cross-examination, decide how best to make it. Keep in mind that patience is a virtue in cross-examination. The jury must understand the context of a given point. The goal is not just to reach the destination. The goal is to lead a journey—a search for truth—on which the jurors want to accompany the lawyer. The cross examiner needs to be willing to lead the journey.

To bring home the point clearly and concisely, take the jury through each step towards the conclusion. By the time you get to the conclusion, it should seem inevitable.

The outline itself should contain whole quotes, or at a minimum, the key phrases and words of any impeachment material you might have. The backup documents should be readily available in hardcopy or electronically to confront the witness with a visual.

Developing a good cross-examination outline is very useful. In the heat of the battle, being organized, effective and quick to the point is critical.

But surprises happen, and in mid-cross, you may want or need to pursue a line of questioning that is out of order in the outline. An article, document or transcript may be needed unexpectedly for impeachment. All these items must be accessible immediately. You must find your own method that allows you streamline your outline and the materials to be used so that you can move around easily. It helps to have the confidence to work from a shorter outline.

You can use separate outlines for each major point. This is especially helpful when you have a lengthy cross-examination. Divide up your outline and the attachments into discrete units that can work on their own, or together, in order or out of order, and with a back-up plan for each anticipated adverse ruling or answer that you might encounter. This is when your preparation will distinguish you from the unprepared lawyer.

3. CONDUCTING AN EFFECTIVE CROSS-EXAMINATION

Leading questions

You should almost never ask an open-ended question to an expert witness, except if the answer to the question literally makes no difference whatsoever. This old rule is a good one; using only leading questions advances one of the important dynamics of the courtroom—control. Control allows the cross-examiner to be forceful, fearless, knowledgeable, informative, and most importantly, credible with the jury.

Technique and Art of Cross-Examination

Be sure that when the witness concedes a point, the jury understands the advantage. There has to be some dramatic flair or some means of drawing attention to the concession. You can use a change in tone of voice, or movement from the podium. Feign inability to hear the answer, or “make sure all of the jurors heard it.” Make the witness repeat it.

All of this involves style and judgment. Highlight and illustrate for the jury. Enumerate key concessions so the jurors can see them. This can be an important way for jurors to remember the points made. They hear the points, and then they see the points. Any time a point can be visually made or recorded, do so. It allows counsel to relate back to this visual point during closing argument.

Demonstrative exhibits or other visual aids generally make cross-examination more interesting, and the more interesting the cross-examination, the more attention the jury will give it.

Application of the rules of evidence and the burden of proof

On direct examination, expert witnesses are required to state opinions to a reasonable certainty within the field of expertise of the witness. On direct exam, your adverse party and the expert carry an extra burden: not only must the opinion be to a reasonable level of certainty within the field of expertise, but it must conform to the requirement that the opinion express the probability—*as opposed to the possibility*—that the conclusion is correct and true, i.e., that it is (or was at the time of the incident) reality.

The law specifies that an expert opinion must be reasonably probable and expressed to a reasonable certainty. It has long been the law of Kansas that expert witnesses “should confine their opinions to relevant matters which are certain or probable, not those which are merely possible.” *Nunez v. Wilson*, 211 Kan. 443 (1973); *see also Ratterree v. Bartlett*, 238 Kan. 11 (1985) (“opinions by expert witnesses should not concern matters which are a mere speculation or conjecture.”). When medical experts provide opinion testimony, the expert must give such opinions within a reasonable degree of medical probability. *Pope v. Ransdell*, 257 Kan. 112, 122 (1992).

Proof of proximate cause has to “afford a reasonable basis for the conclusion that it is more likely than not that the conduct of the defendant was a cause in fact of the result.” *Yount v. Seibert*, 282 Kan. 619, 628 (2006).

For experts presented by an adversary with the burden of proof, the cross-examination can always focus on the two components of the required opinion—*probability* and *certainty*. During cross, the court can’t stop us from referring to these two terms repeatedly. After all, these are the terms required by the law. As a cross examination technique, this reemphasizes and reiterates the burden of proof requirement that is imposed by the law on the other party.

As a matter of persuasion and rhetoric, the more times I can repeat my references to the burden of proof and the need for certainty, the more I can reinforce in the jury’s mind that the adverse party has failed to meet the burden of proof. The desire here is to awaken the jury’s natural cynicism, so I can help the jury to question the authority of the expert witness.

We can do this because extraordinary latitude is given to the cross-examination of experts. *Pope v. Ransdell*, 257 Kan. at 112. Using the broad scope of cross-examination that is allowed by the rules and case law, it is always a good idea to raise questions about alternative explanations for the conclusions and opinions of the expert called by the party with the burden of proof. In *Pope*, cross-examination of expert witnesses based on questions about possibilities was explicitly endorsed. The Court must give “great latitude” in cross-examination of experts so that the “intelligence and powers of discernment” of the witness can be tested and submitted to the jury so it can determine the value of the testimony in light of the witness’s capacity to form a correct opinion. *Pope*, 251 Kan. at 123. Questions

about any number of various possibilities regarding the cause of the plaintiff's injuries were allowed in *Butler v. HCA Health Services*, 27 Kan. App. 2d. 403 (1999).

4. FULFILLING THE GOAL OF LIMITING DAMAGE

Find basic points of agreement that the witness can agree upon. These can include simple opinions, but they can also include factual information.

Limiting damage can be achieved with getting the expert to agree to some basic points; these can include any fact or opinion that the witness might agree upon, including even the simplest point, with the goal being to have this provide some support for any fact in your case so that something (anything) positive can come out of this cross-examination. Examples:

- “That doesn’t mean...”
- “You are not 100% certain...”
- “It is not guaranteed...”
- Alternative possible explanations for the opinion on causation or damages might also be worth exploring. The case law allows you to do this.

You might get lucky and have an expert who disagrees with even the most agreeable basic principles, in which case you have one you don’t even need to attack, because his or her bias will be obvious.

In general, what you want to do to minimize damage or help your client’s case is to bring the expert “into the fold.” This is done by having the witness agree to anything that you ask him, all in terms of facts that are favorable to your client’s case. Find the points that no one can disagree upon, make those points, and move on with this witness, or sit down, and save your major points for another witness.

Careful and judicious questions that seek to bring out separate facts and separate points from the knowledge or experience of the expert that tend to support the theory of the examiner’s own side of the case usually produce good results. This can bring out scientific facts (not necessarily opinions) from the knowledge of the expert that will help your side, and therefore, tend to decrease the weight of the opinion that the expert has given.

There is no reason you cannot cross examine an expert witness on the facts of the case. Use the opportunity. In some cases, you can even get evidence into the record that is otherwise inadmissible. *See, e.g. Fed. R. Evid. 705 and Fed. R. Evid. 703.*

I have seen this done, with devastating consequences, against me. However, you have to keep in mind, what the expert evidence statutes (K.S.A. 60-256) and

Federal Rules of Civil Procedure allow, because they may limit your ability to do this.

5. FULFILLING THE GOAL OF ATTACKING THE EXPERT OR THE EXPERT'S OPINION

When taking on the expert directly, preparation, or the lack of it, will show.

When attacking an expert or the opinion directly, pretrial preparation is even more important. Use both discovery methods and informal background investigation.

You must focus on what you need and what you are willing to do to get it. You must ask yourself: what are the weapons that can be used? Are those weapons worth the effort? How do I get the information?

Preparation must include at least some of these key areas of knowledge or inquiry:

- Knowing the facts of the case is most important. This is one advantage you can easily attain against the expert.
- Research the background of the expert
- Review depositions of the expert taken in other cases
- expert witness databases are available from which to gather background information on a particular expert
- contact lawyers who have encountered the expert
- check for advertisements or expert listings
- carefully review all aspects of the expert's curriculum vitae to ensure that he or she has been accurate in every material respect
- Search the internet
- Look at the expert's own web pages
- Look for their participation in online discussion
- Learn about the substantive basis of the field of expertise that underlies the opinions in the disclosure or report of the expert. But don't make the mistake of thinking you really know it!!
- Figure out the substantive basis for the opinion itself
- Obtain the communications between the expert and the attorneys, but keep in mind the limitations on discovery of these communications. *See, e.g.* 60-226(b)(5)(B) & (C)

Repudiating the Expert's Authority

Repudiate: "to reject the authority or validity of; refuse to accept or ratify"

Effective repudiation removes the veneer of expertise and/or credibility associated with the expert. This is effective because it gets at the heart of what attracted the other side to the expert in the first place. This witness was chosen because of qualifications, extensive knowledge, impressive academic credentials,

publications, and presentations made at important gatherings of other professionals.

There is an inverse correlation between the veneer of reputation/credibility and the impact of impairing or repudiating the reputation or credibility. Often the greater the reputation or veneer of credibility, the easier it is to take apart that edifice. “The bigger they are, the harder they fall.”

Encourage the witness to be or appear to be unreasonable

You can quickly remove the advantages of reputation by contrasting the precise nature of that reputation within the context of the issue in the present case. For example, an academic doctor or other expert may be in the “ivory tower,” and may not be familiar with the real issues “in the real world.” Simple examples may suffice. The expert may be “too important” to participate in the mundane or routine aspects of your case might help show that the other side is relying on his reputation instead of the content of his opinions. A “very important” witness may have gotten to the point where he expects his reputation will be all he needs, and he may have foregone the detail work needed to be persuasive about this case.

A professional witness is always partisan, ready, willing, and eager to serve the party calling him. Those facts, should be in the mind of a cross examiner at all times. An expert called against you who is a professional witness is prepared to do all the harm that he can and will avail himself of every opportunity to do so.

The witness should be encouraged to betray the partisanship. If the witness shows a propensity for overstatement and argumentative answers, consider encouraging him to volunteer statements and opinions and to give unresponsive answers. The simplest methods of repudiation may be the most effective.

Consider these simple techniques:

- If you know the witness will give testimony that seems incredible, then push the expert further and further out on a limb. It’s easier to make him fall the further out you push him.
- Make the witness seem unreasonable. If he isn’t willing to concede the simplest point, by all means keep giving him opportunities.

Sometimes you may want to abandon leading questions. Generally, when you ask open-ended questions, you are handing the expert the opportunity to expand upon his opinion or his basis for the opinion, especially in ways that may not have been fully explained on direct exam.

Here are some examples of when you do not need to ask leading questions. But it’s still best to know the answer before you ask.

- Q. Why don't you just tell the jury how many times you have testified in a court of law?
- Q. How much money did you make last year testifying?
- Q. Of the thousands of learned treatises published around the world, tell the jury how many have asked you to publish the theory you have expressed in this courtroom?
- Q. How many other experts between here and your location would have qualifications similar to yours?

Impeachment

It can be very useful to attack the expert with collateral/tangentially related information. This is done by impeachment of credibility or the use of prior inconsistent statements.

Formal impeachment of credibility relies on information that usually would not be admissible except as to the credibility of the witness. It includes the classic impeachment elements:

Bias
Prejudice
Interest
Corruption.

But PIK allows you to impeach in other ways:

IMPEACHMENT

In deciding the weight and credit you will give to the testimony of a witness, you may consider, along with all the other evidence, all evidence that affects the credibility of the witness, including:

Evidence of prior conduct of the witness.

Evidence that on some former occasion the witness, made a statement, acted in a manner, testified, inconsistent with testimony the witness gave in this case.

Evidence that the reputation of the witness for honesty or veracity is bad.

Evidence of the interest the witness has in the result of the trial or reasons the witness might favor one party over another.

Evidence that the witness has been convicted of a crime involving dishonesty or false statement.

You may consider this evidence only as it affects the credibility of the witness and may not consider it for other purposes.

Impeachment can also be achieved by using specific statements or comments. These generally would need to relate to the case, but not always, and can come from the deposition or report, from prior testimony, and other statements/internet postings, Twitter, Facebook, etc.

Handling the impeachment material also requires preparation and organization. You must know the materials and have them readily available. Key materials should be cross-referenced within the outline and organized in a series of folders to retrieve them quickly.

Impeaching with prior statements (deposition, report, former testimony) also can be tricky since this requires some knowledge before trial that an impeachment opportunity exists. You must first locate the impeaching material. Then you have to ensure that you can lay the foundation. It is not enough to have it and to present it in the courtroom. The impeaching material must be used effectively, and sparingly, and only for telling points.

The same rules apply for any other impeaching material - whether published articles, statements on a website, letters or reports.

Refuting the conclusions and opinions of the expert

This is really a topic for another presentation. The only time to cross-examine an expert on the details of expert's specialty, is when you have thoroughly studied the particular subject, and have sufficient medical or technical literature or books to clearly expose the erroneous conclusions or opinions of the expert.

This can only be done when it is something that the jury will be able to understand readily. The important audience is seated in the jury box. The jury must understand the points being made on cross-examination.

Reduce the technical to the simple. This is important in all phases of the trial, but it is most important in cross-examination when counsel is attempting to undermine the case of an opponent through the testimony of the opponent's witnesses.

Medicaid and VA Update

Presented By:

**Jennifer D. Walters, Attorney
Clinkscales Elder Law Practice**

Medicaid and VA Update



Start with the obvious...



Medicaid and COVID

No one loses Medicaid



Medicaid and COVID

Policy Directive 2020-03-01

- Delayed Discontinuance – COVID-19
- Provides immediate instruction to eligibility staff regarding the handling of reviews, premium delinquency, and other discontinuance processing during the COVID-19 public health emergency declared by the State of Kansas on March 23, 2020.
- Discontinuances suspended except for certain circumstances
- Coverage reinstated if already discontinued effective March 31, 2020
- Applies to renewals

Medicaid and COVID

Policy Memo 2020-04-01

- Policy Implementation Instructions and Information for COVID-19 National Public Health Emergency
- Sets forth instructions for implementation of policy changes related to the COVID-19 National Public Health Emergency and processing guidelines for the duration of this emergency concerning applications and new coverage requests, situations where an applicant/recipient fails to provide requested information, and the receipt of Federal Emergency Relief funds.
- Failure to Provide
- Stimulus Funds
- Not applicable to trusts, annuities and/or promissory notes
- CARE Requirements Waived for 30 Days
- Transfer of Property (not applicable unless active recipient)

Medicaid and COVID

Policy Directive 2020-06-01

- The purpose of this document is to provide immediate instruction regarding the timeline for appeal filing during the COVID-19 Public Health Emergency (PHE) declared by the State of Kansas on March 23, 2020.
- Additional 120 days to request a state fair hearing (on top of normal 33)

Policy Memos

BRACE YOURSELF



A NEW POLICY IS COMING

memegenerator.net

Policy Memos

KDHE-DHCF POLICY NO: 2019-12-01

- Voluntary Contribution for Long Term care and Resource Liquidation to Purchase Funeral Plan
- Options to spend down without losing application filing date or current coverage
- Voluntary contribution one option
- Also
 - Funeral plan
 - Pay due and owing expenses
 - Pre-pay estate recovery
 - Spend down
 - Discontinue eligibility



Policy Memos

Policy Clarification 2020-02-02

- Impact of Private Payment on Resource Eligibility
- The purpose of this document is to provide guidance in situations where a consumer residing in a nursing facility has either partially or fully private paid the facility and what that means in terms of resource eligibility for the long term care program.
- This one is a big deal.
- What about a married couple?

Policy Memos

KDHE-DHCF POLICY NO: 2020-06-01

- Transfer of property penalty cure clarification and glitch fix
- Must be done during the penalty period



Policy Memos

<https://www.kancare.ks.gov/policies-and-reports/kdhe-eligibility-policy>

- Click on Policy Log, then open XLXS policy log (currently 9-17-20-policy-log)

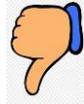


KDHE Policy Log - Revised starting 09-17-2020

Reference #	Date Issued	Date Effective	Name	Summary	Programs Impacted	Keywords	Attachments
PD2020-09-02	9/17/2020	9/17/2020	Policy Directive: ES-3100.8 MSP Only Application and Prior Medical Coverage	If there is eligibility on MSP/LMB and or MSP/ELMB only it can be assumed that consumer has requested prior medical coverage.	Elderly and Disabled	MSP Prior Medical coverage	
PD2020-09-01	9/1/2020	9/1/2020	Policy Directive: Voter Registration	Instructions on implementing new requirements on voter registration process on applications.	All Medical Programs	Voter registration	KC-7203 Voter Registration Companion let KC-7203S Voter Registration Companion I Spanish
SOC2020-09	8/21/2020	9/1/2020	Summary of Changes (SOC) form Medical KEESM Revision 20 and KFMAM Revision 28.	Provides the detailed Summary of Changes for Medical KEESM Revision #20 and KFMAM Revision #28	All Medical Programs		
PM2020-08-02	8/21/2020	9/1/2020	AVS Memo – Phase 2 Implementation, Applications	Instructions for implementation of Phase 2 of AVS on application and request for coverage on Non-MAGI programs	Elderly and Disabled	Asset Verification Solutions (AVS) Direct Express accounts Self-attestation of Excess Resources	KC-7202 Asset Verification Solution (AVS) Requested Months chart
PM2020-08-01	8/21/2020	8/23/2020	August 2020 KEES Release Memo	Implements changes to E&D programs in regard to KEES now having I-013 Annuity Referral form and ES-3122 for pursuit of VA benefits.	Elderly and Disabled	I-1013 form Annuity Referral ES-3122 VA- Potential Benefits Request	
PC2020-08-01	8/13/2020	8/13/2020	Policy Clarification: HCBS and Aged-Out Foster Care	Provides clarification regarding treatment of co-existing HCBS and AGO coverage.	All Medical Programs		
PM2020-06-02	6/26/2020	6/28/2020	Policy Memo: Implementation instructions and information for June 2020 KEES changes	Provides instructions that are applicable to all eligibility actions, including system actions, taken on or after this June 2020 KEES Release.	All Medical Programs		
SOC2020-07	6/26/2020	7/1/2020	Summary of Changes (SOC) form Medical KEESM Revision 19	Provides the detailed Summary of Changes for Medical KEESM Revision #19.	Elderly and Disabled		
PM2020-06-01	6/26/2020	6/26/2020	Policy Memo: Transfer of Property (TOP) Penalty Cure	Provides instructions for policy changes in regard to changes to the transfer of property (TOP) penalty cure policy	Elderly and Disabled	TOP cure	
PD2020-06-01	6/10/2020	3/23/2020	Policy Directive: Fair Hearing Extension -	Provides immediate instruction regarding the timeline for appeal filing during the COVID-19	All Medical	Fair Hearing Extension COVID-19	COVID- 19 Fair Hearing Extension Letter

What has come up for us lately?

Authorizations



Reviews being extended



Farm accounts



Non-answers to specific questions



More lately...

Access to caseworkers



Treatment of community spouse's IRA (do not have to show it's work-related)



Using grievance process more to avoid an appeal



SWITCH TO KDHE except for call center



Faster responses on Medicaid apps



And more...

Inconsistent/out of order notices



90 days after qualification to transfer



Promissory notes vs. annuities



Estate Recovery more aggressive (probates and liens)



Current Medicaid Numbers

Minimum community spouse resource allowance: \$25,728

Maximum community spouse resource allowance: \$128,640

Minimum monthly maintenance needs allowance: \$2,155

Maximum monthly maintenance needs allowance: \$3,216.00

Home equity limit: \$595,000

Penalty divisor: Divide the value of the uncompensated transfer by \$220.50; the resulting number is the number of penalty days.

VA Update



The big one.

October 18, 2018

- Lookback and penalty
- Annuities
- Net worth bright line
- More medical expense deductions



What's new with us?

Caregiver benefit

Using the KanCare form

Planning more limited after 2018 rule

Current VA Numbers

Maximum VA Resource Allowance: \$129,094

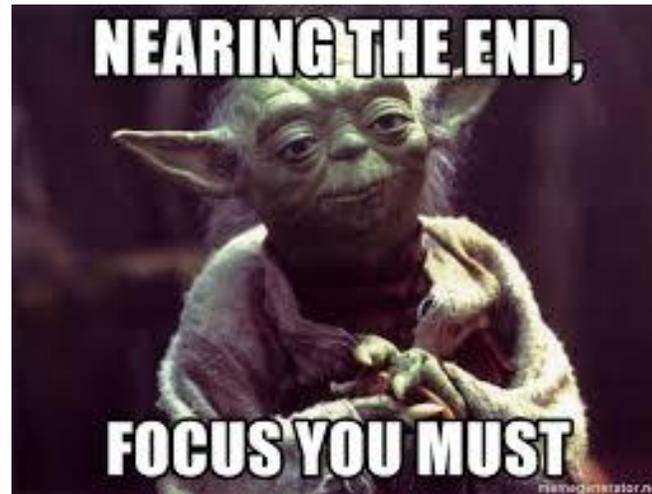
Monthly Pension Rate:

- Single veteran: \$1,911
- Married veteran: \$2,266
- Widow or surviving dependent: \$1,228

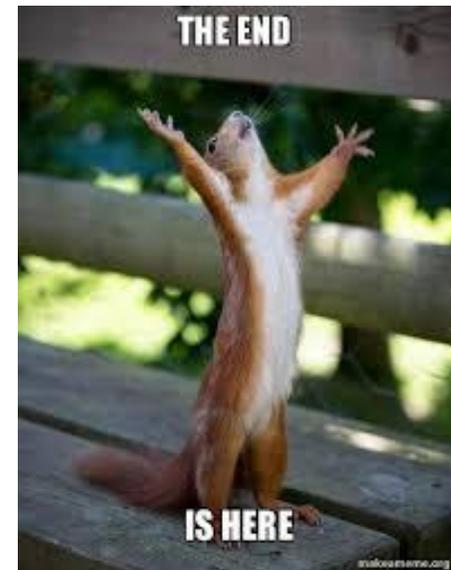
Summary

Medicaid and COVID

KanCare changes



Thank you!



Essential Numbers 2021

Medicaid (Kansas)

Minimum community spouse resource allowance: \$26,076
Maximum community spouse resource allowance: \$130,380

Minimum monthly maintenance needs allowance: \$2,155
Maximum monthly maintenance needs allowance: \$3,216

Home equity limit: \$603,000

Penalty divisor: Divide the value of the uncompensated transfer by \$220.50; the resulting number is the number of penalty days.

Medicare Part A (varies depending on income)

Home Health Care: \$0 for home health care services
20% of the Medicare-approved amount for durable medical equipment

Hospital Inpatient Stay:

Deductible: \$1,484 per benefit period
Coinsurance per day: \$0 for the first 60 days of each benefit period
\$371 per day for days 61-90 of each benefit period
\$742 per "lifetime reserve day" after day 90 of each benefit period

(up to a maximum of 60 days over your lifetime)

Skilled Nursing Facility Stay: \$0 for the first 20 days of each benefit period
\$185.50 per day for days 21-100 of each benefit period
All costs for each day after day 100 in a benefit period

Medicare Part B

Average monthly premium: \$148.50 (higher-income consumers may pay more)
Deductible per year: \$203

Federal Estate and Gift Tax

Annual exclusion: \$15,000
Lifetime exclusion: \$11,700,000

Essential Numbers 2021

Veteran's Aid & Attendance (effective 12/01/2020, but impacting VA checks 01/01/2021)

Maximum VA Resource Allowance: \$130,773
(Net Worth Limit)

Monthly Pension Rate:

Single veteran: \$1,935
Married veteran: \$2,295
Widow or surviving dependent: \$1,244

Maximum Annual Pension Rate (MAPR):

If you are a veteran...

Your yearly income must be less than...

Without a spouse or dependent child.....	\$13,931
<i>To be deducted, medical expenses must exceed 5% of MAPR, or \$696</i>	
With one dependent.....	\$18,243
<i>To be deducted, medical expenses must exceed 5% of MAPR, or \$912</i>	
Housebound without dependents.....	\$17,024
Housebound with one dependent.....	\$21,337
Aid and Attendance without dependents.....	\$23,238
Aid and Attendance with one dependent.....	\$27,549

Social Security (Cost of living adjustment increase for January 1, 2020 is 1.6%)

Social Security income for substantial gainful activity (amount a person on disability cannot exceed):

Non-blind: \$1,310/month
Blind: \$2,190/month

Trial work period: \$940/month

Monthly (annual) earnings limits for retirement benefit recipients:

Under full retirement age: \$1,580 (\$18,960)
Year in which full retirement age is attained: \$4,210 (\$50,520)

Social Security reductions are \$1 for every \$3 in earnings above the limit. No reductions beginning the month an individual attains full retirement age.

Monthly maximum Federal SSI amounts:

Individual: \$794
Couple: \$1,191

Maximum earnings subject to Social Security tax: \$142,800



Policy Clarification 2020-02-02

Title: Impact of Private Payment on Resource Eligibility

Date: February 26, 2020

From: Erin Kelley, Senior Medical Eligibility Policy Manager

Program(s) impacted: Elderly and Disabled Medical Programs

The purpose of this document is to provide guidance in situations where a consumer residing in a nursing facility has either partially or fully private paid the facility and what that means in terms of resource eligibility for the long term care program.

The following Medical KEESM provision states the basic policy:

5410 Types of Personal Property – *“Personal property consists of all property excluding real property. Cash assets which are a form of personal property consist of cash on hand, money in checking and savings accounts, stocks or bonds, cash surrender or loan value of life insurance policies, trust funds, monies or other property provided to a child under the Uniform Transfers to Minors Act (UTMA), and similar items on which a determinate amount of money can be realized. Personal property shall be considered available to the account owner/holder except for property held by a conservator or guardian is considered available to the conservatee or beneficial owner.*

Other personal property as used in the definition include such items as personal effects, household equipment and furnishings, home produce, livestock, equipment, vehicles, inventory, prepaid funeral contracts, and contracts from the sale of real or personal property.

Unless exempt, the value of personal property owned by the individual must be considered.”

If a consumer has been determined otherwise eligible for long term care and Medicaid payment is authorized for months in which the consumer has already private paid the nursing facility, any funds paid to the facility in excess of the liability issued in that month will be held “on account” with the facility and will be subject to reimbursement. This creates a potential resource eligibility issue as once that money is placed on account with the facility, it is now an available asset which may immediately place the consumer over resources as soon as they were found to be otherwise eligible.

When a consumer has private paid the nursing facility for months in which medical assistance has been requested, staff shall contact the facility to determine how much was paid in each

month and/or how much of a private payment was attributed to each month. If the amount paid to the facility exceeds the estimated liability for any month, the difference between the liability and the amount paid shall be compared to the total countable resources owned by the consumer in that month. If the total countable resources owned by the consumer plus the amount of the excess payment results in resource ineligibility, the consumer's request for long term care medical assistance shall be denied in all months applicable.

Note: If only a single month is impacted by resource ineligibility and the amount of excess resources plus the anticipated liability for that month is less than the facility's monthly cost of care, the voluntary contribution policy as outlined in PM2019-12-01 shall be considered. If the consumer agrees to the voluntary contribution and meets the general criteria, the voluntary contribution policy shall be followed. If the consumer does not meet the general criteria or does not agree to apply the voluntary contribution, long term care medical assistance shall be denied for the month impacted by the private payment.

If denied long term care, coverage under other medical programs shall be considered as the money held on account with the facility only becomes available if approved for long term care. However, as there is no way to differentiate between resources tested for long term care medical assistance and those tested for other medical programs, resource records reflecting the excess payment are not necessary and shall not be added to KEES. Rather, a V200 shall be sent with the following snippet added to the "Other Reasons Listed Here" section:

"Long Term Care medical assistance has been denied for the month(s) of {month(s) affected} due to a private payment made to the facility. Had Long Term Care been approved, the monies applied for the month(s) of {month(s) affected} would be subject to reimbursement and are therefore considered available assets for this program. However, as these monies are only available for the Long Term Care program, eligibility under other medical programs will be considered during this time. You will receive a separate notice regarding your eligibility for the other medical programs."

Consider the following examples:

1. Meghan applies for long term care medical assistance in December and requests prior medical. In November, Meghan private paid the facility in full for the months of September through November. Since Meghan had the ability to private pay in the prior medical months, it's determined that she is not eligible for the months of September and October due to the accumulated funds in her personal bank account. However, due to her payment to the facility in November, Meghan appears to be resource eligible in this month. If Medicaid payment were to be authorized effective November, the funds used to private pay the facility in that month would be held "on account" with the facility and would be an available resource to Meghan. The worker calculates Meghan's liability and deducts that amount from the amount of the private payment for the month of November. The amount of payment in excess of the calculated liability far exceeds the \$2,000 resource limit; therefore, Meghan's request for long term care medical assistance is denied for the month of November and a one-month Medically Needy Spenddown is established. Long term care is authorized effective December as only the prior medical months were impacted by Meghan's private payment to the facility. A voluntary contribution would not have been applicable for the month of November as it was a prior medical month.

2. Florence applies for long term care medical assistance in January and requests prior medical. In October, Florence private paid the facility in full for the months of October through December and paid a portion of January – the application month. Florence is otherwise eligible in all months due to the early payment to the facility; however, if Medicaid payment were to be authorized effective October, the funds used to private pay would be held “on account” with the facility and would be available to Florence. After determining that the amount of payment made to the facility in the months of October through December less the anticipated liability in these months exceeds the \$2,000 resource limit, Florence’s request for long term care medical assistance is denied and a Medically Needy Spenddown is established in these months. However, Florence only partially private paid for the application month. The amount of excess payment in the month of January does not exceed the cost of care in the facility; therefore, Florence is informed of the potential to make a voluntary contribution in order to become resource eligible in this month. Florence agrees to the voluntary contribution and medical assistance is authorized effective January.
3. Harvey applies for long term care medical assistance in February and does not request prior medical. Harvey has made a partial private payment to the facility for the month of February; however, this payment less Harvey’s anticipated liability in this month do not exceed the \$2,000 resource limit and there are no other countable resources. The excess payment is considered an available resource; however, because Harvey is within the resource guidelines, long term care medical assistance is authorized February.

For questions or concerns related to this document, please contact one of the KDHE Medical Policy Staff below.

Erin Kelley, Senior Manager – Erin.Kelley@ks.gov

Kris Owensby-Smith, Elderly and Disabled Program Manager-Kristopher.OwensbySmith@ks.gov

Jessica Pearson, Elderly and Disabled Program Manager – Jessica.Pearson@ks.gov

Jerri Camargo, Family Medical Program Manager - Jerri.M.Camargo@ks.gov

Amanda Corneliusen, Family Medical Program Manager – Amanda.Corneliusen@ks.gov



Policy Directive 2020-03-01

Title: Delayed Discontinuance – COVID-19

Date: March 31, 2020

From: Policy Managers

Program(s) Impacted: All Medical Assistance Programs

The purpose of this document is to provide immediate instruction to eligibility staff regarding the handling of reviews, premium delinquency, and other discontinuance processing during the COVID-19 public health emergency declared by the State of Kansas on March 23, 2020. This instruction is effective immediately for all reviews (new, received, and in process) and all open CHIP and Working Healthy cases with delinquent premiums.

All Programs - Discontinuances

Beginning with the issuance of this directive and continuing throughout the scope of the emergency, discontinuance will be suspended in all instances except for out-of-state residency, voluntary withdrawal, incarceration, and death. If coverage was already discontinued effective March 31, 2020 for any household member prior to the release of this policy directive, the coverage must be reinstated effective April 1, 2020.

NOTE: These policies related to COVID-19 do not apply to Presumptive Eligibility (PE) as PE recipients have not been determined eligible under the state plan. PE processes should continue as normal.

For all cases reinstated or coverage continued during this time, staff shall include the appropriate language from the Standard Copy and Paste (SCP) in the case journal.

For situations not covered in this directive, KDHE Policy should be consulted.

Renewals

During the scope of the emergency, no discontinuances will take place at review due to failure to meet eligibility requirements or failure to provide information. Reviews will also not be pended at this time for additional information. For those cases that would have been discontinued March 31, 2020 or later, or pended for additional information, coverage will be extended out four (4) months from the date of processing. A specialized Notice of Action will

be sent manually, and a note will be included in the case journal referring to the State Plan Amendments (SPA's) and corresponding documents.

These cases will need to be manually tracked by operational staff and provided to the KEES team on the first business day of each month. Specific processing instruction will be provided by KEES for these cases.

Cases that will be approved at review with no additional information required may be processed using normal guidelines.

NOTE: Cases that were already discontinued at review as of February 28, 2020 or earlier do not fall under this directive, and reviews received during the Reconsideration Period for these cases should be processed using standard procedure.

Renewal Actions

Effective with the issuance of this directive, eligibility staff shall adhere to the following processes.

All Programs:

1. All actions shall be fully journaled and thoroughly documented in the case file. Actions that result in extended coverage shall also be fully journaled using the approved verbiage from the Standard Text for Cut and Paste (SCP).
2. Renewals that do not require additional information and can be approved shall continue to follow the standard review process.
3. Renewals that do require additional information and would result in a pending action or would result in adverse action (discontinuance) shall have coverage extended four (4) months from the date of processing. This action shall be fully journaled and thoroughly documented in the case file using the verbiage from the SCP.
 - a. **Example:** At review, a new job is reported for the primary applicant, and the reported income cannot be verified through tiers I through III. Rather than placing the case on hold and requesting the income verification from the consumer, existing coverage will be extended four (4) months from the date of processing.
 - b. **Example:** A new job is reported for the spouse, and with the new income, the children previously covered will now be ineligible for all programs. Rather than discontinuing coverage, existing coverage will be extended four (4) months from the date of processing.
4. If an approval will result in greater cost-sharing by the consumer, such as an increase in premium, Spenddown, or Client Obligation, the original coverage should be extended an additional four (4) months from the date of processing. ***Note:** This applies to renewing the same coverage type. This does not apply to living arrangement changes from Independent Living to HCBS, PACE, or NF.

Note: It important to remember that negative changes because of an increase in income are not appropriate during the scope of this emergency. However, for LTC institutional coverage, the consumer's protected income limit is \$62. If there is an expense received that results in an increased PL, this is not considered adverse action because there is no change in the consumer's PIL.

- a. **Example:** Worker is processing an expense change task on an LTC/NF case. The expense document received states that effective next month, the consumer's Dental Insurance is ending, and the consumer will no longer pay for the \$100 monthly premium. It is appropriate to end-date the expense and increase the PL amount to the NF because there is no impact to the consumer. This is money that was being paid to one expense and will now be paid as another expense. The consumer continues to keep the \$62 PIL.
- b. **Example:** At review, with the new income verified, the child on the case previously covered on PLN (Medicaid) will now be CHIP eligible with a \$20.00 premium. Rather than authorizing the program with a premium, the existing Medicaid will be extended four (4) months from the date of processing.
- c. **Example:** An LTC Pre-populated review is received. Consumer is active on HCBS coverage with a \$150 Client Obligation. The consumer reports an increase in earned income and provides proof of wages with the review form. Per this directive, the increase in income would result in an increased client obligation, which cannot be done. Therefore, staff shall extend the review month out four (4) months from the date of processing.
- d. **Example:** An E&D Pre-Populated review is received. Consumer is active on Medically Needy Spenddown coverage with MSP/QMB. The spenddown for the last base-period was previously un-met. Consumer reports on his application that he now has earned income. Verification of income through RC verifies that there is earned income that would both increase the consumer's spenddown and disqualify him from MSP/QMB. Because this change would result in adverse action, the worker determines a new 6-month base period at the previous spenddown amount and the consumer's MSP/QMB continues. It is not appropriate to increase the spenddown or discontinue MSP/QMB with his policy. ***Note:** Specific processing instructions will be provided by KEES.
- e. **Example:** While processing an E&D Pre-Populated review, you find an LTC Communication task advising that the consumer has moved from his apartment into a nursing facility for a permanent stay. While the protected income limit is \$475 for the spenddown coverage and only \$62 for the LTC/NF coverage, this is not considered adverse action because the LTC/NF coverage is an increase in Medicaid coverage for the consumer. Financial and non-financial eligibility is then verified following the verification provisions for the COVID-19 National Public Health Emergency, and LTC/NF coverage. See *section 10. below.*

5. Cases on which a pre-populated review form was sent but not received will have coverage extended an additional four (4) months from the date of processing.
6. Cases on which a pre-populated review is due in the months of April 2020 and May 2020 will have the review due month systematically extended four (4) months.
7. For passive review responses that will result in a negative change, the review period will be shortened to four (4) months from the date of processing the change.
 - a. **Example:** The review batch runs and authorizes a case with a new review period of March 2021. A passive review response is received with changes reported and is processed during the month of April 2020. The changes will have a negative impact in program or cost-sharing, so the review period will need to be shortened to August 2020 and the existing level of coverage extended.

***Note:** Any consumer request to voluntarily withdraw from coverage shall be honored per Medical KEESM 1211.10. This may occur for many reasons including, but not limited to, agreeing to the share of cost.

Renewal Actions E&D and LTC Programs:

1. Medically Needy Spenddown renewals that would result in adverse action because the recipient has either not met the previous spenddowns, is not meeting the current spenddown, and/or is unlikely to meet a future spenddown, shall not be discontinued from the Medically Needy program. Instead, a new 6-month base period needs established for continued coverage with the new spenddown not to exceed the amount of the previous spenddown.
 - a. For cases with where the previous spenddown was met and the consumer was receiving full Medicaid benefits at the time of renewal, verified in MMIS, the consumer's new 6-month spenddown that is to be established shall also be met, as creating a new un-met spenddown is considered Adverse Action and is not allowed per this directive.
2. Long Term Care (LTC) Nursing Facility (NF) and Psychiatric Residential Treatment Facility (PRTF) renewals that include a separate Living Arrangement task to discontinue LTC NF or LTC PRTF coverage to a program other than Title XIX, shall be processed following the delayed CARE Score process as discontinuing LTC coding would result in adverse action. Title XIX coverage shall continue from the date of discharge with no level of care.
3. LTC Home Based Community Services (HCBS) renewals that include a separate living arrangement task to discontinue LTC HCBS coverage to a program other than Title XIX, shall continue to have the LTC HCBS coding remain for the consumer as discontinuing the HCBS coding would result in adverse action. These cases should be tracked for future follow up once the scope of this emergency has ended.
4. Renewals that include a separate Living Arrangement task to add additional LTC level of care shall also be processed in accordance with approved policy and follow the

tiered verification process approved for the COVID-19 Public Health Emergency. Verification of income and resource policies are to be applied. Level of care shall not be granted without verification of financial and functional eligibility.

- a. If verifications show the consumer is financially and non-financially eligible for the additional coverage request, the renewal process shall be completed following standard review policy and process and LTC Level of Care approved.
 - b. If verifications show the consumer is not financially and non-financially eligible for the additional coverage request, or proof of verifications are not received, the additional coverage request shall be denied. Current coverage shall remain active and the review month extended four (4) months from the date of processing.
5. Working Healthy 6-month Desk Reviews that are received and determined eligible per current policy shall be approved for the remaining 6 months when their annual review will be processed.
 6. Working Healthy 6-month Desk Reviews that are either not returned or, are received and result in a pending action or adverse action (discontinuance), shall not have EDBC Accepted and Saved. Coverage will continue until the annual twelve (12) month review is processed without accepting EDBC.

A manual notice will shall be created using verbiage from the COVID-19 tab of the Standard Copy and Paste (SCP).

7. Future Working Healthy Desk Reviews will not be sent to consumers during the scope of this emergency.
8. Working Healthy Annual reviews that are processed and the consumer is determined eligible to continue Working Healthy coverage shall be approved following standard review policies and process.
9. Working Healthy Annual reviews that are received and would require additional information or would result in adverse action shall have coverage extended four (4) months from the date of processing.

Verification and Application of Expenses on Cases with Extended Coverage

For E&D and LTC programs, verified medical expenses can reduce the share of cost and spenddown amounts and the verification and application of expenses shall follow current, established policy. These expenses may be received at any time and are processed as either case maintenance tasks or at review.

Failure to provide proof of an expense will not affect eligibility, however, the expense will not be used to lower the share of cost or spenddown until physical verification is received by the agency.

There may be situations where verification of an expense is received for a consumer who is determined resource ineligible but is receiving extended coverage because of the COVID-19 directive. In these situations, it is important to compare the amount of the expense to the amount of excess resources. This is because there are certain situations where it would not be reasonable to lower a consumer share of cost if the amount of excess resources far exceeds the amount of the expense. Prudent person should be used to determine the reasonability of applying these expenses.

- Example: LTC/NF consumer submits a Passive Review Response to the agency and verification of resources, income, and expenses is received. This consumer reports a new monthly recurring expense of \$210 per month. However, verification of resources shows that the consumer has \$5,000 in the savings account. Because the \$210 expense is significantly lower than the excess resources and would take months of out of pocket payments to become resource eligible, the expense is not applied, and the consumer's LTC/NF coverage remains in place with no change in patient liability.
- Example: Pre-Populated review is worked by the agency for an LTC/HCBS consumer and proof of income, resources, and expenses is received. The consumer reports a new recurring expense of \$119 per month. However, resource verification shows the consumer has \$2100 in resources. Because the \$119 expense is more than the excess resources, the \$119 is used to lower the monthly client obligation.
- Add Sterling Dental example.

***Note:** For cases that are determined to have excess resources, it is imperative that a call is placed to the consumer or authorized representative advising of the future impact this will have on their eligibility, and policy provided on how they can appropriately spenddown their resources.

Premium Delinquency for CHIP and Working Healthy

Beginning March 2020 and continuing throughout the scope of the emergency, discontinuances for failure to pay premiums will be suspended. A file provided by the fiscal agent has been used to update the Delinquency CHIP Premiums and Delinquent WH Premium status from 'Yes' to 'No' on all active cases with a 'Yes' delinquency status, temporarily removing the delinquency and allowing coverage to continue. Many of these will continue to show delinquent in Premium Billing, and this is acceptable.

Likewise, for cases on which a *Reinstate CHIP Coverage – Premium Paid* task is generated, coverage should be reinstated by the worker.

For Working Healthy cases, the *PB No Delinquent Premium* task generated during this update, for Working Healthy programs that were previously closed for delinquent premiums. The age on these tasks varies. It is appropriate to reinstate cases discontinued effective March 31st, 2020. The program block should be rescinded and EDBC re-run to high date the EDBC. In situations where a member would have been discontinued due to categorically not being eligible, further action in KEES may be required. Please review current Job Aids and Manuals. If needed, consult Policy and KEES staff to determine the proper action needed.

When a Notice of Action is not generated, a manual notice will need to be created using verbiage from the COVID-19 tab of the Standard Copy and Paste (SCP). If a Notice of Action is generated, staff should append the notice using the append language also found on the COVID-19 tab of the SCP.

Any unpaid premiums for the months of March through the end of the emergency period will not be penalized. It is anticipated that any outstanding premiums incurred from January 1st, 2020 through the end of the Public Health Emergency shall be waived.

For questions or concerns related to this document, please contact one of the KDHE Medical Policy Staff below.

Erin Kelley, Senior Manager – Erin.Kelley@ks.gov

Kris Owensby-Smith, Elderly and Disabled Program Manager –
Kristopher.OwensbySmith@ks.gov

Jessica Pearson, Elderly and Disabled Program Manager – Jessica.Pearson@ks.gov

Jerri Camargo, Family Medical Program Manager – Jerri.M.Camargo@ks.gov

Amanda Corneliusen, Family Medical Program Manager – Amanda.Corneliusen@ks.gov



Policy Directive 2020-06-01

Title: Fair Hearing Extension – COVID-19

Date: June 10, 2020

From: Policy Managers

Program(s) Impacted: All Medical Assistance Programs

The purpose of this document is to provide immediate instruction regarding the timeline for appeal filing during the COVID-19 Public Health Emergency (PHE) declared by the State of Kansas on March 23, 2020. This instruction is effective retroactively, see details below.

All Programs – State Fair Hearings

In the event a negative decision is made regarding consumer eligibility, the consumer has 33 days from the date on the Notice of Action to request a fair hearing. Due to the COVID-19 emergency, the Centers for Medicare and Medicaid Services (CMS) has approved a temporary waiver allowing applicants and beneficiaries an additional 120 days to request a state fair hearing. The State will allow an applicant or beneficiary an additional 120 calendar days to request a state fair hearing if the 33-day deadline occurs between March 1, 2020 and the end of the Federally declared PHE.

Beginning May 7th, letters will accompany all KEES mailings advising of this change and will need to be included with any locally printed mailings as well. The letter consists of the following text:

This letter is to tell you about extra time the State of Kansas is giving you to ask for a state fair hearing during the COVID-19 public health emergency. If the 33-day deadline to ask for a state fair hearing is between March 1, 2020 and the end of the COVID-19 emergency, you may have 120 more days to ask for a hearing. This letter does not change anything else about your right to request a hearing.

Note: The letters will be managed by the central print vendor for any correspondence sent through KEES and will not be imaged to the case. Staff printing a form or NOA locally will need to print out a copy of the letter, attached to this directive, to include with the outgoing correspondence.

These mailings will continue through the end of the Federally declared PHE.

For questions or concerns related to this document, please contact one of the KDHE Medical Policy Staff below.

Erin Kelley, Senior Manager – Erin.Kelley@ks.gov

Kris Owensby-Smith, Elderly and Disabled Program Manager –

Kristopher.OwensbySmith@ks.gov

Jessica Pearson, Elderly and Disabled Program Manager – Jessica.Pearson@ks.gov

Jerri Camargo, Family Medical Program Manager – Jerri.M.Camargo@ks.gov

Amanda Corneliusen, Family Medical Program Manager – Amanda.Corneliusen@ks.gov



Policy Memo	
KDHE-DHCF POLICY NO: 2019-12-01	From: Erin Kelley, Senior Manager
Date: December 9, 2019	Medical KEESM/KFMAM Reference(s): 5200 (5), 5200 (14), 5430 (26), 6410 (71), 8142 (3), 8172.4, 8243 (4), 8270.4
RE: Voluntary Contribution for Long Term Care and Resource Liquidation to Purchase Funeral Plan	Program(s): Elderly and Disabled Medical Programs

This memo sets forth instructions for policy changes being implemented in January 2020. Unless otherwise indicated, the following implementation instructions are applicable to all eligibility actions taken on or after January 1, 2020. Revisions to the Medical KEESM manual will coincide with the release of this memo. Additional information related to the implementation of these changes is available through training material released to eligibility staff.

I. VOLUNTARY CONTRIBUTION FOR LONG TERM CARE

A. BACKGROUND

When a consumer applies for Long Term Care medical assistance and owns resources in excess of the program standards, or, when it is discovered that an ongoing recipient now owns excess resources, there are very few options available to the consumer to pursue resource eligibility without losing their application filing date or their current coverage.

1. EXCESS RESOURCES IN MONTH OF APPLICATION

It is not uncommon for an applicant for nursing home coverage to have excess resources in the month of application. When the amount of the excess resources is not enough to fully private pay for that month, the applicant is left in a difficult situation. If denied for assistance due to excess resources, he/she does not have enough funds available to private pay the facility. If the excess resources are used to pay towards the cost of care in the facility to achieve resource eligibility, coverage may be approved for that month.

However, if the agency approves coverage for that month and determines the patient liability, if the patient liability is less than what the applicant has already paid towards the cost of care, the facility will refund the difference back to the applicant. This could cause the applicant to again possess resource in excess of the allowable limit. One solution is to simply deny coverage for this month and use the unpaid portion of the nursing home cost of care as a due and owing expense to be applied beginning with the first month of coverage. But, that solution denies Medicaid coverage for the month the applicant is otherwise entitled to receive.

2. EXCESS RESOURCE AT REVIEW

It is also not uncommon to discover at review (or earlier) that a long term care recipient is over the allowable resource limit. This could have occurred for several reasons, but most likely from the acquisition of resources after approval or from accumulation of monies from an exempt income source not considered in the share of cost determination.

a. AFTER ACQUIRED

A recipient may have acquired additional resources after eligibility for long term care coverage has been approved. Unless promptly reported by the recipient, this may not have been discovered until the annual case review. The additional resources may have originated from an inheritance, lottery winnings, or are the proceeds from the sale of an otherwise exempt resource. Whatever the source, eligibility may not be reestablished until countable resources are again within the allowable limit. If the recipient is unable to expend the excess resources on exempt goods or services by the end of the month after the end of the review period, a gap in coverage for medical assistance may occur.

b. EXEMPT INCOME

When the recipient has income that is exempted in determining the long term care share of cost, there is the potential that accumulated income, if unspent, may over time cause the countable resources to exceed the allowable limit. This is not un-common for a nursing home recipient who receives the \$90/month reduced VA payment. That income does not count in determining the monthly patient liability, and if unspent, may over time cause countable resources to exceed the allowable resource limit.

B. POLICY

Effective with the issuance of this memo, applicants for nursing home coverage and long term care recipients may voluntarily contribute excess resources or ongoing exempt income towards a long term care cost of care in order to achieve and/or maintain resources within the allowable limit. This formalizes a policy that eligibility staff have previously been informally following.

1. WHEN TO APPLY THE VOLUNTARY CONTRIBUTION POLICY

This policy only applies to long term care applicants and recipients who have a share of cost obligation. The Voluntary Contribution is applied to increase the calculated share of cost by the amount of the excess resources or ongoing exempt income. This policy cannot be used by independent living applicants or recipients to increase a spenddown or to inflate the amount of a premium.

a. APPLICANTS

For applicants, this policy only applies to those requesting services for institutional care coverage (including institutional PACE) – it does not apply to applicants for HCBS or community PACE. In addition, only excess resources may be applied toward the share of cost as a Voluntary Contribution to achieve initial resource eligibility. Ongoing exempt income may not be applied as a Voluntary Contribution for applicants.

b. RECIPIENTS

This policy applies to all long term care recipients – those receiving institutional care, HCBS or PACE. In addition, both excess resources and ongoing exempt income may be applied toward the share of cost as a Voluntary Contribution to retain resource eligibility.

2. APPLICATION OF VOLUNTARY CONTRIBUTION

The Voluntary Contribution policy shall be applied in the following manner:

a. EXCESS RESOURCES

When an applicant for institutional coverage has resources in excess of the allowable limit in the month of application, the excess amount may be applied towards the patient liability for that month. A long term care recipient with excess resources may increase the share of cost obligation in the next available month, allowing for timely notice of the increase.

i. Calculation

The amount of the Voluntary Contribution shall be no less than the amount of the excess resources needed to make the applicant/recipient resource eligible. Therefore, the amount in excess of \$2,000 is the *minimum* Voluntary Contribution. A lesser amount will not ultimately result in resource eligibility. A greater amount may be applied (within limitation described below), subject to the amount agreed upon by the applicant/recipient. See subsection (3)(a) below.

ii. Application

Once the amount of the Voluntary Contribution has been established, the share of cost obligation and countable resources shall be adjusted as follows:

1) Share of Cost

The normal share of cost for the month of application for applicants, or next available month for recipients, shall be increased by the amount of the Voluntary Contribution. The amount of the Voluntary Contribution shall be entered in KEES as countable income for that month only – resulting in an increase in the patient liability by that amount. The Voluntary Contribution income record shall be end-dated no later than the month it is applied for purposes of this subsection.

Since the Voluntary Contribution is only entered into KEES administratively as income, care should be taken to ensure that this entry does not adversely affect MSP eligibility. That additional income, intended for purposes of increasing the share of cost only, should not be counted in determining MSP eligibility or towards the 300% special income limit. To accomplish that, the following action shall be taken depending on the type of long term care coverage involved:

a) Institutional – For institutional coverage (including institutional PACE), the Voluntary Contribution shall be entered in KEES with an income type of “Other – Exempt”. The income will then be included in the patient liability determination but excluded when determining MSP eligibility and the 300% special income limit.

This appears to be counterintuitive, but due to the post-eligibility treatment of income, all otherwise exempt income (other than that listed in Medical KEESM 8150) will be counted in determining the patient liability for an institutionalized individual. At the same time, that income will then be exempted and therefore not counted in the MSP and 300% determinations.

b) HCBS and PACE – For HCBS and community PACE, the Voluntary Contribution shall be entered in KEES with an income type of “Other – Countable”. The income will be correctly included in the determination of client obligation or participant obligation, but also incorrectly included in determining MSP eligibility and the 300% special income limit.

If the additional income does not adversely affect the MSP or 300% determination, then no further action is required. If the recipient is already on Medicare buy-in and the amount of the

Voluntary Contribution causes the recipient to go from LMB eligible to not LMB eligible, no further action is required since payment of the Medicare Part B premium will continue.

However, if the amount of the Voluntary Contribution causes the recipient to lose QMB coverage (regardless of whether the individual is already on buy-in), or the additional income causes total income to exceed the 300% special income limit, eligibility staff shall contact KDHE-DHCF Eligibility Policy for further guidance on how to proceed.

2) *Countable Resources*

Countable resources shall be reduced by the amount of the Voluntary Contribution. This reduction is effective the month of application for applicants and the month the Voluntary Contribution is applied for recipients. This shall be accomplished administratively by subtracting the amount of the Voluntary Contribution from a liquid resource, such as a checking or savings account.

If the applicant/recipient has no (or not enough) liquid resources to count towards the Voluntary Contribution needed to reduce assets below the allowable resource limit, then this process is not an option. If most or all of the applicant/recipient's countable resources are non-liquid, such as life insurance, real estate, or vehicles, those assets may have to be sold (or borrowed against) to create a cash asset which could then be used to fund a Voluntary Contribution.

Note: If reducing the liquid resource in this manner does not result in resource eligibility, then either the amount of the Voluntary Contribution was not enough, or the resource was reduced by an incorrect amount. Eligibility staff shall confirm that the amounts are correct.

b. INCOME

When a long term care recipient accumulates excess resources over time due to the ongoing receipt of exempt income which is not counted in determining the share of cost, he/she has the option of voluntarily applying some or all of that income towards the monthly share of cost. The share of cost would be increased in the next available month, allowing for timely notice of the increase.

Note: If accumulation of exempt income results in excess resources, those excess resources will also have to be spent down in some manner – either as a separate Voluntary Contribution or towards exempt goods or services for the benefit of the recipient.

i. Calculation

The amount of the Voluntary Contribution is entirely up to the recipient. In most instances, it will be prudent to apply the entire amount of the exempt income towards the share of cost. In other instances, a lesser amount may be sufficient to prevent resource ineligibility over time. However, the amount of the Voluntary Contribution is ultimately up to the recipient. See subsection (3)(a) below.

ii. Application

Once the amount of the Voluntary Contribution has been established, the share of cost obligation and otherwise exempt income shall be adjusted as follows.

1) Share of Cost

The normal share of cost for the next available month (allowing for timely notice) shall be increased by the amount of the Voluntary Contribution. The amount of the Voluntary Contribution shall be entered in KEES as indicated in subsection (a)(ii)(1)(a) and (b) above for that month and each month thereafter. This should correctly increase the share of cost by that amount.

As noted above, care should be taken to ensure that entry of this administrative income does not adversely affect MSP eligibility or count against the 300% special income limit. To accomplish this, eligibility staff shall follow the same procedure outlined in subsection (a)(ii)(1) above. Again, contact with KDHE-DHCF Eligibility Policy may be required.

2) Income Record

Even though all or part of an existing exempt income source is now being voluntarily counted in determining the long term care share of cost by adding a new income record, the exempt income record in KEES shall not be adjusted. That record shall remain in place. This will allow the agency to identify and track the income if necessary. This will also allow the pre-populated review form to accurately reflect that income.

Note: The Voluntary Contribution process shall not be used where the excess resources are attributed to a recipient who has failed to pay the monthly share of cost obligation. In those instances, the recipient should be instructed to make payment for all delinquent months. That should reduce countable resources below the allowable resource limit, unless other factors are involved. If the recipient refuses or fails to comply, discontinuance due to excess resources is appropriate.

3. ADDITIONAL REQUIREMENTS

The following additional requirements shall be met before approving a Voluntary Contribution.

a. AGREEMENT

The applicant or recipient must agree to the Voluntary Contribution either verbally or in writing before the agency may take action to increase the long term care share of cost. If the agreement is verbal, eligibility staff must thoroughly journal that agreement. To expedite the process, eligibility staff shall attempt to contact the applicant or recipient by phone to obtain a verbal agreement to make a Voluntary Contribution of either excess resources or otherwise exempt income. For the verbal agreement to be valid, the individual must be very clear what they are agreeing to, including the amount of the Voluntary Contribution, the effective month, and the source (resources, income, or both).

In addition, it must be stressed that this action is purely optional and not mandated by the agency. As indicated above, the contact with the applicant or recipient and the terms of the agreement must be thoroughly journaled to document the agency decision to apply the Voluntary Contribution.

If eligibility staff are unable to contact the applicant or recipient by phone to establish a Voluntary Contribution agreement, eligibility shall be processed applying the normal resource counting rules. Eligibility staff have no further obligation to make contact with the individual other than by phone.

b. OTHERWISE ELIGIBLE

The applicant or recipient must otherwise be eligible for long term care coverage. If there is ineligibility for a reason other than excess resources, there is no need to pursue a Voluntary Contribution agreement since solely reducing resources will not result in eligibility. Likewise, if the applicant or recipient is not applying for or receiving long term care coverage, there is no appropriate share of cost under this policy to adjust.

c. COST OF CARE

When adding the Voluntary Contribution to the normal share of cost, the new increased share of cost cannot exceed the cost of care for the long term care services. If the increased share of cost exceeds the cost of care amount then this is not an option since there is no eligibility for long term care coverage. reduced, or excess resources must be disposed of in another manner [See subsection (d) below].

Note: If the amount of the excess resources is greater than that which can be applied in a single month to reduce resources within the allowable limit, this Voluntary Contribution policy cannot be used. The applicant/recipient will have to reduce resources in another method. See subsection (d) below.

d. OTHER OPTIONS

While a Voluntary Contribution agreement is an option available to an applicant or recipient, in most instances, it should be offered only after consideration of all other options to reduce resources, including the following:

i. Purchase Funeral Plan

Applicants or recipients with excess liquid resources may purchase an exempt burial plan to reduce resources. See Medical KEESM 5430 (3) (burial spaces) and (10) (funeral agreements). In the alternative, if the individual does not already have monies set aside for burial and the amount of excess resources is relatively small, he/she may designate up to \$1,500 in a separate and identifiable account for burial. See Medical KEESM 5430 (2) (burial funds).

ii. Pay Due and Owing Expenses

A Voluntary Contribution should generally not be used when the applicant or recipient has due and owing medical expenses. The individual shall always be encouraged to meet his/her own medical needs to the fullest extent possible. Using excess resources to pay outstanding medical bills is always preferable to a Voluntary Contribution.

iii. Pre-Pay Estate Recovery

A recipient (but not an applicant) may choose to make a pre-payment against the future Estate Recovery claim. If this option is chosen, verification of the payment, including the amount, is required. The recipient should be referred to Estate Recovery at **1-800-817- 8617** or e-mail at KSestaterecovery@hms.com. Estate Recovery will assess the amount of the proposed payment against the current size of the recovery claim to determine if this is an acceptable option. Estate Recovery cannot accept a payment that exceeds the current amount of the claim. The amount of the claim will be reduced by the amount of any pre-payment accepted by Estate Recovery.

See Medical KEESM 1725.7 and PM2019-06-02 (Section III.D.).

Note: The option to reduce resources by pre-paying Estate Recovery may also be used by non-long term care recipients who received services on or after age 55 since those claims are also subject to recovery. This would include an individual eligible under Medically Needy (MDN), but not a recipient of QMB, LMB, or QWD only as those programs are not subject to Estate Recovery.

iv. Spend Down Assets

An applicant or recipient may choose to reduce countable resources by paying outstanding bills, purchasing items for personal use (i.e. clothing, television, books, etc.) or any other asset that will not count against the

resource limit. There are few, if any, parameters on what may be purchased in this manner other than adequate consideration must be received for all purchases. Gifting of assets to reduce resources may be considered an uncompensated transfer affecting eligibility for long term care programs. See Medical KEESM 5720 and subsections.

Note: Pre-paying for care in a nursing facility to reduce resources is not an option since any amount on account held in the facility for the resident is considered an available resource and therefore will not reduce his/her countable assets. That includes creating a separate pre-paid account at the facility that will pay for the difference between a shared room and a private one.

v. ***Discontinue Eligibility***

In general, the use of the Voluntary contribution option is only available where the amount of excess resources is relatively small. There may be instances where a recipient receives a large lump sum cash asset, such as an inheritance, or proceeds from the sale of an otherwise exempt resource (i.e. home, income producing property) or substantial winnings from a lottery ticket. In that situation, there may be no reasonable option other than to close the case due to excess resources. The former recipient would then private pay for services with the option of reapplying for assistance once resources have been spent down and are again within the allowable limit.

4. NOTICES

The following notice fragments have been created for use when the share of cost has been increased due to a Voluntary Contribution and when the share of cost has been decreased due to the removal of a Voluntary Contribution. These fragments are available on the KDHE Standard Text for Copy and Paste on the E&D Specific tab.

a. **APPLICATION OF VOLUNTARY CONTRIBUTION**

The following notice fragments may be used when a Voluntary Contribution has been applied to increase the share of cost.

i. ***Excess Resources***

This notice fragment may be used where a Voluntary Contribution of excess resources are applied to increase the share of cost in a single month.

*“The normal amount of your share of cost has been increased because you agreed to a Voluntary Contribution in the amount of **#{insert amount}** to reduce your resources under the allowable limit. Your share of cost, including the amount of your Voluntary Contribution, is **#{insert amount}** effective **{insert month and year}**.”*

This is in accordance with Medical KEESM 5200 (14), 5430 (26), 6410

(72), 8142 (3), 8172.4, 8243 (4), 8270.4.”

ii. Exempt Income

This notice fragment may be used where a Voluntary Contribution of exempt income is applied to increase the share of cost on an on-going monthly basis.

*“The normal amount of your share of cost has been increased because you agreed to a Voluntary Contribution in the amount of **#{insert amount}** from your exempt income to keep your resources under the allowable limit. We will continue to count this additional amount on your share of cost each month until you tell us to stop.*

*Your share of cost, including the amount of your Voluntary Contribution, is **#{insert amount}** effective **#{insert month and year}**.*

This is in accordance with Medical KEESM 6410 (72), 8142 (3), 8172.4, 8243 (4), 8270.4.”

b. REMOVAL OF VOLUNTARY CONTRIBUTION

The following notice fragment may be used when the Voluntary Contribution from either excess resources or ongoing exempt income has been removed to decrease the share of cost.

*“Your share of cost has been changed to **#{insert share of cost}** effective **#{insert month and year}** because your Voluntary Contribution in the amount of **#{insert amount}** to reduce resources is no longer counted.*

This is in accordance with Medical KEESM 5200 (14), 5430 (26), 6410 (72), 8142 (3), 8172.4, 8243 (4), 8270.4.”

II.RESOURCE LIQUIDATION TO PURCHASE FUNERAL PLAN

A. BACKGROUND

Normally an applicant is ineligible for medical assistance in any month until countable resources are at or below the allowable limit. However, an exception was developed to allow retroactive coverage for an applicant who was in the process of liquidating an otherwise resource-disqualifying asset in order to purchase an exempt burial fund or plan. This exception was documented in Medical KEESM 5200(5)(b).

The process is complex and difficult to administer, and in most instances, requires the application to pend beyond the 45-day timely processing threshold. To qualify under this special provision, the applicant must initiate the liquidation process within 15 days from the date of the application and complete the process within 90 days. Eligibility staff are then required to pend the application until whichever occurs first – the resource is liquidated, and a burial plan or fund is purchased, or the 90th day.

B. POLICY

Effective with the issuance of this memo, this policy has been eliminated. The regular verification and resource counting rules apply to situations where a liquid resource is being accessed to fund a burial fund or plan. The liquid resource is a countable resource up until the month accessed and converted to an exempt resource – including a burial fund or plan. This means the application will no longer pend while the applicant pursues this process.

Even with this change in policy, the following provisions remain unchanged.

1. REDUCING COUNTABLE RESOURCES

The agency, as a policy, shall continue to encourage applicants and recipients to reduce excess resource by providing for their own final needs in the form of funeral or burial plans. However, should the applicant choose this option of reducing countable resources, the application shall no longer pend throughout the conversion process. Assuming there are no other outstanding issues, this shall allow the application to be processed in a timely manner.

a. ADDITIONAL TIME

An applicant may request, and the agency may grant, additional time to provide information requested by the agency. However, the agency shall be under no obligation to grant additional time exclusively for an applicant to verify that he/she is liquidating or will be liquidating an otherwise resource-disqualifying asset with the funds to be used for some other purpose – including purchasing an exempt burial fund or plan.

b. REACTIVATION

A denied application or discontinued coverage due to excess resources may be reactivated in the following circumstances.

i. Application

If the application is denied due to excess resources, the applicant may reactivate the original application by providing verification that the excess resource has been liquidated and was used to purchase an exempt burial fund or plan. The verification must be provided within 45 days from the date of application in order to reactivate the application. Otherwise, a new application is required. See Medical KEESM 1414.2(1)(b).

ii. Discontinuance

If eligibility has been discontinued due to excess resources, coverage may be reinstated if verification that resources are within the allowable limit is provided by the end of the month after the month of discontinuance. This could include verifying that countable resources have been liquidated to purchase an exempt burial fund or plan. If verification is not provided by the end of the month after the month of discontinuance, a new application

is required. See Medical KEESM 1423.

2. TRANSITION

Any current application that is pending due to the previous policy at the time the new policy was implemented shall continue to pend and be processed based on the old policy. To qualify, the process to liquidate the disqualifying resource must have been initiated within 15 days of the date of application (or report of excess resources by a recipient) with the process to purchase and verify the exempt funeral fund or plan completed within 90 days. Otherwise, this special policy does not apply.

Any new request received after issuance of this memo to pend an application based on liquidation of resources under the old policy shall be denied.

III. QUESTIONS

For questions or concerns related to this document, please contact one of the KDHE Medical Policy Staff listed below.

Erin Kelley, Senior Manager – Erin.Kelley@ks.gov

Kris Owensby-Smith, Elderly and Disabled Program Manager - Kristopher.OwensbySmith@ks.gov

Jessica Pearson, Elderly and Disabled Program Manager – Jessica.Pearson@ks.gov

Jerri Camargo, Family Medical Program Manager - Jerri.M.Camargo@ks.gov

Amanda Corneliusen, Family Medical Program Manager – Amanda.Corneliusen@ks.gov

Questions regarding any KEES issues are directed to the KEES Help Desk at KEES.HelpDesk@ks.gov



Policy Memo	
KDHE-DHCF POLICY NO: 2020-04-01	From: Erin Kelley, Senior Manager
Date: April 17, 2020	Medical KEESM/KFMAM Reference(s):
RE: Policy Implementation Instructions and Information for COVID-19 National Public Health Emergency	Program(s): All Medical Programs

This memo sets forth instructions for implementation of policy changes related to the COVID-19 National Public Health Emergency and processing guidelines for the duration of this emergency concerning applications and new coverage requests, situations where an applicant/recipient fails to provide requested information, and the receipt of Federal Emergency Relief funds. For purposes of this directive, the COVID-19 National Public Health Emergency is defined as the events transpiring beginning March 1st, 2020, the beginning of the national emergency proclaimed by President Trump on March 13th, 2020.

Unless otherwise indicated, the following implementation instructions are applicable to all eligibility actions taken on or after March 18th, 2020.

For situations not covered in this memo, KDHE Policy should be consulted.

Applicable to all Medical Programs:

- Failure to Provide
- COVID-19 Federal Stimulus Funds
- Journal Requirements

Applicable to Family Medical Programs only:

- Partial Approvals When Prior Medical Income Verification is Needed
- Employer Statements

Applicable to Non-MAGI Programs only:

- Verification of Resources
- Verification of Income/End of Income
- AVS for Applications and New Coverage Requests
- Long Term Care – CARE Scores
- Expenses

- Medicare Buy-In
- Transfer of Property

I. CHANGES IMPACTING ALL MEDICAL PROGRAMS

A. FAILURE TO PROVIDE

When an applicant/recipient fails to timely provide requested information and the application is denied or coverage is discontinued, that action may be rescinded if the applicant/recipient later contacts the agency to report the failure was due to circumstances associated to the outbreak of COVID-19. The explanation must be plausible, and directly related to the outbreak of COVID-19 to qualify under this directive. Each situation shall be examined on a case-by-case basis following the direction provided in the PD2019-06-01 [Failure to Provide – Natural Disaster](#) Policy Directive.

This would include 14-day quarantines, access to authorized representatives or businesses, transportation, and other plausible impacts the consumer may report.

Note: This policy directive is reactive, not proactive in nature. The applicant/recipient must contact the agency citing the outbreak of COVID-19 as the reason the requested information was not timely provided. The extension request must still come from the applicant/recipient or authorized representative.

B. COVID-19 FEDERAL STIMULUS FUNDS

The Phase III, H.R. 758 (116) or CARES Act Mar. 25, 2020, also known as the stimulus bill, provides most adults with a one-time payment of \$1,200 (\$2,400 for couples filing jointly). Each child aged 16 and under would get an additional \$500. These payments will start distribution in April 2020. For purposes of this implementation, these payments are exempt as income in the month received and exempt as a resource through the consumers review period, not to exceed twelve (12) months. Additionally, there may be additional funds (ex: increased unemployment funds) that may also be exempt under this policy.

Example: Consumer receives \$200 per week in regular unemployment income, however, because the cause of unemployment was because of the COVID-19 emergency, the consumer receives an additional \$600 in unemployment income.

The standard unemployment income of \$200 is countable unearned income. The \$600 additional unemployment income for COVID-19 is exempt.

C. JOURNALING REQUIREMENTS

For all case actions taken in accordance with this policy memo, staff shall include the appropriate language from the Standard Copy and Paste (SCP) in the case journal.

II. CHANGES IMPACTING FAMILY MEDICAL PROGRAMS ONLY

A. PARTIAL APPROVALS WHEN PRIOR MEDICAL INCOME VERIFICATION IS NEEDED

Current policy states that when prior medical coverage is requested, and there was a change in household or income during the prior medical months that would fundamentally alter the expected income to be received, and the Prior Medical simplification found in KFMAM 6132.01 using KDOL wages cannot be used to approve Prior Medical coverage, proof of actual income for those months must be requested from the consumer. For the duration of the COVID-19 Public Health Emergency, cases requiring actual income for prior medical months that can be approved in the month of application should be authorized beginning that month and the case placed on hold for the prior medical income.

B. EMPLOYER STATEMENTS

Current policy states that when there is an income change reported that will result in either a decrease or elimination of premium or a change in program from TransMed (TMD) or Extended Medical (EXT) to Caretaker Medical (CTM), a statement from the employer must be provided as verification of the change. For the duration of the COVID-19 Public Health Emergency, this requirement will be waived, and we will consider the income change verified through the consumer's self-attestation.

III. CHANGES IMPACTING NON-MAGI PROGRAMS ONLY

A. VERIFICATION OF RESOURCES

1. TIERED VERIFICATION

Eligibility staff shall continue to follow the Tiered Verification policy when requesting proof of income and resources to determine eligibility. During the scope of the COVID-19 Public Health Emergency, the verification policy has been modified to include AVS requests being completed following the direction in section III(4)(B) of this memo and client attestation acceptance prior to denying a request for failure to provide if a consumer or their authorized representative advises the agency of their difficulty in obtaining verifications specifically because of the COVID-19 Public Health Emergency. This request must be made prior to the last day of the verification due date or before the maximum 20-day extension date expires.

- Tier 1 – Confirmed/Payer Source
- Tier 2 – Interface/Reasonable Compatibility
- Tier 3 – Research (including collateral contact)
- Tier 4 – Contact the consumer

2. COLLATERAL CONTACTS

Staff shall make every concerted effort to obtain verification of resources by collateral contact prior to requesting information from the consumer. When a consumer is unable to provide verification and this request has been communicated to the agency, it is appropriate for the agency to provide additional information or other options for obtaining the necessary information as an initial step as KEESM 1321.2 indicates the agency shall offer assistance to the household in obtaining documentary evidence when it is difficult or next to impossible for the household to obtain it.

Note: The obligation of the agency to assist does not release the consumer of their responsibility to report/provide information.

3. CLIENT ATTESTATION

Once all options have been exhausted, and proof of liquid resources (bank accounts, CD's, Stocks, etc.) have not been received or verified via AVS, staff shall use information attested on the application if available or contact the consumer or authorized representative by phone to verify, or obtain, client attestation of the missing resources.

All assets verified by client attestation shall be considered *Verified* and will be accepted throughout the program's current review period. All verification decisions to approve or deny an extension request to provide requested information must be journaled thoroughly using the approved COVID- 19 journal noted in section I(C) of this memo.

4. TRUSTS, ANNUITIES, AND PROMISSORY NOTES

Consumer's that report ownership of Trusts, Annuities, and/or Promissory Notes must continue to provide physical verification of these resources. Therefore, these resources shall follow established policy, and are not included in the verification process for COVID-19. Trust and Annuity clearance process established in Policy Directive 2020-01-01 [Separation of Trust/Annuity Clearance Request Form \(B-6\)](#) shall continue to be completed prior to case approvals.

Failure to provide verification of these specific resources shall result in a denial for failure to provide.

B. AVS REQUESTS FOR APPLICATIONS AND NEW COVERAGE REQUESTS

During the scope of this emergency, either the AVS response or verification voluntarily provided by the applicant at the time of application or request for assistance shall be used to verify all bank account related resources without exception. Accounts verified by AVS will use the amount found on the AVS results as the verified amount unless that amount is in excess of the applicable resource limit. Known income shall not be subtracted from the verified AVS amount. This process shall be used for application and new coverage requests during the scope of the COVID-19 National Public Health Emergency.

1. AVS REQUEST AND VERIFICATION REQUESTS

The AVS request shall be sent during the initial application or coverage request process. This request may be completed prior to the worker initially reviewing the application or new coverage request. To avoid any unnecessary delays in processing there may be situations where a dual AVS and formal applicant request for verification may be completed.

- a) If the AVS request is not completed prior to the eligibility worker reviewing the application or new coverage request, an AVS request shall be requested at the time a V044 verification notice is sent.
- b) If the AVS request was completed prior to the eligibility worker reviewing the application or new coverage request but the AVS response is not received, eligibility staff shall proceed with tiered verification of the accounts from the consumer per section III(3)(A) of this policy.

- c) If the AVS response is received and imaged to the case file prior to the eligibility worker reviewing the application/new coverage request and the accounts are verified by AVS along with other known or reported resource amounts:
1. **Does not** make the consumer resource ineligible, the verified account does not require further verification from the consumer.
 2. **Does** make the consumer resource ineligible, continue with the tiered verification of the accounts per section III(3)(A) to verify the true account value.

Note: There may be situations where excess resources in these accounts are caused from the Federal COVID-19 Stimulus package. Remember, these funds are exempt per this policy, therefore, verification of the cause of excess resources must also follow the tiered verification steps noted in this policy.

2. AVS RESPONSE VERSUS ACCOUNT VERIFICATION

There may be instances where both the AVS and the applicant provide valid verification of the bank account(s). It is prudent as a general rule, to use the applicant verification provided over the AVS response because in most cases, that amount will be lower. However, if the AVS response verifies a lower account balance than the verification provided by the applicant, the AVS verification shall be used.

Assets that are not verified by AVS or if no AVS results are received prior to the last day of the verification due date or before the maximum 20-day extension date expires, staff shall attempt to verify the accounts following the instructions in section III(A) (2 – 3) of this memo.

C. VERIFICATION OF INCOME/END OF INCOME

1. EARNED AND UNEARNED INCOME

Eligibility staff shall continue to follow the Tiered Verification policy when requesting proof of income to determine eligibility. During the scope of the COVID-19 Public Health Emergency, accepting client attestation once the tiered verification process has been exhausted shall be accepted for both earned and unearned income and proof of end of income. The process noted in section III(A) 1-3 above shall be the same with the exception of AVS for verification of income/end of income.

2. SECA VERIFICATION FOR WORKING HEALTHY

For the self-employed, Social Security and Medicare tax is paid through the Self-Employment Contributions Act (SECA) rather than FICA. Proof of this SECA payment is a requirement for the Working Healthy program, therefore, there will be no change to the requirement that verification be provided of these payments prior to authorizing Working Healthy coverage.

Client attestation shall not be accepted for this verification. Failure to provide proof of the SECA verification per Medical KEESM 2664.3 shall result in ineligibility for the Working Healthy program and coverage under a different Medicaid program shall be considered.

D. LONG TERM CARE – CARE REQUESTS

1. CARE REQUIREMENTS WAIVED FOR 30 DAYS

- a.) In accordance with the state's 1135 Waiver, Pre-Admission Screening and Annual Resident Review (PASRR) or CARE Level I and Level II assessments are waived for 30 days. All new admissions can be treated like exempted hospital discharges and if otherwise eligible may be coded temporarily based on the Level of Care indicated on the 2126.
- b) After 30 days, new admissions with mental illness (MI) or intellectual disability (ID) should receive a Resident Review as soon as resources become available. There is not a set timeframe for when a Resident Review must be completed, but it should be conducted as resources become available.
1. LTC/NF and LTC/MH admissions, if otherwise eligible, may be approved without the ES-3164 on file as these are treated as exempt hospital stays. Once this time frame has passed and resources become available to complete the Level 1 and Level II assessments, KDADS will complete the ES-3164. LTC coding on the case shall then be completed according to sections A-F of the ES-3164 to either continue or discontinue coverage.
 - i. If the ES-3164 shows that the consumer is not authorized on a Level 1 or Level 2 CARE, coverage already authorized shall not be retroactively terminated. Instead any level of care coverage already authorized shall cease effective the date the ES-3164 is completed by KDADS. The consumer's Title XIX shall continue following the Delayed CARE Score policy and process.

E. VERIFICATION AND APPLICATION OF EXPENSES

For E&D and LTC programs, verified medical expenses can reduce the share of cost and spenddown amounts and the verification and application of expenses shall follow current, established policy. Failure to provide proof of an expense will not affect eligibility; however, the expense will not be used to lower the share of cost or spenddown until physical verification is received by the agency.

F. MEDICARE BUY-IN

Medicare Buy-In policy per Medical KEESM 2911 shall continue to be applied. PD2020-03-01 [COVID-19 Delayed Discontinued](#) Policy Directive states that discontinuances shall not be acted on with the exception of consumers who have moved out of state, become incarcerated, voluntary withdraw from coverage, or are deceased. Another exception to acceptable discontinuances of coverage is when a consumer loses their Medicare Eligibility as reported to the agency by Social Security. If the agency is advised that a consumer's Medicare coverage is terminated by Social Security and the consumer is currently receiving Medicare Savings Program (MSP) Only in Kansas, it is appropriate to discontinue the consumer's MSP coverage.

- 1) The consumer should then have coverage established on the Medically Needy program with a 6-month base period. This is because the MSP program's purpose is to cover Medicare costs and MSP is not required if there is no Medicare eligibility.

Any case that was active on Buy-In effective March 18th, 2020 shall remain active on Buy-In throughout the scope of this emergency. Cases in the Buy-In Deletion process as identified by the agency shall

have their same coverage reinstated and authorized per PD2020-03-01 [COVID-19 Delayed Discontinued](#) Policy Directive unless discontinuance is appropriate because of state residency, become incarcerated, voluntary withdraw from coverage, are deceased, or have had their Medicare Enrollment ended by Social Security.

G. TRANSFER OF PROPERTY

During the scope of the emergency, there shall be no change in the effective date of applying a transfer of property for both applicants and recipients. The effective dates shall continue to be applied per Medical KEESM 5724.5.

However, for active recipients that have a transfer of property applied effective March 2020 throughout the scope of this emergency, coverage shall not be discontinued, and level of care shall continue. The effective date will still be applied as appropriate; however, the penalty will not affect coverage until the month after the month the National Public Health Emergency is declared to end. Coverage continued under this provision is not considered overstated eligibility. This action is taken in accordance with PD2020-03-01, [COVID-19 Delayed Discontinued](#) Policy Directive.

Example: Consumer is actively receiving LTC/NF coverage. Verification that the consumer's home was gifted to a relative is received and processed by the agency on 3/19/20. The transfer amount is \$75,000. As the consumer is an active recipient, per Medical KEESM 5724.5, the start date of this transfer is 5/1/2020 and will end 4/19/2021. As the consumer was actively receiving coverage at the start of this emergency, LTC/NF coverage is left active until the emergency is declared over.

On 5/20/2020, the emergency is declared over. Therefore, the worker re-enters the case to apply the penalty. LTC/NF is discontinued effective 6/30/2020 allowing for timely and adequate notice. A spenddown is established with a 6-month base period beginning with the correct penalty start date of 5/1/2020. Although the spenddown start date is May 1st, 2020, the consumer will have July 1st, 2020 through 10/31/2020 to meet this spenddown because the LTC/NF coverage granted during the months of May 2020 and June 2020 cannot be taken away.

Example: Application is received requesting LTC/NF coverage and is processed on 4/3/2020. Verifications received confirm the applicant had a transfer of property. The consumer is verified as otherwise eligible for LTC/NF coverage 4/1/2020, however, as the applicant was not active on coverage at the start of the National Public Health Emergency, the transfer is applied and a Medically Needy Spenddown with a 6-month base period is established effective 4/1/2020.

IV. QUESTIONS

For questions or concerns related to this document, please contact one of the KDHE Medical Policy Staff listed below.

Erin Kelley, Senior Manager – Erin.Kelley@ks.gov

Kris Owensby-Smith, Elderly and Disabled Program Manager - Kristopher.OwensbySmith@ks.gov

Jessica Pearson, Elderly and Disabled Program Manager – Jessica.Pearson@ks.gov

Jerri Camargo, Family Medical Program Manager - Jerri.M.Camargo@ks.gov

Amanda Corneliusen, Family Medical Program Manager – Amanda.Corneliusen@ks.gov

Questions regarding any KEES issues are directed to the KEES Help Desk at KEES.HelpDesk@ks.gov



Policy Memo	
KDHE-DHCF POLICY NO: 2020-06-01	From: Erin Kelley, Senior Manager
Date: June 26, 2020	Medical KEESM Reference: 5721.10
RE: Transfer of Property (TOP) Penalty Cure	Program(s): Long Term Care Medical Assistance Programs

This memo sets forth instructions for policy changes being implemented in June 2020 regarding changes to the transfer of property (TOP) penalty cure policy. Unless otherwise indicated, this policy shall be effective with the issuance of this memo. Revisions to the Medical KEESM manual will be made with in July 2020 revision. Additional information related to the implementation of these changes is available through training material released to eligibility staff.

I. BACKGROUND

A transfer of property (TOP) penalty imposed due to an uncompensated transfer may be cured (in whole or in part) when the property is returned to the individual who transferred the property. The timing and value of the returned property determine how the transfer penalty is modified.

A. CURRENT POLICY

The following explains the current policy and the difference between a full and a partial cure.

1. FULL CURE – TOP VOIDED

A full cure of the TOP occurs where all property (or the fair market equivalent value) has been returned to the individual who transferred the property. In that instance, the TOP penalty is voided. The returned property is considered available continuously back to the date of the original transfer through the month the property was returned. Eligibility for long term care coverage may be redetermined based on the value and/or exempt/countable status of the returned property.

2. PARTIAL CURE – TOP MODIFIED

A partial cure of the TOP occurs where some, but not all, of the property (or the fair market equivalent value) has been returned to the individual who transferred the property. In that instance, the TOP penalty is not voided, but instead modified. The returned property is again considered available continuously back to the date of the original transfer through the month the property was returned.

A new modified TOP penalty is not applied unless and until the individual is otherwise eligible (including resource eligible) for long term care coverage. Assuming the returned property is resource-disqualifying, this means that the modified penalty will not be imposed (if at all) until the countable resources are less than or equal to the \$2,000 allowable resource limit. Therefore, unless the returned property is an exempt resource, or of such nominal value there is immediate resource eligibility, a modified penalty period will always commence on a date sometime after the start date of the original transfer penalty.

B. UNINTENDED CONSEQUENCES

There is one exceptionally concerning unintended consequence of the current TOP cure policy. When the TOP is partially cured, and a modified TOP is applied because the individual is otherwise eligible for payment of long term care services, the new modified penalty period may very well extend beyond the original TOP penalty end date. To that affect, a partial return of property has actually extended the transfer penalty period rather than shortened it.

This occurs because the new modified transfer penalty cannot start until the individual is otherwise eligible for payment of long term care services. By counting the returned property as available back to the date of the original transfer through to the date returned (and thereafter if not immediately expended on exempt resources or services), in most instances there will be no resource eligibility until sometime after the original transfer penalty start date. By floating the penalty period forward in this manner, even a shorter modified penalty period may extend beyond the original transfer penalty period end date since it begins later than the original transfer penalty period start date.

The reason for counting the returned property as available back to the date of the original transfer is rather complex but in simple terms is intended to prevent the gifting and subsequent return of property as an effective mechanism to inappropriately shelter additional property from the Medicaid resource spend down process.

C. ADDITIONAL GUIDANCE NEEDED

In addition to the unintended consequences mentioned above, guidance to eligibility staff concerning several issues in administering the current TOP penalty cure process has never been adequately provided. Those include the timing of the cure, whether a new application

is required, and how returned property is treated if it has increased or decreased in value. Those issues will be addressed in the new policy below.

II. TRANSFER OF PROPERTY (TOP) PENALTY CURE

Effective with the issuance of this memo, the TOP penalty cure policy shall be as follows.

A. NEW POLICY

A transfer of property that would otherwise be subject to a transfer of property penalty per Medical KEESM 5724 which has been returned to the individual or spouse prior to the filing of an application or request for long term care assistance shall not be considered an inappropriate transfer. The value of the returned property shall not be subject to a transfer of property penalty. In this instance, a TOP penalty cure is not required because no penalty has been applied. However, unless the transfer was specifically exempted, any transferred property that remains unreturned at the time of application or request shall be subject to a TOP penalty.

When transferred property (or the fair market equivalent) which is subject to a TOP penalty is returned, the established penalty shall be adjusted by either voiding the penalty entirely or modifying, but not eliminating, the penalty depending on the timing, status and extent of the property returned. In general, a full return of transferred property shall result in the penalty being voided. A partial return of transferred property may result in a modified penalty, but not in all instances.

B. APPLICATION OF POLICY

The TOP penalty cure policy shall be applied in the following manner.

1. FULL CURE

When the property subject to a TOP penalty (or the fair market equivalent of that property) has been returned, the penalty shall be voided. However, the returned property shall be considered when determining eligibility, including back to the date of the original transfer. This means for eligibility purposes the returned property will be treated as if it had never been transferred and had been continuously owned by the applicant/recipient. This may or may not result in eligibility depending on the exempt or non-exempt status of the returned property.

2. PARTIAL CURE

When only some or a portion (but not all) of the property (or the fair market equivalent of that property) subject to a TOP penalty has been returned, the penalty shall be modified (but not eliminated) if the returned property is exempt as a resource. Again, the returned property shall be considered when determining eligibility, including back to the date of the original transfer as though the property had never been transferred.

However, if the returned property is an exempt resource, it should not impact resource eligibility.

a. RETURN OF EXEMPTED PROPERTY

As indicated above, the partial return of transferred property in the form of an exempt resource shall result in the modification of the established TOP penalty. If the returned property is both exempt and non-exempt in nature, the TOP penalty shall not be modified unless the value of the non-exempt property in combination with all other non-exempt property owned by the applicant/recipient is less than or equal to the \$2,000 allowable resource limit.

b. RETURN OF NON-EXEMPTED PROPERTY

The partial return of transferred property in the form of a non-exempt resource shall not result in the modification of the established TOP penalty unless the value of the non-exempt property in combination with all other non-exempt property owned by the applicant/recipient is less than or equal to the \$2,000 allowable resource limit. This means that in most instances, the established TOP penalty will not be modified when non-exempt property is returned.

3. RETURN OF PROPERTY DEFINED

The return of transferred property shall be defined as the direct transfer of property back to the applicant/recipient, any payment made which indirectly results in a gain or benefit to the applicant/recipient, and a modification or revision to a financial instrument which makes the instrument Medicaid compliant.

a. DIRECT TRANSFER

A direct transfer is where ownership is given to the applicant/recipient. That could include return of the actual property that was originally transferred, such as a vehicle, real estate, or a coin collection. Also included is anything of measurable value, even if not the actual property originally transferred, given back to and possessed by the applicant/recipient.

b. INDIRECT TRANSFER

An indirect transfer is where ownership of the property is not being returned directly to the applicant/recipient. Instead, a payment has been made on behalf of the applicant/recipient which results in a gain or benefit to the applicant/recipient. Even though the applicant/recipient exercised no ownership or control of the indirectly returned property, the value of the payment shall be considered a return of property. This would include payment of any expenses or debts of the applicant/recipient such as nursing home bills, home mortgage, credit card balance, or non-covered medical bills.

An indirect payment made on behalf of the applicant/recipient shall be considered returned property in the form of a cash asset. Multiple payments

made in this manner shall be totaled and treated as though returned back to the date of the original TOP penalty start date.

c. MODIFICATION OF FINANCIAL INSTRUMENT

There are instances where the language or structure of a financial instrument, such as an annuity or promissory note, make the instrument subject to a TOP penalty. See Medical KEESM 5722 (4) and (6) concerning actuarial soundness.

Should a TOP penalty be applied due to actuarial unsoundness, the penalty may be cured by modifying the financial instrument to make it actuarially sound. In that instance, there is no technical return of resource to the applicant/recipient, but the TOP penalty has been cured nonetheless. A proper modification making the financial instrument Medicaid compliant shall be considered a full cure (or return of property) for purposes of this policy.

4. VALUATION OF RETURNED PROPERTY

To determine what extent, if any, the TOP penalty has been cured, the value of the returned property must be determined. The value of the returned property shall be determined as follows.

a. CASH ASSET

A cash asset is cash or other property that is readily convertible to cash, such as bank accounts, life insurance, stocks, or bonds. This also includes indirect payments made on behalf of the applicant/recipient as indicated in subsection (3)(b) immediately above. The value of a cash asset is the assigned or market value at the time returned to the applicant/recipient.

b. NON-CASH ASSET

A non-cash asset for purposes of this policy is property [other than cash assets as described in subsection (a) above] that has a subjective measure of value. That would include a vehicle, real estate, or any other property where the value is based on an appraisal. The value of a non-cash asset is the appraised value at the time returned to the applicant/recipient, with one exception.

If the same property that was originally transferred (such as a vehicle or real estate) is returned, the agency shall assume the full value of the property has been returned, even if the value at the time of return is different. The agency shall disregard any depreciation or appreciation in the value of the property that is due to normal wear-and-tear or market fluctuation. However, if there has been a substantial change in the property value due to an improvement (new structure added to real estate increasing the value) or wasting (existing structure demolished decreasing the value), the new verified value of the

property shall be used.

For example, if a new \$25,000 vehicle was transferred and then returned five (5) months later, the agency would accept this as a full return of the transferred property, disregarding any devaluation due to normal use and age. However, if the vehicle was totaled in an accident before return, the diminished value of the property would be used to determine how much of the original \$25,000 value had been returned since the change in value would not be attributed to normal use and age.

C. ANNUITY OR PROMISSORY NOTE

As indicated in subsection (3)(c) above, modification of an otherwise Medicaid non-compliant annuity or promissory note (due to actuarial unsoundness) to make the financial instrument compliant shall be deemed a full return of the transferred resource and therefore a total cure of the TOP penalty. As such, there is no need to determine the value of the returned resource.

For example, a promissory note that was deemed to be actuarially unsound because the terms of the note failed to fully pay back the transferred amount within the lender's life expectancy, the scheduled payments were unequal or provided for deferred or balloon payments, or there was no provision prohibiting cancellation of the note upon the death of the lender would be subject to a TOP penalty based on the value of the note. If the note language was modified to make it actuarially sound, the TOP penalty would be voided without the need to determine the value of the note at the time of the modification.

The same would be true for an annuity that is not considered actuarially sound and a TOP penalty has been applied. Modification of the annuity to be Medicaid compliant would void the penalty. There is no need to determine the value of the annuity as modified since a full return of property has been deemed to have occurred.

C. MODIFYING THE TOP PENALTY

A properly established TOP penalty shall be modified in the following manner when a return of property occurs.

1. FULL CURE

Where the property, or the fair market equivalent of that property, subject to the TOP penalty has been returned, the penalty has been fully cured. The TOP penalty shall be voided as though never implemented. However, for eligibility purposes the returned property shall be considered continuously available to the applicant/recipient back to the date of the original transfer and for all months forward.

If the applicant/recipient is resource eligible (and otherwise eligible), eligibility may be determined for all months (if appropriate) beginning with the month of the original transfer. If the applicant/recipient is not resource eligible, there is no eligibility for any month beginning with the month of the original transfer through the month the property was returned. The returned property will continue to result in ineligibility until the value of all countable resources have been spent down to the allowable resource limit.

2. PARTIAL CURE

Where the full value of the property subject to the TOP penalty has been only partially returned, the TOP penalty shall be modified, but not eliminated.

The returned property will be considered continuously available to the applicant/recipient back to the original TOP penalty start date. This means that unless the returned property is an exempt resource or a countable resource with a value (in conjunction with all other countable resources owned by the individual) less than or equal to the \$2,000 allowable resource limit, the new modified penalty period cannot be imposed because the individual is not otherwise eligible for long term care coverage.

a. NOT OTHERWISE ELIGIBLE

When the applicant/recipient is not otherwise eligible, the existing TOP penalty period remains in place. The return of property does not result in a modification of the transfer penalty. In addition, eligibility for any non-long term care coverage the individual currently receives may need to be discontinued prospectively due to excess resources. Timely notice of the discontinuance is required. However, any non-long term care coverage received from the date of the original transfer through the month of discontinuance is not considered to be overstated eligibility since that coverage has been properly received.

b. OTHERWISE ELIGIBLE

When the applicant/recipient is otherwise eligible (including resource eligible) after the return of the transferred property, the transfer penalty shall be modified. The new modified penalty period shall begin on the date the original TOP penalty period began. The new modified TOP penalty period end date shall be based on the value of property that was transferred but not returned. Since the TOP penalty start date does not change, the same private pay penalty divisor used in the original penalty determination shall be used in calculating the new modified TOP penalty period. See Medical KEESM 5724.4.

If the applicant/recipient is not otherwise eligible back to the original TOP penalty period start date, but eligible in some month thereafter, then the new modified transfer penalty period policy does not apply. The not-otherwise-eligible policy described in subsection (a) above applies. The

applicant/recipient would not be entitled to a new modified TOP penalty period.

Note: Return of property does not change a properly determined community spouse resource allowance (CSRA). Even though returned property is considered to be continuously available back to the start date of the original penalty period, that provision shall not be used to retroactively adjust the CSRA. Only countable property actually owned at the time the long term care arrangement began shall be used for that determination. See Medical KEESM 8144.1 and 8244.1.

D. ADDITIONAL FACTORS

The following additional factors will determine how the modified TOP penalty is applied.

1. DATE PROPERTY RETURNED

In order to void or modify an established TOP penalty period, the return of property must occur prior to the end date of the penalty period. If the return of property occurs after the TOP penalty end date, there is no need to adjust the penalty because the entire penalty period has already been served. In that instance, receipt of the returned property will be considered a gift to the recipient for eligibility purposes rather than a return of property. See Medical KEESM 6410 (27) for the treatment of gift income.

2. NEW APPLICATION REQUIRED

If the individual provides verification of a full or partial cure of the TOP penalty period after forty-five (45) days from the application date, a new application requesting long term care coverage is required. If verification of the return of resources is timely provided [within forty-five (45) days from the date of application], the cure (full or partial as appropriate) shall be completed and eligibility redetermined without a new application. See Medical KEESM 1414.2 (1)(b).

If a new application is required, eligibility for long term care coverage based on a full or partial TOP penalty cure may begin no earlier than the first day of the prior medical assistance period if prior medical is requested and the applicant is otherwise eligible. The agency shall not be required to act on information provided outside of the forty-five (45) day application window which verifies a purported TOP penalty cure unless a new application has been filed.

E. NOTICES

The following notice fragments have been created for use when a TOP penalty period has been applied and property has been returned to potentially cure the penalty either in full or in part. These fragments may be found on the KEES Repository, KDHE Standard Text for Copy and Paste.

1. TOP PENALTY CURED IN FULL – VOIDED

This notice may be used where an established TOP penalty period has been voided due to a full return of transferred property.

“We removed your transfer of property penalty because the property was returned to you. We will tell you if you are eligible for long term care coverage.

This is in accordance with Medical KEESM 5721 (10).”

2. TOP PENALTY PARTIAL CURE - MODIFICATION

This notice may be used where an established TOP penalty period has been partially cured and modified due to a return of some, but not all, of the transferred property.

“We changed your transfer of property penalty period because some of the property was returned to you. Your penalty is shortened to {insert penalty start date} through {insert penalty end date}. You are not eligible for payment of long term care services until this penalty period ends.

This is in accordance with Medical KEESM 5720.1 and 5721 (10).”

3. PROPERTY RETURNED – NO MODIFICATION

The following notices may be used where transferred property has been returned but does not result in a modification of the existing TOP penalty period.

a. NON-EXEMPT PROPERTY RETURNED

When the property returned is non-exempt and will not result in a modification of the existing TOP penalty period, the following fragment may be used.

“We received proof that some of the property you transferred was returned to you. Your transfer of property penalty period will not be changed at this time. Your transfer of property penalty period remains {insert penalty start date} through {insert penalty end date}. You are not eligible for payment of long term care services until the penalty period ends.

This is in accordance with Medical KEESM 5720.1 and 5721 (10).”

b. TOP PENALTY ALREADY SERVED

When some, or all, of the transferred property has been returned after the TOP penalty period has expired, the following fragment may be used.

“We received proof that some, or all, of the property you transferred was returned to you. Your transfer of property penalty period ended on {insert

penalty end date}. Because your penalty period has already ended, the penalty period will not be changed. You are not eligible for payment of long term care services prior to the penalty period end date.

This is in accordance with Medical KEESM 5720.1 and 5721 (10)."

III. QUESTIONS

For questions or concerns related to this document, please contact one of the KDHE Medical Eligibility Policy Staff listed below.

Erin Kelley, Senior Manager – Erin.Kelley@ks.gov

Jessica Pearson, Elderly and Disabled Program Manager – Jessica.Pearson@ks.gov

Kristopher Owensby-Smith, Elderly and Disabled Program Manager –

Kristopher.OwensbySmith@ks.gov

Amanda Corneliusen, Family Medical Program Manager – Amanda.Corneliusen@ks.gov

Jerri Camargo, Family Medical Program Manager – Jerri.M.Camargo@ks.gov

Questions regarding any KEES issues are directed to the KEES Help Desk at KEES.HelpDesk@ks.gov

**Medicare Liens in
Personal Injury Cases**

Presented By:

**Todd D. Powell, Partner
Glassman Bird Powell, L.L.P.**



Medicare Liens in Personal Injury Cases

Todd D. Powell
Partner, Glassman Bird
Powell, LLP



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

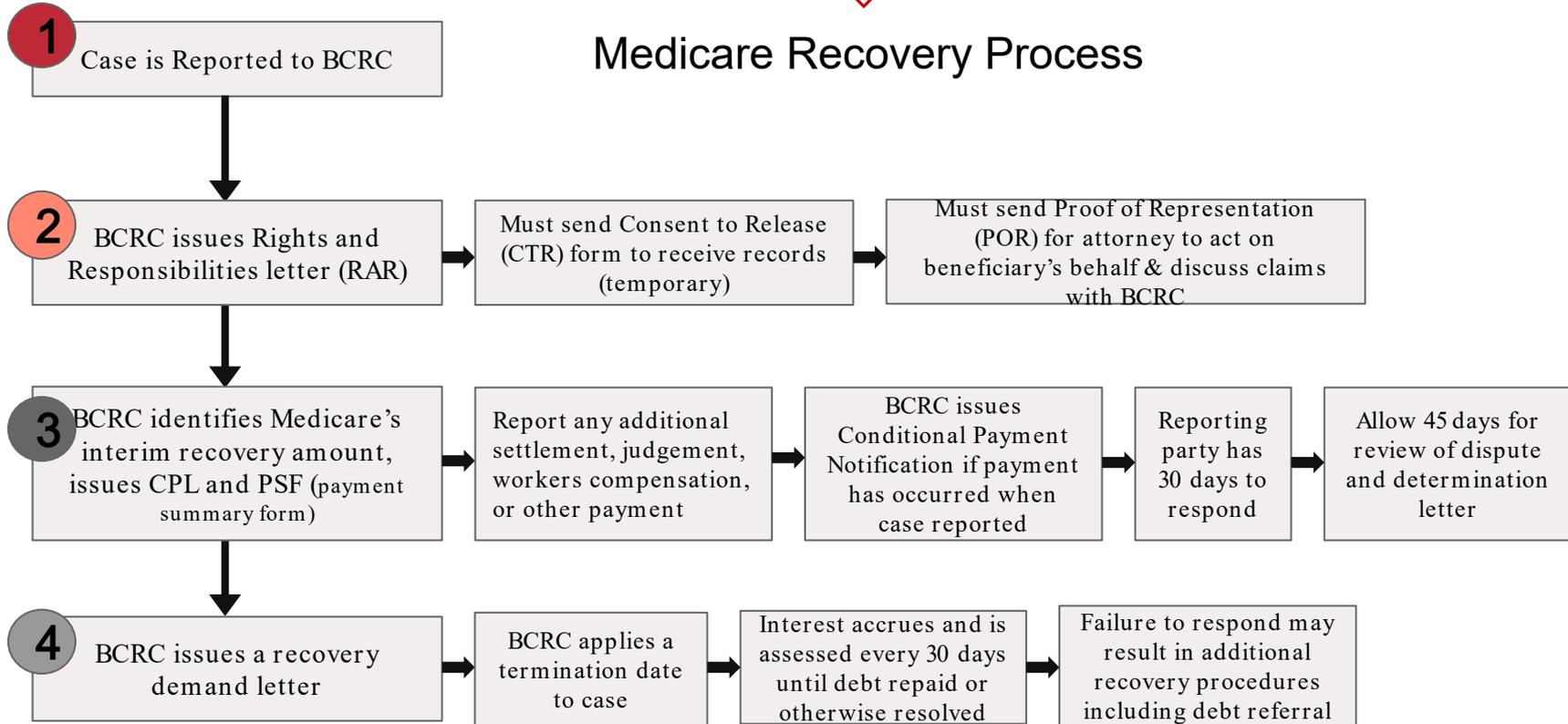


Key Terms

- ◆ **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 $.40 \times 25,000 = \text{Repayment amount of } \$15,000$
- ◆ 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

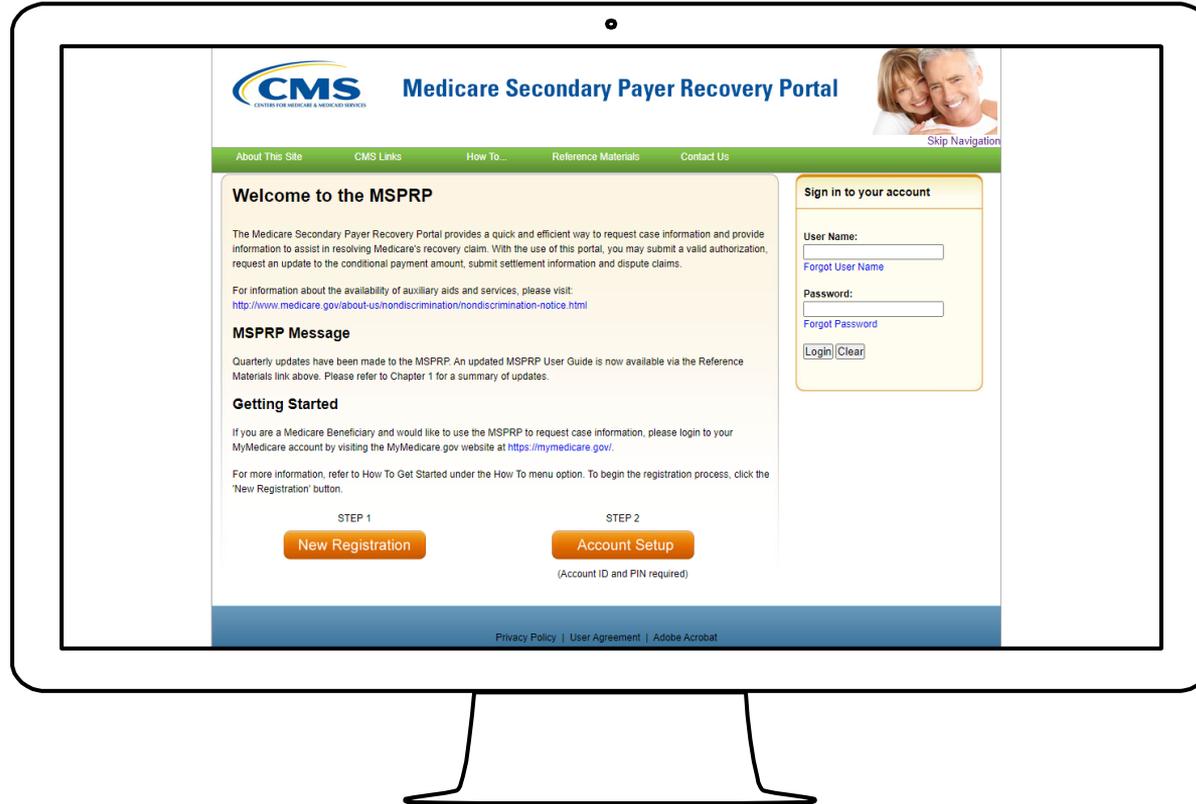
- ◆ Currently*, no requirement to establish a Set - Aside or seek CMS approval (except in extreme circumstances), but...
- ◆ Prudence dictates considering Medicare's interest in a third - party liability action where there will likely be the need for future medical treatment after the date of settlement/award
- ◆ **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





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

(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(I)(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—

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 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.

Michael P. Abate, Dinsmore & Shohl, LLP, Louisville, KY, Jeffrey T. Kuntz, Daniel Alter, GrayRobinson, PA, Fort Lauderdale, FL, Eileen Kuo, Thomas H. Lawrence, Lawrence & Russell, PLC, Memphis, TN, Caroline L. Schiff, Humana, Inc., Chicago, IL, for Plaintiff–Appellee. Anthony John Russo, Lewis F. Collins, Jr., William Philip Schoel, Butler Weihmuller Katz Craig, LLP, Tampa, FL, Neil H. Selman, Selman Breitman, Los Angeles, CA, Jennifer J. Capabianco, Selman Breitman, LLP, San Francisco, CA, for Defendant–Appellant. David Joseph Farber, King & Spalding, LLP, Washington, DC, for Amici Curiae The Marc Coalition, The Property Casualty Insurers Association of America. Ryan Lee Woody, Matthiesen Wickert & Lehrer, SC, Hartford, WI, John David Kolb, Gibson & Sharps, PSC, Louisville, KY, for Amici Curiae The National Association of Subrogation Professionals, America’s Health Insurance Plans. Frank Carlos Quesada, MSP Law Firm, Miami, FL, for Amicus Curiae MSP Recovery, LLC.

BLACK, Circuit Judge

Michael P. Abate, Dinsmore & Shohl, LLP, Louisville, KY, Jeffrey T. Kuntz, Daniel Alter, GrayRobinson, PA, Fort Lauderdale, FL, Eileen Kuo, Thomas H. Lawrence, Lawrence & Russell, PLC, Memphis, TN, Caroline L. Schiff, Humana, Inc., Chicago, IL, for Plaintiff–Appellee.

Anthony John Russo, Lewis F. Collins, Jr., William Philip Schoel, Butler Weihmuller Katz Craig, LLP, Tampa, FL, Neil H. Selman, Selman Breitman, Los Angeles, CA, Jennifer J. Capabianco, Selman Breitman, LLP, San Francisco, CA, for Defendant–Appellant.

David Joseph Farber, King & Spalding, LLP, Washington, DC, for Amici Curiae The Marc Coalition, The Property Casualty Insurers Association of America.

Ryan Lee Woody, Matthiesen Wickert & Lehrer, SC, Hartford, WI, John David Kolb, Gibson & Sharps, PSC, Louisville, KY, for Amici Curiae The National Association of Subrogation Professionals, America’s Health Insurance Plans.

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-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 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 ¹²³⁴ 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.

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 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. Engstrom*, 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 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 insufficient to extinguish 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:

either 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.



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:
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).

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/incident which 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's insurance/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.

Initial Determination letter to insurer / formerly known as “demand letter”

Mail all correspondence to:

NGHP
PO BOX 138832
OKLAHOMA CITY, OK 73113

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 letter 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 July 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. If 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 on 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 second. 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

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



SelfRECDDTE 312812016VLSCAN 550312812016 12:46PM031002

oQB&R

Centralmail
Print/Email/Close

action.

If you have any questions concerning this matter, please call the Benefits Coordination & Recovery Center (BCRC) at 1-855-798-2627 (1TYfIDP: 1-855-797-2627 for the hearing and speech impaired) or you may contact us in writing 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's red, white and blue Medicare card), and the date of the incident. Providing us with this information will help us respond more quickly to any questions you may have.

Sincerely,

BCRC



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 which 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/beneficiary>) 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/beneficiary>) 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

FOR SSA USE ONLY	
ROAR Input	<input type="checkbox"/> Yes <input type="checkbox"/> No
Input Date	
Waiver	<input type="checkbox"/> Approval <input type="checkbox"/> Denial
SSI	<input type="checkbox"/> Yes <input type="checkbox"/> No
AMT OF OP \$	
PERIOD (DATES) OF OP	

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.

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: Yes No

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.

SECTION II-YOUR FINANCIAL STATEMENT

NAME: _____

SSN: _____

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

		\$ PER MONTH	SSA USE ONLY
20.	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	
	<input type="checkbox"/> INC. EXCEEDS ADJ EXPENSE	\$ +
	<input type="checkbox"/> 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)

() -

WORK TELEPHONE NUMBER IF WE MAY CALL YOU AT WORK (Include area code)

() -

**SIGN
HERE** 

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 under **U. 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, MD 21235-6401. **Send only comments relating to our time estimate to this address, not the completed form.**

United States v. Sosnowski, 822 F. Supp. 570 (W.D. Wis. 1993)

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

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)

Copy Citation

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

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

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.

Child Support Guidelines

Presented By:

**Amy Raymond,
Director of Trial Court Programs
Office of Judicial Administration,
Kansas Judicial Center**

**2021 Legislative Review
and Budget Update**

Presented By:

**Joseph Molina,
Director, Legislative Services
Kansas Bar Association**

**PRELIMINARY SUMMARY OF LEGISLATION
2021 KANSAS LEGISLATURE**

KL RD

*Providing objective research and fiscal
analysis for the Kansas Legislature*

This publication contains summaries of selected bills enacted by the Legislature as of the end of the legislative day on March 31, 2021. Bills that have not yet been signed by the Governor and select resolutions are included.

A supplement containing summaries of major bills that were enacted after that date will be distributed during the week of April 12, 2021. An additional supplement will be mailed after the wrap-up session in May.

Highlights, a summary of major legislation, will be prepared after the Legislature adjourns and will be mailed to legislators as soon as possible. *The Summary of Legislation*, which accounts for all bills enacted by the 2021 Legislature, will be distributed at a later date.

These documents are available on the Kansas Legislative Research Department's website: kslegislature.org/klrd (under "Publications").

Kansas Legislative Research Department
300 SW 10th Avenue
Room 68-West, Statehouse
Topeka, Kansas 66612-1504

Telephone: (785) 296-3181
kslegres@klrd.ks.gov
kslegislature.org/klrd

Table of Contents

ABORTION	1
“Value Them Both” Constitutional Amendment; HCR 5003.....	1
AGRICULTURE AND NATURAL RESOURCES	2
Aboveground and Underground Storage Tanks; Sunset; Fund Limitations; SB 27.....	2
Pollutant Releases and Cleanup; HB 2155.....	3
Multi-year Flex Accounts for Groundwater Water Rights; HB 2172.....	4
BUSINESS, COMMERCE, AND LABOR	6
COVID-19; Extension of Provisions Regarding Telemedicine, Temporary Licensure, and Immunity; SB 283.....	6
Self-service Storage Agreements; HB 2112.....	7
ECONOMIC DEVELOPMENT	8
High Performance Incentive Program; Decoupling Kansas Industrial Training and Kansas Industrial Retraining; SB 65.....	8
Angel Investor Tax Credit; SB 66.....	8
Rural Housing Incentive Districts; SB 90.....	10
STAR Bonds Renewal and Modification; House Sub. for SB 124.....	10
EDUCATION	14
In-person K-12 Instruction; House Sub. for SB 63.....	14
Private and Out-of-State Postsecondary Education; SB 64.....	14
Permitting Credit Card Surcharges for Private Not-for-Profit Postsecondary Institutions; HB 2070.....	18
Kansas State Department of Education Degree Information; HB 2085.....	18
University Engineering Initiative Act; HB 2101.....	18
Healing Arts School Clinics; HB 2124.....	19
ELECTIONS AND ETHICS	20
Census Population Data; Repeal Outdated Statutes; HB 2162.....	20
Federal For the People Act of 2021; HCR 5015.....	20
FINANCIAL INSTITUTIONS AND INSURANCE	22
Kansas Economic Recovery Loan Deposit Program; Credit Unions, Field of Membership; Privilege Tax, Deductions; SB 15.....	22
Insurance Producer Licensing Requirements; SB 37.....	27
City Utility Low-Interest Loan Program; House Sub. for SB 88.....	32
Fire Insurance Premium Levy Distribution; HB 2270.....	35
HEALTH	36
Audiology and Speech-Language Pathology Interstate Compact; SB 77.....	36
COVID-19 Vaccination Plan; SR 1707.....	38
Urging the Legislative Coordinating Council to Revoke Any Executive Order Mandating Face Coverings; HR 6015 and SR 1717.....	38
JUDICIARY	39
Statutory Speedy Trial; Deadline Suspension; Reports; Prioritization of Cases for Trial; HB 2078.....	39
Adult Care Homes; Covered Facilities; COVID-19; Immunity from Civil Liability; HB 2126.....	39
State of Disaster Emergency; Orders by Chief Justice; HB 2227.....	40

RETIREMENT	42
KP&F Service-connected Benefits; Michael Wells Memorial Act; HB 2063.....	42
STATE AND LOCAL GOVERNMENT	43
Division of Tourism; ERO 48.....	43
COVID-19; Extension of State of Disaster Emergency; Extension of Related Provisions; Closure or Cessation of Business Activity; SB 14.....	45
COVID-19; Kansas Emergency Management Act; State of Disaster Emergencies; Legislative Coordinating Council; SB 40.....	46
Sedgwick County Nuisance Abatement; SB 52.....	52
City or County Assumption of Special District Duties; SB 118.....	54
Attorney General Coordination of Training Regarding Missing and Murdered Indigenous Persons; HB 2008.....	55
Public Agency Fee Prohibition; Legislative Division of Post Audit; Sub. for HB 2049.....	55
Legislative Division of Post Audit; State Agency Reports; HB 2050.....	55
Vacating Lots in the City of Americus; Vacation of City Streets; HB 2178.....	56
Transferring Department of Corrections Land to the City of Beloit; HB 2214.....	56
Donation Limit to Benefit Libraries; HB 2238.....	57
Service of Process; Secretary of State; HB 2298.....	57
Disapproval of ERO 47, Merging Certain Agencies; HR 6009.....	58
TAXATION	59
Property Tax; SB 13.....	59
Cherokee County Sales Tax Authority; SB 21.....	61
Marketplace Facilitators and Income Tax Deductions and Exemptions; SB 50.....	61
TRANSPORTATION AND MOTOR VEHICLES	65
Permit for a Motor Vehicle Display Show; SB 33.....	65
Vehicle Dealer Bonding; Permit for Motor Vehicle Display Show; House Sub. for SB 99.....	65
Military Surplus Vehicles; HB 2014.....	66
Exempting Municipal Motor Grader Operators from CDL Requirements; HB 2295.....	67
Peer-to-Peer Vehicle Sharing Program Act; HB 2379.....	67
UTILITIES	75
Kansas Energy Choice Act; SB 24.....	75
Crimes Related to Critical Infrastructure Facilities; SB 172.....	75
Plugging of Abandoned Wells; HB 2022.....	78
Utility Financing and Securitization Act; Senate Sub. for HB 2072.....	80
Electric Vehicle Charging; HB 2145.....	90
Construction of Urban Electric Transmission Lines; HB 2321.....	90
Kansas Corporation Commission Regulation of Wire Stringing Activities; HB 2367.....	91

ABORTION

“Value Them Both” Constitutional Amendment; HCR 5003

HCR 5003 proposes an amendment to the *Kansas Constitution* for consideration at a special election called on August 2, 2022, to be held in conjunction with the primary election held on that date. That amendment, if approved by a majority of Kansas voters, would create a new section in the *Kansas Bill of Rights* concerning the regulation of abortion. The resolution states the amendment may be cited as the Value Them Both Amendment.

The new section would state the *Kansas Constitution* does not require government funding of abortion and does not create or secure a right to abortion. Further, the language would state, to the extent permitted by the *U.S. Constitution*, the people of Kansas, through their elected state representatives and senators, may pass laws regarding abortion, including, but not limited to, laws that account for circumstances of pregnancy resulting from rape or incest, or circumstances of necessity when necessary to save the life of the mother.

AGRICULTURE AND NATURAL RESOURCES

Aboveground and Underground Storage Tanks; Sunset; Fund Limitations; SB 27

SB 27 extends the sunset dates for certain funds, an advisory board, and operators' ability to apply for funds relating to underground storage tanks (USTs). The bill also increases deductible amounts and liability and replacement limits for certain funds within the Kansas Storage Tank Act that are managed by the Kansas Department of Health and Environment.

Sunset Date Extensions

The bill extends the following sunset dates:

- Underground Petroleum Storage Tank Release Trust Fund (Underground Fund) from July 1, 2024, to July 1, 2034;
- Aboveground Petroleum Storage Tank Release Trust Fund (Aboveground Fund) from July 1, 2024, to July 1, 2034;
- UST Redevelopment Fund Compensation Advisory Board from July 1, 2024, to July 1, 2032;
- UST Redevelopment Fund from July 1, 2024, to July 1, 2032;
- The ability for certain petroleum storage tank owners and operators to apply for reimbursement for corrective action if contamination is discovered and reported during the replacement of single-wall underground storage tanks, from June 30, 2020, to June 30, 2030; and
- The ability for owners and operators to apply for reimbursement for the replacement of underground single-wall storage tank systems with a secondary containment system, from June 30, 2020, to June 30, 2030.

Increase of Fund Limitations

The bill increases from \$1.0 million to \$2.0 million, less the deductible amount, the limit on the liability of the State from the Underground Fund or the Aboveground Fund for any release from a petroleum storage tank. In continuing law, the owner or operator of a petroleum storage tank must agree to such limitation of state liability.

The bill also increases from \$1.0 million to \$2.0 million the total limitation on the liability of the Underground Fund and the Aboveground Fund for corrective action, less any applicable deductible amounts of the owner or operator for costs incurred in response to any one release from an underground or aboveground petroleum storage tank.

Finally, the bill increases the reimbursement limit for the replacement of single-wall USTs and single-wall UST systems with a secondary containment system to an amount of no more than \$100,000 per facility for replacement work completed on and after July 1, 2020, and before

July 1, 2030. The bill also clarifies the \$50,000 reimbursement limit in current law applies to replacement work completed on and after August 8, 2005, and before July 1, 2020.

Pollutant Releases and Cleanup; HB 2155

HB 2155 replaces and updates law regarding soil and water pollutant releases and cleanup.

Definitions

The bill establishes definitions relating to the release of certain water and soil pollutants for these terms: “cleanup,” “cleanup costs,” “emergency,” “person,” “pollutant,” and “release.”

The bill excludes from the definition of “pollutant” any animal or crop waste or manure on an agricultural operation or in an agricultural facility. The bill also excludes from the definition of “release” the releases that occur as part of normal agricultural activities or when done in compliance with the conditions of a federal or state permit or in accordance with the product label.

Pollutant Releases and Cleanup

The bill requires, for the purpose of preventing water and soil pollution detrimental to the public health or environment, the Secretary of Health and Environment (Secretary) to:

- Adopt rules and regulations that, in the Secretary’s judgment, are necessary to respond to and report the release of a pollutant (release);
- Designate a 24-hour statewide telephone number for individuals to provide notice of any release;
- Provide minimum reportable quantities;
- Order a person who is responsible for a release to clean up such release; and
- Provide for cleanup of a release if the individual responsible cannot be identified within a reasonable period of time.

The bill also permits the Secretary to:

- Provide technical guidance, oversight, and assistance to other state agencies, political subdivisions of the State, and other persons for the cleanup of and response to a release;
- Take necessary action for the cleanup of a release if the individual responsible for the release fails to take reasonable action required by the Secretary to clean up the release; and
- Perform cleanup of a release if it poses an emergency.

Cleanup Responsibilities

The bill requires an individual responsible for a release to be responsible for the cleanup of the release. The individual is required to provide notice to the Kansas Department of Health and Environment (KDHE) if the release exceeds the minimum reportable quantities set by the Secretary. The individual is required to repay cleanup costs incurred by KDHE upon reasonably detailed notice by the Secretary or the Secretary's designee.

Costs and Penalties

The bill requires the Attorney General, in the district court of the county where the costs were incurred, to bring action for repayment of costs for a cleanup against individuals responsible for a release who fail to submit payments to KDHE promptly after notice is given.

The bill allows the Secretary to impose a penalty, not to exceed \$5,000, on an individual who violates any provision of the bill or any regulations adopted by the Secretary. For continuing violations, the maximum penalty cannot exceed \$15,000.

The bill permits the Secretary to impose a penalty only after notice of the violation and an opportunity for a hearing has been issued in writing to the individual who committed the violation. The bill requires any request for a hearing to be in writing and directed to and filed with the Secretary within 15 days after service of the order. Any hearing will be conducted in accordance with the Kansas Administrative Procedure Act.

Funds

The bill requires the Secretary to remit moneys received to the State Treasurer who, upon receipt of the funds, will deposit the entirety of the funds to the credit of the existing Emergency Response Activities Account in the Natural Resources Damages Trust Fund. The bill repeals a statute establishing the Pollutant Discharge Cleanup Fund.

Multi-year Flex Accounts for Groundwater Water Rights; HB 2172

HB 2172 amends the Kansas Water Appropriation Act to expand the opportunity for the establishment of multi-year flex accounts (MYFAs) for groundwater water rights to water right holders who did not have water use between 2000 and 2009.

The bill creates the definition of "alternative base average usage" that may be used in place of the base average usage as:

An allocation based on net irrigation requirements calculated as 500 percent of the product of the annual net irrigation requirement multiplied by the flex account acreage, multiplied by 110 percent, but not greater than 5 times the maximum annual quantity authorized by the base water right.

The bill amends the definition of "base water right" to include the following conditions:

- Groundwater is the authorized source of water supply, and

- The water right is not currently the subject of a multi-year allocation due to a change approval that allows an expansion of the authorized place of use.

The bill amends the definition of “base average usage” to mean the average amount of water actually diverted for the authorized beneficial use under the base water right during calendar years 2000 through 2009. In addition, the bill also:

- Excludes from the definition of “base average usage” any amount of water applied to the unauthorized place of use from:
 - Any amount diverted in any year that exceeded the amount authorized by the base water right;
 - Any amount applied to an unauthorized place of use; and
 - Diversions in calendar years when water was diverted under a multi-year allocation with an expansion of the authorized place of use due to a change approval;
- Provides the chief engineer of the Division of Water Resources of the Department of Agriculture (chief engineer) may calculate the base average usage with less than all ten calendar years of 2000 to 2009 if water usage records are inadequate to accurately determine actual water use or upon application of good cause by the applicant; and
- Specifies if the chief engineer is satisfied with the base water right holder’s showing that water conservation reduced water usage under the base water right during 2000 to 2009, then the base average usage must be calculated with the five calendar years immediately before when the water conservation began.

The bill amends the definition of “flex account acreage” to exclude any acres irrigated under a multi-year allocation that allowed for an expansion of the authorized place of use due to a change approval toward the maximum number of acres lawfully irrigated during a calendar year if certain conditions are met. The bill adds a condition that if an application to appropriate water was approved after December 31, 2004, then the calendar year used for the calculation can be any year during the perfection period.

The bill authorizes, if the base water right is eligible, the base water right holder to establish an MYFA in which the base water right holder may deposit the authorized quantity of water for five consecutive calendar years in advance, except when the chief engineer determines a shorter period is necessary for compliance with a local enhanced management area or an intensive groundwater use control area and the corrective controls in the area do not prohibit the use of MYFAs. If the MYFA is approved for less than five calendar years, the amount of water deposited in the MYFA will be prorated based on the number of calendar years approved or calculated as required by the bill on the amount of water deposited in the MYFA.

BUSINESS, COMMERCE, AND LABOR

COVID-19; Extension of Provisions Regarding Telemedicine, Temporary Licensure, and Immunity; SB 283

SB 283 amends law regarding the governmental response to the COVID-19 pandemic in Kansas. The bill takes effect upon publication in the *Kansas Register*.

Telemedicine

In the statute authorizing the use of telemedicine, the bill amends a provision allowing an out-of-state physician to practice telemedicine to treat Kansas patients, to replace a requirement that such physician notify the State Board of Healing Arts (Board) and meet certain conditions with a requirement the physician hold a temporary emergency license granted by the Board. The expiration date of this section is extended for one year, from March 31, 2021, until March 31, 2022.

Temporary Licensure

The bill amends a statute allowing the Board to grant temporary emergency licenses to practice the professions overseen by the Board to add a provision allowing an applicant to practice in Kansas pursuant to such license upon submission of a non-resident health care provider certification form to the Kansas Health Care Stabilization Fund and without paying the annual premium surcharge required by the Health Care Provider Insurance Availability Act. The bill also extends the expiration of this statute for one year, from March 31, 2021, until March 31, 2022.

Amendments to COVID-19 Response and Reopening for Business Liability Protection Act

Business Immunity Extension

The bill amends the COVID-19 Response and Reopening for Business Liability Protection Act (Act) to extend the expiration date of the statute governing COVID-19 claim immunity for persons or agents of persons conducting business in the state by one year, until March 31, 2022.

Health Care Provider Immunity

The bill amends a statute in the Act regarding immunity for health care providers related to COVID-19 to specify such immunity applies to claims arising between March 12, 2020, and March 31, 2022, and removes references to a declared state of disaster emergency.

Retroactivity

The bill amends a statute regarding retroactivity of causes of action arising under the Act to specify the provisions related to health care provider immunity apply retroactively to any

cause of action accruing on or after March 12, 2020, and prior to March 31, 2022, rather than applying retroactively on or after March 12, 2020, and prior to termination of the state of disaster emergency related to COVID-19.

Expiration of Other Provisions

The bill amends a statute regarding hospital facility usage for COVID-19 purposes to change its expiration to March 31, 2022, from 120 calendar days after the expiration or termination of the COVID-19 state of disaster emergency proclamation.

The bill amends a provision regarding critical access hospital bed limits to extend its expiration from June 30, 2021, until March 31, 2022.

Self-service Storage Agreements; HB 2112

HB 2112 amends the Self-service Storage Act (Act) as it pertains to liability claims and the contents of storage agreements, as follows:

- Limits claims of damage or loss of personal property to the maximum value of personal property as specified in the rental agreement;
- Requires self-service storage rental agreements to ask the occupant if such occupant wishes to designate an alternative contact and permits them to do so. Alternative contacts are not given rights to the rental space or its contents merely by virtue of being designated as such;
- Permits the online sale of stored personal property in the event of default by the occupant, as currently defined by the Act; and
- Grants discretion to the operator to give seven days' notice of the sale by any commercially reasonable manner. Currently, the Act requires such notice to be made by newspaper only:
 - The manner of advertising a sale would be deemed not commercially reasonable and a sale would be canceled and subsequently rescheduled and re-advertised if fewer than three independent bidders were present in person or online.

ECONOMIC DEVELOPMENT

High Performance Incentive Program; Decoupling Kansas Industrial Training and Kansas Industrial Retraining; SB 65

SB 65 decouples participation in the Kansas Industrial Training program or the Kansas Industrial Retraining program as a method to qualify for the High Performance Incentive Program (HPIP) tax credit. The bill also eliminates the HPIP certification and recertification by a business to dedicate 2.0 percent of payroll for training purposes.

The bill also allows a company to transfer up to 50 percent of HPIP tax credits to another company or individual per year. Transferability is allowed only for projects placed into service on or after January 1, 2021. In the event a transferee's tax liability is less than the amount transferred, the transferee may carry forward the credits for up to 16 years. The bill states in the event the Secretary of Revenue determines a tax credit is not allowable, the taxpayer who originally earned the credit is liable for the amount that is disallowed.

Angel Investor Tax Credit; SB 66

SB 66 revises certain tax credits pertaining to angel investors and home renovations for disabled family members.

Angel Investor Tax Credit

The bill revises the Kansas Angel Investor Tax Credit Act (Act) by extending the sunset on the program from tax year 2021 to tax year 2026, amending applicable definitions, removing certain program restrictions, and increasing program tax credit amounts and annual program limits.

Program Sunset

The bill extends the sunset on the angel investor tax credit from tax year 2021 to tax year 2026.

Definitions

The bill amends the definition of "qualified securities" with respect to the use of debt instruments as qualifying forms of investment. Debt instruments permitted to be used as a form of investment include any debt that:

- Is subordinate to the creditors of the business receiving the investment;
- Requires no payment by such business; and
- Will convert to some form of equity before the business receives any additional funds.

Tax Credit Limits

The bill makes the following changes to limits on tax credit dollar amounts:

- Increases single-year tax credit amounts:
 - From \$50,000 to \$100,000 for a single Kansas business; and
 - From \$250,000 to \$350,000 for a single qualified investor;
- Changes the maximum value of the tax credit from equal to 50 percent, to up to 50 percent of the qualifying investment; and
- Sets annual tax credit limits at \$6.0 million in tax years 2021 and 2022, with a \$500,000 increase each tax year after that through tax year 2026:
 - Any unused tax credits for a given year will be carried over for use in future tax years until tax year 2026.

Restrictions on Investments and Investors

The bill removes or modifies certain restrictions on investments and investors:

- Venture capital companies are permitted to receive tax credits;
- Investments in Kansas Venture Capital, Inc., are permitted;
- The bill requires an investor, in order to receive a transferable credit, to have no current tax liability at the time of investment, rather than no tax liability for the preceding three years;
- The recipient of a transferable credit will not need to be an accredited investor as defined by federal regulation (17 CFR 230.501(a)); and
- Provided that an investment was made lawfully, investors will not lose any tax credits if the business in which the investment was made were to lose its designation as a qualified business.

Clawback Provision

The bill modifies the clawback provision in the Act. Currently, any business receiving financial assistance under the Act is required to make repayment to the Kansas Department of Commerce if the business ceases to be a qualified business or moves its operations outside of Kansas within ten years. The bill requires bioscience businesses to meet these qualifications for a minimum of ten years and any other business to meet these qualifications for five years.

Home Renovation Tax Credit for Disabled Family Members

The bill increases the maximum tax credit, from \$9,000 to \$15,000, for home renovations made for a disabled family member's access. Under current law, the tax credit that may be claimed is equal to the lesser of either \$9,000 or the applicable percentage of construction expenditures, which decreases as the taxpayer's federal adjusted gross income (FAGI) increases; a taxpayer with an FAGI no greater than \$25,000 can claim the full credit. The bill allows taxpayers with an FAGI of \$60,000 or less to be eligible for a tax credit of \$15,000. The bill phases out the credit by increments of 10.0 percent for each \$10,000 increase in FAGI. The bill also distinguishes tax credits eligible for married individuals filing jointly and all other individual taxpayers, who are eligible for the maximum credit if their FAGI is no greater than \$40,000.

Under current law, if a taxpayer's liability is less than \$2,250, then portions of the credit may be refundable in the first, second, and third years equal to one-fourth, one-third, and one-half of the credit, respectively. The bill increases the taxpayer's liability threshold from \$2,250 to \$3,750.

Starting in tax year 2022 and for all subsequent tax years, the bill adjusts the maximum tax credit and the tax liability threshold by a cost-of-living amount determined under Internal Revenue Code section 1(f)(3).

Rural Housing Incentive Districts; SB 90

SB 90 allows vertical renovations of certain buildings for residential purposes to be a permitted use of bond proceeds and amends definitions under the Kansas Rural Housing Incentive District Act.

The bill provides that, within a rural housing incentive district, proceeds from the special obligation bonds may be used for the renovation of buildings that are located in central business districts and exceed 25 years of age as certified by the Secretary of Commerce.

The bill also limits the eligible improvements to those on the second or higher floor of a building that are residential in nature. Improvements for commercial purposes are not eligible improvements under the program.

The bill amends the definition of an eligible city to remove the population limit of less than 80,000 for the county in which the city is located. The population limit of less than 60,000 for the city remains.

The bill also amends the definition of an eligible county to increase the county population limit from 60,000 to 80,000.

STAR Bonds Renewal and Modification; House Sub. for SB 124

House Sub. for SB 124 supplements, amends, and reauthorizes the Sales Tax and Revenue (STAR) Bonds program (program).

Restriction on Financial Benefits

The bill states no state or local government official shall be employed by a STAR Bond project developer or manager through direct employment or through work as an independent contractor.

The bill defines a “state or local government official” as:

- A member of the Legislature;
- An appointed or elected official or officer of a state agency, office, board, commission, authority, or institution; and
- An appointed or elected official, officer, or member of the governmental authority of a city, county, township, school district, special district, board, or commission.

Definitions

The bill adds “major business facility” to the list of types of areas or facilities defined as “eligible areas” for the program. A “major business facility” is defined as a significant business headquarters or office building that is designed to draw a substantial number of new visitors to Kansas. The term “substantial” is not defined. The bill requires major business facilities to meet sales tax increment revenue requirements established by the Secretary of Commerce (Secretary) independent of associated retail businesses located in the STAR Bond project district and agree to provide visitor tracking data, including aggregate visitor residence zip code data, to the Secretary.

The bill also adds a “rural redevelopment project” to the list of eligible costs for which a STAR Bond project could expend funds. A “rural redevelopment project” is defined as a project that is not in a city with a population of more than 50,000; has regional importance; has a minimum of \$3.0 million in capital investment; allows for vertical building and rehabilitation; and would enhance the quality of life in the community and region. The bill does not define what is considered an enhancement of quality of life for the community and region.

The definition of “STAR Bond project district” is amended to state if a project is in a metropolitan statistical area, as defined by the federal Office of Management and Budget, then the district must be a contiguous parcel of real estate.

The bill amends the definition of “commence work” to require the work be done pursuant to an approved plan of construction. The bill amends the definition of “developer” to include, for reporting purposes, the names of the owners, partners, officers, or principals of the developer.

Eligibility

The bill adjusts the eligibility requirements for a project under the program by increasing the minimum required capital investment and projected gross annual sales amounts from \$50.0 million each to \$75.0 million each, or \$40.0 million each if the project is in a metropolitan area with a population between 50,000 and 75,000 and the project is deemed of high value by the Secretary.

The bill also includes rural redevelopment projects, as defined in the bill, as being eligible for the program.

Project Proposal

The bill clarifies and expands requirements that must be fulfilled prior to consideration or approval of a project under the program.

A city or county wishing to propose a project must first have a feasibility study conducted by one or more consultants. The bill requires these consultants to be selected and approved by the Secretary, and the costs paid by the developer, city, or county in question. The bill also gives the Secretary control and oversight over the scope of the project. The Secretary is also allowed to establish a list of preapproved consultants and preapproved study parameters and methods.

The “visitation expectations” element of the proposal is required to contain a plan detailing how the project’s number of visitors would be tracked and reported to the Secretary on a yearly basis. The plan must include the reporting of visitor zip code data to the Secretary in an aggregate manner without personal identifying information.

The bill requires the economic impact portion of a feasibility study for a STAR Bond project to include the anticipated effects of the project on the regional and statewide economies.

The bill also requires a net return on investment analysis; a summary of community involvement, participation, and support for the project; and a full disclosure of all federal, state, and local tax incentives applicable to the STAR Bond district to be included in the proposal. The information concerning tax incentives must be provided at the public hearing considering the adoption of the STAR Bond project plan.

The bill requires the resolution and ordinance required upon a city or county establishing a STAR Bond project district to include a description of all federal, state, and local tax incentives applicable to the STAR Bond district and any business located in the district.

The bill clarifies that if a developer has not commenced work on the project within two years of approval of the STAR Bond project plan, funding will cease, and the developer can resubmit the project to the Secretary for reapproval within one year.

Financing

Rural redevelopment projects can finance projects from sales tax revenues annually up to \$10.0 million and are not required to issue special obligation bonds unless the amount to be financed exceeds \$10.0 million for each project.

The bill states for all projects established after July 1, 2021, with existing sales tax revenue, such pledge cannot exceed 90.0 percent of new state sales tax collections in excess of the existing base sales tax revenue.

Reporting and Website Links

The bill requires the annual STAR Bond report provided by the Department of Commerce to the Legislature to include information on gross annual sales, gross annual sales projected pursuant to the STAR Bond project plan and feasibility study, and gross annual sales required to meet bond debt service requirements and other expenses. The report must also include visitor tracking plan data, including zip code residence data and a description of all federal, state, and local tax incentives applicable within the STAR Bond district or to any business located in the district.

The bill requires cities, counties, and developers to provide all information requested by the Secretary for the Department of Commerce Economic Development Incentive Program Database.

The bill requires cities and counties that have websites to include on the first page of their websites notice for the public hearing to consider the establishment of a STAR Bond district; the ordinance or resolution, including the STAR Bond project district plan and legal description of the district; and any information concerning public hearing records and feasibility studies for STAR Bond projects. Additionally, the bill requires direct links to information for each STAR Bond project within the Department of Commerce Economic Development Incentive Program Database.

Sale of Land

Any transfer of ownership in real property acquired with the proceeds of STAR Bonds under the program requires authorization from the Secretary and, while STAR Bonds remain outstanding, the disclosure of the sale price and the name of the purchaser and any individual owner, partner, officer, or principal of the purchaser.

Sunset

The program is authorized until July 1, 2026.

EDUCATION

In-person K-12 Instruction; House Sub. for SB 63

House Sub. for SB 63 requires all unified school districts in the state to provide a full-time, in-person attendance option for all students enrolled in kindergarten through grade 12 beginning no later than March 31, 2021, for school year 2020-2021.

The bill takes effect upon publication in the *Kansas Register*.

Private and Out-of-State Postsecondary Education; SB 64

SB 64 amends the Kansas Private and Out-of-State Postsecondary Education Institution Act (Act) to clarify the State Board of Regents' (Board) authority over private and out-of-state institutions.

Certificate of Approval Application

The bill allows an institution exempt from the Act to apply to the Board for a certificate of approval if it is required for the institution to be eligible to receive student financial aid under Title IV of the federal Higher Education Act of 1965. Any institution that applies for and receives a certificate of approval is subject to the jurisdiction of the Board. The institution can return to exempt status by not renewing the certificate of approval.

The bill requires a certificate of approval be issued to the owner of an institution, and such a certificate is not transferable. If the institution has a change of ownership due to the death of the owner, a court order, or the operation of law, the new owner is required to immediately apply for a new certificate of approval. If a change of ownership occurs for any other reason, the new owner is required to apply for a new certificate of approval 60 days prior to the change of ownership. The bill authorizes the Board to adopt rules and regulations to ensure an orderly transition to a new owner, including requirements regarding the maintenance of all student records.

The bill requires a court-appointed receiver of an institution with a certificate of approval to provide the Board with notice of appointment and copies of all documents required from the receiver by the court. The receiver must comply with the provisions of the Act.

The bill allows the Board to assess a civil fine against an institution for violations of the Act. For the first violation, the fine is limited to up to 1.0 percent of the institution's tuition revenue, with a minimum fine of \$125 and a maximum fine of \$15,000. For subsequent violations, the fine is limited to up to 2.0 percent of the institution's tuition revenue, with a minimum fine of \$250 and a maximum fine of \$20,000. These fines are subject to judicial review.

Definitions

The bill amends the definitions of "distance education," "out-of-state postsecondary educational institution," "owner of an institution," "physical presence," and "private postsecondary educational institution." The bill also adds a definition for "provisional certificate,"

which means a certificate of approval that can be granted to a degree-granting institution that is not yet accredited but is seeking to establish a physical presence in Kansas.

Exempt Courses and Institutions

The bill amends law exempting certain types of education and certain institutions from the provisions of the Act. The bill exempts education offered as a review course designed solely to prepare students for graduate or professional school entrance exams or professional licensure exams. Institutions actively regulated by another agency under another statute are also exempt and receive an affirmative approval to operate in Kansas. The bill also lists the institutions exempted from the Act:

- Baker University, Baldwin City;
- Barclay College, Haviland;
- Benedictine College, Atchison;
- Bethany College, Lindsborg;
- Bethel College, North Newton;
- Central Baptist Theological Seminary, Kansas City;
- Central Christian College of Kansas, McPherson;
- Cleveland University–Kansas City, Overland Park;
- Donnelly College, Kansas City;
- Friends University, Wichita;
- Hesston College, Hesston;
- Kansas Christian College, Overland Park;
- Kansas Wesleyan University, Salina;
- Manhattan Christian College, Manhattan;
- McPherson College, McPherson;
- MidAmerica Nazarene University, Olathe;
- Newman University, Wichita;
- Ottawa University, Ottawa;
- Southwestern College, Winfield;
- Sterling College, Sterling;
- Tabor College, Hillsboro; and
- University of Saint Mary, Leavenworth.

Rules and Regulations, Standards

The bill requires the Board to adopt rules and regulations governing the closure of any institution subject to the provisions of the Act. These may include notice requirements, teach-out plans, maintenance of academic records, refund requirements, and transcript requests. Additionally, the bill requires degree-granting institutions that are not yet accredited to make progress toward accreditation. Once accreditation is achieved, an institution is required to maintain accreditation. The bill allows the Board to set additional standards for institutions that receive federal Title IV student financial aid, including requiring audited financial statements.

Physical Presence of Institution in Kansas

The bill prohibits an institution from establishing a physical presence in Kansas without obtaining a certificate of approval from the Board.

Notification Requirement and Provisional Certificate of Approval

The bill requires any institution planning on opening a branch campus in Kansas to notify the Board of its intent at least 60 days prior to the opening of the branch campus.

The bill allows the Board to issue a provisional certificate to a degree-granting institution that is not yet accredited and wishes to establish a physical presence in Kansas. The provisional certificate can be renewed annually as long as the institution continues to progress toward accreditation. The bill requires an institution with a provisional certificate to submit to the Board a plan for achieving accreditation and quarterly updates on the institution's progress toward accreditation. The bill also allows the Board to adopt rules and regulations imposing additional surety bond requirements for the indemnification of any student for any loss suffered as a result of a failure to achieve full accreditation.

Certificate of Approval Minimum Standards

The bill adds the following to the list of minimum standards an institution must meet to be awarded a certificate of approval:

- An institution is not allowed to award a certificate or degree based solely on the payment of tuition or fees, credit earned at another institution, credit for life experience, testing out, or research and writing;
- An institution is not allowed to award an honorary degree if it does not award that same degree and is not allowed to charge a fee for an honorary degree;
- An institution must maintain adequate financial records, which include financial aid information and loan default rates for institutions receiving federal Title IV student financial aid;
- An institution must protect students' personally identifiable information and promptly address any breach of that information; and
- An institution must publish graduation rates, placement rates, and loan default rates as required by the Board.

Certificate of Approval Renewal

The bill states an application for the renewal of a certificate of approval will be deemed late if it is not submitted at least 60 days prior to the expiration of the institution's certificate. When an application for renewal is deemed late, the Board may require the institution to begin the closure procedure. The bill also requires any institution that is closing, either voluntarily or

involuntarily, to follow the closure requirements until notified by the Board that all requirements are satisfied.

Board Refusal to Issue Certificate of Approval and Appeal Process

The bill updates and clarifies language regarding refusals by the Board to issue a certificate of approval and the process to request a hearing to contest such a refusal.

Conditional Certificate of Approval

The bill allows the Board to condition a certificate of approval if the Board has reasonable cause to believe additional information is necessary, a violation of the Act occurred, or it is in the students' best interests for the institution to continue operating while completing closure requirements. The conditions imposed by the Board may include reporting requirements, performance standard requirements, securing new or additional bonds, and limiting the period of time to operate during change or ownership, or be for the purpose of teaching out students. The Board may require an institution with a conditional certificate of approval to suspend or cease institutional activities, including enrolling students and advertising or delivering certain classes or programs. The Board-imposed conditions remain in effect until all the circumstances causing the conditional status are corrected and the Board has completed all reviews related to the institution's conditional status.

Revocation of Certificate of Approval

The bill amends language related to the revocation of certificates of approval. The bill prohibits any institution that has had a certificate of approval revoked from applying for a new certificate for 12 months after the final order of revocation. After that 12-month period, an institution may apply for a certificate of approval only if the Board agrees the institution has cured all deficiencies. Prior to revoking an institution's certificate of approval, the Board is required to give written notice to the holder of the certificate. Such written notice must include the grounds for the revocation and notification that the institution may request a hearing on the revocation of the certificate of approval. If a hearing is requested, it must be conducted within 30 days after the written notice was sent.

Requirements of Institution and Employees

The bill requires an institution, including its officers, agents, representatives, and employees, to comply with the provisions of the Act and any rules and regulations adopted by the Board, including, but not limited to, the protection of students' personally identifiable information.

Prohibited Actions under the Act

The bill prohibits the use of fraud or misrepresentation to obtain a certificate of approval. The Board can revoke or condition a certificate of approval for any violation of the Act.

Civil Fines

The bill increases the maximum civil penalty for an intentional violation from \$5,000 to \$20,000.

Statewide Data Collection

The bill specifies an institution is in violation of the Act for failure to submit complete and accurate data on a timely basis when requested by the Board.

Permitting Credit Card Surcharges for Private Not-for-Profit Postsecondary Institutions; HB 2070

HB 2070 allows private, not-for-profit postsecondary educational institutions in Kansas to collect a surcharge on credit card payments. The Kansas Uniform Consumer Credit Code does not allow sellers to collect a surcharge on credit card payments, with certain exceptions that also include Kansas public institutions, municipal universities, community colleges, technical colleges, and vocational schools.

Kansas State Department of Education Degree Information; HB 2085

HB 2085 creates the Students' Right to Know Act, which requires the Kansas State Department of Education (KSDE) to ensure the distribution, electronic or otherwise, of certain information to all students in grades 7 through 12. Information to be distributed will include:

- The State Board of Regents degree prospectus information;
- The placement and salary report of the Kansas Training Information Program; and
- Any other information relevant to students' understanding of potential earnings as determined by the Department of Labor and each branch of the armed services of the U.S. military.

The bill also authorizes KSDE to enter into memorandums of understanding and other agreements with state agencies or other entities as needed to accomplish this task.

University Engineering Initiative Act; HB 2101

HB 2101 extends the current transfer of the first \$10.5 million credited to the Expanded Lottery Act Revenues Fund (ELARF) from ELARF to the Kan-grow Engineering Fund – KU, the Kan-grow Engineering Fund – KSU, and the Kan-grow Engineering Fund – WSU with each fund receiving equal amounts of \$3.5 million in each fiscal year, for FY 2023 through FY 2032. The transfer first occurred in FY 2013 and is currently scheduled to end with the transfer in FY 2022.

The bill amends the goal of the University Engineering Initiative Act (Act) to continue to generate the same number of engineering graduates per year as is currently set for 2021—

1,365 graduates—to meet the needs of the engineering workforce for as long as the Act is financed with annual transfers from the ELARF.

The bill adds requirements for the educational institutions, the State Board of Regents, and the Secretary of Commerce to report to the House Committee on Appropriations and Senate Committee on Ways and Means. The reports will include how many engineering graduates remain in the state over the previous three years, what efforts are taken to increase retention of graduates and opportunities for graduates in the state, and information regarding the number of engineering graduates from each state educational institution that were initially enrolled as in-state or out-of-state students.

Healing Arts School Clinics; HB 2124

HB 2124 clarifies the authority of healing arts school clinics to provide healing arts services. The bill allows schools statutorily exempted from State Board of Regents (Board) approval requirements to be exempted from the prohibition on the corporate practice of medicine. Current law requires that for a school clinic to be exempted from the prohibition on the corporate practice of medicine, the school must be approved by the Board.

The bill allows off-site clinics owned or operated by a school in partnership with other providers to engage in the practice of healing arts.

ELECTIONS AND ETHICS

Census Population Data; Repeal Outdated Statutes; HB 2162

HB 2162 adds and amends law related to data used in adopting representative and senatorial district boundaries. It also repeals law related to data used in adopting senatorial and representative district boundaries, election-related contributions by certain corporations and stockholders, and a presidential preference primary.

Population Data

The bill adds law to specify the population data used in adopting Kansas legislative districts must be identical to the data collected by the U.S. Bureau of the Census (Census) and used for the apportionment of the U.S. House of Representatives. The bill prohibits use of any other Census counts, including the use of statistical sampling, to add or subtract population.

Repealed Statutes

The bill repeals provisions in the *Kansas Statutes Annotated*, Chapter 11, Census, and in Chapter 25, Elections.

State census. The bill repeals provisions related to an enumeration of Kansas residents as of January 1, 1988. The bill also repeals a requirement for the Secretary of State to adjust the Census numbers for military personnel and postsecondary students for purposes of reapportioning senatorial and representative districts and provisions related to obtaining and using data for that adjustment.

Elections. The bill repeals a prohibition on political contributions from certain types of government-regulated corporations, such as banks and railroads, and the penalties for violating that prohibition. The bill also repeals statutes related to the presidential preference primary, on the topics of the state canvass of the votes, certification of results, payment of election expenses, eligibility to vote, the form of the ballot, county canvasses of votes, and transmitting results to the Secretary of State.

Other Provisions

The bill amends law to remove references to the 1988 state census; in law regarding data used for grant applications and for certain credit union field-of-membership determinations, refers to the law added by the bill rather than to a section to be repealed; and removes a reference to a section that is repealed by the bill from exceptions to the Kansas Open Records Act.

Federal For the People Act of 2021; HCR 5015

HCR 5015 states each state legislature should have the freedom and flexibility to determine election practices that best meet the needs of their state. The concurrent resolution states the authority to legislate changes to the election process should be left to the states.

The concurrent resolution contains whereas clauses related to the federal For the People Act of 2021, contained in H.R. 1 and S. 1.

The concurrent resolution requires the Secretary of State to send enrolled copies of the resolution to the President of the United States, the Majority Leader and Minority Leader of the U.S. Senate, the Speaker of the U.S. House of Representatives, the Minority Leader of the U.S. House of Representatives, and each member of the U.S. Senate and U.S. House of Representatives serving Kansas.

FINANCIAL INSTITUTIONS AND INSURANCE

Kansas Economic Recovery Loan Deposit Program; Credit Unions, Field of Membership; Privilege Tax, Deductions; SB 15

SB 15 establishes the Kansas Economic Recovery Loan Deposit Program (Program); amends law governing linked deposit programs and related investment procedures; amends field-of-membership requirements placed on state-chartered credit unions to increase the permissible geographic area for a credit union's field of membership; and permits national banking associations, state banks, trust companies, and savings and loan associations, for all taxable years commencing after December 31, 2022, to deduct from net income the net interest income received from qualified agricultural real estate loans and the net interest income received from single-family residence loans to the extent such interest is included in the Kansas taxable income of a corporation.

Kansas Economic Recovery Loan Deposit Program (New Sections 1-7; Section 9)

Program Citation; Definitions (New Sections 1-2)

The bill designates sections 1 through 7 of the bill as the Kansas Economic Recovery Loan Deposit Program and further provides the Program shall be part of and supplemental to Article 42, Chapter 75 of the *Kansas Statutes Annotated* (Article 42 pertains to state moneys including the investment of state moneys, activities of the Pooled Money Investment Board, and the administration of certain loan deposit programs).

Definitions (New Section 2)

The bill defines terms, including the following:

- “Economic recovery loan deposit” means an investment account placed by the Director of Investments under the provisions of statutes pertaining to investment of state moneys with an eligible lending institution for the purpose of carrying out the intent of the Program;
- “Economic recovery loan deposit loan” or “loan” means a loan made by an eligible lending institution to an eligible borrower from the eligible lending institution's economic recovery loan deposit as part of the Program;
- “Economic recovery loan deposit program” or “program” means a state-administered program in which eligible lenders are charged less than the market rate of interest and eligible borrowers receive a reduction in interest charged on a loan in the amount of the deposit;
- “Eligible borrower” means any individual or entity operating a business primarily for commercial or agricultural purposes with no more than 200 full-time employees maintaining offices or operating facilities and transacting business in the state of Kansas and is not an individual obtaining a loan primarily for personal, family, or household purposes; and

- “Eligible lending institution” means a financial institution that is:
 - A bank, as defined in KSA 75-4201, that agrees to participate in the Program and is eligible to be a depository of state funds;
 - A credit union, as defined in the State Credit Union Code, that agrees to participate in the Program and provides securities acceptable to the Pooled Money Investment Board (PMIB) pursuant to statutes pertaining to investment of state moneys; or
 - An institution of the Farm Credit System organized under the federal Farm Credit Act of 1971, as amended, having at least one branch in the state of Kansas that agrees to participate in the Program and provides securities acceptable to the PMIB pursuant to statutes pertaining to investment of state moneys.

The bill also defines the terms “director of investments” and “economic recovery loan deposit loan package.”

Program Administration and Purpose (New Section 3)

The bill authorizes the State Treasurer to administer the Program and states the Program shall be for the purpose of providing incentives for the making of business loans. The bill further specifies the total aggregate amount of loans made under the Program must not exceed \$60.0 million of unencumbered funds pursuant to statutes pertaining to investment of state moneys.

Rules and Regulations

The bill requires the State Treasurer to adopt all rules and regulations necessary to enact and administer the provisions of the Program. Such rules and regulations must be adopted no later than February 1, 2022.

Annual Report; Legislative Review

The bill requires the State Treasurer to submit an annual report to the Legislature and the Governor identifying the eligible lending institutions participating in the Program and the eligible borrowers who have received an economic recovery loan deposit loan. The bill also requires the annual report to provide the aggregate amount of moneys loaned and the amount of moneys still available for loan, if any. The report will be due on or before January 1, 2023, and each January 1 thereafter. The bill requires the Legislature perform a review of the Program as part of the State Treasurer’s annual report on or after January 1, 2024.

Program Loan Package Requirements and Loan Information (New Section 4)

The bill authorizes the State Treasurer to disseminate information and provide economic recovery loan deposit loan packages (loan packages) to the eligible lending institutions.

Eligible Borrowers, Applications, Loan Limitations

The bill provides the following requirements and other criteria for participation in the Program:

- The loan package must be completed by the eligible borrower before being forwarded to the lending institution for consideration;
- An eligible lending institution that agrees to receive an economic recovery loan deposit must accept and review applications for loans from eligible borrowers;
- The lending institution must apply all usual lending standards to determine the credit worthiness of eligible borrowers;
- No single economic recovery loan deposit loan can exceed \$250,000;
- Only one economic recovery loan deposit loan can be made and be outstanding at any one time to any eligible borrower; and
- No loan may be amortized for a period of more than ten years.

Certification and Loan Approval

The bill requires an eligible borrower to certify on the loan application that the reduced rate loan will be used exclusively for the expenses involved in operating the borrower's business in Kansas. The eligible lending institution will be permitted to approve or reject a loan package based on the institution's evaluation of the eligible borrowers included in the package, the amount of the individual loan in the package, and other appropriate considerations. The eligible lending institution is required to forward to the State Treasurer an approved loan package in the prescribed form and manner. The bill requires the package to include a certification by the applicant that such applicant is an eligible borrower.

Evaluation of the Economic Recovery Loan Deposit Loan Package; Interest and Market Rates; Loan Agreement (New Section 5)

The bill permits the State Treasurer to either accept or reject the loan package based on the State Treasurer's evaluation of whether the loan meets the Program requirements. The bill would further provide, if sufficient funds are not available for a loan deposit, then the applications may be considered in the order received when funds are once again available, subject to a review by the lending institution.

Upon acceptance of a loan package, the State Treasurer will be required to certify to the Director of Investments (Director) the required amount for the package and the Director will be required to place an economic recovery loan deposit in the amount certified with the eligible lending institution at an interest rate that is 2.0 percent below the market rate provided in KSA 75-4237 (a floating rate). The bill requires such rate to be recalculated on the first business day of January each year using the market rate then in effect. The bill further specifies the minimum

interest rate (or floor) would be 0.25 percent if the market rate is below 2.25 percent. The bill permits the State Treasurer to request the Director place an economic recovery loan deposit with the eligible lending institution prior to acceptance of a loan package when necessary.

An eligible lending institution is required to enter into an economic recovery loan deposit agreement with the State Treasurer. Such agreement will include requirements necessary to implement the purposes of the Program. The bill specifies requirements must include an agreement by the eligible lending institution to lend an amount equal to the loan deposit to eligible borrowers at an interest rate that is not more than 3.0 percent greater than the interest rate made available to the lending institution (effectively capping the interest rate spread at 3.0 percent). The borrower's rate must be recalculated on an annual basis. The bill provides the loan agreement will include provisions for the loan deposit to be placed for a time not to exceed a period of ten years and that is considered appropriate in coordination with the underlying loan. The bill also requires the agreement to include provisions for the reduction of the loan deposit in an amount equal to any payment of loan principal by the eligible borrower.

Funding of the Loan by the Lending Institution (New Section 6)

The bill requires, upon placement of a loan deposit with an eligible lending institution, the institution to fund the loan to each approved eligible borrower listed in the loan package in accordance with the agreement between the institution and the State Treasurer. The bill requires the loan to be at the rate established in the agreement and established pursuant to requirements of this bill.

Liability for Default or Delay in Payments (New Section 7)

The bill states the State and the State Treasurer shall not be liable to any eligible lending institution in any manner for payment of the principal or interest on any economic recovery loan deposit loan to an eligible borrower. The bill also states any delay in payments or default on the part of the eligible borrower does not in any manner affect the economic recovery loan deposit agreement between the eligible lending institution and the State Treasurer.

Amendments to Linked Deposit Loan Program Law (Section 9)

The bill amends law governing the investment of state moneys, which also includes previously authorized linked deposit programs, to add those loan deposits made under the Program and applicable interest rates established by the bill.

Field of Membership—Credit Unions (Section 8)

The bill also amends geographic area criteria associated with defining field of membership for state-chartered credit unions in the State Credit Union Code (Code). Continuing law requires credit union members to be linked by one of three fields of membership: geographic area, occupation, or association.

Under current law, a geographic area is permitted to include a single political jurisdiction or multiple contiguous political jurisdictions, until the aggregate total of the population of the geographic area reaches 500,000. The law further provides, however, if the headquarters of the

credit union is located within a metropolitan statistical area (MSA) of more than one county, a different maximum population limit would apply. That limit is determined by a formula:

Multiply the population of the most populous MSA within Kansas (*i.e.*, the population of the Kansas City MSA counties within Kansas) by the fraction having 1.0 million as the numerator and 750,000 as the denominator. [*Note:* Current population numbers are those of the adjusted federal census information presented to the Legislature by the Secretary of State.]

The bill permits a single political jurisdiction (continuing law) but modifies other criteria to:

- Increase the permitted maximum for multiple contiguous political jurisdictions for an aggregate of the total population from 500,000 to 2.5 million, as determined by official state population figures, or any portion thereof, which are identical to the decennial census data from the enumeration conducted by the U.S. Census Bureau (language attributable to the Census data is located in the definition of “population data” in the current field-of-membership requirements); and
- Remove language that separately applied to credit unions with headquarters located within an MSA of more than one county (allowed for a different maximum population limit).

The bill also modifies a requirement that provides, from and after July 1, 2008, no geographic area shall consist of any congressional district or the entire state of Kansas to instead state no geographic area shall consist of the entire state of Kansas.

The bill removes definitions within the Code for “MSA,” “population data,” and “overt act.” Some of the requirements within the definitions had been specific to operations of credit unions, including branch locations, construction of new buildings, and membership of occupation or association groups on or before either February 1, 2008, or June 30, 2008.

Kansas Financial Institutions Privilege Tax—Definitions (Section 10)

The bill permits a deduction from net income, beginning in tax year 2023, for financial institutions subject to the Kansas Financial Institutions Privilege Tax (privilege tax) equal to the net interest income received from qualified agricultural real estate and single family residence loans attributable to Kansas to the extent such interest is included in the Kansas taxable income. The bill creates definitions for the terms “interest,” “qualified agricultural real estate,” and “single family residence” and also creates a calculation methodology for “net interest income received from qualified agricultural real estate loans” and for “net interest income from single family residence loans” as follows:

- “Interest” means interest on indebtedness attributed to Kansas and incurred in the ordinary course of the active conduct of any business and interest on indebtedness incurred that is secured by a single family residence;

- “Qualified agricultural real estate loans” means loans made on real property that is substantially used for the production of one of more agricultural products and that:
 - Have maturities of not less than 5 years and not more than 40 years;
 - Are secured by a first lien interest in real estate, except that the loans may be secured by a second lien interest if the institution also holds the first lien on the property; and
 - Have an outstanding loan balance when made that is less than 85 percent of the appraised value of the real estate, except that a loan for which private mortgage insurance is obtained may exceed 85 percent of the appraised value of the real estate to the extent the loan amount in excess of 85 percent is covered by such insurance;
- “Net interest income received from qualified agricultural real estate loans attributed to Kansas” means the product of the ratio of the interest income earned on qualified agricultural real estate loans over total interest income earned, in relation to the net income of the national banking association, state bank, trust company, or savings and loan association without regard to this deduction;
- “Net interest income received from single family residence loans attributed to Kansas” means the product of the ratio of the interest income earned on single family residence loans over total interest income earned, in relation to the net income of the national banking association, state bank, trust company, or savings and loan association without regard to this deduction; and
- “Single family residence” means a residence that is:
 - The principal residence of its occupant;
 - Located in Kansas in a rural area, as defined by the U.S. Department of Agriculture, that is not within an MSA and has a population of 2,500 or less as determined by the most recent census for which data is available; and
 - Purchased or improved with the proceeds of the loan.

Insurance Producer Licensing Requirements; SB 37

SB 37 amends provisions governing agent licensing and renewal licensure requirements in the Uniform Agents Licensing Act and in the Public Adjusters Licensing Act and also amends a statute governing the examination of applicants for agent licensure. The bill also provides for an exemption and extension in complying with the continuing education requirements of licensed insurance agents serving on active duty in the National Guard or armed services of the United States for a specified period of time. The bill further requires certification by pre-need-only insurance agents that the agent transacted no other insurance business.

Examination for Applicant Agent Licensure

The bill modifies the requirement of examination for applicants and prospective applicants for an agent's license to remove a six-month waiting period for the retaking of an examination after a third or subsequent failure.

Uniform Insurance Agents Licensing Act

Definitions

The bill modifies the definition of "biennial due date" as the term applies to both agents (the last day of the agent's birth month) and to registered businesses (the last day of the month of the business' initial licensure).

Biennial Renewal Fee and Continuing Education Requirements for Licensure

Biennial renewal fee. In addition to the current criteria specified for residential agents to meet educational requirements in the biennial license period, the bill requires agents to submit an application for renewal on a form prescribed by the Commissioner of Insurance (Commissioner) and, on and after January 1, 2022, to pay a \$4.00 biennial renewal application fee.

Continuing education credits. Under current law, licensed agents holding only a property and casualty (P&C) or a life, accident, and health (L&H) qualification are required to obtain biennially a minimum of 12 continuing education credits (CECs), including at least 1 hour in insurance ethics and no more than 3 CECs in insurance agency management. If an agent holds both the P&C and L&H certifications, the agent is required to obtain a minimum of 24 CECs biennially.

On and after January 1, 2022, the bill amends the CEC requirement for agents to require each licensed agent to earn 18 CECs biennially, permit at least 3 hours of instruction in ethics, and remove the required insurance agency management hours.

The bill updates the CEC requirements for specified lines of insurance to add exemptions for insurance agents licensed to hold only a qualification in either self-service storage unit or travel insurance.

Pre-need agent reporting requirement. The bill requires that, at the biennial due date, a licensed insurance agent, who is an individual and holds a life insurance license only for the purpose of selling pre-need funeral insurance or annuity products, provide certification from an officer of each insurance company that has appointed such agent that the agent transacted no other business during the period covered by the report. Under current law, the certification is required only upon request of the Commissioner.

Exemption and extension for licensed agents in active duty armed services. The bill exempts a licensed agent who is a member of the National Guard or any reserve component of the armed services of the United States who serves on active duty for at least 90 consecutive days from continuing education requirements during the time such insurance agent is on active duty. The bill requires the Commissioner to grant an extension to any such licensed agent until

the biennial due date that occurs in the year next succeeding the year in which such active duty ceases.

Appointment of Agents; Notification

Appointment of agents. The bill removes affiliation requirements for business entities (insurance companies). Under current law, each officer, director, partner, and employee of the business entity who acts as an insurance agent must be licensed as an insurance agent. The business entity is required to disclose to the Kansas Insurance Department (Department) the names of all of its officers, directors, partners, and employees, regardless of whether such persons are licensed as insurance agents. The current notification requirement and licensure of the business entity's representatives include an associated time frame for notification to the Department and penalties for failure to notify. The bill removes the notification time frames and penalties.

The bill, on and after January 1, 2022, also removes a required annual certification and related certification fee for a licensed insurance agent who is an officer, director, partner, or employee or is otherwise legally associated with a corporation, association, partnership, or other legal entity appointed by an insurance company. Under current law, an annual certification fee must be paid for each licensed agent certified by the company at the time the company files its premium tax returns.

Notification. The bill creates reporting requirements on each person or entity licensed in the state as an insurance agent. The bill requires the following information to be reported to the Commissioner within 30 calendar days of an occurrence:

- Each disciplinary action on the agent's license or licenses by the regulatory agency of another state or territory of the United States;
- Each disciplinary action on an occupational license held by the licensee, other than an insurance agent's license;
- Each judgment or injunction entered against the licensee on the basis of conduct involving fraud, deceit or misrepresentation, or a violation of any insurance law;
- All details of any conviction of a misdemeanor or felony (details are specified in the bill; minor traffic violations may be omitted);
- Each change in name (if the change is effected by court order, a copy of such order must be provided to the Commissioner);
- Each change in residence or mailing address, email address, or telephone number;
- Each change in the name or address of the agency with which the agent is associated; and

- Each termination of a business relationship with an insurer if the termination is for cause, including the reason for the termination.

In addition, each person or entity licensed in Kansas as an insurance agent is required to provide to the Commissioner, upon request, a current listing of company affiliations and affiliated insurance agents. Business entities licensed in Kansas as insurance agents are required to report each change in legal or mailing address, email address, and telephone number to the Commissioner within 30 days of occurrence. These entities also are required to report each change in the name and address of the licensed agent who is responsible for the business entity's compliance with the insurance laws of Kansas to the Commissioner within 30 days of occurrence.

Commissioner—Licenses and Renewals; Permissible Considerations

Under continuing law, the Commissioner is permitted to deny, suspend, revoke, or refuse renewal of licenses if the Commissioner finds violation of several listed actions of the applicant or license holder (e.g., providing incorrect, misleading, incomplete, or untrue information; violations of insurance law; a misdemeanor or felony conviction). The bill adds “failed to respond to an inquiry from the Commissioner within 15 business days” to this list of actions.

In addition, the bill requires the Commissioner to consider the following criteria when determining whether to grant or renew a license:

- Applicant's age at the time of the conduct;
- Recency of the conduct;
- Reliability of the information concerning the conduct;
- Seriousness of the conduct;
- Factors underlying the conduct;
- Cumulative effect of the conduct or information;
- Evidence of rehabilitation;
- Applicant's social contributions since the conduct;
- Applicant's candor in the application process; and
- Materiality of any omissions or misrepresentations.

Separately, the Commissioner is required to consider when determining whether to reinstate or grant to an applicant a license that has been revoked:

- Present moral fitness of the applicant;

- Demonstrated consciousness by the applicant of the wrongful conduct and disrepute that the conduct has brought to the insurance profession;
- Extent of the applicant's rehabilitation;
- Seriousness of the original conduct;
- Applicant's conduct subsequent to discipline;
- Amount of time that has elapsed since the original discipline;
- Applicant's character, maturity, and experience at the time of the revocation; and
- Applicant's present competence and skills in the insurance industry.

The bill provides that an applicant to whom a license has been denied after a hearing may not apply for a license again until after the expiration of a period of one year from the date of the Commissioner's order. A licensee whose license was revoked cannot reapply until after two years from the date of the order.

Renewal Application—Penalties

The bill amends provisions applying to the renewal of licensure for an insurance agent to create corresponding penalty provisions when the required renewal application is not received by the Commissioner by the agent's biennial due date. The bill provides, if the required renewal application is late:

- Such individual insurance agent's qualification and each corresponding license shall be suspended automatically for a period of 90 calendar days or until such time as the agent satisfactorily submits a completed application, whichever occurs first; and
- The Commissioner shall assess a penalty of \$100 for each license suspended:
 - If such agent fails to provide the required renewal application and the monetary penalty within 90 calendar days of the biennial due date, the agent's qualification and each corresponding license will expire on such agent's biennial due date;
 - If, after more than 3 but less than 12 months from the date the license expired, the agent desires to reinstate his or her license, the agent must provide the required renewal application and pay a reinstatement fee in the amount of \$100 for each license suspended; and
 - If, after more than 12 months have passed since license expiration, the agent desires to reinstate the license, this agent is required to apply for an insurance agent's license, provide the required proof of CEC completion, and pay a reinstatement fee in the amount of \$100 for each license suspended.

The bill permits, upon receipt of a written application from an agent claiming extreme hardship, the Commissioner to waive any penalty associated with renewal of an agent's license.

Public Adjusters Licensing Act

The bill amends the Public Adjusters Licensing Act to add fingerprinting and criminal history record checks of applicants. Under the bill, the Commissioner is allowed to:

- Require a person applying for a public adjuster license to be fingerprinted and submit to a state and national criminal history record check, to submit a background check, or both:
 - The fingerprints shall be used to identify the applicant and to determine whether the applicant has a record of criminal history in this state or another jurisdiction. The Commissioner is required to submit the fingerprints to the Kansas Bureau of Investigation and the Federal Bureau of Investigation for a state and national history record check. Local and state law enforcement officers and agencies are required to assist the Commissioner in the taking and processing of fingerprints of applicants and to release all records of an applicant's arrests and convictions to the Commissioner; and
- Conduct or have a third party conduct a background check on a person applying for a public adjuster license.

The bill requires the applicant to pay any associated costs whenever the Commissioner requires fingerprinting or a background check, or both. The Commissioner is permitted to use the information obtained from a background check, fingerprinting, and the applicant's criminal history only for purposes of verifying the identity of the applicant and in the official determination of the applicant's fitness to be issued a license as a public adjuster.

The bill also amends the biennial renewal provisions for licensure as a public adjuster to clarify the term "biennial due date" and increase, from 12 to 18 hours, the biennial minimum continuing education courses for licensees and to specify such education include 3 hours of ethics. The bill removes a requirement that such education include 11 hours of P&C or general continuing education courses.

City Utility Low-Interest Loan Program; House Sub. for SB 88

House Sub. for SB 88 creates the City Utility Low-Interest Loan Program (Program), which provides loans to cities for extraordinary electric or natural gas costs incurred during the extreme winter weather event of February 2021. The total aggregate amount of loans issued under the Program, which will be administered by the State Treasurer, cannot exceed \$100.0 million of unencumbered funds. The bill also amends law governing the investment of state moneys to add Program loans and applicable interest rates.

The bill took effect upon publication in Issue 9A of the *Kansas Register* on March 4, 2021.

City Utility Low-Interest Loan Program (New Section 1)

The bill designates its provisions and amendments thereto as the Program. The Program is part of and supplemental to Article 42 of Chapter 75 of the *Kansas Statutes Annotated* (Article 42 pertains to state moneys, including the investment of state moneys, activities of the Pooled Money Investment Board, and the administration of certain loan deposit programs).

Program Definitions (New Section 2)

The bill establishes definitions for terms including:

- “City” to mean a city organized and existing under the laws of Kansas; and
- “Loan” to mean a deposit of unencumbered state funds to a city pursuant to the Program.

The bill also defines the terms “director of investments” and “program.”

Program Administration; Report and Legislative Review (New Section 3)

The bill authorizes the State Treasurer to administer the Program. The bill states the Program’s purpose is to provide loans to cities for extraordinary electric or natural gas costs incurred during the extreme winter weather event of February 2021. The bill restricts the total amount of loans under the Program to an amount not to exceed \$100.0 million of unencumbered funds pursuant to statutes pertaining to investment of state moneys.

The State Treasurer is required to adopt all rules and regulations necessary to administer the Program, including the development of a streamlined application process, no later than January 1, 2022, except the streamlined application process must be established within 14 days from the effective date of the act (*Kansas Register* publication). The bill further specifies the adoption of such rules and regulations is not be a prerequisite for the approval of Program loans by the State Treasurer. The bill states the State Treasurer shall approve loans under the Program in the most expeditious manner possible on or after the effective date of this act.

The State Treasurer is required to submit an annual report to the Governor and Legislature identifying the cities participating in the Program. The report must provide the aggregate amount of moneys loaned and the amount of moneys available for loan. The report is due on or before January 1, 2022, and each January 1 thereafter. The Legislature is required to perform a review of the Program as part of the State Treasurer’s annual report on or after January 1, 2024.

Program Loan Applications (New Section 4)

The bill authorizes the State Treasurer to disseminate information and to provide loan applications as soon as practicable on or after the effective date of this act to cities for Program participation.

A city must forward an application to the State Treasurer in a form and manner prescribed by the State Treasurer. The application is required to:

- Include information regarding the amount of the loan requested by the city and such information the State Treasurer may require, including, but not limited to, the specific fund or account of the city in which loan proceeds will be deposited; and
- Contain a certification by the governing body of the city that, if the city receives any federal moneys related to the extreme winter weather event of February 2021, the first priority for expenditure of such moneys is for the payment of any outstanding balance of a loan made to the city under the Program.

The bill further specifies a Program loan can be used only for those extraordinary electric or natural gas costs incurred during the extreme weather event of February 2021, as certified by the city's governing body, and not for any other utility costs previously budgeted for by the city.

The bill also provides that no loan can be amortized for a period of more than ten years. Payments on such loan will not be required to be more frequently than annually but can be made more frequently upon agreement between the city and State Treasurer.

Certification of Program Loans; Interest Rate (New Section 5)

The bill authorizes the State Treasurer to accept or reject an application based on the State Treasurer's evaluation of whether the city meets the Program requirements. If sufficient funds are not available for a Program loan, the applications may be considered in the order received when funds become available.

Upon the acceptance of an application, the bill requires the State Treasurer to certify to the Director of Investments the amount required for the loan, and the Director will place a deposit of this certified amount in the specific fund or account of the city indicated in the loan application and approved by the State Treasurer.

The bill provides the interest rate on a loan must be 2.0 percent below the market rate provided in KSA 75-4237 (a floating rate). The bill requires such rate to be recalculated on the first business day of January each year using the market rate then in effect. The bill further specifies the minimum interest rate (or floor) will be 0.25 percent if the market rate is below 2.25 percent. The bill authorizes the State Treasurer to request the Director of Investments to place such deposit with the city prior to approval of an application when necessary.

The bill requires all moneys received by the State Treasurer from cities for payments of the Program loans to be deposited in the State Treasury to the credit of the Pooled Money Investment Portfolio.

Conflict of Provisions with Other Law Governing State Moneys; Exemption from Bonded Indebtedness (New Section 6)

The bill provides, in the event a conflict arises between provisions of this bill and provisions statutes pertaining to investment of state moneys, or any other provision of law, the provisions of the bill shall control.

The bill also provides that any Program loan made to a city shall not be considered bonded indebtedness for the purposes of KSA 10-308 (pertaining to bonded indebtedness of cities) or any other statute imposing a limitation on indebtedness of a city.

Program Interest Rates, Investment in State Moneys (Section 7)

The bill amends law governing the investment of state moneys to add those loan deposits made under the Program and applicable interest rates established by the bill.

Fire Insurance Premium Levy Distribution; HB 2270

HB 2270 places a limit of \$100,000 on deposits into the State General Fund (SGF) each fiscal year from moneys from a levy placed on each fire insurance company doing business in Kansas for the purpose of maintaining the Office of State Fire Marshal. Continuing law requires the State Treasurer to credit 10.0 percent of moneys from the levy to the SGF.

The bill directs the remainder of this levy to be distributed as specified in the bill: 64.0 percent to a fee fund of the Office of State Fire Marshal, 20.0 percent to the Emergency Medical Services Operating Fund, and 16.0 percent to Fire Service Training Program Fund of the University of Kansas Fire and Rescue Training Institute.

HEALTH

Audiology and Speech-Language Pathology Interstate Compact; SB 77

SB 77 enacts the Audiology and Speech-Language Pathology Interstate Compact (Compact). The Compact's uniform provisions are outlined below.

Purpose

The purpose of the Compact is to facilitate the interstate practice of audiology and speech-language pathology with the goal of improving public access to audiology and speech-language pathology services.

Definitions

The Compact defines various terms used throughout the Compact.

State Participation in the Compact

The Compact provides licensure requirements for states participating in the Compact. Licenses issued by a home state to an audiology or speech-language pathologist are recognized by each member state as authorizing the practice of audiology or speech-language pathology in each member state. States are required to implement criminal history record checks of license applicants. The privilege to practice audiology or speech-language pathology is derived from the home state license. Member states are authorized to charge a fee for granting a compact privilege and are required to comply with bylaws and rules of the Audiology and Speech-Language Pathology Compact Commission (Compact Commission).

Compact Privilege

The Compact requires audiologists and speech-language pathologists to comply with certain requirements to exercise compact privilege and state audiologists and speech-language pathologists can hold only one home state license at a time. The Compact establishes the requirements to restore an encumbered license.

Compact Privilege to Practice Telehealth

The Compact requires member states to recognize the right of an audiologist or speech-language pathologist licensed in a member state to practice in another member state *via* telehealth.

Active Duty Military Personnel or Their Spouses

The Compact allows active duty military personnel or their spouses to designate a home state where such service member or spouse has a license in good standing and allows such military personnel or spouse to retain that home state designation during the period of time the service member is on active duty.

Adverse Actions

The Compact allows a member state to take adverse action against an audiologist's or speech-language pathologist's privilege to practice in such member state and to issue subpoenas. Only the licensee's home state has the power to take adverse action against the audiologist's or speech-language pathologist's license issued by such home state. The Compact allows joint investigations of licensees by member states.

Establishment of the Audiology and Speech-Language Pathology Compact Commission

The Compact creates the Compact Commission and includes provisions relating to the membership, voting, powers and duties, and financing of the Compact Commission.

Data System

The Compact requires the Compact Commission to develop, maintain, and utilize a coordinated database and reporting system on all licensed individuals in member states. Additionally, the Compact Commission is required to promptly notify all member states of an adverse action taken against a licensee or applicant. Any information contributed to the database can be designated by a member state as not for the public.

Rulemaking

The Compact authorizes the Compact Commission to exercise rulemaking powers. The bill requires notice of proposed rules to be filed at least 30 days prior to the meeting where the Compact Commission will consider such rule. Additionally, the Compact Commission is required to grant the opportunity for a public hearing if certain conditions are met. However, the Compact provides for emergency rulemaking procedures.

Oversight, Dispute Resolution, and Enforcement

The Compact requires the Commission, upon member request, to resolve disputes arising among member states and between member states and nonmember states. In addition, the Compact Commission is allowed to enforce the provisions of the Compact and, by majority vote, could initiate legal action in federal court against a member state.

Date of Implementation of the Interstate Commission for Audiology and Speech-Language Pathology Practice and Associated Rules, Withdrawal, and Amendment

The Compact is effective on the date on which the Compact statute is enacted into law in the tenth member state. Any member state is allowed to withdraw from the Compact by enacting a statute that repeals the Compact, but this does not take effect until six months after the enactment of the repealing statute. Member states can amend the Compact, but any amendment is not effective until it is enacted by all member states.

Construction and Severability

The Compact is to be liberally construed and the provisions of the Compact are severable.

Binding Effect of Compact and Other Laws

The Compact does not prevent the enforcement of any other law of a member state that is not inconsistent with the Compact. Laws in conflict with the Compact are superseded to the extent of the conflict and all lawful actions of the Compact Commission are binding upon member states.

The bill is in effect upon publication in the *Kansas Register*.

COVID-19 Vaccination Plan; SR 1707

SR 1707 recognizes the COVID-19 pandemic and acknowledges the work of developing a vaccine for distribution to combat the disease. The resolution acknowledges the vaccination and distribution plan by the Governor and the data provided by the U.S. Centers for Disease Control and Prevention regarding Kansas and its ranking among other states in vaccine distribution. The resolution states the current vaccination plan submitted by the Governor of Kansas prioritizes the COVID-19 vaccination of healthy, incarcerated individuals over Kansans between the ages of 16 to 64 who have severe medical risks.

The resolution calls upon the Governor to revise the current COVID-19 vaccination plan by removing prisoners from the front of the line in Phase 2 and instead prioritize the vaccination of the elderly, teachers, and Kansans aged 16 to 64 who have severe medical risks.

Urging the Legislative Coordinating Council to Revoke Any Executive Order Mandating Face Coverings; HR 6015 and SR 1717

HR 6015 and **SR 1717** urge the Legislative Coordinating Council (LCC) to revoke any executive order issued by the Governor pursuant to the Kansas Emergency Management Act establishing a face coverings protocol, if such executive order is issued by the Governor while the Legislature is not in Session or is adjourned for three or more days during the Legislative Session. The resolution directs the Chief Clerk of the House to send an enrolled copy of the resolution to the chairperson of the LCC.

JUDICIARY

Statutory Speedy Trial; Deadline Suspension; Reports; Prioritization of Cases for Trial; HB 2078

HB 2078 suspends the provisions of the speedy trial statute in the Kansas Code of Criminal Procedure until May 1, 2023, in all criminal cases and removes a provision in the statute authorizing the Chief Justice to issue an order to extend or suspend any deadlines or time limitations and requiring trials to be scheduled within 150 days of termination of such order.

Additionally, the bill adds a provision requiring trial courts to consider relevant factors when prioritizing cases for trial, including, but not limited to:

- The trial court's calendar;
- Relative prejudice to the defendant;
- The defendant's assertion of the right to speedy trial;
- The calendar of trial counsel;
- Availability of witnesses; and
- The relative safety of the proceedings to participants as a result of the response to the COVID-19 public health emergency in the judicial district.

The bill requires the Office of Judicial Administration to prepare and submit a report to the Senate Committee on Judiciary and the House Committee on Judiciary on or before January 17, 2022, and January 16, 2023, containing information by judicial district regarding the number of criminal cases that are pending, resolved, or newly filed and the number of jury trials conducted in criminal cases.

The bill states the amendments made by the bill are procedural in nature and shall be construed and applied retroactively.

The bill takes effect upon publication in the *Kansas Register*.

Adult Care Homes; Covered Facilities; COVID-19; Immunity from Civil Liability; HB 2126

HB 2126 amends the COVID-19 Response and Reopening for Business Liability Protection Act by replacing the definition of "adult care facility" with the following definition of "covered facility":

- An adult care home, as defined in the Adult Care Home Licensure Act, except that "covered facility" would include a center approved by the Centers for Medicare and Medicaid Services as a Program for All-inclusive Care for the Elderly (PACE) that provides services only to PACE participants;
- A community mental health center and a crisis intervention center, as defined elsewhere in statute; and

- A community service provider, a community developmental disability organization, and an institution, as defined in the Developmental Disabilities Reform Act.

The bill replaces an affirmative defense available in certain circumstances for an adult care facility in a civil action for damages, administrative fines, or penalties for a COVID-19 claim with immunity from liability for a covered facility in a civil action for damages for a COVID-19 claim if such facility was in substantial compliance with public health directives applicable to the activity giving rise to the cause of action when the cause of action accrued.

For purposes of this immunity provision, “public health directives” means any of the following required by law to be followed related to COVID-19:

- State statutes or rules and regulations; or
- Federal statutes or regulations from federal agencies, including the U.S. Centers for Disease Control and Prevention and the Occupational Safety and Health Administration of the U.S. Department of Labor.

The bill states this immunity provision shall not apply to civil liability when it is established the act, omission, or decision giving rise to the cause of action constituted gross negligence or willful, wanton, or reckless conduct.

The bill states the amendments replacing the affirmative defense with an immunity provision apply retroactively to any cause of action accruing on or after March 12, 2020, and prior to termination of the state of disaster emergency related to the COVID-19 public health emergency.

The bill takes effect upon publication in the *Kansas Register*.

State of Disaster Emergency; Orders by Chief Justice; HB 2227

HB 2227 amends law governing orders issued by the Chief Justice to secure the health and safety of court users, staff, and judicial officers during a state of disaster emergency.

The bill became effective March 30, 2021, upon its publication in Issue 12B of the *Kansas Register*.

State of Disaster Emergency Suspension Orders

The bill amends a statute that allows the Chief Justice, during a state of disaster emergency, to issue an order to extend or suspend statutory deadlines or time limitations when the Chief Justice determines such action is necessary to secure the health and safety of court users, staff, and judicial officers, to also allow the Chief Justice to issue such orders during a state of local disaster emergency.

Orders issued may remain in effect up to 150 days after the termination of the applicable state of disaster emergency or state of local disaster emergency.

The bill also allows the Chief Justice to suspend appeals verification requirements contained in the Revised Kansas Code for the Care of Children if the above conditions are met.

Operation of Deadlines or Time Limitations Upon Termination of Order

The bill provides that on the date an order issued under this statute terminates, for a deadline or a time limitation that did not begin to run due to the order, a person shall have the full period provided by law to comply with such deadline or time limitation and have the same number of days to comply with the deadline or time limitation as the person had when the deadline or time limitation was extended or suspended.

Audio-visual Communication

The bill amends the provision allowing the Chief Justice to issue an order to authorize the use of two-way electronic audio-visual communication in any court proceeding after a determination that such action is necessary to secure the health and safety of court users, staff, and judicial officers, and to also authorize such action when necessary to expeditiously resolve pending cases.

Sunset Provision

The bill extends the sunset for the provisions relating to the Chief Justice's authority to issue orders to extend or suspend statutory deadlines, time limitations, or appeals verifications from March 31, 2021, to June 30, 2022.

RETIREMENT

KP&F Service-connected Benefits; Michael Wells Memorial Act; HB 2063

HB 2063 revises the benefits for members of the Kansas Police and Firemen's Retirement System (KP&F) who are Tier II members, meaning those employees hired since July 1, 1989, who are disabled and ultimately die due to a "service-connected" condition, as that term is defined by law. The bill will apply to deaths that occurred on and after January 1, 2017, and designates these amendments to law as the Michael Wells Memorial Act.

Assuming no death benefits are payable, the new benefit will be the greater of:

- A monthly benefit equal to 50.0 percent of the member's final average salary at the time of the disability, plus 10.0 percent for each dependent child who is under the age of either 18 years or 23 years, if a full-time student; or
- The retirement benefit the deceased member would have received if the member had been able to retire, if there are no dependent children.

The total amount of benefits payable can not exceed 75.0 percent of the member's final average salary.

Under the current benefit structure, when a Tier II KP&F member becomes disabled and later dies due to a service-connected condition before reaching eligibility, the spouse receives both a one-time, lump-sum payment equal to 50.0 percent of the member's final average salary, which is the average of the three highest of the previous five years of employment, and a monthly benefit equal to 50.0 percent of the member's disability benefit. If there is no spouse, dependent children receive the benefit in equal shares.

STATE AND LOCAL GOVERNMENT

Division of Tourism; ERO 48

ERO 48 Executive Reorganization Order (ERO) No. 48 establishes the Division of Tourism (Division) within the Department of Commerce, effective July 1, 2021, rather than continue it within the Kansas Department of Wildlife, Parks and Tourism (KDWPT). The ERO states the head of the Division shall be the Director of Tourism (Director) and is to be appointed by the Secretary of Commerce. The position of Director will be an unclassified position and will receive an annual salary set by the Secretary of Commerce.

The ERO states the Director will appoint employees as necessary to carry out the powers and duties of the Division. Such employees will act for and exercise the powers of the Director if the Director delegates such powers. The Director may organize the Division in the most efficient manner.

Changes to the Department of Wildlife, Parks and Tourism

The ERO abolishes the Division of Tourism and the Office of the Director of Tourism within the KDWPT.

The ERO states all KDWPT powers, duties, and functions related to the Division are transferred to and imposed upon the Division and the Director within the Department of Commerce.

The ERO renames the KDWPT as the Kansas Department of Wildlife and Parks and the Secretary of Wildlife, Parks and Tourism (Secretary) as the Secretary of Wildlife and Parks. The ERO states the Kansas Department of Wildlife and Parks and the Secretary of Wildlife and Parks will be the successor in every way to the powers, duties, and functions of the KDWPT and of the Secretary granted prior to the effective date of the ERO. Every act performed under the powers, duties, and functions by or under the authority of the Kansas Department of Wildlife and Parks or the Secretary of Wildlife and Parks will have the same force and effect as if performed by the KDWPT or the Secretary.

The ERO states that whenever the KDWPT is referred to or designated by a statute, contract, or other document regarding the KDWPT's powers, duties, or functions related to the KDWPT, such reference shall apply to the Kansas Department of Wildlife and Parks. The ERO states that whenever the Secretary is referred to or designated by a statute, contract, or other document regarding the Secretary's powers, duties, or functions related to the Secretary, such reference shall apply to the Secretary of Wildlife and Parks. All rules, regulations, orders, and directives of the Secretary that are in effect on July 1, 2021, shall continue to be effective and shall be deemed the rules, regulations, orders, and directives of the Secretary of Wildlife and Parks until revised, amended, revoked, or nullified by law.

The ERO states the Secretary of Wildlife and Parks will appoint an assistant secretary for operations. The position of assistant secretary for operations will be an unclassified position with a salary set by the Secretary of Wildlife and Parks. The Secretary of Wildlife and Parks will assign powers, duties, and functions to the assistant secretary for operations. The assistant secretary for operations will act for and exercise the powers of the Secretary of Wildlife and Parks, if the Secretary delegates such powers.

The ERO abolishes the positions of assistant secretary for parks and tourism and the assistant secretary of wildlife, fisheries, and boating within the KDWPT.

Division of Tourism within the Department of Commerce

The ERO states the Division and the Director will be the successor in every way to the powers, duties, and functions of the Division of Tourism and the Director of Tourism of KDWPT granted prior to the effective date of this ERO and transferred as part of this ERO. Every act performed under the powers, duties, and functions by or under the authority of the Division and Director will have the same force and effect as if performed by the Division of Tourism or the Director of Tourism of KDWPT.

The ERO states that whenever the Division of Tourism of the KDWPT is referred to or designated by a statute, contract, or other document regarding the Division of Tourism of the KDWPT and such document is related to the Division of Tourism of the KDWPT, such reference shall apply to the Division.

The ERO states that whenever the Director of Tourism of KDWPT is referred to or designated by a statute, contract, or other document regarding the Director of Tourism of KDWPT's powers, duties, or functions and such document is related to the Director of Tourism of the KDWPT, such reference shall apply to the Director.

All rules, regulations, orders, and directives of the Secretary that are in effect on July 1, 2021, and that relate to the functions, powers, or duties of the Director of Tourism of the KDWPT shall continue to be effective and shall be deemed the rules, regulations, orders, and directives of the Secretary of Commerce until revised, amended, revoked, or nullified by law.

All orders or directives of the Division of Tourism or the Director of Tourism of the KDWPT that are in effect on July 1, 2021, and that relate to any function, power, or duty of the Division of Tourism or the Director of Tourism of the KDWPT shall continue to be effective and shall be deemed the orders and directives of the Division and Director until revised, amended, revoked, or nullified by law.

Transfers of Funds, Accounts, Liability, Property, and Records

The ERO transfers the balances of all funds and accounts appropriated or reappropriated to the KDWPT for activities related to the Division from the KDWPT to the Department of Commerce.

The ERO states liability for all accrued compensation or salaries of officers and employees who are transferred to the Division shall be paid by the Department of Commerce.

The ERO transfers all property, property rights, and records relating to the powers, duties, or functions transferred to the Division to the Department of Commerce. Any conflict that arises regarding the transfers described above will be resolved by the Governor, whose decision will be final.

The ERO states lawsuits, criminal actions, or other proceedings by or against any state agency or program or by or against any officer of the State in such officer's official duties will not be affected by reason of governmental reorganization.

Transfer of Employees

The ERO states officers and employees that are engaged in duties relating to the Division and are necessary to perform those duties, in the opinion of the Secretary of Commerce, are transferred to the Division. All classified employees will retain their status as classified employees.

The ERO states all retirement benefits and leave balances and rights that are accrued or granted prior to the date of transfer of such officers and employees transferred by this order shall be retained. The service of each transferred officer or employee will be declared continuous. The ERO will not affect the classified status of any transferred person employed by KDWP prior to the date of transfer. The ERO states any subsequent transfer, layoff, or abolition of classified service positions will be made in accordance with the civil service laws and any related rules and regulations. The date of transfer of each transferred officer or employee shall commence at the start of a payroll period.

COVID-19; Extension of State of Disaster Emergency; Extension of Related Provisions; Closure or Cessation of Business Activity; SB 14

SB 14 amends law regarding the governmental response to the COVID-19 pandemic in Kansas. The bill became effective upon publication in Issue 3A of the *Kansas Register* on January 25, 2021.

Ratification and Extension of State of Disaster Emergency

The bill amends the statute ratifying and continuing the COVID-19-related state of disaster emergency declared by the Governor on March 12, 2020, to reflect the September 15, 2020, ratification and continuation of the state of disaster emergency by 2020 Special Session HB 2016 and subsequent extensions and continuations by the State Finance Council, and ratifies and continues in existence the state of disaster emergency through March 31, 2021. The bill also amends this statute to extend from 2020 through 2021 a provision prohibiting the Governor from proclaiming any new state of disaster emergency related to the COVID-19 health emergency without approval by at least six legislative members of the State Finance Council.

Extension of Provisions

The bill amends statutory provisions regarding the following to extend their expiration from January 26, 2021, until March 31, 2021:

- Removal of alcohol from premises of a licensed club or drinking establishment;
- In the section of the Kansas Emergency Management Act (KEMA) governing declaration of a state of disaster emergency, provisions regarding extension of the COVID-19 state of disaster emergency when the Legislature is not in session by application of the Governor to the State Finance Council. This section is also amended to permit this procedure when the Legislature is adjourned during session for three or more days;

- In the section of KEMA governing powers of the Governor during a state of disaster emergency, extending provisions regarding the powers of the Governor and boards of county commissioners enacted in 2020 Special Session HB 2016. [Note: This section appears to make substantive amendments to the statute. However, these apparent substantive amendments reflect current statutory language as of the date of enactment of SB 14 and appear as amendments only to continue the then-effective language beyond the original January 26, 2021, expiration date.] Effective March 31, 2021, the bill returns this section to the version effective before enactment of 2020 Special Session HB 2016, removing the amendments made by 2020 Special Session HB 2016 and this bill;
- Telemedicine;
- Temporary emergency licensure by the State Board of Healing Arts;
- Temporary licensure measures for additional health care providers and provision of certain health care services; and
- Business immunity from liability for a COVID-19 claim.

Closure or Cessation of Business Activity

The bill amends the KEMA statute limiting the Governor's closure or cessation of business activity.

Under previous law, this statute prohibited the Governor from ordering, during any state of disaster emergency, the closure or cessation of any for-profit or nonprofit business or commercial activity for more than 15 days, required the Governor to consult with the State Finance Council prior to issuing such an order, and required approval of six legislative members of the State Finance Council for additional closure or cessation beyond 15 days. The bill amends these provisions to instead prohibit the Governor, during any state of disaster emergency related to COVID-19, from issuing an order that substantially burdens or inhibits the gathering or movement of individuals or operation of any religious, civic, business, or commercial activity, whether for-profit or not-for-profit.

The expiration date of this statute is also extended from January 26, 2021, until March 31, 2021.

COVID-19; Kansas Emergency Management Act; State of Disaster Emergencies; Legislative Coordinating Council; SB 40

SB 40 creates and amends law regarding the Kansas Emergency Management Act (KEMA), state of disaster emergencies, the Legislative Coordinating Council, and the COVID-19 health emergency. The bill became effective March 25, 2021, upon publication in Issue 12A of the *Kansas Register*.

Local School Board Actions during COVID-19 State of Disaster Emergency (New Section 1)

The bill creates a section of law providing that, during the COVID-19 state of disaster emergency, only the board of education responsible for the maintenance, development, and operation of a school district (local school board) shall have the authority to take any action, issue any order, or adopt any policy made or taken in response to such disaster emergency that affects the operation of any school or attendance center of the school district, including, but not limited to, any action, order, or policy that:

- Closes or has the effect of closing any school or attendance center of such school district;
- Authorizes or requires any form of attendance other than full-time, in-person attendance at a school in the school district, including, but not limited to, hybrid or remote learning; or
- Mandates any action by any students or employees of a school district while on school district property.

Any such action, order, or policy shall only affect the operations of schools under the jurisdiction of the local school board and shall not affect the operation of nonpublic schools.

During any such disaster emergency, the State Board of Education, the Governor, the Department of Health and Environment, a local health officer, a city health officer, or any other state or local unit of government may provide guidance, consultation, or other assistance to the local school board but may not take any action related to such disaster emergency that affects the operation of any school or attendance center of the school district.

Any meeting or hearing of a local school board discussing an action taken, order issued, or policy adopted shall be open to the public and may be conducted by electronic audio-visual communication when necessary to secure the health and safety of the public, the board, and employees.

Grievance Process for Actions Taken by School Boards; Request for Hearing

The bill provides that an employee, a student, or the parent or guardian of a student aggrieved by an action taken, order issued, or policy adopted by a local school board under the above provisions or by an action of any employee of a school district violating any such action, order, or policy may request a hearing by such board to contest the action within 30 days of the action, and such request shall not stay or enjoin the action, order, or policy.

Upon receipt of a request for a hearing, the local school board must conduct a hearing within 72 hours of receiving such request for the purposes of reviewing, amending, or revoking such action, order, or policy. The board must issue a decision within seven days after the hearing is conducted. The board may adopt emergency rules of procedure to facilitate the efficient adjudication of any hearing requested under these provisions, including, but not limited to, rules for consolidation of similar hearings.

The bill allows any party aggrieved by such decision of the local school board to file a civil action, within 30 days after the issuance of the decision, in the district court of the county where the party resides or in Shawnee County District Court. Notwithstanding any order issued by the Chief Justice regarding deadlines or time limitations during a state of disaster emergency, the bill requires the court to conduct a hearing within 72 hours of receiving a petition in such action. The court must grant the request for relief unless the court finds the action, order, or policy is narrowly tailored to respond to the state of disaster emergency and uses the least restrictive means to do so. The bill requires the court to issue an order on such petition within seven days after the hearing. If the court does not do so, the relief requested in the petition shall be granted. Relief under these provisions may not include a stay or injunction concerning the contested action, order, or policy that applies beyond the county in which the petition was filed, and the Supreme Court may adopt emergency rules of procedure to facilitate the efficient adjudication of any hearing under these provisions, including rules for consolidation of similar hearings.

Community College and Technical College Actions during COVID-19 State of Disaster Emergency (New Section 2)

The bill creates a section of law, in substantially similar form to Section 1, regarding the authority of and actions taken by the governing body of a community college or technical college during the COVID-19 state of disaster emergency, with the following adjustments:

- Provisions regarding schools affected by local school board actions and nonpublic schools are not included;
- Some of the entities and officials who may offer guidance, consultation, or other assistance are changed; and
- Parents are not included in those who may request a hearing.

Legislative Coordinating Council Membership (Section 3)

The bill amends the statute establishing the Legislative Coordinating Council (LCC) to add the Vice President of the Senate as a member, increasing the total number of LCC members to eight.

Amendments to KEMA (Sections 4-9)

Responsibilities during State of Disaster Emergency (Section 4)

The bill provides the LCC, instead of the State Finance Council, has the authority to extend a state of disaster emergency beyond the initial 15-day state of disaster emergency period, for specified periods not to exceed 30 days each. The bill requires an affirmative vote of five LCC members for such extension and removes a limit of one such extension.

The bill similarly replaces the State Finance Council with the LCC in extension provisions for a state of disaster emergency regarding domestic animals, plants, raw agricultural

commodities, animal feed, or processed food, and changes the vote required from a unanimous vote to an affirmative vote of five LCC members.

The bill amends a specific provision regarding the COVID-19 state of disaster emergency to reflect an extension of the state of disaster emergency in Section 3, to reflect the replacement of the State Finance Council with the LCC in the extension procedure, and to remove a prohibition on such extensions past March 31, 2021.

*Ratification and Extension of COVID-19 State of Disaster Emergency; Executive Orders
(Section 5)*

The bill ratifies and continues in existence the COVID-19 state of disaster emergency originally declared by the Governor on March 12, 2020, through May 28, 2021.

The bill amends a prohibition on proclamation of new state of disaster emergencies related to the COVID-19 health emergency during 2020 or 2021 to specify the prohibition includes state of disaster emergencies related in whole or in part to the COVID-19 health emergency, including, but not limited to, any economic, financial, or other crisis caused by such emergency, and to reflect the replacement of the State Finance Council with the LCC in the extension procedure.

The bill states, notwithstanding any other provision of law to the contrary, all executive orders (EOs) issued during the COVID-19 state of disaster emergency will be revoked on March 31, 2021, and shall be null and void. The bill provides that any new EOs issued during the COVID-19 state of disaster emergency or during a new state of disaster emergency related to the COVID-19 health emergency are subject to revocation by the Legislature or by the LCC, pursuant to procedures provided in Section 6 of the bill.

Powers during State of Disaster Emergency (Section 6)

The bill adds the term “executive” to those orders issued by the Governor under its provisions and replaces the State Finance Council with the LCC in provisions regarding review and revocation of EOs related to state of disaster emergency. The bill requires the chairperson of the LCC to call a meeting of the LCC to occur within 24 hours of the issuance of such EO for purposes of reviewing the order, and allows the LCC, when the Legislature is not in session or is adjourned during session for three or more days, to revoke such EOs with the affirmative vote of five members. This section is amended to reflect the specific limitations placed on EOs related to the COVID-19 state of disaster emergency by Section 4 of the bill.

The bill amends a provision restricting the Governor’s power or authority to take certain actions regarding firearms or ammunition during a state of disaster emergency to state the Governor shall not have the power or authority to limit or otherwise restrict the sale, purchase, transfer, ownership, storage, carrying, or transporting of firearms or ammunition, or any component or combination thereof, including any components or combination thereof used in the manufacture of firearms or ammunition, or seize or authorize the seizure of any firearms or ammunition, or any component or combination thereof, except as otherwise permitted by state or federal law.

The bill removes an expired provision regarding restrictions on business operations and movement or gathering of individuals.

The bill allows any party aggrieved by an EO issued under this section that has the effect of substantially burdening or inhibiting the gathering or movement of individuals or the operation of any religious, civic, business, or commercial activity (whether for-profit or not-for-profit) to file a civil action, within 30 days after the issuance of the EO, in the district court of the county where the party resides or in Shawnee County District Court. Notwithstanding any order issued by the Chief Justice regarding deadlines or time limitations during a state of disaster emergency, the bill requires the court to conduct a hearing within 72 hours of receiving a petition in such action. The court must grant the request for relief unless the court finds the EO is narrowly tailored to respond to the state of disaster emergency and uses the least restrictive means to do so. The bill requires the court to issue an order on such petition within seven days after the hearing. If the court does not do so, the relief requested in the petition shall be granted. Relief under these provisions may not include a stay or injunction concerning the contested EO that applies beyond the county in which the petition was filed, and the Supreme Court may adopt emergency rules of procedure to facilitate the efficient adjudication of any hearing under these provisions, including rules for consolidation of similar hearings.

The bill amends provisions regarding the powers of a board of county commissioners to issue an order relating to public health that includes provisions less stringent than a statewide EO to state that such orders shall operate in the county in lieu of the Governor's EO.

Business Activity; Gathering or Movement of Individuals (Section 7)

The bill amends the KEMA section prohibiting the issuance of an order during a COVID-19 state of disaster emergency that substantially burdens or inhibits the gathering or movement of individuals or operation of any religious, civic, business, or commercial activity, to remove the section's expiration date of March 31, 2021, allowing the section to remain effective past that date.

State of Local Disaster Emergency (Section 8)

The bill amends the KEMA section governing states of local disaster emergency to add provisions allowing a party aggrieved by specified actions taken by a local unit of government pursuant to the section to file a civil action in the district court of the county where the action was taken. The parameters and procedures for such action are otherwise be substantially similar to those provided by Section 5 of the bill regarding EOs.

Violations (Section 9)

The bill provides an exception to continuing civil penalties for violations of KEMA or related rules and regulations or lawful orders or proclamations. The exception makes a knowing violation of an executive order issued pursuant to Section 5 that mandates a curfew or prohibits public entry into an area affected by a disaster a class A nonperson misdemeanor.

Kansas Intrastate Emergency Mutual Aid Act (Section 10)

The bill amends the definition of “emergency responder” in the Kansas Intrastate Emergency Mutual Aid Act to include 911 call center public safety telecommunicators and physician assistants.

Revocation of Orders of the Secretary of Health and Environment (Section 11)

The bill amends a statute governing the powers of the Secretary of Health and Environment (Secretary) to provide that, in the event of a state of disaster emergency declared by the Governor or a state of local disaster emergency, the Legislature may revoke, by concurrent resolution, an order issued by the Secretary to take action related to such disaster emergency. The bill allows the LCC, when the Legislature is not in session or is adjourned during session for three or more days, to revoke such orders with the affirmative vote of five members.

Authority of County Health Board and Local Health Officers (Section 12)

The bill amends a statute governing the powers of the board of county commissioners acting as the county board of health (board) and local health officers (officers) to provide, if an officer determines it is necessary to issue an order mandating the wearing of face masks, limiting the size of gatherings of individuals, curtailing the operation of business, controlling the movement of the population of the county, or limiting religious gatherings, the officer must propose such order to the board. At the next regularly scheduled meeting of the board or at a special meeting of the board, the board must review the proposed order and may take any action related to the proposed order the board determines is necessary. The proposed order shall become effective if approved by the board or, if the board is unable to meet, if approved by the chairperson of the board or the vice chairperson of the board in the chairperson’s absence or disability.

The bill allows any party aggrieved by an order issued under the above provisions to file a civil action in the district court of the county in which the order was issued. The procedures for such action are substantially similar to those provided elsewhere in the bill regarding EOs and states of local disaster emergency.

Amendment and Repeal of Additional Statutes (Sections 13 and 15)

The bill amends a statute regarding the State Finance Council to remove a reference to the KEMA statute regarding responsibilities during a state of disaster emergency to reflect the other amendments made by the bill.

The bill repeals a version of the KEMA statute regarding the powers of the Governor during a state of disaster emergency that would have gone into effect on March 31, 2021, and a KEMA section prohibiting closure of schools without the approval of the State Board of Education.

Severability Clause (New Section 14)

The bill provides the provisions of this act are severable and, if any portion of the act or application to any person or circumstance is held unconstitutional or invalid, the invalidity shall not affect other portions of the act that can be given effect without the invalid portion or application, and the applicability of such other portions of the act to any person or circumstance shall remain valid and enforceable.

Sedgwick County Nuisance Abatement; SB 52

SB 52 establishes the Sedgwick County Urban Area Nuisance Abatement Act (Act).

The bill authorizes the Board of County Commissioners (Board) to order the removal or abatement of any nuisance from any property in the unincorporated area of Sedgwick County (County). All costs associated with the abatement are the responsibility of the property owner. Before the abatement process can begin, the bill requires the County to first obtain a conviction for a county code violation regarding the nuisance no more than 12 months before the issuance of the abatement order.

The bill states the Act shall not apply to any land, structures, machinery, equipment, or vehicles used for agricultural activity as defined in continuing law to include the growing or raising of horticultural and agricultural crops, hay, poultry, and livestock and the handling, storage, and transportation of agricultural commodities. The Act also excludes all real and personal property, machinery, equipment, stored grain, and agricultural input products that are owned or maintained by commercial grain elevators and agribusiness facilities.

Abatement Process

To begin the abatement process, the bill requires the Board, or an agency designated by the Board, to file a statement with the Sedgwick County Clerk describing the nuisance and declaring it a menace and health risk to county residents. The bill authorizes the Board to issue an order requiring the nuisance to be removed or abated. The bill requires the order to provide a minimum of ten days (as specified in the order) for the owner to remove and abate the nuisance; the Board is empowered to grant extensions to the time period in question. The property owner is also provided the right to request a hearing before the Board if the request is made prior to the end of the waiting period or any extension. The bill subjects any decision made by the Board or its designated representative on this matter to review under the Kansas Judicial Review Act (KSA 77-601 *et seq.*).

The abatement order is to be sent to the owner of record by personal service. [*Note:* Methods of service of process are provided in KSA 2020 Supp. 60-303.] The bill, if the owner fails to accept delivery or effectuate receipt during a preceding 24-month period, authorizes the Board to use alternative notification methods such as, but not limited to, door hangers, telephone communications, or first-class mail. Telephone communication or first-class mail is required if the property is unoccupied and the owner is a nonresident.

If the owner of the property fails to abate the nuisance before the time limit stated in the abatement order, the Board is authorized to order the repair or demolition of any structure, have items described in the order removed, and provide notice to the owner by certified mail, with

return receipt requested, that the abatement has occurred and include the total cost of the abatement incurred by the County. The bill requires the notice to state payment for the abatement to the County would be due and payable no later than 60 days after the mailing of the notice. If payment is not made within the 60-day period, the County is authorized to assess the cost of the abatement to the lot or parcel of land on which the nuisance was located. The bill requires the county clerk to certify the costs and extend the cost on the tax roll against the lot or parcel of land.

The bill requires all orders and notices to be served on the owner of record for the property. In the event of more than one owner of record, the County is required to notify at least one of the owners of record.

County Abatement Costs

The bill states, when assessing the cost of removal or abatement of a nuisance, the County shall subtract the value of the property that was removed or abated from the total cost of the abatement or removal. If the value of the property removed or abated is greater than the total cost of the removal or abatement, the bill requires the County to pay the property owner the difference.

A property owner who contests the value of the property is allowed to request a hearing before the Board or its designated representative prior to the deadline for payment of removal or abatement costs to the County.

Motor Vehicles

The bill states the County is authorized to remove a motor vehicle determined to be a nuisance, except when the vehicle is on public property or property open to the public. The County is authorized to impound and auction vehicles removed by this process following provisions of continuing law applicable to removing a vehicle from public property or property open to the public. The bill states an individual who purchases a vehicle in this manner may file proof of purchase with the Division of Vehicles (Division) in order to receive the title to the vehicle purchased. If no responsible bid is received during the auction, the County is authorized to file proof with the Division and be issued the title in the County's name.

Any individual whose vehicle is sold *via* this process is eligible for a refund of motor vehicle tax imposed, and the amount of the refund will be determined as provided in continuing law.

Policies and Procedures

The Board may adopt a resolution to establish policies, procedures, a designated body, or other matters for hearings that property owners or their agents may request pursuant to the Act.

Sunset

The Act expires on July 1, 2024.

City or County Assumption of Special District Duties; SB 118

SB 118 establishes a procedure by which a city or county may assume the powers, responsibilities, and duties of a special district within the city's corporate boundary or the county's boundaries.

The bill defines a "special district" to include airport authorities, cemetery districts, drainage districts, fire districts, industrial districts, library districts, port authorities, rural water districts, sewer districts, and rural watershed districts.

Procedure

The bill requires the city or county and the special district to reach an agreement regarding the city or county assuming the powers, responsibilities, and duties of the special district and to pass a joint resolution stating their intent to dissolve the special district into the city or county. The joint resolution must also contain the time and location for a joint public hearing on the issue of dissolution.

Upon both the special district and the city or county governing body passing the joint resolution, the special district is prohibited from issuing new debt without notifying and receiving approval from the city or county governing body.

The joint resolution must be published once a week for two consecutive weeks in a newspaper of general circulation in the county or counties where the city or county and special district are located.

The bill requires that, after the public hearing has been held, the governing bodies of the city or county and the special district decide whether to proceed with consolidation or abandon the proposed dissolution. If both agree to proceed, the governing body of the city or county adopt a city ordinance or county resolution stating the special district is dissolved and the city or county is assuming all powers, responsibilities, and duties of the special district.

The special district is considered dissolved on the effective date of the ordinance or resolution.

Results of Consolidation

Upon the dissolution of the special district, the city or county is the successor to all powers, duties, and responsibilities of the special district. The city or county would:

- Acquire the property of the special district subject to any lease or agreement;
- Pay or retire district debts or obligations;
- Be vested with all property, funds, and assets of the district; and
- Have legal custody of records, memoranda, writings, entries, prints, representations, and electronic data of the special district.

References to the special district in a contract or other document that are in regard to any of the powers, duties, and functions transferred to the city or county would be deemed to apply to the city or county as the context requires.

All legal action, judicial or administrative, pending against the special district or an officer of the special district would abate by reason of this governmental reorganization, but the court would be authorized to allow any such suit, action, or other proceeding to be maintained by or against the successor.

Attorney General Coordination of Training Regarding Missing and Murdered Indigenous Persons; HB 2008

HB 2008 authorizes the Attorney General to coordinate training regarding missing and murdered indigenous persons for law enforcement agencies throughout Kansas, in consultation with Native American Indian tribes, the Kansas Bureau of Investigation, the Kansas Law Enforcement Training Center, and other appropriate state agencies.

Public Agency Fee Prohibition; Legislative Division of Post Audit; Sub. for HB 2049

Sub. for HB 2049 amends a statute authorizing the Legislative Post Audit Committee to direct the Post Auditor and Legislative Division of Post Audit (LPA) to audit state agencies and other entities specified in the Legislative Post Audit Act. Specifically, the bill adds a provision prohibiting a public agency that is the subject of an audit pursuant to the statute or any other law from charging a fee for copies of or access to certain records described in the statute.

Legislative Division of Post Audit; State Agency Reports; HB 2050

HB 2050 amends statutes to remove requirements that the following reports and certifications be provided to the Legislative Division of Post Audit, the Post Auditor, or the Legislative Post Audit Committee:

- An audited statement of actual expenditures incurred by a Kansas nonprofit corporation providing legal services to indigent inmates of Kansas correctional institutions;
- A certified summary of the write-off of any accounts receivable or taxes receivable by the Director of Account and Reports;
- An annual audit of corporations that contract with the Board of Regents (Board) or any state educational institution and are substantially controlled by the Board or such institution; and
- An annual report by the Secretary of Revenue regarding tax abatements that reduce final tax liability by \$5,000 or more.

Vacating Lots in the City of Americus; Vacation of City Streets; HB 2178

HB 2178 vacates lots in the City of Americus from a dedication and amends law regarding the vacation of streets.

City of Americus

The bill vacates lots dedicated for a college and a park in the original town plat of the City of Americus from that dedication. The bill also confers fee simple title to the lots to the City of Americus, which the city's governing body can dispose of at its discretion.

Vacation of City Streets

Time Limit for Challenge of an Ordinance Vacating Property

The bill allows any landowner aggrieved by the decision of a city governing body to vacate certain property to bring action in a district court challenging the reasonableness of such decision within 30 days following publication of the vacation ordinance.

Authorization

The bill amends a statute to remove redundancy with continuing law and makes conforming changes. Continuing laws (KSA 13-334, 14-423, and 15-427) provide processes for local governments to request street vacations based on a city's classification.

The bill authorizes cities to utilize the process of the bill by following the notice and public hearing requirements established in the bill.

Public Hearing

The bill clarifies that, when a resident petitions a city to vacate a street, the governing body must give public notice of the request and, in the notice, specify whether the hearing on the petition will be conducted by the governing body or the planning commission. The bill requires all interested persons to be given an opportunity to be heard on the petition.

If a city chooses to use the same process to deannex land or vacate any public reservation, the bill requires the hearing to be held before the city governing body.

The bill requires the city governing body to enact an ordinance containing an order to vacate if, at the hearing, it is determined the request of the petitioner should be granted.

Transferring Department of Corrections Land to the City of Beloit; HB 2214

HB 2214 authorizes the Secretary of Administration, on behalf of the Department of Corrections, to convey real estate adjacent to the site of the former Beloit Juvenile Correctional Facility to the City of Beloit. This 6.38-acre tract of land was inadvertently omitted when the

former juvenile correctional facility was transferred to the City of Beloit in 2010 (KSA 76-2221). All costs related to the conveyance will be paid by the City of Beloit.

Donation Limit to Benefit Libraries; HB 2238

HB 2238 removes the \$500,000 limit on gifts school districts, governing bodies of cities, or both are jointly able to accept for the express purpose of the construction or furnishing of a library.

Service of Process; Secretary of State; HB 2298

HB 2298 amends law related to the Secretary of State (Secretary) and service of process, as follows.

Service of Process against Nonresidents in Cases Arising from Motor Vehicle Accidents or Collisions

The bill clarifies the requirements for service of process on nonresident drivers or their representatives through the Secretary. Current law provides that nonresident drivers or their representatives are deemed to accept the Secretary as their agent for service of process arising from any accident or collision that occurs while operating a vehicle in Kansas and requires a notice to be delivered to the defendant by registered mail or personally outside of the state by a sheriff or deputy sheriff in such state.

The bill provides that a plaintiff may serve a defendant by paying a fee to the Secretary and providing to the Secretary a copy of the summons, petition, and order, and the last known address, residence, or place of abode for each defendant. The Secretary is directed to immediately mail a notice of service and copy of the summons, petition, and order to each defendant by return receipt delivery. The bill requires the notice of service to be signed, dated, and using language substantially in the form specified by the bill.

The bill allows a plaintiff, upon written notification to the Secretary, to personally serve a defendant in a foreign state by an adult person not party to the suit or an officer duly qualified to serve legal process in the state or jurisdiction where the defendant is found, by delivering the appropriate documents, or offering to make such delivery, in the case of refused delivery, on a defendant. The plaintiff is required to provide the Secretary with a copy of the notice of service, summons, petition, and order provided to the defendant. The process server is required to file an affidavit, declaration, or any other competent proof, stating the time, manner, and place of service on or before the return day of process or within a further time the court may allow.

The Secretary is required to keep a record of all process served upon the office pursuant to the bill, showing the day of service of each process.

Compliance with these provisions constitutes sufficient service on the defendant.

Service of Process on Limited Liability Partnerships

The bill clarifies a domestic limited liability partnership or foreign limited liability partnership authorizes the Secretary, as each entity's agent, to accept service of process on the entity's behalf.

Disapproval of ERO 47, Merging Certain Agencies; HR 6009

HR 6009 disapproves Executive Reorganization Order (ERO) No. 47, which was issued by the Governor on January 26, 2021.

ERO 47 would have renamed the Department for Children and Families (DCF) as the Kansas Department of Human Services (DHS) and transferred all jurisdiction, powers, functions, and duties for the Kansas Department for Aging and Disability Services (KDADS) to DHS, effective July 1, 2021. Under this merger, all jurisdiction, powers, functions, and duties from DCF and KDADS, as well as all the jurisdiction, powers, functions, and duties for which these agencies are serving as the operating agency or grants manager for another agency, would have been imposed upon DHS and the Secretary of Human Services.

The ERO stated whenever the secretaries of, or names of, these agencies, or predecessor agencies—the Department of Social and Rehabilitation Services or the Department of Aging—are referred to or designated by any statute, rule and regulation, contract, or other document, such reference should be deemed to apply to DHS. The ERO further stated DHS would be the successor to the powers, duties, and functions of these agencies, and any potential remaining rights, titles, or interest belonging to the Department of Social and Rehabilitation Services or Department of Aging in real property. Actions performed by DHS would have had the same force and effect as if performed by the above entities, in which the same powers, duties, and functions were vested prior to July 1, 2021.

Under this merger, the rule and regulation authority, fees, funds, grant funds, advisory group funds, loan repayment funds, account balances, property and property rights, liability, and liability for accrued compensation of salaries of personnel, including officers and employees of both DCF and KDADS, would have been located within DHS.

TAXATION

Property Tax; SB 13

SB 13 repeals the property tax lid law applicable to cities and counties and certain budget requirements applicable to other municipalities, establishes notice and public hearing requirements for certain taxing subdivisions seeking to collect property taxes in excess of the subdivision's revenue-neutral rate, prohibits valuation increases resulting solely from normal maintenance of existing structures, and expands the allowed acceptance of partial payments or payment plans for property taxes. The bill is in effect upon publication in the *Kansas Register*.

Tax Lid Repeal

The bill eliminates, effective January 1, 2021, the property tax lid that currently requires a public vote for certain property tax increases by cities and counties. The bill also eliminates a requirement that municipalities, other than cities and counties, that levy at least \$1,000 in property taxes not approve any budget that includes revenue produced by property taxes in excess of the amount produced the preceding year without first publishing notice in the official county newspaper where the municipality is located of the budget and the scheduled vote thereon.

Notice and Public Hearing Requirements

The bill establishes new notification and public hearing requirements for all taxing subdivisions seeking to increase property taxes above those provided for by their "revenue-neutral rate." A taxing subdivision is prohibited from levying taxes exceeding its revenue-neutral rate without first approving a resolution or ordinance in accordance with the procedure provided by the bill.

The bill requires county clerks to notify taxing subdivisions of their revenue-neutral rate by June 15. "Revenue-neutral rate" means the tax rate for the current tax year that would generate the same amount of property tax revenue as levied the previous tax year, using the current tax year's total assessed valuation.

Governing bodies of taxing subdivisions are required to publish notice of their intent to exceed the revenue-neutral rate. The bill requires the notice to include the date, time, and location of a public hearing on the resolution or ordinance providing for the levy. The bill requires publication on such governing body's website at least ten days in advance of the hearing and in a weekly or daily newspaper that has general circulation within the county. Taxing subdivisions are required to notify county clerks by July 15 of their intent to exceed the revenue-neutral rate, including information concerning the hearing.

Beginning in tax year 2022, county clerks are required to mail notification of the intent of the taxing subdivision to each taxpayer with property within the taxing subdivision at least ten days in advance of the public hearing. County clerks are required to consolidate the information for all taxing subdivisions relevant to each piece of property on one notice. Notifications may be sent by electronic means with the consent of the taxpayer.

The bill creates the Taxpayer Notification Costs Fund in the State Treasury and provides, for calendar years 2022 and 2023, for any printing and postage costs incurred by county clerks

to be reimbursed by that fund. County clerks are required to notify the Secretary of Revenue of such costs, and the Secretary will certify such amounts to the Director of Accounts and Reports, who will then be required to transfer an equal amount of money from the State General Fund to the Taxpayer Notification Costs Fund.

Any printing and postage costs incurred by county clerks for required notices that are not reimbursed from the Taxpayer Notification Costs Fund will be borne by the taxing subdivisions proposing to exceed their revenue-neutral rates in proportion to the total property tax levied by the subdivisions.

The bill requires the notifications to contain:

- The revenue-neutral rate for each relevant taxing subdivision;
- The proposed tax rate and amount of tax revenue to be levied by each taxing subdivision seeking to exceed its revenue-neutral rate;
- The tax rate and amount of tax from each taxing subdivision for the property from the previous year's tax statement;
- The appraised value and assessed value for the taxpayer's property for the current year;
- The estimated amount of tax for the current year for each subdivision based on the revenue-neutral rate and any tax rate in excess of the revenue-neutral rate and the difference between such amounts for any taxing subdivision seeking to exceed its revenue-neutral rate;
- The date, time, and location of the public hearing for each taxing subdivision seeking to exceed its revenue-neutral rate; and
- Information concerning statutory mill levies imposed by the State of Kansas.

The bill requires the hearing on the resolution or ordinance providing for a taxing subdivision to exceed its revenue-neutral rate to be held by September 10 and to include an opportunity for interested taxpayers to present testimony within reasonable limits and without unreasonable restrictions on the number of individuals allowed to comment. The governing body of each taxing subdivision is required to approve exceeding the revenue-neutral rate by a majority vote at the public hearing.

Taxing subdivisions failing to comply with the notice and hearing procedures are required to refund any property taxes collected in excess of the revenue-neutral rate.

The bill requires information regarding the revenue-neutral rate and taxing subdivision's decision to levy taxes in excess of the rate to be published in the taxing subdivision's annual budget form prescribed by the Division of Accounts and Reports.

Prohibited Valuation Increases

The bill prohibits an increase in the appraised value of real property solely as a result of normal repair, replacement, or maintenance of existing structures, equipment, or other improvements on the property.

Partial Payments and Payment Plans

The bill authorizes county treasurers to accept partial payments and establish payment plans for all property taxes. Current law allows county treasurers to accept partial payments for delinquent property taxes.

Cherokee County Sales Tax Authority; SB 21

SB 21 retroactively ratifies the results of a November 2020 election in Cherokee County that would impose a 0.5 percent retail sales tax for the purpose of financing ambulance services, renovation and maintenance of county buildings and facilities, or other projects within the county approved by the governing body of Cherokee County. The bill provides that the entire proceeds of the tax will be retained by the county and will not be subject to apportionment to other municipalities. The bill requires the tax to terminate prior to January 1, 2033. The bill will be in effect upon publication in the *Kansas Register*.

Marketplace Facilitators and Income Tax Deductions and Exemptions; SB 50

SB 50 requires the collection and remittance of certain taxes by marketplace facilitators. The bill also amends income tax law regarding fraudulent unemployment benefits, itemized and standard deductions, business income related to 2017 federal legislation, corporation return filing, net operating losses, and the business expensing deduction.

Marketplace Facilitators Tax Collection and Remittance

The bill requires the collection and remittance of sales and compensating use tax by most marketplace facilitators beginning July 1, 2021. Such entities with annual gross receipts from sales sourced into Kansas in excess of \$100,000 are subject to the requirement, which also applies to out-of-state retailers with annual receipts from sales sourced into Kansas exceeding \$100,000.

The bill requires marketplace facilitators that reach the \$100,000 threshold for the first time in the current calendar year to collect and remit the tax on cumulative gross receipts from sales into the state in excess of \$100,000 during the current calendar year.

The bill defines “marketplace facilitators” to include entities that contract with sellers to facilitate the sale of products or lodgings through a physical or electronic marketplace operated, owned, or otherwise controlled by the entity and either directly or indirectly collect the payment from the purchaser and transmit all or part of the payment to the seller. The definition excludes platforms that exclusively provide advertising services, principally provide payment processing, or are a certain type of commodity futures trading organization.

The bill authorizes the Department of Revenue (KDOR) to waive the obligation of a marketplace facilitator to collect and remit taxes upon a showing by the marketplace facilitator that substantially all of its marketplace sellers are already collecting and remitting all applicable taxes. The bill also allows marketplace facilitators to contract with marketplace sellers with at least \$1.0 billion of annual gross sales in the United States to require the marketplace seller to collect and remit all applicable taxes and fees.

The bill further clarifies that, in addition to state and local sales and use tax, marketplace facilitators also are responsible for collecting and remitting local transient guest taxes beginning January 1, 2022, and certain prepaid wireless 911 fees beginning April 1, 2022.

KDOR is authorized to require marketplace facilitators to provide any information necessary to assure implementation of the bill's provisions, including the documentation of sales.

The Director of Taxation, KDOR, is required to remove the line for reporting compensating use tax from individual income tax returns beginning January 1, 2022.

The Secretary of Revenue is required to adopt any rules and regulations for purposes outlined in the bill.

The bill repeals the "click-through" nexus provisions for affiliated persons related to sales and use tax collections.

Fraudulent Unemployment Benefits

The bill clarifies that victims of identify theft do not owe Kansas individual income tax on unemployment compensation that was fraudulently obtained by another individual.

Itemized Deductions

Beginning in tax year 2021, the bill provides individual income taxpayers the option to take Kansas itemized deductions regardless of whether deductions are itemized or the standard deduction is claimed for federal income tax purposes.

Standard Deductions

The bill, beginning in tax year 2021, increases the standard deduction amounts to \$3,500 for single filers, \$6,000 for single head-of-household filers, and \$8,000 for married filers filing jointly. These amounts are currently set at \$3,000, \$5,500, and \$7,500, respectively.

Business Income

Global Intangible Low Tax Income (GILTI)

The bill provides, beginning in tax year 2021, a subtraction modification exempting GILTI, as defined in section 951A of the federal Internal Revenue Code (IRC), before any deductions allowed under section 250(a)(1)(B) of the IRC.

Business Interest

The bill provides, beginning in tax year 2021, a subtraction modification exempting certain business interest, to the extent such business interest is currently disallowed as a deduction pursuant to the IRC but was deductible under the IRC as in effect on December 31, 2017.

Capital Contributions

The bill, beginning in tax year 2021, specifies for Kansas corporation income tax purposes that the exemption from federal taxable income for capital contributions shall be the exemption as it existed in section 118 of the IRC as in effect on December 31, 2017.

Federal Deposit Insurance Corporation Premiums

The bill provides, beginning in tax year 2021, a subtraction modification for the amount disallowed as a deduction by section 162(r) of the IRC, as in effect on January 1, 2018, for Federal Deposit Insurance Corporation (FDIC) premiums paid by the taxpayer.

Business Meal Expenses

The bill provides, beginning in tax year 2021, a subtraction modification exempting certain meal expenditures, to the extent such expenditures are currently disallowed as a deduction pursuant to the IRC but were deductible under the IRC as in effect on December 31, 2017.

Expensing Deduction

The bill allows individual income taxpayers to claim the expensing deduction (provided by KSA 79-32,143(a)) for the costs of placing certain tangible property and computer software into service in the state beginning in tax year 2021. A second change, also effective with tax year 2021, requires all taxpayers claiming the Kansas expensing deduction to offset the amount of federal expensing deduction claimed pursuant to Section 179 of the IRC.

Corporation Income Tax Return Filing Deadline

The bill extends the deadline for the filing of Kansas corporation income tax returns to one month after the due date established under federal law. The bill also provides that no late-filing penalty will be assessed on taxpayers filing state corporation income tax returns when the return is filed within one month after the taxpayer has received an extension to file a federal return by the Internal Revenue Service.

The provisions of this section are applicable to returns for tax year 2020 and all future years.

Net Operating Loss Carry Forward Extension

The bill allows Kansas income taxpayers to carry forward net operating losses indefinitely, beginning with such losses incurred in tax year 2018. Current law provides for net operating losses to be carried forward for ten years.

TRANSPORTATION AND MOTOR VEHICLES

Permit for a Motor Vehicle Display Show; SB 33

SB 33 authorizes the Director of Vehicles (Director), Kansas Department of Revenue, to issue a temporary display show license to a sponsor of a motor vehicle display show. A display show sponsor, which the bill requires to be a licensed new vehicle dealer, will be responsible for organizing and operating the display show under such terms and conditions as the Director may reasonably require. The sponsor will pay a fee of \$100 upon application, and each show participant displaying vehicles will pay \$35 to the sponsor. All fees will be remitted to the Director.

The bill authorizes new vehicle dealers, first stage manufacturers, second stage manufacturers, first stage converters, second stage converters, and distributors (manufacturers and distributors) to attend and participate in the display of new motor vehicles at a temporary display show without regard to geographical territorial assignment or relevant market area. The bill requires participating new vehicle dealers to be licensed motor vehicle dealers, but manufacturers and distributors will not be required to be licensed to participate. The bill authorizes participation by new motor vehicle dealers without the approval of any manufacturer or distributor, and it prohibits a manufacturer or distributor from barring or treating a new vehicle dealer adversely for participating in a display show.

The bill prohibits sales or lease transactions at a display show but authorizes test drives for purposes other than sale or lease, to demonstrate the vehicle and its features.

The bill also adds leases and test drives to sales transactions as activities that can not occur at the temporary location of a new vehicle dealer that is not a display show.

Vehicle Dealer Bonding; Permit for Motor Vehicle Display Show; House Sub. for SB 99

House Sub. for SB 99 amends law regarding vehicle dealer license requirements and vehicle display shows.

The bill will be in effect upon publication in the *Kansas Register*.

Dealer License Requirements

The bill increases the bond required for licensure as a dealer of used or new vehicles from \$30,000 to \$50,000, on and after January 1, 2022.

Vehicle Display Show

The bill authorizes the Director of Vehicles (Director), Kansas Department of Revenue, to issue a temporary display show license to a sponsor of a motor vehicle display show. A display show sponsor, which the bill requires to be a licensed new vehicle dealer, will be responsible for organizing and operating the display show under such terms and conditions as the Director may reasonably require. The sponsor will pay a fee of \$100 upon application, and each show participant displaying vehicles will pay \$35 to the sponsor. All fees will be remitted to the Director.

The bill authorizes new vehicle dealers, first stage manufacturers, second stage manufacturers, first stage converters, second stage converters, and distributors (manufacturers and distributors) to attend and participate in the display of new motor vehicles at a temporary display show without regard to geographical territorial assignment or relevant market area. The bill requires participating new vehicle dealers to be licensed motor vehicle dealers, but manufacturers and distributors will not be required to be licensed to participate. The bill authorizes participation by new motor vehicle dealers without the approval of any manufacturer or distributor, and it prohibits a manufacturer or distributor from barring or treating a new vehicle dealer adversely for participating in a display show.

The bill prohibits sales or lease transactions at a display show, but authorizes test drives for purposes other than sale or lease to demonstrate the vehicle and its features.

The bill also adds leases and test drives to sales transactions as activities that can not occur at the temporary location of a new vehicle dealer that is not a display show.

[*Note:* Provisions regarding vehicle display shows are the same of those of SB 33 except that they become effective upon publication in the *Kansas Register*.]

Military Surplus Vehicles; HB 2014

HB 2014 defines “military surplus vehicle” in the Uniform Act Regulating Traffic on Highways and in law regarding vehicle registration.

The bill defines such a vehicle as one that meets the following requirements:

- Has three or fewer axles;
- Meets size and weight limits in continuing law;
- Is less than 35 years old; and
- Was manufactured for use in the U.S. military forces or the military force of any country that was a member of the North Atlantic Treaty Organization at the time the vehicle was manufactured and that is subsequently authorized for sale to civilians.

The definition excludes a tracked vehicle. The bill adds references to military surplus vehicles in definitions of “collector” and “parts car.”

The bill authorizes the owner of a military surplus vehicle to register it upon payment of an annual fee of \$26. A special interest vehicle license plate will be furnished upon payment of a one-time fee of \$20; the bill requires a decal to be displayed on the license plate to identify the vehicle as a military surplus vehicle.

The bill authorizes a military surplus vehicle to be used as are other vehicles of the same type, but prohibits the use of a military surplus vehicle to transport passengers for hire. The bill specifies special interest vehicles, including street rod vehicles, are prohibited from hauling material weighing more than 500 pounds.

The bill prohibits a military surplus vehicle from being registered until a vehicle identification number inspection has been completed by the Kansas Highway Patrol.

Exempting Municipal Motor Grader Operators from CDL Requirements; HB 2295

HB 2295 exempts municipal motor grader vehicles from requirements of the Kansas Uniform Commercial Driver's License Act.

Under current law, five types of vehicles are listed as exempt from the Act: farm vehicles, vehicles operated by firefighters, military vehicles operated by military personnel, commercial vehicles used solely for private noncommercial use, and certain farm tractors moved by implement dealers. The bill adds a sixth exemption for motor grader vehicles operated by an employee of a municipality, if such employee is operating the motor grader vehicle within the boundaries of such municipality.

"Municipality" is defined under continuing law referenced by the bill to mean any county, township, city, school district, or other political or taxing subdivision of the state, or any agency, authority, institution, or other instrumentality thereof.

Peer-to-Peer Vehicle Sharing Program Act; HB 2379

HB 2379 enacts the Peer-to-Peer (P2P) Vehicle Sharing Program Act.

The bill is effective and in force from and after January 1, 2022, and its publication in the statute book.

Definitions

The bill establishes several definitions associated with P2P vehicle sharing, including:

- "Peer-to-peer vehicle sharing," meaning the authorized use of a shared vehicle by an individual other than the shared vehicle's owner through a P2P program:
 - P2P vehicle sharing does not mean rental or lease of a motor vehicle for the purposes of law regarding an excise tax on certain lease or rental vehicles; and
 - Does not include the use of a vehicle that is used for demonstration purposes or a leased, temporarily loaned, or borrowed vehicle owned by a new or used vehicle dealer licensed under the provisions of the Vehicle Dealers and Manufacturers Licensing Act (Act);
- "Peer-to-peer vehicle sharing program," meaning a business platform that connects vehicle owners with drivers to enable the sharing of vehicles for financial consideration:
 - The term does not mean a rental car company; a lessor; or a service provider who is solely providing hardware or software as a service to a person or entity that is not effectuating payment of financial consideration for use of a shared vehicle; and

- Does not include the use of a vehicle that is used for demonstration purposes or a leased, temporarily loaned, or borrowed vehicle owned by a new or used vehicle dealer licensed under the provisions of the Act;
- “Vehicle sharing program agreement,” meaning the terms and conditions applicable to a shared vehicle owner, a shared vehicle driver, and a P2P vehicle sharing program that govern the use of a shared vehicle through a P2P vehicle sharing program:
 - Vehicle sharing program agreement does not include a rental agreement; and
 - Does not include a vehicle that is used for demonstration purposes or a leased, temporarily loaned, or borrowed vehicle owned by a new or used vehicle dealer licensed under the provisions of the Act;
- “Shared vehicle,” meaning a vehicle that is available for sharing through a P2P vehicle sharing program:
 - Shared vehicle does not mean a rental car or rental commercial-type vehicle; and
 - Does not include a vehicle that is used for demonstration purposes or a leased, temporarily loaned, or borrowed vehicle owned by a new or used vehicle dealer licensed under the provisions of the Act;
- “Shared vehicle driver,” meaning the individual authorized to drive the shared vehicle by the shared vehicle owner under a vehicle sharing program agreement:
 - Shared vehicle driver does not include a lessee; and
 - Does not include the operator of a vehicle that is used for demonstration purposes or the operator of a leased, temporarily loaned, or borrowed vehicle owned by a new or used vehicle dealer licensed under the provisions of the Act;
- “Shared vehicle owner,” meaning the registered owner, or person or entity designated by the owner, of a vehicle made available for sharing to shared vehicle drivers through a P2P vehicle sharing program:
 - Shared vehicle owner does not include a person or entity in the business of providing rental vehicles to the public, a leasing company, or a rental car company; and
 - Does not include an owner of a vehicle that is used for demonstration purposes or a leased, temporarily loaned, or borrowed vehicle owned by a new or used vehicle dealer licensed under the provisions of the Act;
- “Vehicle sharing delivery period,” meaning the period of time during which a shared vehicle is being delivered to the location of the vehicle sharing start time, if applicable, as documented by the governing vehicle sharing program agreement;

- “Vehicle sharing period,” meaning the period of time that commences with the vehicle sharing delivery period or, if there is no vehicle sharing delivery period, that commences with the vehicle sharing starting time and, in either case, that ends at the vehicle sharing termination time; and
- “Vehicle sharing termination time,” meaning the earliest of the following:
 - Expiration of the agreed-upon period of time established for the use of a shared vehicle according to the terms of the vehicle sharing program agreement if the shared vehicle is delivered to the location agreed upon in the vehicle sharing program agreement;
 - When the shared vehicle is returned to a location as alternatively agreed upon by the shared vehicle owner (owner) and shared vehicle driver (driver) as communicated through a P2P vehicle sharing program and the alternatively agreed upon location is incorporated into the vehicle sharing program agreement; or
 - When the registered shared vehicle owner or the shared vehicle owner’s authorized designee takes possession and control of the shared vehicle.
- **Liability Coverage**

The bill requires, with exceptions specified in the bill, a P2P vehicle sharing program to assume liability of an owner for bodily injury or property damage to third parties for uninsured and underinsured motorist or personal injury protection losses during the vehicle sharing period in amounts stated in the P2P vehicle sharing program agreement. The bill requires coverage to be not less than the coverage required in the Kansas Automobile Injury Reparations Act (KAIRA).

Notwithstanding the definition of “vehicle sharing termination time,” a P2P vehicle sharing program does not assume owner liability when the owner:

- Makes an intentional or fraudulent material misrepresentation or omission of fact to the P2P vehicle sharing program before the vehicle sharing period in which the loss occurred; or
- Acts in concert with a shared vehicle driver who fails to return the shared vehicle pursuant to the vehicle sharing program agreement.

However, the assumption of liability applies to bodily injury, property damage, uninsured and underinsured motorist, or personal injury protection losses by damaged third parties as required by the KAIRA.

The bill requires a P2P vehicle sharing program to ensure that, during each vehicle sharing period, the owner and the driver are insured under a motor vehicle liability insurance policy that provides coverage in amounts no less than those prescribed in KAIRA. The policy must:

- Recognize that the vehicle insured under the policy has been made available as a shared vehicle and is used through a P2P vehicle sharing program; or
- Not exclude the use of the vehicle by a shared vehicle driver.

The bill provides the requirement for motor vehicle liability insurance can be satisfied by such insurance maintained by an owner, as driver, a P2P vehicle sharing program, or a shared vehicle owner or a shared vehicle driver and a P2P vehicle sharing program.

Insurance satisfying this requirement is considered as primary during each vehicle sharing period and, if a claim occurs in another state with insurance policy coverage amounts that exceed the minimum amounts set forth in state law during the vehicle sharing period, the coverage described in the bill satisfies the difference in minimum coverage amounts, up to the applicable policy limits.

The insurer or P2P vehicle sharing program assumes primary liability for a claim when it is, in whole or in part, providing the insurance required by the bill and in these additional instances:

- A dispute exists as to who was in control of the shared vehicle at the time of the loss or as to whether the shared vehicle was returned to the alternatively agreed-upon location; and
- The P2P vehicle sharing program does not have available, did not retain, or fails to provide information required under recordkeeping provisions in the bill.

The bill also requires, if the insurance maintained by an owner or driver has lapsed or does not provide the required coverage, insurance maintained by the P2P vehicle sharing program to provide such coverage beginning with the first dollar of the claim and to have the duty to defend such claim. The bill states coverage under the P2P vehicle sharing program insurance shall not be dependent on another motor vehicle insurer first denying a claim nor shall another motor vehicle insurance policy be required to first deny a claim.

The bill states nothing in the section pertaining to liability coverage shall be construed to:

- Limit the liability of the P2P vehicle sharing program for any act or omission of the program itself that results in injury to any person as a result of using a shared vehicle through the program; or
- Limit the ability of the P2P vehicle sharing program to contractually seek indemnification from the owner or the driver for economic loss sustained by the program resulting from a breach of the terms and conditions of the vehicle sharing program agreement.

Lienholder Notice

The bill requires, between the time that a vehicle owner registers as a shared vehicle owner on a P2P vehicle sharing program and the time the owner makes a vehicle available as a shared vehicle on the program, the program to notify the owner that, if the shared vehicle has a lien against it, the use of the shared vehicle through such program, including use without physical damage coverage, could violate the terms of the contract with the lienholder.

Exclusions; Liability Coverage

The bill permits an authorized insurer writing motor vehicle liability insurance in Kansas to exclude any and all coverage and the duty to defend or indemnify for any claim afforded under an owner's motor vehicle liability insurance policy, including, but not limited to:

- Liability coverage for bodily injury and property damage;
- Personal injury protection coverage, as defined in KAIRA;
- Uninsured and underinsured motorist coverage;
- Medical benefits coverage, as defined in KAIRA;
- Comprehensive physical damage coverage; and
- Collision physical damage coverage.

The bill further states nothing in this section (coverage exclusions) invalidates or limits an exclusion contained in a motor vehicle liability insurance policy, including any insurance policy in use or approved for use that excludes coverage for motor vehicles made available for rent, sharing, hire, or any business use; invalidates, limits, or restricts an insurer's ability to underwrite any insurance policy; or invalidates, limits, or restricts an insurer's ability to cancel and non-renew insurance policies.

Recordkeeping

The bill requires P2P vehicle sharing programs to collect and verify records pertaining to the use of a vehicle, including, but not limited to:

- The times used;
- Vehicle sharing period pick up and drop off locations;
- Fees paid by the shared vehicle driver; and
- Revenues received by the shared vehicle owner.

The bill also requires the program to provide this information, upon request, to the owner, the owner's insurer, or the driver's insurer to facilitate a claim coverage investigation, settlement, negotiation, or litigation. The bill requires the program to retain the records for a time period not less than the applicable personal injury statute of limitations.

Vicarious Liability; Exemption

The bill exempts a P2P vehicle sharing program and a shared vehicle owner from vicarious liability in accordance with 49 USC § 30106 (provisions of the 2005 Safe, Accountable,

Flexible, Efficient Transportation Equity Act: A Legacy for Users – applying to rented or leased motor vehicle safety and financial responsibility) and under any state or local law that imposes liability solely based on vehicle ownership.

Indemnification

The bill provides that a motor vehicle insurer that defends or indemnifies a claim against a shared vehicle that is excluded under the terms of its policy shall have the right to seek recovery against the insurer of the P2P vehicle sharing program if the claim is:

- Made against the owner or the driver for loss or injury that occurs during the vehicle sharing period; and
- Excluded under the terms of its policy.

Insurable Interest

The bill provides, notwithstanding any any other law, statute, rule, or regulation to the contrary, a P2P vehicle sharing program shall have an insurable interest in a shared vehicle during the vehicle sharing period. The bill further states nothing in this section (insurable interest) shall be construed to require a P2P program to maintain the coverage mandated by provisions of the bill relating to liability coverage.

The bill permits a P2P vehicle sharing program to own and maintain as the named insured one or more policies of motor vehicle liability insurance that provides coverage for:

- Liabilities assumed by the P2P program under a P2P vehicle sharing program agreement;
- Any liability of the owner;
- Damage or loss to the shared vehicle; or
- Any liability of the driver.

Disclosures to Shared Vehicle Owner; Driver

The bill requires every vehicle sharing program agreement made in Kansas to disclose the following information to the owner and driver, as appropriate:

- Any right of the P2P vehicle sharing program to seek indemnification from the owner or driver for economic loss sustained by the P2P program resulting from a breach of the terms and conditions of the P2P vehicle sharing program agreement;

- A motor vehicle liability insurance policy issued to the owner for the shared vehicle or to the driver does not provide a defense or indemnification for any claim asserted by the P2P vehicle sharing program;
- The P2P vehicle sharing program's insurance coverage on the owner and the driver is in effect only during each vehicle sharing period and that, for any use of the shared vehicle by the driver after the vehicle sharing termination time, the driver and the owner may not have insurance coverage;
- The daily rate, fees and, if applicable, any insurance or protection costs that are charged to the shared vehicle owner or the shared vehicle driver;
- The owner's motor vehicle liability insurance may not provide coverage for a shared vehicle; and
- If there are conditions under which a driver must maintain a personal motor vehicle liability insurance policy with certain applicable coverage limits on a primary basis in order to reserve a shared motor vehicle.

The bill also requires every vehicle sharing program agreement made in Kansas to provide an emergency telephone number to personnel capable of fielding roadside assistance and other customer service inquiries.

Driver's License; Data Retention

The bill prohibits a P2P vehicle sharing program from entering into a P2P vehicle sharing program agreement with a driver unless the driver who will operate the shared vehicle:

- Holds a driver's license issued by the state of Kansas to drive vehicles of the class of the shared vehicle;
- Is a nonresident who:
 - Has a driver's license issued by the state or country of the driver's residence that authorizes the driver to drive vehicles of the class of the shared vehicle;
 - Is at least the legal age required of a resident to drive in Kansas; or
 - Otherwise is specifically authorized by the State of Kansas to drive vehicles of the class of the shared vehicle.

The bill also requires P2P vehicle sharing programs to maintain a record of the name, address, driver's license number, and place of issuance of the driver's license of the driver and any other person who will also drive the shared vehicle.

Equipment Responsibility

The bill places sole responsibility on a P2P vehicle sharing program for any equipment, such as a GPS system or other special equipment, that is installed in or on the shared vehicle to monitor or facilitate the vehicle sharing transaction. The bill also requires the P2P program to agree to indemnify and hold harmless the owner for any damage to or theft of such equipment during the vehicle sharing period the owner did not cause. The P2P program has the right to seek indemnity from the driver from any loss or damage to such equipment that occurs during the sharing period.

Safety Recalls

Between the time a vehicle owner registers as a shared vehicle owner on a P2P vehicle sharing program and when the owner makes a vehicle available as a shared vehicle on the P2P program, the bill requires the P2P program to verify there are no outstanding safety recalls on the shared vehicle and notify the shared vehicle owner of the following requirements:

- If a vehicle owner receives an actual notice of a safety recall, the owner may not make such vehicle available as a shared vehicle on a P2P vehicle sharing program until the safety recall repair has been made;
- If an owner receives actual notice of a safety recall on a shared vehicle while the shared vehicle is available on the P2P vehicle sharing program, the owner must remove the shared vehicle from the P2P program as soon as practicable after receiving the notice and must not replace it on the program until the safety recall repair has been made; and
- If an owner receives an actual notice of a safety recall while the shared vehicle is being used and is in the possession of a driver, as soon as practicable after receiving such notice, the owner shall notify the P2P vehicle sharing program about the safety recall, so the shared vehicle owner may address the repair.

Definition Amendments

The bill amends the definitions section of the Kansas Collision Damage Waiver Act to add the following exclusions:

- “Lessor” does not include a P2P vehicle sharing program or a shared vehicle owner;
- “Lessee” does not include a shared vehicle driver;
- “Rental agreement” does not include a vehicle sharing program agreement; and
- “Rental motor vehicle” does not include a shared vehicle.

UTILITIES

Kansas Energy Choice Act; SB 24

SB 24 creates the Kansas Energy Choice Act.

The bill defines the terms “municipality” and “utility service” for the purpose of prohibiting a municipality from imposing any ordinance, resolution, code, rule, provision, standard, permit, plan, or any other binding action that prohibits, discriminates against, restricts, limits, impairs, or has a similar effect on an end-use customer’s use of a utility service, defined as the retail provision of natural gas or propane.

The bill states it should not be construed in its interpretation to restrict the ability of a municipality, as defined in the bill, to limit an end use customer’s use of a utility service if that end use customer is the municipality.

The bill will be in effect upon publication in the *Kansas Register*.

Crimes Related to Critical Infrastructure Facilities; SB 172

SB 172 amends the Kansas Criminal Code regarding crimes involving property by eliminating the crime of tampering with a pipeline and establishing four new crimes: trespassing on a critical infrastructure facility (CIF), aggravated trespassing on a CIF, criminal damage to a CIF, and aggravated criminal damage to a CIF. The bill also allows a judge to order restitution for property damage to any victim of the four new crimes.

Right to Peacefully Protest

The bill includes a “whereas” clause that states the provisions of the bill protect the right to peacefully protest for all Kansans and citizens of the four sovereign nations within the state’s borders while also protecting the critical infrastructure located within the state.

Definition of Critical Infrastructure Facility

The bill defines a CIF, as used in the bill, as any:

- Petroleum or alumina refinery;
- Electric generation facility, substation, switching station, electrical control center, electric distribution or transmission lines, or associated equipment infrastructure;
- Chemical, polymer, or rubber manufacturing facility;
- Water supply diversion, production, treatment, storage, or distribution facilities and appurtenances, including, but not limited to, underground pipelines and a wastewater treatment plant or pump station;

- Natural gas compressor station;
- Liquid natural gas or propane terminal or storage facility;
- Facility that is used for wireline, broadband, or wireless telecommunications or video services infrastructure, including backup power supplies and cable television headend;
- Port, railroad switching yard, railroad tracks, trucking terminal, or other freight transportation facility;
- Gas processing plant, including a plant used in the processing, treatment, or fractionation of natural gas, propane, or natural gas liquids;
- Transmission facility used by a federally licensed radio or television station;
- Steelmaking facility that uses an electric arc furnace to make steel;
- Facility identified and regulated by the U.S. Department of Homeland Security Chemical Facility Anti-Terrorism Standards program, facility operated by the Office of Laboratory Services under the supervision of the Secretary of Health and Environment, or the National Bio and Agro-Defense Facility or Biosecurity Research Institute at Kansas State University;
- Dam that is regulated as a hazard class B or class C dam by the state or federal government;
- Natural gas distribution utility facility, or natural gas transmission facility, including, but not limited to, pipeline interconnections, a city gate or town border station, metering station, belowground or aboveground piping, a regular station, or a natural gas storage facility;
- Crude oil, including Y-grade or natural gas liquids, or refined products storage and distribution facility, including, but not limited to, valve sites, pipeline interconnections, pump station, metering station, belowground or aboveground pipeline or piping, and truck loading or offloading facility; or
- Portion of any belowground or aboveground oil, gas, hazardous liquid, or chemical pipeline, tank, railroad facility, or any other storage facility that is enclosed by a fence or other physical barrier or clearly marked with signs prohibiting trespassing that are obviously designed to exclude intruders.

Crimes Related to Critical Infrastructure Facilities

The bill eliminates the crime of tampering with a pipeline and creates four new crimes.

Trespassing on a Critical Infrastructure Facility

Under the bill, trespassing on a CIF means, without consent of the owner or the owner's agent, knowingly entering or remaining in:

- A CIF; or
- Any property containing a CIF, if such property is completely enclosed by a fence or other physical barrier that is obviously designed to exclude intruders or is clearly marked with a sign or signs that are posted on the property that are reasonably likely to come to the attention of intruders and indicate that entry is forbidden without site authorization.

The bill classifies trespassing on a CIF as a class A nonperson misdemeanor.

Aggravated Trespassing on a Critical Infrastructure Facility

Under the bill, aggravated trespassing on a CIF means, with the intent to damage, destroy, or tamper with a CIF or impede or inhibit operations of the facility, knowingly entering or remaining in:

- A CIF; or
- Any property containing a CIF, if such property is completely enclosed by a fence or other physical barrier that is obviously designed to exclude intruders or is clearly marked with a sign or signs that are posted on the property that are reasonably likely to come to the attention of intruders and indicate that entry is forbidden without site authorization.

The bill classifies aggravated trespassing on a CIF as a severity level 7 nonperson felony.

Criminal Damage to a Critical Infrastructure Facility

Under the bill, criminal damage to a CIF means knowingly damaging, destroying, or tampering with a CIF. The bill classifies criminal damage to a CIF as a severity level 6 nonperson felony.

Aggravated Criminal Damage to a Critical Infrastructure Facility

Under the bill, aggravated criminal damage to a CIF means knowingly damaging, destroying, or tampering with a CIF with the intent to impede or inhibit operations of the facility. The bill classifies aggravated criminal damage to a CIF as a severity level 5 nonperson felony.

Damages

The bill declares nothing in the bill would prevent an owner or operator of a CIF that has been damaged from pursuing any other remedy in law or equity and a person who commits these crimes may also be prosecuted for, convicted of, and punished for any other offense regarding crimes involving property (current law) or criminal trespass on a nuclear generating facility (current law). The bill allows a judge to order restitution for damages associated with these crimes.

Plugging of Abandoned Wells; HB 2022

HB 2022 amends law concerning the filing of complaints and investigations pertaining to abandoned wells, responsible parties for plugging abandoned wells, and funds used by the Kansas Corporation Commission (KCC) for plugging abandoned wells.

Definitions

The bill amends the definition of “well” to include “penetration of the surface of the earth.” In that definition, the bill also amends the purpose of drilling a well to include providing cathodic protection to prevent corrosion to tanks or structures.

With regard to KCC investigations of abandoned wells, the bill defines “abandoned well” as a well that is not claimed on an operator’s license that is active with the KCC and is unplugged, improperly plugged, or no longer effectively plugged.

Filing of Complaints

The bill amends the reasons to file a complaint with the KCC secretary to include abandoned wells that are causing or likely to cause:

- Loss of any usable water;
- Pollution of any usable water strata;
- Imminent loss of any usable water; or
- Imminent pollution of any usable water.

The bill requires the KCC to investigate such complaints and also authorizes the KCC to take appropriate action or issue any order according to the Kansas Administrative Procedure Act (KAPA).

Responsibility for Plugging Abandoned Wells

The bill requires the KCC to hold proceedings in accordance with KAPA if the KCC determines a well is abandoned and has reason to believe a person is legally responsible for the proper care and control of such well. After such proceedings, the bill allows the KCC to issue

orders obligating a person to plug the well or to cause the well to be brought into compliance, if the KCC finds that such person is legally responsible.

The bill limits persons that could be held legally responsible for proper care and control of an abandoned well to one or more of the following:

- Any person, including any operator, causing pollution or loss of usable water through the well;
- The most recent operator to produce from or inject or dispose into the well; however, if no production or injection has occurred, the person that caused the well to be drilled;
- The person that most recently accepted responsibility for the well through written documentation that adequately identifies the well and expressly transfers responsibility for such well;
- The operator that most recently filed a completed transfer report with the KCC in which such operator accepted responsibility for the well;
- The operator that most recently plugged the well if no KCC funds were used; and
- Any person that does any of the following to an abandoned well without KCC authorization:
 - Tampers with or removes surface or downhole equipment attached to the well;
 - Intentionally destroys, buries, or damages the well;
 - Intentionally alters the physical status of the well in such a way that will result in an increase in plugging costs; or
 - Conducts any physical operations upon the well.

The bill also allows any person who has no obligation to plug, replug, or repair a well to seek reimbursement for plugging a well from the Abandoned Oil and Gas Well Fund, if such well has been abandoned for five or more years. The bill requires the KCC to promulgate rules and regulations for the reimbursement process.

The bill states a person who plugs, replugs, or repairs an abandoned well shall not become legally responsible for the care and control of that well. The bill allows any abandoned well to be plugged by any person if such person has written consent from a surface owner of the land upon which the well is located and if such person is licensed by the KCC in accordance with the KCC's rules and regulations.

The bill also clarifies individuals would not be entitled to reimbursement for plugging of an abandoned well unless approved by the KCC.

Abolishing the Well Plugging Assurance Fund

The bill amends law concerning funds used by the KCC to plug abandoned wells.

The bill allows for the deposit of all moneys previously credited to the Well Plugging Assurance Fund to be credited to the Abandoned Oil and Gas Well Fund, and the bill removes the limitation of the Abandoned Oil and Gas Well Fund to be used only for investigating abandoned wells and well sites of which the drilling began before July 1, 1996.

The bill transfers all moneys in and liabilities of the Well Plugging Assurance Fund to the Abandoned Oil and Gas Well Fund and abolishes the Well Plugging Assurance Fund on July 1, 2021.

The bill also removes requirements for the transfers from the Conservation Fee Fund and the State General Fund to the Abandoned Oil and Gas Well Fund.

Repealing an Interagency Agreement

The bill repeals KSA 55-163, which pertains to an interagency agreement between the KCC and the Secretary of Health and Environment for a management plan for integrating field operations for the regulation of oil and gas operations.

Utility Financing and Securitization Act; Senate Sub. for HB 2072

Senate Sub. for HB 2072 creates the Utility Financing and Securitization Act (UFSA), which allows for the securitization of utility assets to recover energy transition costs for electric public utilities whose retail rates are subject to the jurisdiction of the Kansas Corporation Commission (KCC). The UFSA also allows electric and natural gas public utilities whose retail rates are subject to the KCC to pursue securitization to help finance qualified extraordinary expenses, such as fuel costs incurred during extreme weather events. The bill amends the provisions of the Kansas Energy Security Act and the Uniform Commercial Code to conform to the new provisions created in the UFSA.

The bill takes effect upon publication in the *Kansas Register*.

Utility Financing and Securitization Act

Definitions

The bill defines various terms used throughout the UFSA, including these key terms.

“Electric public utility” means the same as defined in KSA 66-101a and includes a for-profit electric utility whose retail rates are subject to the jurisdiction of the KCC. The definition does not include a cooperative that has opted to deregulate or an electric public utility owned by one or more such cooperatives.

“Energy transition costs” includes, at the option of and upon application by an electric public utility, and as approved by the KCC, any of the pretax costs that the electric public utility

has incurred or will incur that are caused by, associated with, or remain as a result of a retired, abandoned, to-be-retired, or to-be-abandoned electric generating facility that is the subject of an application for a financing order filed under the UFSA where such early retirement or abandonment is deemed reasonable and prudent by the KCC through a final order issued by the KCC.

As used in this definition, pretax costs, if determined reasonable by the KCC and not inconsistent with a KCC order granting predetermination regarding retirement or abandonment of the subject generating facility, include, but are not limited to, the undepreciated investment in the retired or abandoned electric generating facility and any facilities ancillary thereto or used in conjunction therewith, costs of decommissioning and restoring the site of the electric generating facility, other applicable capital and operating costs, accrued carrying charges, and deferred expenses. Such pretax costs are reduced by applicable tax benefits of accumulated and excess deferred income taxes, insurance, and scrap and salvage proceeds, and include the cost of retiring any existing indebtedness, fees, costs, and expenses to modify existing debt agreements or for waivers or consents related to existing debt agreements.

Energy transition costs also include pretax costs that an electric public utility has previously incurred related to the retirement of such an electric generating facility occurring before the effective date of the UFSA.

“Financing order” means an order from the KCC pursuant to the UFSA that authorizes:

- The issuance of securitized utility tariff bonds in one or more series;
- The imposition, collection, and periodic adjustments of a securitized utility tariff charge;
- The creation of securitized utility tariff property; and
- The sale, assignment, or transfer of securitized utility tariff property to an assignee.

“Public utility” means an electric or natural gas public utility whose rates are subject to the jurisdiction of the KCC.

“Qualified extraordinary costs” include, at the option of and upon application by a public utility and as approved by the KCC, costs of an extraordinary nature that the public utility has incurred before, on, or after the effective date of the UFSA that would cause extreme customer rate impacts if recovered through customary rate-making, including, but not limited to, purchases of gas supplies, transportation costs, and fuel and power costs including carrying charges incurred during anomalous weather events.

“Securitized utility tariff bonds” means bonds, debentures, notes, certificates of participation, certificates of beneficial interest, certificates of ownership, or other evidences of indebtedness or ownership that have a scheduled maturity date as determined reasonable by the KCC, but not later than 32 years from the issue date, that are issued by an electric public utility or an assignee pursuant to a financing order, the proceeds of which are used directly or indirectly to recover, finance, or refinance KCC-approved energy transition costs and financing costs and that are secured by or payable from securitized utility tariff property, or an electric or

natural gas public utility or assignee pursuant to a financing order, the proceeds of which are used directly or indirectly to recover, finance, or refinance KCC-approved qualified extraordinary costs and financing costs that are secured by or payable from securitized utility tariff property.

“Securitized utility tariff charge” means the amounts authorized by the KCC to provide a source of revenue solely to repay, finance, or refinance securitized utility tariff bonds and financing costs and that are nonbypassable charges imposed on and part of all retail customer bills, including bills to special contract customers collected by an electric or natural gas public utility or its successors or assignees, or a collection agent, in full, separate and apart from the electric or natural gas public utility’s base rates.

Such charges are to be paid by all existing or future retail customers receiving electrical or natural gas service from the public utility or its successors or assignees under KCC-approved rate schedules or special contracts, even if a retail customer elects to purchase electricity or natural gas from an alternative electricity or natural gas supplier following a fundamental change in regulation of public utilities in Kansas.

“Securitized utility tariff costs” means either energy transition costs or qualified extraordinary costs.

“Securitized utility tariff property” includes all rights and interests of a public utility, its successor, or assignee under a financing order, including the right to impose, bill, charge, collect, and receive securitized utility tariff charges authorized under the financing order and to obtain periodic adjustments to such charges authorized under the bill and as provided in the financing order.

The definition also includes all revenues, collections, claims, rights to payments, payments, money, or proceeds arising from the rights and interests specified in the financing order, regardless of whether such revenues, collections, claims, rights to payment, payments, money, or proceeds are imposed, billed, received, collected, or maintained together with or commingled with other revenues, collections, rights to payment, payments, money, or proceeds.

“Special contract” means the terms of a contract governing the supply of electricity that has been approved by the KCC that is not included in generally applicable rate schedules.

Financing Order

Application schedule for recovery of energy transition costs. The bill allows an electric public utility, in its sole discretion, to apply to the KCC for a financing order for the recovery of energy transition costs. In applying for the financing order, the electric public utility can file an application to issue securitized utility tariff bonds in one or more series; impose, charge, and collect securitized utility tariff charges; and create securitized utility tariff property related to the recovery of energy transition costs.

Within 25 days after a complete application is filed, the bill requires the KCC to establish a procedural schedule that requires the KCC to issue a decision on the application no later than 135 days from the date a completed application is filed.

The KCC is required to take final action to approve, approve subject to conditions the KCC considers appropriate and authorized by the bill, or deny any application for a financing

order in a final order, within 135 days of receiving a complete application as authorized by the UFSA. Such final order is subject to judicial review and deemed as arising from a rate hearing.

As a prerequisite of filing an application, the bill requires an electric public utility to obtain an order from the KCC under the KCC process for predetermination under KSA 66-1239 finding retirement or abandonment of the subject generating facility to be reasonable.

Application schedule for recovery of qualified extraordinary costs. The bill allows a public utility, in its sole discretion, to apply to the KCC for a financing order for the recovery of qualified extraordinary costs.

In applying for the financing order, the public utility can file an application to issue securitized utility tariff bonds in one or more series, charge and collect securitized utility tariff charges, and create utility tariff property related to the recovery of qualified extraordinary costs.

Within 25 days after a complete application is filed, the bill requires the KCC to establish a procedural schedule that requires the KCC to issue a decision on the application no later than 180 days from the date a complete application is filed.

The KCC is required to take final action to approve, approve subject to conditions the KCC considers appropriate and that are authorized by the bill, or deny any application for the recovery of qualified extraordinary costs and a financing order in a final order within 180 days of receiving a complete application as authorized by the UFSA. The final order is subject to judicial review and deemed as arising from a rate hearing.

Contents of financing order application. The bill outlines the requirements of the application, including these key elements:

- A description:
 - Of the electric generating facility or facilities that the electric public utility has retired or abandoned, or proposes to retire or abandon, prior to the date that all undepreciated investment relating thereto has been recovered through rates and the reasons for undertaking such early retirement or abandonment. If the electric public utility is subject to a separate KCC order or proceeding relating to such retirement or abandonment (predetermination under KSA 66-1239), the bill requires that application to include a description of the order or other proceeding; or
 - Of the qualified extraordinary costs that the public utility proposes to recover and how customary rate-making treatment of such costs would result in extreme customer rate impacts;
- A description of the securitized utility tariff costs the applicant proposes to recover with the proceeds of the securitized utility tariff bonds;
- An indicator of whether the public utility proposes to finance all or a portion of the securitized utility tariff costs using securitized utility tariff bonds. If the public utility proposes to finance a portion of the securitized utility tariff costs, the public utility is required to identify the specific portion in the application;

- By electing not to finance all or any portion of such securitized utility tariff costs using securitized utility tariff bonds, a public utility is not deemed to waive its right to recover or request recovery of such costs pursuant to a separate proceeding with the KCC;
- An estimate of the financing costs related to the securitized utility tariff bonds;
- An estimate of the securitized utility tariff charges necessary to recover the securitized utility tariff costs and all financing costs, the period for recovery of such costs, and a description of the proposed financing structure, including the proposed scheduled final payment dates and final maturity of the securitized utility tariff bonds; and
- A comparison between the net present value of the costs to customers that are estimated to result from the issuance of securitized utility tariff bonds and the costs that would result from the application of the traditional method of financing and recovering the undepreciated investment of facilities that may become energy transition costs from customers. The bill requires the comparison to demonstrate that the issuance of securitized utility tariff bonds and the imposition of securitized utility tariff charges are expected to provide net quantifiable rate benefits to customers or will avoid or mitigate rate impacts on customers.

Review and findings by the KCC. After notice and hearing on an application for a financing order, the KCC is authorized to issue a financing order if the KCC finds:

- Securitized utility tariff costs described in the application are just and reasonable; and
- Proposed issuance of securitized utility tariff bonds and the imposition and collection of securitized utility tariff charges are expected to provide net quantifiable rate benefits to customers when compared to the costs that would result from the application of the traditional method of financing and recovering the securitized utility tariff costs with respect to energy transition costs or avoid or mitigate rate impacts on customers.

The bill details the elements that must be contained in a financing order issued by the KCC in response to an application filed by a public utility, including these key elements:

- An approved customer billing mechanism for securitized utility tariff charges, including a specific methodology for allocating the necessary securitized utility tariff charges among the different customer classes, including special contract customers, and a finding that the resulting securitized utility tariff charges will be just and reasonable; provided that the amount of securitized utility tariff charges allocated to special contract customers in connection with the securitization of energy transition costs does not exceed the benefits from the retirement or abandonment of the subject electric utility generating assets that are assigned or allocated to special contract customers. The bill requires the securitized utility charges allocated to special contract customers as a result of a financing order regarding a retirement or abandonment be offset by net quantifiable rate benefits of at least the same amount. The initial allocation of securitized utility tariff

- charges remains in effect until the public utility files a general rate base proceeding;
- Once the KCC's order regarding the general base rate proceeding becomes final, the bill requires all subsequent applications of an adjustment mechanism regarding securitized utility tariff charges to incorporate changes in the allocation of costs to customers, as detailed in the KCC's order from the public utility's most recent general base rate proceeding;
 - A finding the proposed issuance of securitized utility tariff bonds and the imposition and collection of a securitized utility tariff charge are expected to provide net quantifiable rate benefits to customers as compared to the traditional methods of financing and recovering securitized utility tariff costs from customers or to avoid or mitigate rate impacts to customers;
 - An approved plan for the public utility, by means other than on the monthly bill, to provide information regarding the benefits of securitization obtained for customers through the financing order;
 - A finding that the structuring, pricing, and financing costs of the securitized utility tariff bonds are expected to result in the lowest securitized utility tariff charges, consistent with market conditions at the time the securitized tariff bonds are priced and the terms of the financing order;
 - A statement specifying a future rate-making process to reconcile any differences between the actual securitized utility tariff costs financed by securitized utility tariff bonds and the final securitized utility tariff costs incurred by the utility or assignee provided that any such reconciliation shall not affect the amount of securitized utility tariff bonds or the associated security tariff charges by customers;
 - In a financing order granting authorization to recover energy transition costs by issuing securitized utility tariff bonds, a procedure for the treatment of accumulated deferred income taxes and excess deferred income taxes in connection with the retired or abandoned, or to-be-retired or -abandoned, electric generating facility. The accumulated deferred income taxes, including excess deferred income taxes, shall be excluded from the rate base in future rate cases, and the net tax benefits relating to amounts that will be recovered through issuance of securitized utility tariff bonds shall be credited to retail customers by reducing the amount of such securitized utility tariff bonds that would otherwise be issued. The customer credit shall include the net present value of the tax benefits, calculated using a discount rate equal to the expected interest rate of the securitized utility tariff bonds, for the estimated accumulated and excess deferred income taxes at the time of securitization, including timing differences created by the issuance of securitized utility tariff bonds amortized over the period of the bonds multiplied by the expected interest rate on such securitization utility tariff bonds;
 - In the case of securitized utility tariff bonds issued to recover energy transition costs, provisions that specify the timing of rate-making and regulatory accounting

actions required by the financing order to protect the interests of customers and the electric public utility, which shall be limited to the following requirements, to the extent that the KCC:

- Has issued an order granting predetermination and prescribing rate-making parameters or regulatory accounting for retirement or abandonment of the subject electric public utility generating assets, then the electric public utility shall be permitted to implement and effectuate such rate-making parameters or regulatory accounting mechanisms; and
- Has not issued an order granting predetermination prescribing rate-making parameters or regulatory accounting to credit customers with the benefits from retirement of the subject electric public utility generating assets, then the KCC shall address such matters in the financing order and customers shall receive the benefits as determined by KCC order simultaneously with the inception of the collection of securitized utility tariff charges; and
- Any other conditions the KCC deems appropriate that are consistent with the bill.

A financing order issued to a public utility must permit, and may require the creation of, the public utility's securitized utility tariff property that is conditioned upon the sale or other transfer of the securitized utility tariff property to an assignee and the pledge of the securitized utility tariff property to secure securitized utility tariff bonds.

Annual filing. The bill requires a public utility that has been issued a financing order to file with the KCC, at least annually, an application or letter applying the adjustment mechanism based on estimates of consumption for each rate class and other mathematical factors and requesting administrative approval to make the applicable adjustments. The KCC's review of the filing is limited to determining if any mathematical or clerical errors are present in the application of the adjustment mechanism relating to the appropriate amount of any over-collection or under-collection of securitized utility tariff charges and the amount of an adjustment.

The adjustments ensure the recovery of revenue is sufficient to provide for the payment of principal, interest, acquisition, defeasance, financing costs, or redemption premium and other fees, costs, and charges with respect to the securitized utility tariff bonds approved under the financing order. Within 30 days after receiving a public utility's application or letter, the KCC is required to either approve the application or letter or inform the public utility of any mathematical or clerical errors present in its calculation, and, if there are errors, the public utility may correct its error and refile its request. The time frames previously described apply to the refiled request.

Irrevocability and KCC requirements. Upon the transfer of the securitized utility tariff property to an assignee or the issuance of securitized utility tariff bonds, whichever occurs first, a financing order becomes irrevocable. The KCC is prohibited from amending, modifying, or terminating the financing order by a subsequent action or reduce, impair, postpone, terminate, or otherwise adjust securitized utility tariff charges approved in the financing order, with the exception of changes made *via* the adjustment mechanism.

The public utility retains sole discretion on whether securitized utility tariff bonds should be issued after the issuance of a financing order. The KCC is required to afford the public utility flexibility in establishing the terms and conditions for the securitized tariff bonds to accommodate changes in market conditions.

Issuance advice letter. The public utility is required to provide to the KCC, to the extent requested and prior to the issuance of each series of bonds, an issuance advice letter following the determination of the final terms of such series of bonds no later than one day after the pricing of the securitized utility tariff bonds. The KCC has the authority to designate a representative from KCC staff to observe all facets of the process undertaken by the public utility to place the securitized utility tariff bonds to market so the KCC's representative can be prepared, if requested, to provide the KCC with an opinion on the reasonableness of the pricing, terms, and conditions of the securitized utility tariff bonds on an expedited basis. The form of such issuance advice letter must be included in the financing order and must indicate the final structure of the securitized utility tariff bonds and provide the best available estimate of total ongoing financing costs.

The issuance advice letter reports the initial securitized utility tariff charges and other information specific to the securitized utility tariff bonds to be issued, as the KCC may require. Unless an earlier date is specified in the financing order, the public utility may proceed with the issuance of the securitized utility tariff bonds unless, prior to noon on the fourth business day after the KCC receives the issuance advice letter, the KCC issues a disapproval letter directing that the bonds as proposed not be issued and including the basis for that disapproval.

In performing the responsibilities regarding the issuance advice letter, the KCC may engage a financial adviser and counsel as the KCC deems necessary.

An adversely affected party may petition for judicial review of the financing order.

Refinancing, retiring, or refunding securitized utility tariff bonds. The bill describes the process the KCC may commence for issuing a subsequent financing order regarding refinancing, retiring, or refunding securitized utility tariff bonds or any subsequent issue of a financing order.

KCC Powers and Duties

In exercising its powers and carrying out its duties regarding any matter within its authority, the KCC cannot consider:

- Securitized utility tariff bonds issued pursuant to a financing order to be the debt of the public utility other than for federal and state income tax purposes;
- Securitized utility tariff charges paid under the financing order to be the revenue of the public utility for any purpose; or
- Securitized utility tariff costs or financing costs specified in the financing order to be the costs of the public utility.

The bill states no public utility is required to file an application for a financing order. The KCC does not have the power to order or otherwise directly or indirectly require a public utility to use securitized utility tariff bonds to recover securitized utility tariff costs or to finance any project, addition, plant, facility, extension, capital improvement, equipment, or any other expenditure.

The bill outlines additional elements the KCC may not consider in the securitization application process. The KCC cannot approve an application for a financing order associated with an asset retirement or abandonment if the application does not establish that the securitization of the specified retired or abandoned generating facility provides net quantifiable rate benefits to customers as required under the UFSA.

Customer Energy Bills

The bill requires the customer bills of a public utility that has obtained a financing order and caused securitized utility tariff bonds to be issued to explicitly reflect that a portion of the charges on the customer bill represents securitized utility tariff charges approved in a financing order issued to the public utility, and, if the securitized utility tariff property has been transferred to an assignee, a customer bill must include a statement that the assignee is the owner of the rights to the securitized utility tariff charges and the public utility or other entity, if applicable, is acting as a collection agent or servicer for the assignee. The tariff applicable to the customer must indicate the securitized utility tariff charge and the ownership of the charge. The public utility is required to also include on the bill the securitized utility tariff charge on each customer's bill as a separate line item and include both the rate and the amount of the charge on each bill.

Failure to meet these requirements by the public utility does not invalidate, impair, or otherwise affect any financing order, securitized utility tariff property, securitized utility tariff charge, or securitized utility tariff bond.

Property Rights and Procedures

The bill states all securitized utility tariff property specified in the financing order constitutes an existing, present, intangible property right or interest, notwithstanding that the imposition and collection of securitized utility tariff charges depends on the public utility to which the financing order is issued performing its servicing functions relating to the collection of securitized utility tariff charges and on future electricity or natural gas consumption.

The bill describes the nature of securitized utility tariff property and the powers of a public utility to transfer, sell, convey, or assign the securitized utility tariff property. The bill describes the process of payment if a public utility defaults on any required remittance of securitized utility tariff charges and the process if a public utility reorganizes, becomes insolvent, files for bankruptcy, or is sold or merged with another entity.

Security Interest

The bill describes the timeline for creation, perfection, and enforcement of a security interest in the securitized utility tariff property and the conditions in which a security interest may be created. The bill states the security interest attaches without physical delivery of collateral or other act and is perfected upon the filing of a financing statement with the Office of the Secretary of State.

Sale, Assignment, or Other Transfer

The bill describes the requirements and process for any sale, assignment, or other transfer of securitized utility tariff property, the conditions under which a transfer of an interest in

securitized utility tariff property may occur, and when the transfer of an interest in securitized utility tariff property may be enforced.

Description of Securitized Utility Tariff Property

The bill outlines the description of a securitized utility tariff property that must be included when such property is transferred to an assignee in a sales agreement, purchase agreement, or other transfer agreement; granted or pledged to a pledgee in a security agreement, pledge agreement, or other security document; or indicated in any financing statement. The bill requires the description to indicate or describe the financing order that created the securitized utility tariff property and state the agreement or financing statement covers all or part of the property described in the financing order.

Financing Statements

The Secretary of State is required to maintain all financing statements filed to perfect a sale or other transfer of securitized utility tariff property and any security interest in securitized utility tariff property. All financing statements are governed by the Uniform Commercial Code.

Choice of Laws

The bill requires the laws of Kansas to govern the validity, enforceability, attachment, perfection, priority, and exercise of remedies with respect to the transfer of an interest or right or the pledge or creation of security interest in any securitized utility tariff property.

Liability of Securitized Utility Tariff Bonds

The bill provides securitized utility tariff bonds shall not be considered debts of the State; neither the State nor any political subdivisions, agencies, or instrumentalities of the State shall be liable for such bonds; and all securitized utility tariff bonds shall have on the face thereof the statement: "Neither the full faith and credit nor the taxing power of the State of Kansas is pledged to the payment of the principal of, or interest on, this bond."

Investment in Securitized Utility Tariff Bonds

The bill lists the entities that may legally invest in securitized utility tariff bonds.

Prohibited Actions

The bill lists the actions the State may not engage in, including impairing the value of the securitized utility tariff property and the securitized utility tariff bonds or the rights and remedies of bondholders, assignees, or other financing parties.

Discretion of Public Utility

A public utility has sole discretion to determine the method by which it expends or invests the proceeds received from the issuance of securitized utility tariff bonds.

Kansas Energy Security Act

The bill amends the Kansas Energy Security Act regarding the KCC procedure for rate-making and predetermination to add that, prior to retiring or abandoning a generating facility, or within a reasonable time after retirement or abandonment if filing before retirement or abandonment is not possible under the circumstances, a public utility may file with the KCC an application for a determination of rate-making principles and treatment. That determination will apply to recovery in wholesale or retail rates for the costs to be incurred by the public utility to acquire such public utility's stake in the generating facility or to reflection in wholesale or retail rates of the costs to be incurred and the cost savings to be achieved by the public utility in retiring or abandoning such public utility's stake in the generating facility, including, but not limited to, the reasonableness of such retirement or abandonment.

The bill amends certain provisions regarding KCC orders considering the retirement or abandonment of generating facilities.

Uniform Commercial Code

The bill amends provisions of the Uniform Commercial Code to reflect any new security interests that may be created under the provisions of UFSA.

Electric Vehicle Charging; HB 2145

HB 2145 exempts from the definition of "public utility" the marketing and sale of electricity purchased through a retail electric supplier in such supplier's certified service territory for the sole purpose of the provision of electric vehicle charging services to an end user.

Construction of Urban Electric Transmission Lines; HB 2321

HB 2321 requires certain electric utilities—all electric utilities excluding municipal utilities, electric cooperatives, or their subsidiaries—to take steps before exercising eminent domain to acquire an interest in land or beginning work related to the construction of an urban electric transmission line. For the purposes of the bill, "urban electric transmission line" means any line or line extension that is at least 2.5 miles in length; traverses at least 2.5 contiguous miles through a city of at least 300,000 people; and is designed to transfer at least 69, but less than 230, kilovolts of electricity.

Electric utilities are required to:

- Provide notice to the city in which the project is proposed at least six months prior to construction with preliminary plans, including the locations and dimensions of equipment to be installed relative to existing infrastructure, with visual examples;

- Conduct an open house in such city that:
 - Allows affected landowners to provide public comment;
 - Is attended by a commissioner and a staff person of the Kansas Corporation Commission (KCC); and
 - Is held on a weekend day or after 5:00 p.m. on a weekday;
- Provide notice of the proposed construction and open house to:
 - All landowners and tenants of property within 660 feet of proposed improvements;
 - The governing body of the city and its infrastructure planning authority; and
 - The KCC;
- Publish notice of the time, place, and subject of the open house in a local newspaper; and
- Obtain any required permits.

Provisions of the bill do not apply to construction or repair required due to physical damage.

Kansas Corporation Commission Regulation of Wire Stringing Activities; HB 2367

HB 2367 amends law to clarify the Kansas Corporation Commission has authority to regulate the activities or facilities of an otherwise jurisdictional entity with regard to wire stringing along or across streets, highways, or public places.

**NUMERICAL INDEX OF BILLS
House Bills and Resolutions**

<u>Bill</u>	<u>Page</u>	<u>Bill</u>	<u>Page</u>
HB 2008.....	55	HB 2162.....	20
HB 2014.....	66	HB 2172.....	4
HB 2022.....	78	HB 2178.....	56
Sub. for HB 2049.....	55	HB 2214.....	56
HB 2050.....	55	HB 2227.....	40
HB 2063.....	42	HB 2238.....	57
HB 2070.....	18	HB 2270.....	35
Senate Sub. for HB 2072.....	80	HB 2295.....	67
HB 2078.....	39	HB 2298.....	57
HB 2085.....	18	HB 2321.....	90
HB 2101.....	18	HB 2367.....	91
HB 2112.....	7	HB 2379.....	67
HB 2124.....	19	HCR 5003.....	1
HB 2126.....	39	HCR 5015.....	20
HB 2145.....	90	HR 6009.....	58
HB 2155.....	3	HR 6015.....	38

**NUMERICAL INDEX OF BILLS
Senate Bills and Resolutions**

<u>Bill</u>	<u>Page</u>	<u>Bill</u>	<u>Page</u>
SB 13.....	59	SB 65.....	8
SB 14.....	45	SB 66.....	8
SB 15.....	22	SB 77.....	36
SB 21.....	61	House Sub. for SB 88.....	32
SB 24.....	75	SB 90.....	10
SB 27.....	2	House Sub. for SB 99.....	65
SB 33.....	65	SB 118.....	54
SB 37.....	27	House Sub. for SB 124.....	10
SB 40.....	46	SB 172.....	75
SB 50.....	61	SB 283.....	6
SB 52.....	52	SR 1707.....	38
House Sub. for SB 63.....	14	SR 1717.....	38
SB 64.....	14		

Executive Reorganization Orders

<u>Bill</u>	<u>Page</u>
ERO 48.....	43

Kansas Legislative Research Department

Conference Committee Report Briefs:

[http://www.kslegresearch.org/KLRD-
web/CCRB.html](http://www.kslegresearch.org/KLRD-web/CCRB.html)

**Getting Things Done:
Overcoming Stress and
Managing Productivity**

Presented By:

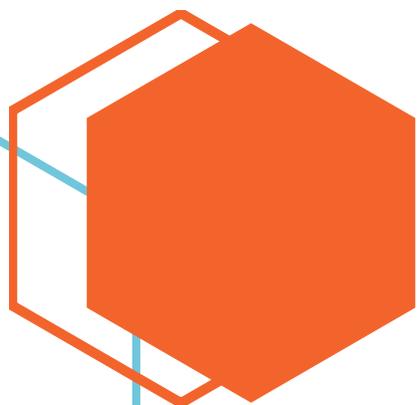
**Danielle Hall,
Executive Director
Kansas Lawyers Assistance Program**



Getting Things Done

**Overcoming Stress and
Managing Productivity**

Danielle M. Hall, Executive Director
Kansas Lawyers Assistance Program





STRESS, BURNOUT, AND WORK-LIFE BALANCE

Burnout vs. Stress

Burnout has become such a familiar term that it's common to hear people casually say, "Oh, I'm so burned out," when they're merely referring to a bad day or a bad week. But for those who truly are burned out, it is much more than a bad day or a bad week. It's a problem that significantly interferes with one's health, happiness, and overall quality of life.

Stress, on the other hand is a general feeling of emotional or physical tension. It is a normal reaction in the body. In fact, the body is designed to experience stress and react to it. Stress can at times be positive. For example, if you have something significant you are working on and it is due, a stress response might help the body work harder and stay awake longer. Some go as far as saying stress can even be good for us in small doses. When stress,



however, begins to continue without periods of relief, that is when it can be dangerous and lead to other emotional and physical concerns. Stress exists on a continuum, and it's important to know your place on it as you get more work, finish projects, meet with clients, and generally go about your day. If not, chronic workplace stress can lead you down a path to burnout.

The term "burnout" was coined in the 1970s by the American psychologist Herbert Freudenberger. He used it to describe the consequences of severe stress and high ideals in "helping" professions. Burnout is a state of emotional, mental, and physical exhaustion caused by excessive and prolonged stress. It can negatively affect both your work and your life. As the stress continues, you begin to lose the interest or motivation that led you to take on a certain role in the first place.

There are many contributing factors that can lead to burnout. Work-related causes of burnout can include:

- Feeling like you have little or no control over your work
- Lack of recognition or rewards for good work
- Unclear or overly demanding job expectations
- Doing work that's monotonous or unchallenging
- Working in a chaotic or high-pressure environment

Burnout is a gradual process, however, that occurs over an extended period. It doesn't happen overnight, but it can creep up on you if you're not paying attention to the warning signals. The signs

Getting Things Done



and symptoms of burnout are subtle at first, but they get more pronounced as time goes on. Here are the signs and symptoms to watch out for:

Physical	Emotional	Behavioral
Feeling tired and drained most of the time	Sense of failure and self-doubt	Withdrawing from responsibilities
Lowered immunity, feeling sick a lot	Feeling helpless, trapped, and defeated	Isolating from others
Frequent headaches (migraines), back pain, muscle aches	Detachment, feeling alone in the world	Procrastinating, taking longer to get things done
Change in appetite or sleep habits	Loss of motivation	Using food, drugs, or alcohol to cope
	Increasingly cynical and negative outlook	Taking out frustrations on others
	Decreased satisfaction and sense of accomplishment	Skipping work or coming in late and leaving early

If you can relate to any of these signs and symptoms and are wondering if you might be suffering from burnout, here is an easy test you can try. The first step is to completely commit to treating yourself to a relaxing, stress-free weekend. Try to sleep in both days. Eat right. Occupy your time with relaxing activities that you rarely allow yourself to enjoy. Whatever you do, it is important that you fully commit to relaxing. If on Monday morning, you wake up tired and dreading your day, you may be suffering from burnout. The next step is to take more time off, remove all the stressors, and add stress reducers. If after you take a longer vacation—a week or even two weeks—and you are still dreading going into the office and are waking up tired, it is likely time you seek professional help and make significant changes for your well-being.

The key to dealing with stress and preventing burnout out is to implement coping strategies that allow you to effectively handle stress when it comes your way. Building your resiliency skills is also imperative to your overall wellness. Additionally, adopting healthy habits and practices are important. Lastly, setting boundaries can help you to achieve a better work-life balance, ultimately reducing your stress.



Work-Life Balance

Simply put, work-life balance is a state where a person equally prioritizes the demands of one's career and the demands of one's personal life. Obtaining work-life balance is important to help lawyers stay healthy and engaged in their work. Balance, however, can mean different things for different people. For some, work is everything. While for others work is good but spending time with family and friends is more important. Some of us want time to focus on activities that bring us enjoyment, such as reading, art, or music. Some of us want more time to focus on our physical health through exercise. Others may just need more time for rest and relaxation. Ultimately, it is important to figure out what's important to you before determining what work-life balance means for you.

Depending on where you are professionally, achieving a work-life balance may seem hard and unrealistic, but it is important. If you are teetering and fail to find some level of work-life balance, consequences may follow. Some of these consequences can include:

- **Fatigue** – If you are in a state of being constantly tired, then your ability to work productively and think clearly may be reduced over time. Fatigue can also affect your ability to competently represent your clients and mistakes can occur.
- **Lost Time** – If you are struggling to find balance, you might feel as though you have lost time with your loved ones. Maybe you missed milestones with your children. You might also feel like you have lost time to do the activities that bring you enjoyment.
- **Increased Expectations** – Working extra or odd hours may lead to increased expectations or responsibilities. Keep in mind that once you have established a pattern, it is often harder to reverse course.
- **Physical Health Risks** – If you are struggling to find work-life balance, chances are you are feeling stressed and you might also be getting less sleep since there is a direct correlation between stress and sleep. If so, your physical health can certainly be impacted. Studies show that stress and a lack of sleep can lead to conditions such as stroke and heart disease.
- **Mental Health Risks** – Just as with an increased risk to your physical health, a work-life imbalance can also lead to an increased risk to your mental health. Work-life imbalance can lead to stress, burnout, and an increased risk for depression and anxiety.
- **Negative Effects on Relationships** – In addition to feeling like you have lost time with your loved ones, a work-life imbalance can also lead to strains on your relationships.

“Work-life balance is equally prioritizing the demands of one’s career and the demands of one’s personal life.”



Knowing that it is important for our overall health and well-being, you might now be thinking how do we *actually* achieve a work-life balance? First, start thinking about this in terms of work-life harmony, rather than balance. Sometimes, we deem balance to mean 50/50. For most, 50/50 is not always going to be attainable and when it doesn't happen, we let our perfectionist brains take over and then we get disappointed and feel as though we failed. Then we give up as we start feeling it isn't possible. By thinking about achieving work-life harmony, we allow ourselves some room to breathe. Our schedules will ebb and flow. Some weeks will be better than others, but ideally, we should be in a state of harmony with our work and with our life outside of work. Additionally, identifying what work-life balance (or harmony) looks like for you is important. What it is for me, may be something completely different for you.

After we define what work-life balance looks like, then you start setting boundaries and minimizing interruptions throughout your day, both of which should lead to taking back your calendar and most importantly your time. Once your boundaries are set, however, you must then stick with them. Otherwise, your boundaries may quickly go out the window. For example, if you set a communication boundary establishing you will not answer emails after 7 p.m., but then begin to answer a client's emails after 7 p.m. on a few select nights, those few nights can quickly become every night. The client's expectations will change and the next thing you know you have no boundaries with this client. So, keep this in mind, setting a boundary and then not enforcing it is to have no boundary at all.

OVERCOMING WORK RELATED STRESS

Cross Examine Your Own Thinking

Stress can be caused by several different factors. Many of these factors can be obvious ones, such as a difficult project at work, making a financial decision, or getting into an argument with someone. But stress can also be caused by less obvious factors, such as negative thoughts and feelings. You might not even notice you are having these feelings. We all give power to our thoughts, both positive and negative. Those thoughts lead to emotions and then to actions (or inaction). Sometimes, we just need to cross-examine our thinking to shift our outlook. This shift can help with producing better results, including getting things done.

The next time you are stressed and overwhelmed at work, I want you to think about these five components: Circumstances, Thoughts, Feelings, Actions, and Results.

- Circumstances – Circumstances include events that happen, things people say, and actions people take. Circumstances are often beyond our control. They are measurable facts, free from qualifiers.
- Thoughts – Thoughts can be positive or negative. They either serve you, or they do not. Our thoughts often give meaning to our circumstances.



- Feelings – Feelings are one-word emotions that we experience as vibrations through our bodies. Much like your thoughts, feelings can be either positive or negative. Your feelings are experienced in response to your thinking.
- Actions – Simply put, actions are the behaviors you take or don't take based upon your feelings. These actions can be put into three categories: overt action, reaction, and inaction.
- Results – Results are the effects of your actions.

First, it's important to recognize what you can and can't control under any given circumstance. When you begin focusing your time and energy only on things you can control—and stop worrying about what you can't—it can help you feel better about a situation or circumstance, because you spend your efforts only on what you can change or impact.

A lot of this, however, comes down to shifting the way we think about circumstances, especially when our minds go to the worst of the worst thoughts. It's often those thoughts that begin to make us feel stressed and maybe even anxious. So, ask yourself 1) is this thought true, and 2) why am I choosing this thought?

We might often think it is a particular circumstance that causes a feeling, when in fact it is our thoughts about that circumstance that is causing the feeling. These feelings can then dictate your actions, so if your thinking a negative thought and feeling a negative feeling, you will then react negatively. You might also take no action—think procrastination.



Often, when we are avoiding a particular task or circumstance, it is not the task or circumstance we are avoiding. Instead, it is the feelings we are trying to avoid. In these instances, we need to shift our thoughts about the circumstance or task from negative to positive, if we want positive results. This concept even applies to the work we are avoiding.

Eliminating Distractions

Distractions—they seem to be everywhere, especially in our hyper-connected world. We are all familiar with what our distractions are and we all more than likely loathe them. While our distractions may be different in nature, they happen daily for many of us and can be our biggest productivity killer.

Getting Things Done



A 2016 CareerBuilder [survey](#) identified cell phones and texting as the biggest distraction and productivity killer at work. The next biggest distraction? The internet. Also making the list, social media and email. Of the employers who took the survey, over half reported their companies losing between one and two hours of productivity a day because of distracted employees.



In 2017, researchers at The McCombs School of Business at The University of Texas at Austin released a [study](#) comprised from a series of experiments that were conducted on 800 smartphone users in an attempt to measure how well people complete tasks when their phones are nearby. Researchers asked participants to perform a concentration test in four different scenarios: with their smartphone in their pocket, on their desk, locked away in a drawer, and in another room. Test results were

lowest when the smartphone was on the desk, but with every additional layer of distance between participants and their smartphones, test performance increased. Overall, test results were 26 percent higher when phones were removed from the room entirely. The key takeaway finding from the study, however, is that your cognitive capacity is significantly reduced when your smartphone is within reach—even if it is off.

In addition to the cellphone, email can be a leading cause of distraction for many. According the [Harvard Business Review](#), the average professional spends 28% of the workday reading and answering email. That can amount to 2.6 and 120 messages received per day. This just might be the reason so many lawyers report email as a number one contributor to stress and frustration.

In addition to email, several digital work tools are now available on our phones, desktops, and watches leaving us vulnerable to distraction. These tools or apps encourage us to graze from item to item as we switch back and forth. In fact, it is [reported](#) by ZDNet.com, 68% of workers switch apps 10 times an hour. It is surprising that any of us get anything done. Research shows that even the smallest distractions can cause a person to take longer to complete a task. Not only does it extend the length of time it takes to complete tasks, but it can also decrease the quality of their work.

Reducing Clutter

Research tells that us that our physical environment in our workplace has a significant effect on the way we work. If we think about this logically it makes it sense. If you can't find something on your desk, you spend precious time looking for it. That of course is an example of how clutter can affect you directly, but there are also indirect ways it can affect us.



[Research](#) recently highlighted by the Harvard Business Review shows that our physical environments can also influence our cognition, emotions, and behavior. Your environment can also affect your anxiety levels, sleep, and productivity levels. So, what does this mean for your work? [Scientists at the Princeton University Neuroscience Institute](#) have used fMRI and other approaches to show that our brains like order and constant visual reminders of disorganization drain our cognitive resources and reduce our ability to focus. They also found that when participants cleared clutter from their work environment, they were better able to focus and process information and their productivity increased.

In their book, [How to Do More in Less Time](#), law practice management and technology experts Allison Shields and Daniel Seigel point out, clutter:

- wastes time;
- wastes money;
- creates distraction;
- waste energy; and
- can be scary.

When I read that last one—clutter can be scary—it caught my attention. As I thought about this, it makes sense. I talk to so many lawyers who have said, “things just piled up and I didn't know where to start, so I just walked away.” The problem is leaving those piles unattended can lead to issues later, possibly even ethical violations. In their book, Shields and Seigel explain the piles on your desk can seem daunting. You might not know what lies within and that can be scary. You can't, however, continue to ignore those piles. This is not an out of sight out of mind circumstance. The more you let pile up, the scarier it can get, and the more distraction it can also cause. Putting a plan in place to tackle the clutter (and the piles) can assist you in ultimately alleviating the distraction and avoid further problems down the road.

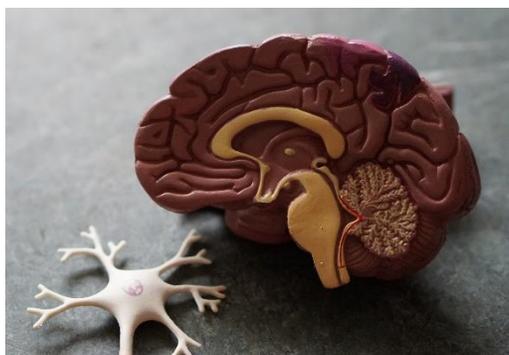
SHALLOW VS. DEEP WORK

The concepts of shallow work and deep work come from productivity expert and Georgetown University professor, Cal Newport. Newport published a book titled [Deep Work: Rules for Focused](#)

[Success in a Distracted World](#). In the book, he explains the two types of work. Here are brief explanations:

- Shallow Work – Non-cognitively demanding, logistical-style tasks, often performed while distracted. These efforts tend to not create much new value and are easy to replicate.
- Deep Work – professional activities performed in a state of distraction-free concentration that push your cognitive capabilities to their limit. These efforts can improve your skills.

There is an obvious parallel between deep work and the work we do as lawyers. For instance, items such as writing briefs and motions or preparing for a hearing or trial are prime examples of the deep work we do. We also do shallow work, however, that distracts us from the deep work. For instance, rapid fire communication, social media, and basic busy tasks often serves as a proxy for productivity. To some degree the technology that we rely upon—especially in the form of emails—has the potential to interfere with the actual work of lawyering. If you have ever asked yourself, “Where has my day gone and what do I have to show for it?” Chances are, you fell victim to shallow work.



So, what happens when you go back and forth throughout your day between the shallow and deep work? This cognitive switching is absolutely draining. Draining on your time and draining on your energy. It also doesn't equate to increased productivity. Think about your brain for a second and the havoc this cognitive switching can wreak on an individual. To grasp this concept, I ask you to think about your brain like a computer. A computer processes information and performs specific tasks. What happens to computers when we have multiple programs running, multiple tabs open, and are running things in the background? More than likely it will start to eventually run at a slower pace. It might even stop working properly all together if we continue to push the machine in this manner. The same thing can happen to you unless you make changes and operate differently.

The good news is that deep work isn't about working harder or longer. Instead, it is about working smarter, being less reactive, and changing the focus of your schedule to prioritize the highest value tasks. Focusing on deep work means you are intentional about how you spend your time. You stop working in a state of perpetual distraction.

There are great benefits to developing your skill sets to focus on deep work. Not only does it do the obvious—increase your productive and focus—but it also provides other benefits. First, it is a skill set that seems hard to come by nowadays and as a result, makes you a highly marketable worker. Additionally, you will improve your overall satisfaction at work and improve your sense of self. Having



the ability to accomplish difficult and meaningful tasks can lead to an increased sense of self-value, which ultimately leads to more feelings of happiness and having purpose.

TIME MANAGEMENT

According to [Mindtools](#), time management is the process of organizing and planning how to divide your time between specific activities. Good time management enables you to work smarter – not harder – so that you get more done in less time, even when time is tight, and pressures are high. Time management, however, seems to be one area many lawyers struggle with. Part of the reason is those distractions we discuss above. To some degree, it is also affected by our inability to set boundaries with others to stick to the schedules we promise ourselves.

Having poor time management skills can also affect your ethical obligations. When I worked for the Kansas Office of the Disciplinary Administrator, we saw many instances of poor time management and organizational skills playing a role in violations. I particularly noted time management skills can affect our abilities to adhere to our duty of:



- Competence –KRPC 1.1 states, “A lawyer shall provide competent representation to a client. Competent representation requires the legal knowledge, skill, thoroughness and preparation reasonably necessary for the representation.
- Diligence – KRPC 1.3 states, “A lawyer shall act with reasonable diligence and promptness in representing a client.”
- Communication – KRPC 1.4 states, “A lawyer shall keep a client reasonably informed about the status of a matter and promptly comply with reasonable requests for information.”

These rules collectively suggest lawyers should exercise time management skills to meet their obligations to their clients. Comment [2] to KRPC 1.3, takes it a step further by stating, “Perhaps no professional shortcoming is more widely resented than procrastination. A client's interests often can be adversely affected by the passage of time or the change of conditions...”

In addition to meeting your baseline obligations, lawyers who are organized and have good time management skills are likely to work more productively and utilize their other skill sets more effectively. Ultimately, having good time management skills leads to better client service and increases in your bottom line.

Time Management Techniques

If you find yourself struggling to stay on top of things, implementing a time management technique can be useful. Something to remember, however, is this is not a one size fit all sort of situation. Sometimes, finding the right time management technique takes trial and error until you find one that works specifically for you. Below you will find a few of my favorite techniques followed by other time management tips and tools to try.

The Pomodoro Technique

This time management method was developed by Francesco Cirillo in the late 1980s and is named after the tomato-shaped kitchen timer which was used by Cirillo as a university student. (Pomodoro is Italian for tomato.) The idea behind the technique is simple: you set a timer for 25 minutes and work on only one thing for the duration of that time. When the timer rings, you reward yourself with a short break. This technique forces you to focus on that one task for a set period, while taking breaks to avoid mental fatigue. For instance, rather than working on a brief until it is "done," you work on it until your 25 minutes is up. Then, you get up and stretch (or whatever else you like to do on a break) for 5 minutes. Once your break is over, you go back to working on the brief for another 25 minutes, and so on, until you complete 4 pomodoros (25-minute segments). After completing 4 pomodoros, you take a longer 20-30 break.

The goal should be to work towards task completion to meet your daily goals. As a result, first you will need to create a prioritized task list to determine what your workday will include. Using the task list and implementing the Pomodoro Technique should help you to avoid interruptions and distractions while improving your concentration. The more you can concentrate, the more work you should be able to complete. The key, however, is to not fall victim to checking your email, looking at social media, or chitchatting during the pomodoro.

If you want to try implementing this simple time management technique, here is quick recap:

- Pick a task.
- Set a time to 25 minutes and focus on that task for the entire 25 minutes.
- When the 25 minutes is up, take a short 3-5 min break.
- After 4 pomodoros, take a longer 20-30 min break.



A kitchen timer (or [Google's Built-in Timer](#)) will do the trick, but if you are looking for something more hi-tech to use, there are plenty of Pomodoro



Technique apps out there for both Apple and Android devices. There are also Chrome apps available to use with your Chrome web browser, some of which allow you to block websites during use.

Here are a few apps:

- [PomoDone](#) (Web, Mac, Windows, Linux, iOS, Android)
- [Focus Booster](#) (Web, Mac, Windows, iOS, Android)
- [Focus To-Do: Pomodoro Timer & To Do List](#) (Mac, Windows, iOS, Android)
- [Focus Keeper](#) (iOS)
- [Pomodor](#) (Web)
- [Pomofocus](#) (Web)

To read more about the Pomodoro Technique visit <https://francescocirillo.com/pages/pomodoro-technique>.

The Quadrant Method

This time management method developed by speaker and author, Stephen Covey. The quadrant method takes your linear to-do list and asks you to split the items up into two buckets: what's important and what is not. From there you split the tasks even further into what is due soon and what is due later. Here is what should be included in each of your quadrants:

- **Quadrant 1** would include only those activities that need your immediate attention. This space should stay reserved for emergencies and extremely important deadlines. When you start your day, you know where to work first: the upper left corner in Quadrant 1.
- **Quadrant 2** should be comprised of things that are important to you and your business but need not be done until a later date. A good example for this quadrant would be something like strategic planning.
- **Quadrant 3** would contain items that are more than likely interruptions in your day. Items like emails, phone calls, some meetings. Setting aside a time to specifically handle these interruptions at one time should save you some time in your day and allow you to focus on Quadrant 1 tasks. Delegation may also be an option for some of your Quadrant 3 tasks.
- **Quadrant 4** activities are those that waste your time and offer no value. These are the tasks you want to eliminate. Think: surfing the internet or social media.



Here is a sample:

	Urgent	Not Urgent
Important	<p>Quadrant 1</p> <ul style="list-style-type: none"> • Crisis • Pressing problems • Deadline driven projects • Last minute preparation <p>Strategy: Just Do It Key Action: Manage</p>	<p>Quadrant 2</p> <ul style="list-style-type: none"> • Relationship building • Finding new opportunities • Long-term planning • Preventive activities • Preparation and planning <p>Strategy: Schedule It Key Action: Focus</p>
Not Important	<p>Quadrant 3</p> <ul style="list-style-type: none"> • Interruptions • Distractions • Certain emails, calls, meetings • Urgency masquerading as importance <p>Strategy: Delegate or Push Back Key Action: Use Caution</p>	<p>Quadrant 4</p> <ul style="list-style-type: none"> • Time wasters (but maybe pleasant) • Busy work • Escapist activities • Mindless activities – surfing the net <p>Strategy: Don't Do It Key Action: Avoid</p>

You should find that most of your time is spent in Quadrants 1 and 3; however, having a more organized and prioritized list should open time in your schedule to work on Quadrant 2 tasks, allowing time to focus on items that enhance your skills and your business.

Calendar Blocking

Calendar Blocking is a relatively simple time management technique. Essentially, you take your calendar and block out every hour to totally coordinate your day. Do you have a brief or motion to work on? Block that out on the calendar to ensure you have designated time to work on it. Would you like to exercise more? Block it out on the calendar. Do you have meetings? Of course, get those on the calendar, too. The other key to calendar blocking is setting aside time in your day to deal with the distractions (or chaos). For instance, block out time that you will dedicate to responding to emails and phone calls.

Why do I like calendar blocking so much? It allows you to take your calendar back. Too often, we allow others to dictate *our* calendars in their entirety. If you always find yourself in a state of responsiveness to others, calendar blocking might be the right time management technique to try.



To learn more about calendar blocking visit:

- [Build the life you want to build with a block schedule part 1](#) from Solo Practice University.
- [Build the life you want to build with a block schedule part 2](#) from Solo Practice University.

Other Time Management Tips and Tools

- **Use a calendar** – There are few things to keep in mind with your calendar: 1) consider using a macro and a micro calendar to get a clearer picture of your schedule and what is to come; 2) consider using time blocks on your calendar; and 3) make some room on your calendar as it shouldn't all be filled with entries.
- **Make to-do lists** – If a daily list seems overwhelming and never-ending, consider the power of three. In their book, Shields and Daniels recommends instead of focusing on your entire to-do list, use the power of three to help you prioritize. A few examples include choosing three big goals where each of those big goals will have objectives or many action steps to give you a list of to-dos. The other thing you can do is identify your top three tasks on your list, focus your energy on completing those items. This can result in a sense of accomplishment when you complete the three tasks, despite having other items left on the list.
- **Make to-don't lists** – a to-don't list is your list of tasks you are going to stay away from or delegate. If you are constantly giving in to the distractions, having a to-don't list can serve as a reminder about what to stay away from.
- **Don't answer email first things in the morning** – There is a simple and logical explanation for this recommendation. When you start your day by answering emails you are starting with other people's problems or tasks, rather than your own. If possible, spend the first hour of the day focusing on something you need to accomplish. This will allow you to take ownership of your day, rather than being so responsive to others. Also, consider blocking of time on your calendar specifically for email, this will allow you to eliminate it as a distraction.
- **Delegate when appropriate** – You don't need to do everything! I know that comes as a shocker, but it is true. Some of the most successful leaders are those who know how to appropriately delegate throughout the day. Find the tasks or the distractions that you can delegate to others and let them help you. This will also let you focus on the higher-level work you need to get done.
- **Eliminate clutter** – As we discussed the above, organization and time management go hand and hand. Part of the process of getting rid of the clutter is implementing some organization and/or processes within your practice. For instance, if you have a paper clutter problem, you might want to implement a scanning process for documents. Is the mail piling up? Then you might need to implement some processes for opening mail. Once you implement processes, start eliminating the clutter. This comes down to sorting it and clearing it out.

Getting Things Done



- **Have processes in place** – A lack of processes can create chaos, so find key areas that you can streamline. For instance, do you have a process for client intake, file retention and destruction, and billing. Start by making a list of your current processes and ask yourself are you doing those well. Note any major problems areas you need to address.
- **Utilize technology** – Technology can be a great ally in managing your schedule. There are many different applications out there that can set appoints, send you reminders, sync with your calendar, or manage a project. The most important thing is finding the technology that works best for you. Just like time management techniques, technology is not a one size fits all. I would recommend, if given the opportunity, take a test drive of the application before committing long term. The last thing I will mention about technology is that increasing your skill sets with the technology will go a long way with eliminating issues that waste time. Additionally, our ethical rules remind us that we have a duty to be competent with our use of technology per Comment [8] of KRPC 1.1.
- **Leave time for self-care** – You need a break and that is OK. We are not robots and we should not expect ourselves to be. An important aspect for productivity includes leaving time for self-care. Sleep, rest, and taking breaks will improve your focus and concentration, enabling you to complete your work more efficiently. Research has shown all-nighters to be counterproductive, so give yourself permission to take breaks to re-energize. Eating well and exercise can give you the boost you need to get through your task.

**Effective Legal Writing
for the Digital Audience**

Presented By:

**Hon. Sarah E. Warner
Kansas Court of Appeals**

Effective Writing for a Digital Audience (in a hybrid world)

Hon. Sarah E. Warner
Kansas Court of Appeals
April 2021

The Reality

An electronic brief is more
than a PDF printout of a paper brief.

The mechanics of electronic and paper briefs are all the same (required sections, page limits, font requirements, etc.).

But the reader of an electronic brief processes the information differently.

Examples:

- No easy method of flipping back and forth between sections.
- Justified margins are harder to read on a screen.
- Footnotes are the bane of a digital reader's existence.

The Problem

How do you effectively convey your position to a
(partially) digital audience without losing the
persuasive power of a paper brief?

Put another way, how can you adapt your writing within the existing rules so that it will be equally compelling in both digital and paper form?

The Point

Effective brief writing in a hybrid world requires a
reexamination of attorneys' traditional practices—in
terms of both *form* and *substance*.

Digital Formatting Tips

This is not just about making your brief look "fancy" or "lawyerly." The form of your brief is a persuasive tool.

Below are a few easy (and a few controversial) formatting suggestions for immediate improvements.

Easy changes that will make all the difference:

- Avoid ALLCAPS and underlining like the plague. These are hard to read in digital form and cause your reader to skip the information you're attempting to emphasize. This tip applies across the board—for emphasis, case names, issue statements, and headings.
- Avoid fully justified margins; judges across the board prefer ragged right margins because they're easier to read.
- Use *italics* for emphasis and case names. Use **bold** sparingly and only for headings (not for emphasis); it is distracting. Never use the two together.
- Organize your brief mindfully, and choose a numbering system that reminds the reader where he or she is within the structure of your brief. (In other words, adopt a nested numeric format—1., 1.1, 1.1.1.—instead of a traditional outline system with Roman numerals and letters.)
- Don't overlook the power of a well-constructed Table of Contents.
- Remember that white space, when used consciously, provides judges an important opportunity to think and to reflect on your position.

And a few *outside-the-box formatting suggestions* for advanced writers:

- Placing important statutory language in the corner of every page where it might be relevant and helpful to the discussion.
- Using tables for comparison.
- Choosing a font type and size that is easier to read in digital form—maybe even (gasp!) a sans serif font.

Substantive Suggestions to Improve Your Writing (in both digital and paper form)

The #1 improvement on judges' wish lists, regardless of court or subject matter, is for lawyers' writing to be *more concise*.

This is particularly important for the digital reader, who reviews a document progressively (from beginning to end) and does not have an opportunity to physically flip between sections. Convey your point early and effectively.

A note about terminology:

Conciseness \neq Brevity (though there is often a correlation between the two).

Conciseness is saying everything you need
without distractions or clutter.

In a nutshell, conciseness

- implicates organization, word choice, editing, and polish;
- involves a thoughtful consideration of your brief as a persuasive whole (not just its individual parts);
- requires an understanding of who your audience is (judges, clerks) and how they consider the information you provide.

Does everything in your brief "spark joy meaning"?

To this end, there are three sections where you can make immediate and marked improvements in every brief:

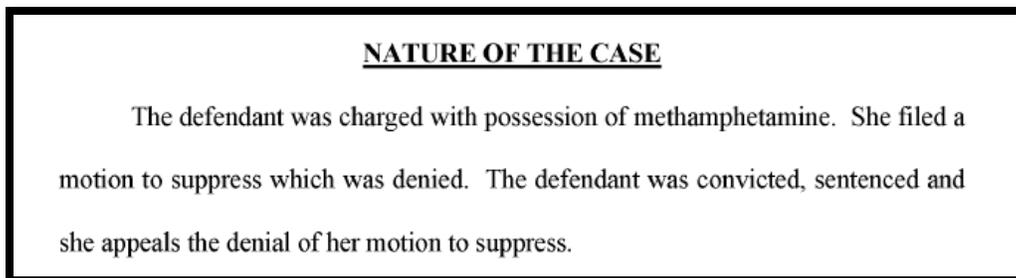
- Nature of the Case
- Statement of the Issues
- Conclusion

Nature of the Case

Defined in Supreme Court Rule 6.02(a)(1)(2) (Appellant's Brief):

- "A brief statement of the nature of the case—e.g., whether it is a personal injury suit, injunction, quiet title, etc.—and a brief statement of the nature of the judgment or order from which the appeal was taken."
- Nothing about Appellee's Brief. But see Rule 6.03(a) ("An appellee's brief must contain"—not must *only* contain—"the following . . .").

Typical example—and missed opportunity:



Questions for consideration:

- Is this an appellant's or appellee's brief?
- What are the important issues we will be considering?
- Are there facts that we should be watching for?
- Does this inspire active/engaged reading or a passive, surface review?

The Nature of the Case (or Introduction/Overview) is the opportunity to provide an executive summary and frame your case before the judges read further.

- What is this case about?
- Who are the key players?
- What are the salient issues we will be discussing?
- Why should the court be interested in resolving the case in your favor?

These same principles apply in a Prayer for Review (Petition for Review) or an Introduction/Overview (if you represent the appellee or respondent).

Another example:

This is a case about fault. The wrongful-death action underlying this garnishment arose out of a farm accident. In that case, there were three parties whose actions could have contributed in some way to the accident: the decedent, the decedent's father (██████████ insured), and the farm-equipment manufacturer. A few months before trial, the father gave a \$1,500,000 consent judgment to the plaintiffs—his adult grandchildren and daughter-in-law—in exchange for a covenant not to execute against his personal assets. The consent judgment approved by the district court made no finding as to any party's negligence, but remained silent on these issues so the plaintiffs could litigate their claims against the manufacturer at trial. In fact, the district court explicitly noted it had not made any finding regarding the father's fault in approving the \$1,500,000 judgment.

Because there were other claims of fault, the case proceeded to trial. After the jury heard all the facts, it concluded *none* of the three parties were at fault for the accident. The plaintiffs then brought this garnishment action against ██████████ in an attempt to recover the \$1,500,000 plus interest and attorney's fees. On appeal, the Court of Appeals correctly recognized that under Kansas law, judgments must reflect the degree of the parties' comparative fault. Because the consent judgment against ██████████ lacked this essential element, the Court of Appeals held it was not enforceable against ██████████.

This well-reasoned decision does not warrant this court's review. Rather:

- Comparative fault is well-established in this state; the unpublished Court of Appeals' opinion in this matter creates no new rule of law. Instead, it correctly applies the analysis adopted by this court's previous case law.
- This case does not present a matter of public concern or repeatability. The plaintiffs have cited no other case where parties have attempted to take a judgment against a defendant without assessing fault. In fact, Kansas law specifically proscribes the claim-splitting attempted by the plaintiffs here.

The Nature of the Case section should stand alone on one (and only one) page. Use this opportunity to immediately engage your reader and frame your case.

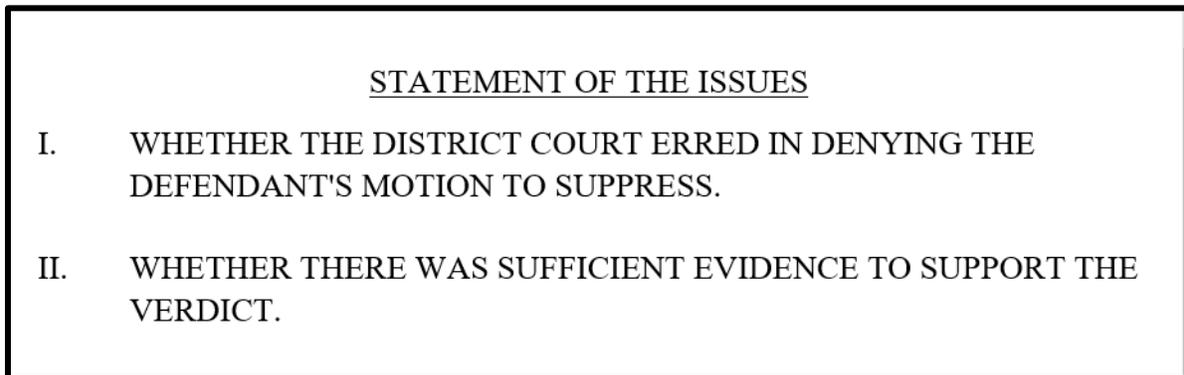
Note that these considerations apply regardless of whether you are the appellant or appellee, but your posture will cause you to frame the section differently.

Statement of the Issues

Defined in Supreme Court Rule 6.02(a)(1)(3) (Appellant's Brief) and Rule 6.03(a)(2) (Appellee's Brief):

- Appellant: "A brief statement, without elaboration, of the issues to be decided in the appeal."
- Appellee: "A statement either concurring in the appellant's statement of the issues involved or stating the issues the appellee considers necessary to disposition of the appeal."

Typical example—and missed opportunity:



Easy improvements:

- Get rid of ALLCAPS, Title Case, and underlining. Just write like a human.
- Don't use a "Whether" issue, or a one-sentence run-on strewn with facts and law that is difficult to understand (a style you may have learned in law school). You don't want to make the interpretation of your issue statement a chore for the reader.
- Consider using a short title/heading (i.e. Motion to Suppress, Constitutionality of K.S.A. 60-455, Evidence Supporting the Ruling, etc.).

For more advanced writers:

- Frame your issue as a *Deep Issue*.

Originally described by Bryan Garner, a Deep Issue breaks an issue statement down into a multi-sentence syllogism.

First sentence – Concisely describes the applicable law.

Middle sentences – Describe salient facts (without argument).

Final sentence – Provide a short question ("Did the district court err?" "Did the district court correctly apply the law?" "Was the verdict supported by evidence in the record?")

Strive to keep your issue statement to about 75 words.

Another example:

STATEMENT OF THE ISSUES ON APPEAL

I. **DAMAGES UNDER K.S.A. 58a-1002(a)**. K.S.A. 58a-1002(a) states that a trustee who commits a breach of trust "is liable for the greater of" three formulas for the statutory-damages calculation. The formula that would provide the greater recovery here is in K.S.A. 58a-1002(a)(3), which sets damages for embezzlement or conversion at "double the value" of the amount taken. The trial court found that ██████, the trustee of the ██████ had embezzled and converted \$1,541,827.59, but when calculating the damages the court did not double the value of the amount taken.

Was it error for the trial court to refuse to apply the statute's plain language?

II. **PUNITIVE/EXEMPLARY DAMAGES UNDER K.S.A. 58a-1002(c)**. K.S.A. 58a-1002(c) states that an award for a trustee's breach of duty "shall not exclude an award of punitive damages." One purpose of punitive/exemplary damages in Kansas is to deter others from engaging in similar conduct. The trial court found that ██████, while trustee of the ██████, willfully breached his duty by embezzling and converting Trust funds, but the court refused to consider the beneficiaries' request for punitive/exemplary damages, solely because ██████ died prior to the trial.

Did the trial court err in refusing to consider the request for punitive or exemplary damages when such claims are explicitly authorized by the statute?

Your Statement of the Issues should stand alone on one page. This allows your reader to process this information before moving on to the rest of the brief.

Note that your Statement of the Issues should correspond with the organization of your Argument. But the headings in your argument should not merely be a cut-and-paste of your issues.

- The two sections serve different purposes.
- The Statement of the issues is syllogistic abstract of your position.
- The headings in your Argument tell the story and provide a roadmap for your discussion.

The Goal

After considering your Statement of the Issues, your reader should be focused on the key arguments in your brief (and have this context for when he or she reads the Statement of Facts).

Conclusion

The Supreme Court Rules do not mention a Conclusion. But virtually all briefs include one. Why?

Typical example—and missed opportunity:

CONCLUSION

For all the foregoing reasons, Appellee respectfully requests this court to affirm the district court's ruling.

What is the point of a Conclusion like this? What does it convey to the judge?

Broadly speaking, the Conclusion provides a final chance to frame your issues, reminding the judge what he or she has read and why the court should rule in your favor.

A few tips for effective Conclusions:

- Briefly summarize your salient points, reinforcing the reasons the court should take your position.
- Include any facts that are particularly compelling to reiterate these points.
- Specifically identify the relief or outcome you are seeking (don't leave the disposition to fate).

Finally, a quick reminder—don't give up on other persuasive sections!

- Statement of Facts (without argument—let the facts tell the story)
- Argument (using persuasive headings, organized according to your issues but worded more concisely to allow the argument to flow)

The Bottom Line

Concise writing is effective writing!

You have no control whether your brief will be read in paper or electronic form. So you must use every section in the brief to "spark meaning," regardless of the reader's chosen medium.

Think of your brief as one persuasive work, not a collection of individual sections.

Instead of throwing together Nature of the Case, Statement of the Issues, and Conclusion at the last minute before you file, spend some time crafting each section so you can frame your issues and give your reader direction and context.

Always remember your reader.

This is where your brilliance as an advocate shines!

Drug Court on the Prairie

Presented By:

**Hon. Glenn Braun, Chief Judge
23rd Judicial District, State of Kansas**

**Teresa Greenwood,
Drug Court Coordinator
Ellis County Drug Court**

Ellis County Drug Court

Judge Glenn Braun, Chief District Judge, Drug Court Judge

Teresa Greenwood, Court Services Officer, Drug Court Coordinator

Aaron Cunningham, Asst. Ellis County Attorney

Curtis Brown, Defense Attorney

Erin Geist, Director, Northwest Kansas Community Corrections

Kyle Bartling, Intensive Supervision Officer, NWKCC

Trevor Roa, Intensive Supervision Officer, NWKCC

Jobeth Haselhorst and Katelyn Pilgrim, Smoky Hill Foundation for Chemical Dependency

Amy Bird, High Plains Mental Health Center

Nick Eiden, Drug Court Case Manager

Det. Brian Shannon, Ellis County Sheriff's Office

Det. JB Burkholder, Hays Police Department

Dr. Paul Lucas, Evaluator

What is a Drug Court?

- ▶ The concept of treatment courts was created in 1989, first starting in Florida as a remedy to the growing epidemic of drug addiction and jail overcrowding due to addicts spending time incarcerated. Ellis County held it's first drug court on August 30, 2018.
- ▶ The goal is to combat the addiction while having an alternative to jail for participants.
- ▶ Nationwide, there are currently more than 3,000 drug courts serving 150,000 people each year.
- ▶ Drug court participants complete an intensive regimen of treatment, supervision, random urinalysis testing, and attendance in court in front of the judge in order to not only beat their addiction but have the support to maintain their sobriety and not be a drain on community resources.

What is a Drug Court?

- ▶ Ellis County Drug Court participants must complete multiple requirements in a series of five phases and have the potential of being in the Drug Court for fourteen months or longer.
- ▶ They have intensive supervision from their probation officers, random UAs multiple times a week and intensive substance use treatment. Mental health and medical services are available for referral for those with underlying issues.
- ▶ Ellis County Drug Court meets bi-weekly and is for higher risk and higher needs offenders. The participant will stand directly in front of the judge in the court and discuss their progress, treatment, goals, and any setbacks. Their achievements are celebrated in open court with their peers, and setbacks are addressed with additional treatment, assigned tasks or sanction if appropriate.
- ▶ Participants are given the foundation and support to long term recovery.

Why Drug Court?

- ▶ Treatment courts are the single most successful intervention in our nation's history for leading people living with substance use and mental health disorders out of the justice system and into lives of recovery and stability.
- ▶ Instead of viewing addiction as a moral failing, drug courts view it as a disease. Instead of punishment, treatment is offered. Instead of indifference, there is compassion.
- ▶ The current practice of incarcerating addicts instead of helping them combat their addiction simply is not working.
- ▶ The history of treatment courts has shown that supervision, structure, and evidence-based treatment is a far more successful approach to substance use than incarceration and punishment.

Why Drug Court?

- ▶ Nationally, these courts save up to \$13,000 for every individual they serve and return as much as \$27 for every \$1 invested.
- ▶ They improve education, employment, housing, and financial stability. They promote family reunification, reduce foster care placements, and increase the rate of mothers with substance use disorders delivering fully drug-free babies.
- ▶ Treatment courts refer more people to treatment than any other intervention in America, and those people are more successful in recovery because they remain in treatment long enough to be successful.
- ▶ The average national completion rate for treatment courts is nearly 60%, more than twice the rate of people on probation with substance use disorders without treatment court intervention. 75% of treatment court graduates do not reoffend.

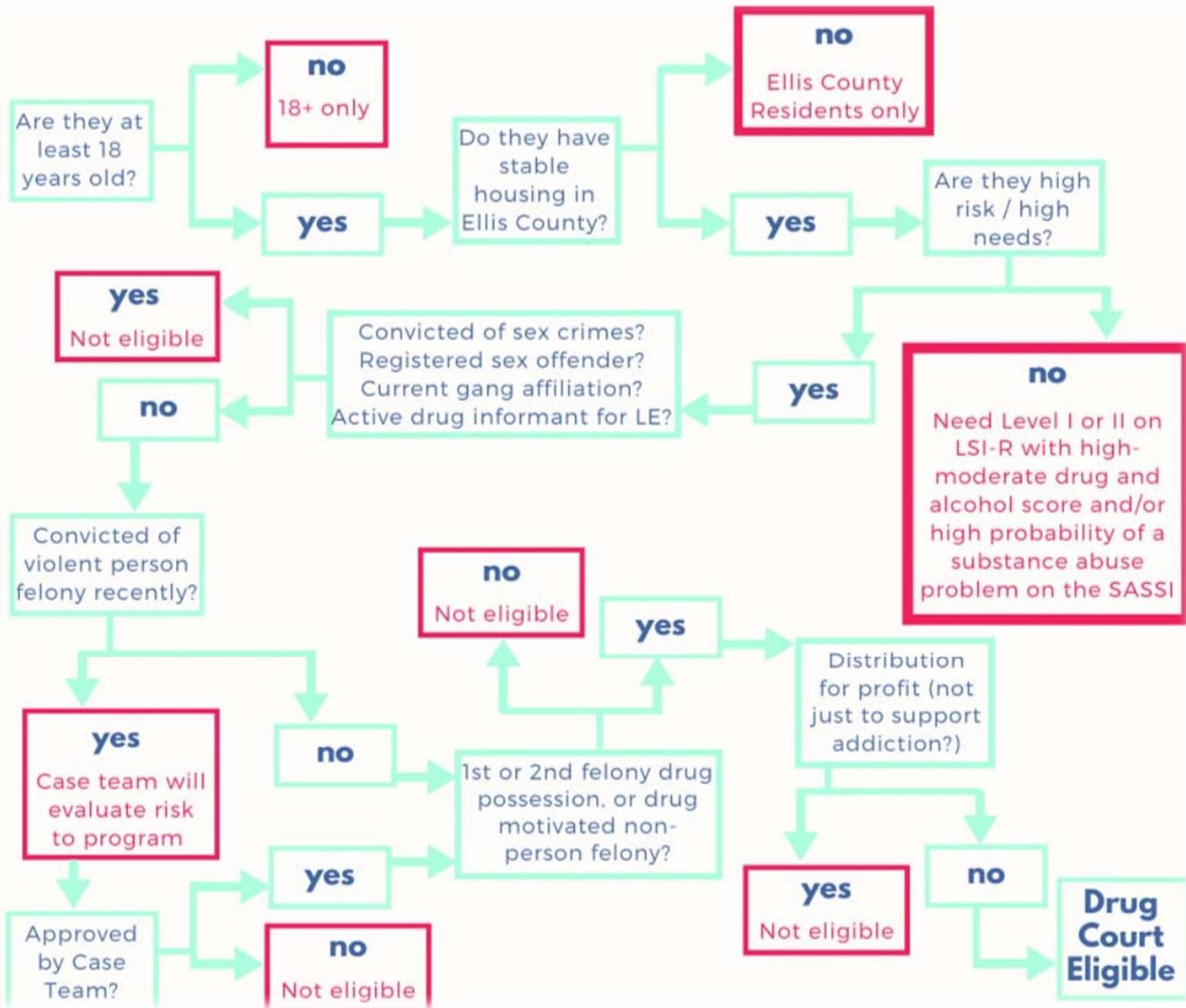
The National Epidemic

- 70,000 Americans died of drug overdoses in 2019
- 2/3 of all fatal drug overdoses in the US are due to opioids.
- 65% of all US inmates have a substance use disorder
- \$80 billion annually is spent in the US on incarceration
- 20.2 million American adults (1 in 10) have a substance use disorder
- People are more likely to be incarcerated than treated.

Who Can be in Drug Court?

- ▶ High Risk – High Needs offenders with a felony conviction and a high probability of a substance use disorder
- ▶ Must be non-violent and live in Ellis County
- ▶ Cannot be a registered sex offender or be a drug distributor for profit (consideration given for small time distributors supporting their own habit)
- ▶ Most Senate Bill 123 eligible offenders who live in Ellis County are eligible and placed in drug court.

ARE THEY ELIGIBLE FOR ELLIS COUNTY DRUG COURT?



Drug Court Phases

- ▶ Ellis County Drug Court is divided into five phases:

Acute Stabilization – Phase 1 (requires 14 days sober to advance)

Clinical Stabilization –Phase 2 (30 days sober to advance)

Pro Social Habilitation – Phase 3 (45 days sober to advance)

Adaptive Habilitation – Phase 4 (60 days sober to advance)

Continuing Care – Phase 5 (90 days sober to advance)

Participants in Ellis County Drug Court will spend a minimum of 14 months in the program, and longer if they have not met the basic requirements of the program to advance to the next phase.

Incentives - Sanctions

Incentives given for when all requirements have been met

- ▶ Gift cards
- ▶ Verbal Praise
- ▶ Phase advancement

Sanctions include:

- ▶ Community service
- ▶ Extra UAs or extra reporting
- ▶ Writing an essay to share with the court
- ▶ Jail sanction

Roles of the Drug Court Team

Drug Court Judge

Drug Court Coordinator

Prosecutor

Defense Attorney

Treatment Provider

Evaluator

Intensive Supervision Officers

Treatment Provider

Mental Health

Case Manager

Law Enforcement

Success Story - Mark

Success of Ellis County Drug Court

- ▶ Graduates: We've graduated 21 participants from the Ellis County Drug Court since it began in August of 2018.
- ▶ We know of only three that have been arrested for new cases since their graduation. 86% Success Rate
- ▶ We are continuing to grow and develop our program to be efficient and effect, and are developing an after care program to better serve our later phase participants and graduates of the program.

Costs

In 2018 we asked the Ellis County Commission for \$30,000 in start up funds. We have more than half of that money left nearly three years later.

In 2019 we were awarded a federal grant from the Bureau of Justice Administration. Funding is used for treatment, housing assistance for participants, cab vouchers, payment for defense attorney services, office supplies, medical check-ups and the entire wage of our part-time drug court case manager, Nick Eiden. This funding is available until October 2022 and can be renewed upon application.

Gift card incentives, which are not covered by the federal grant, cost the court \$650 in 2018, \$2990 in 2019, and \$1665 in 2020. Generous donations from organizations including the Ellis County Bar Association have helped fund these gifts to our hard-working participants.

Additional Resources

www.nadcp.org

www.ndci.org

**ELLIS COUNTY
DRUG COURT**



RISE TO RECOVERY

Zoom Depositions—Practical Pointers

Presented By:

**Pablo Mose, Attorney
Rebein Brothers PA**

Zoom Depositions and Hearings

Tips & Tricks

Ellis County Bar Association -- 2021

Core Authority on Remote Discovery and Hearings

- Federal Rules of Civil Procedure & Comparable Kansas Statutes
 - Rule 26 (K.S.A. § 60-226) – Discovery Generally
 - Note difference in Disclosure requirements
 - Rule 30 (K.S.A. § 60-230) – Depositions

“Remote means”

- FRCP 30 provides:
 - (4) By Remote Means. The parties may stipulate—or the court may on motion order—that a deposition be taken by telephone or other remote means. For the purpose of this rule and Rules 28(a), 37(a)(2), and 37(b)(1), the deposition takes place where the deponent answers the questions.
- Notice still required:
 - “A party who wants to depose a person by oral questions must give reasonable written notice to every other party. The notice must state the time and place of the deposition and, if known, the deponent's name and address.”

Local Rules and State Guidance

- 2020 Spec. Sess. House Bill 2016, § 24 & 2021 Senate Bill 14
 - Legislative grant of authority to Courts
- 2021-PR-009
 - Most recent Order from 1/26/2021 extending core administrative orders

Key parts of 2020-PR-123 that were extended into 2021:

- “To the extent possible, any hearing related to an essential function must be conducted by two-way telephonic or electronic audio-visual communication. No hearing related to a nonessential function may be conducted except by two-way telephonic or electronic audio-visual communication.”
- “Courts must continue to expand the use of remote hearings as much as possible to reduce any backlog and to dispose of new cases efficiently and safely. All remote hearings must comply with 2020-PR-056. Courts should consider all virtual courtroom standards and guidance posted on the Kansas judicial branch website and any updates that follow.”

Published Court Rulings

- No published court rulings from a March 2021 Westlaw search appear to reject requests for Zoom Depositions or evidentiary hearings. The rulings favoring requests for remote depositions and proceeds all appear to support the use of remote means.
- *Swenson v. GEICO Casualty Company*, 336 F.R.D. 206 (D. Nev. 2020)

“Plaintiff urges that the depositions should move forward by remote means. . . Defendant argues that the depositions should be halted so that they can take place in person at some future time when the pandemic is no longer an impediment . . . Plaintiff has the better argument. . . courts have overwhelmingly endorsed depositions moving forward by remote means during the pandemic.”

Learning Resources, Inc. v. Playgo Toys Enterprises Ltd., 335 F.R.D. 536 (N.D. Ill. 2020)

“ . . . while the Court is sympathetic to Learning Resources' preference for an in-person deposition, that preference is outweighed by the risks posed by the COVID-19 pandemic and the hardship that the Walmart defendants will likely experience if their lead counsel is unable to be physically present during Ms. Latham's in-person deposition. Consequently, in its discretion, the Court orders that Ms. Latham's deposition take place via remote videoconference.”

Tips & Tricks from Participation in Zoom Proceedings and Depositions

- Working with a 3rd Party Reporter
 - Who?
 - How?
 - What?
 - Where?

Who all is needed?

- i. Reporter
- ii. Interpreter?
 - 1. Website portal in same language?
- iii. Witness
 - 1. Having cell phone contact number can be important

**IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF MISSOURI**

RADAMES MOLINA ALBELO, on behalf of
himself and all other persons similarly situated,

Plaintiffs,

v.

EPIC LANDSCAPE PRODUCTIONS, L.C.,

Defendant.

Case No. 4:17-cv-0454-DGK

**SECOND AMENDED NOTICE TO
TAKE DEPOSITION OF OPT-IN PLAINTIFF ERIC LARA**

PLEASE TAKE NOTICE that Counsel for Defendant Epic Landscape Productions, L.C., will take the Zoom deposition of Eric Lara on Tuesday, December 29, 2020 beginning at 1:00 p.m. Central Time. The Zoom deposition shall be taken by stenographic means by Veritext Court Reporting, and shall continue from day to day until complete. Interpreting services will be provided and coordinated through Veritext Court Reporting. Zoom information will be provided by The Hodgson Law Firm, LLC.

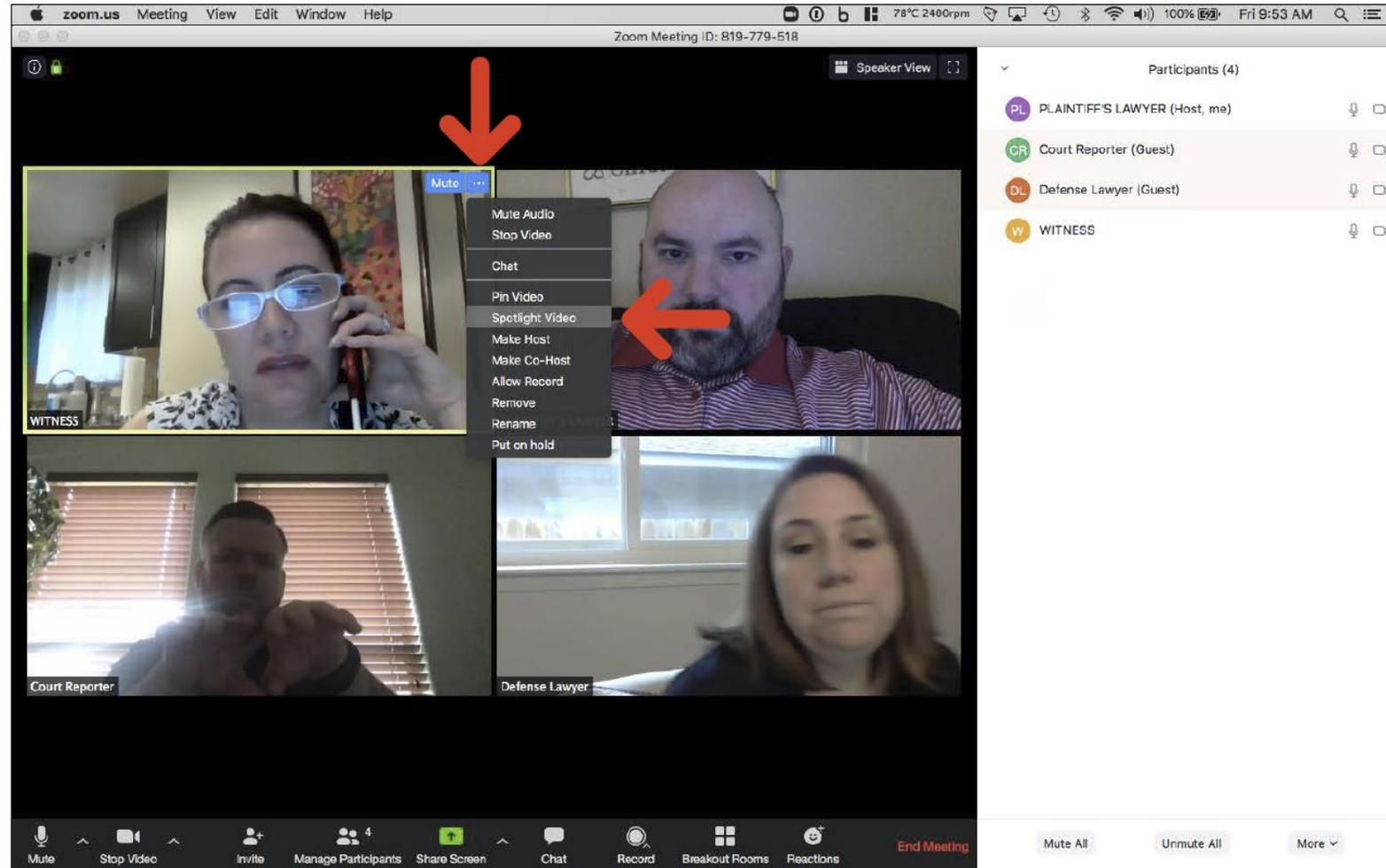
NOTICE IS FURTHER GIVEN that we reserve the right to conduct this Zoom deposition utilizing the secure web-based deposition option afforded by Veritext or in the alternative video teleconferencing (VTC) services offered by Veritext (“Web Deposition”) or telephonically only to provide remote access for those parties wishing to participate in the

deposition via the internet and/or telephone. Also, take notice that the court reporter may also be remote via one of the options above for the purposes of reporting the proceeding and may or may not be in the presence of the deponent. Please contact the noticing attorney immediately to advise that it is your desire to appear via this remote participating means so that the necessary credentials, call-in numbers, testing, and information, if necessary, can be provided to you prior to the proceedings.

This deposition will be taken for the purpose of discovery, for use as evidence in this action, for use at trial, or for any other purposes as authorized under applicable statutes and the Federal Rules of Civil Procedure.

Dated this 29th day of December, 2020.

You can isolate a witness in the interface



zoom.us Meeting View Edit Window Help Zoom Meeting ID: 819-779-518 78°C 321Grpm 100% Fri 9:55 AM

Participants (5)

- PL PLAINTIFF'S LAWYER (Host, me)
- CR Court Reporter (Guest)
- DL Defense Lawyer (Guest)
- I Intepreter (Guest)
- W WITNESS

Cancel the Spotlight Video

Mute Stop Video Invite Manage Participants Share Screen Chat Record Breakout Rooms Reactions End Meeting Mute All Unmute All More

How do participants join?

- Hosted by 3rd party itself?
- Law firm hosting via Zoom?
- Combination or backup if main system fails?

You're Invited to Join a Remote Session Using Veritext Virtual

PLEASE RETAIN THIS EMAIL. IT CONTAINS CRITICAL INFORMATION FOR YOUR REMOTE SESSION.
Albelo,Radames Molina v. Epic Landscape Productions LC | Wednesday, Dec 30 2020 4:30PM (Central Time (US & Canada)) | 4388522 | Luis Castillo

JOINING YOUR SESSION



Connect to Your Session through MyVeritext.

Click "Connect" to launch MyVeritext into your web browser and login with your username and password. Then select the "Live Sessions" button and click "Join Now" to launch your session.

CONNECT

MyVeritext Username:
tim@bertramgraf.com

**Note: If you have not used MyVeritext before you will need to activate your account. After clicking the connect button to the right, please select "Activate Account or Forgot Password". This will prompt you to set your password prior to joining your session. Please note that your assigned Username is listed in this email under the "Connect" button to the right.*

OTHER INFORMATION



Self Test.

It is recommended that participants test all equipment and the Internet connection that will be used for the actual session at the location where the session will take place. This self test typically takes 3 to 5 minutes.

START SELF TEST

Did your system fail?
Contact: 855.440.4861



Have You Ordered Realtime or Exhibit Share.

If so, you can expect an email with instructions for further setup.

A decent internet connection.

The image shows a Google search interface for the query "google speed test". The search results page displays "About 1,950,000,000 results (0.49 seconds)". A search card for "Internet speed test" is highlighted, featuring a description of the test, a "RUN SPEED TEST" button, and an "About" link. The card text states: "Check your internet speed in under 30 seconds. The speed test usually transfers less than **40 MB of data**, but may transfer more data on fast connections. To run the test, you'll be connected to **Measurement Lab (M-Lab)** and your IP address will be shared with them and processed by them in accordance with their **privacy policy**. M-Lab conducts the test and publicly publishes all test results to promote internet research. Published information includes your IP address and test results, but doesn't include any other information about you as an internet user."

Google

google speed test

All Books News

About 1,950,000,000 results (0.49 seconds)

Internet speed test

Check your internet speed in under 30 seconds. The speed test usually transfers less than **40 MB of data**, but may transfer more data on fast connections.

To run the test, you'll be connected to **Measurement Lab (M-Lab)** and your IP address will be shared with them and processed by them in accordance with their **privacy policy**. M-Lab conducts the test and publicly publishes all test results to promote internet research. Published information includes your IP address and test results, but doesn't include any other information about you as an internet user.

About

speed.googlefiber.net

Google Fiber speed test

Speed test. Speed to: Stanford, DM. PING: DOWNLOAD. UPLOAD. What's

developers.google.com > speed > page

PageSpeed Insights - Google

Read the latest Google Webmaster Central

Performance. Learn more about web

support.google.com > fiber > answer

google speed test

All Books News Videos Shopping More Settings Tools

About 1,950,000,000 results (0.49 seconds)

Internet speed test

Check your internet speed in under 30 seconds. The speed test usually transfers less than **40 MB of data**, but may transfer more data on fast connections.

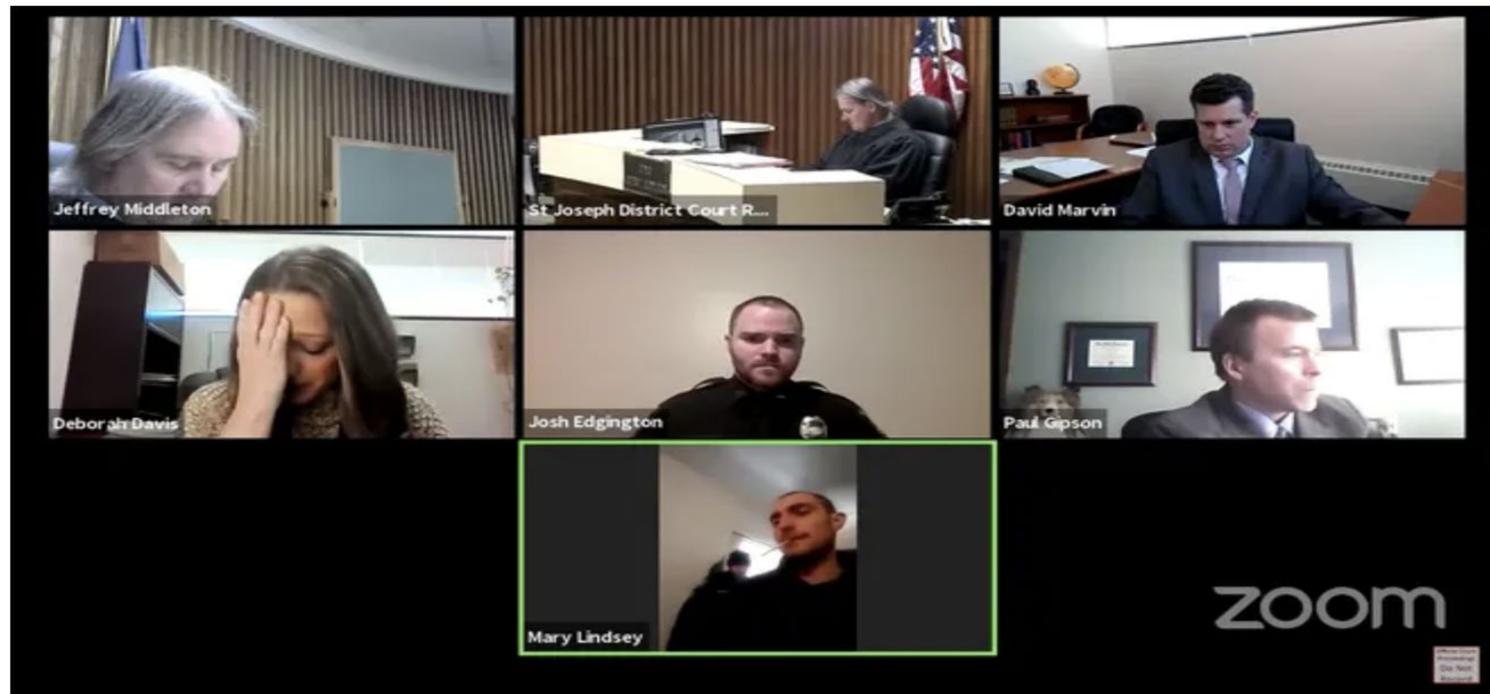
To run the test, you'll be connected to **Measurement Lab (M-Lab)** and your IP address will be shared with them and processed by them in accordance with their **privacy policy**. M-Lab conducts the test and publicly publishes all test results to promote internet research. Published information includes your IP address and test results, but doesn't include any other information about you as an internet user.

About

RUN SPEED TEST

Where are participants located?

- Other parties nearby?
- Example from criminal case – Defendant and Victim in the same apartment....



Attorney Deborah Davis, left center, reacts during a livestream court proceeding March 2, after it was confirmed the defendant in an assault case was at the same house as the alleged victim, during the live hearing. Davis made her suspicion known to the court during the preliminary examination, after noting the witness' body language. *Provided*

The story continues...

About seven minutes into the proceeding, Deborah Davis, prosecuting attorney and representing Lindsey, said she believed Lindsey and Harris were in close proximity during the livestream, based on Lindsey's answers and body language.

"Your Honor ... I have reason to believe that the defendant is in the same apartment as the complaining witness right now, and I am extremely scared for her safety," Davis said. "The fact that she's looking off to the side and he's moving around, I want some confirmation that she is safe before we continue."

Middleton told Harris to go outside with his cell-phone and take a photograph of the house number. Harris declined, saying he was limited by low phone battery and that his device was connected to a charger. A few moments later, Davis said the police were at the door of Lindsey's confirmed location to check on her.

"Your Honor, me and Mary both don't want the no-contact," Harris said. "I ask that be dropped. I'm sorry I lied to you. I knew the cops were outside. I don't know why I..."

Middleton interrupted Harris. "Mr. Harris, my advice is, don't say anything else"

What documents will be used?

- Reporter likely needs documents in advance
- Still good practice to file a deposition notice with a “deuces tecum” request if the other party is in possession of documents that will be reviewed at the deposition

If the remote proceeding is hosted by the Court, remember:

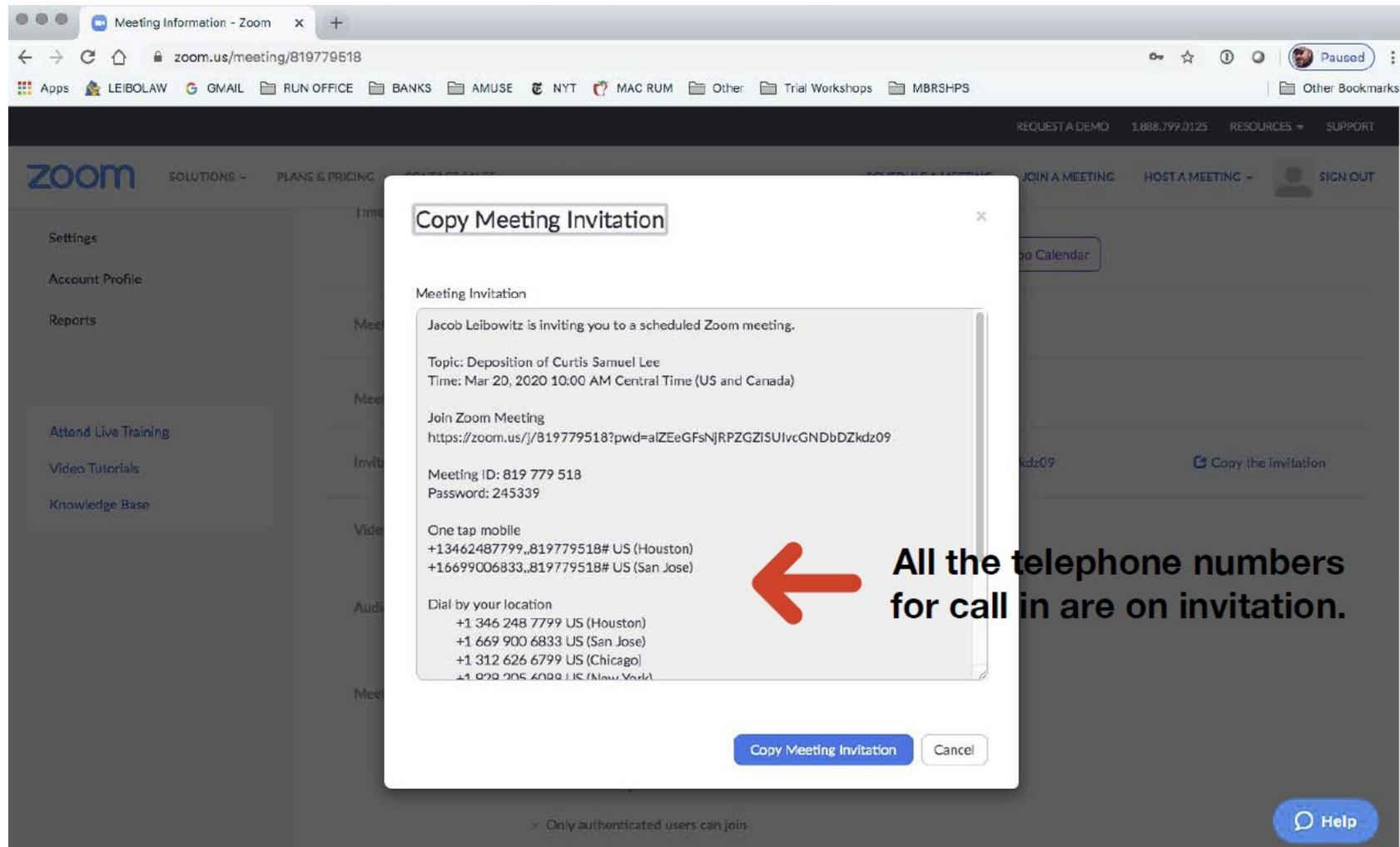
Every court is different!

Figure out logistics in advance!

Items specific to Zoom

- Best practices are for the court reporter and the witness (or anyone with a temperamental internet connection) to use a telephone for their AUDIO connection
 - Phone numbers all work in Zoom email listing

You can always call-in and run audio that way



The image shows a screenshot of a Zoom meeting invitation dialog box. The dialog box is titled "Copy Meeting Invitation" and contains the following text:

Meeting Invitation

Jacob Leibowitz is inviting you to a scheduled Zoom meeting.

Topic: Deposition of Curtis Samuel Lee
Time: Mar 20, 2020 10:00 AM Central Time (US and Canada)

Join Zoom Meeting
<https://zoom.us/j/819779518?pwd=aIZEeGFsNjRlZGZlSUlvcGNDbDZkdz09>

Meeting ID: 819 779 518
Password: 245339

One tap mobile
+13462487799,,819779518# US (Houston)
+16699006833,,819779518# US (San Jose)

Dial by your location
+1 346 248 7799 US (Houston)
+1 669 900 6833 US (San Jose)
+1 312 626 6799 US (Chicago)
+1 929 205 6099 US (New York)

A red arrow points from the text "All the telephone numbers for call in are on invitation." to the telephone numbers listed in the dialog box. At the bottom of the dialog box, there are two buttons: "Copy Meeting Invitation" and "Cancel".

All the telephone numbers for call in are on invitation.

Before your deposition, organize your exhibits in a folder on your desktop for quick access.

Sharing Exhibits

- Before you share a specific exhibit on Zoom, it needs to be open on your computer
- If you don't open the exhibit first, you may accidentally share the screen that shows all of your exhibits



Cancel the Spotlight Video

Basic Advanced Files

Desktop 1

Whiteboard

iPhone/iPad via AirPlay

iPhone/iPad via Cable

Finder - Deposition Exhibits - Curtis Samuel Lee

Finder - Deposition Exhibits...

← This is the folder of exhibits. If you share this...

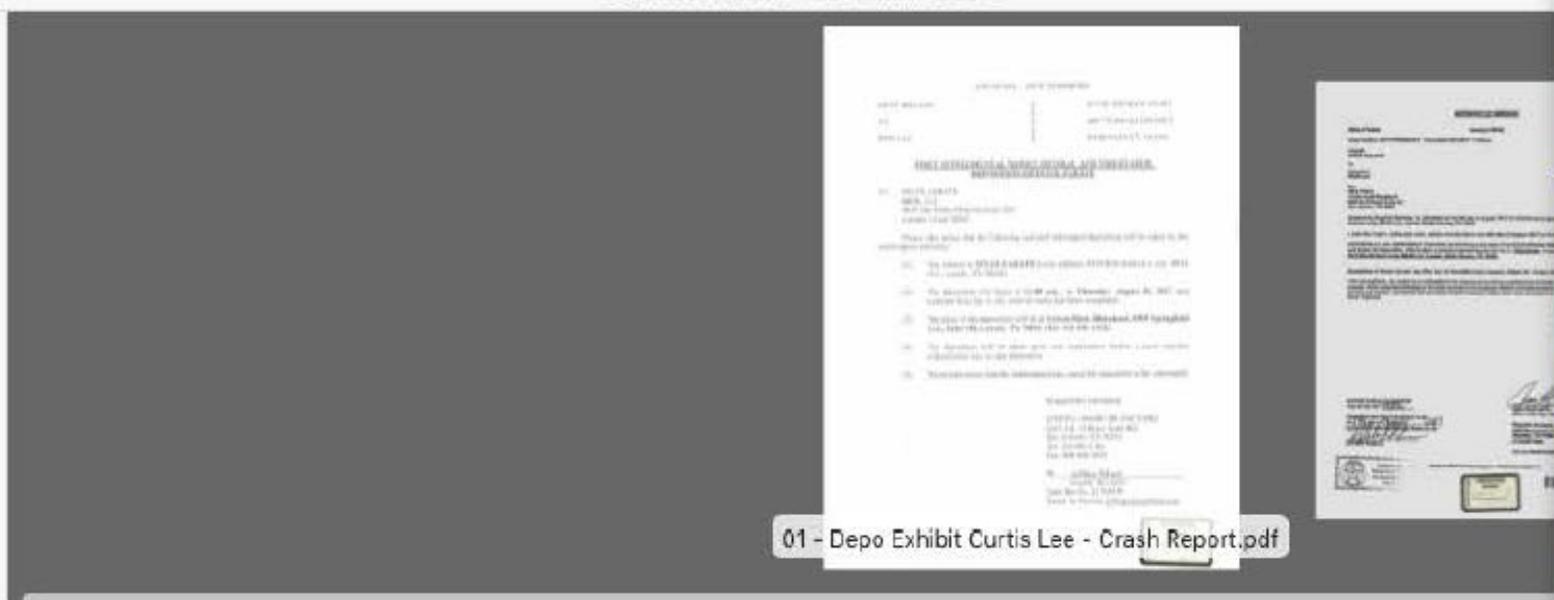
This dialog box opens with the files that are available to share.

Share computer sound Optimize Screen Share for Video Clip Share



WITNESS

- Favorites
- Dropbox
 - Recents
 - domain-AirDrop
 - Applications
 - Downloads
 - Movies
 - Music
 - Pictures
 - Box Sync
 - jacobleibowitz
- iCloud
- iCloud Drive
 - Desktop
 - Documents
- Devices
- Jacob's MacBook Air
 - Remote Disc
 - Macintosh HD



Name	Date Modified
01 - Depo Exhibit Curtis Lee - Crash Report.pdf	Sep 12, 2017 at 10:5
02 - Depo Exhibit Curtis Lee - Meth Pipe Photo.pdf	Sep 12, 2017 at 10:5
03 - Depo Exhibit Curtis Lee - Employment Application.pdf	Sep 12, 2017 at 10:5



Everyone would be able to see all of your exhibits.

Basic Advanced Files

Desktop 1 Whiteboard iPhone/iPad via AirPlay iPhone/iPad via Cable

Preview - 01 - Depo Exhibit... Finder - Deposition Exhibits...

↑

Specific exhibit appears.

Share computer sound Optimize Screen Share for Video Clip

PLAINTIFF'S LAWYER

WITNESS

Court Reporter

Defense Lawyer

Intepreter

continue from day to day until the same has been completed.

Hard Drive space for recordings

- It took 10 minutes to convert a 10 minute, 122MB recording
- That means you need about 750MB of space on your computer for each hour of video you record

- Favorites
- Dropbox
 - Recents
 - domain-AirDrop
 - Applications
 - Downloads
 - Movies
 - Music
 - Pictures
 - Box Sync
 - jacobleibowitz
- iCloud
- iCloud Drive
 - Desktop
 - Documents
- Devices
- Jacob's MacBook Air
 - Remote Disc
 - Macintosh HD

 **Converting meeting recording**

You have a recording that needs to be converted before viewing

0%

[Stop Converting](#)



New Meeting



Schedule



Share Screen

10:00 AM - 2:00 PM | NOW

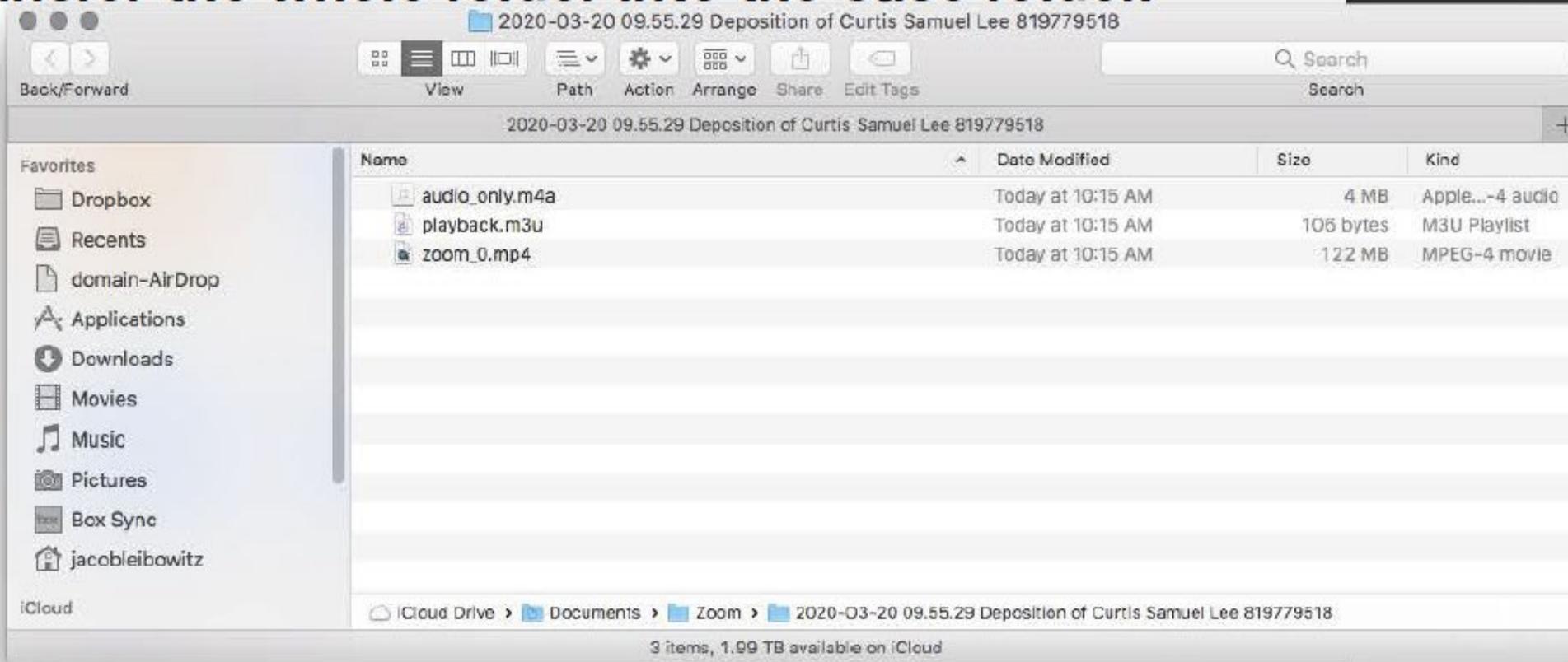
Meeting ID: 819-779-518



Start

Kind
PDF document
PDF document
PDF document

When it's done, a folder like this one appears.
Transfer the whole folder into the case folder.



REMOTE DEPOSITIONS AND HEARINGS – ZOOMING INTO TIPS & TRICKS

A. Core Authority on Remote Discovery and Hearings

1. Discovery Rules (very similar to Kansas Rules)
 - a. FRCP 26
 - i. KSA 60-226
 - b. FRCP 30
 - i. K.S.A 60-230
2. Local Rules and State Guidance
 - a. 2020 Spec. Sess. House Bill 2016, § 24 & 2021 Senate Bill 14
 - i. Legislative grant of authority to Courts
 - b. 2021-PR-009
 - i. Most recent Order from 1/26/2021 extending core administrative orders
 - ii. Key parts of 2020-PR-123 that were extended into 2021:

To the extent possible, any hearing related to an essential function must be conducted by two-way telephonic or electronic audio-visual communication. No hearing related to a nonessential function may be conducted except by two-way telephonic or electronic audio-visual communication.

Courts must continue to expand the use of remote hearings as much as possible to reduce any backlog and to dispose of new cases efficiently and safely. All remote hearings must comply with 2020-PR-056. Courts should consider all virtual courtroom standards and guidance posted on the Kansas judicial branch website and any updates that follow.

3. No published court rulings from a March 2021 Westlaw search appear to reject requests for Zoom Depositions or evidentiary hearings. The rulings favoring requests for remote depositions and proceeds all appear to support the use of remote means.
 - a. *Swenson v. GEICO Casualty Company*, 336 F.R.D. 206 (D. Nev. 2020)

“Plaintiff urges that the depositions should move forward by remote means. . . Defendant argues that the depositions should be halted so that they can take place in person at some future time when the pandemic is no longer an impediment . . . Plaintiff has the better argument. . . courts have overwhelmingly endorsed depositions moving forward by remote means during the pandemic.”
 - b. *Learning Resources, Inc. v. Playgo Toys Enterprises Ltd.*, 335 F.R.D. 536 (N.D. Ill. 2020)

“ . . . while the Court is sympathetic to Learning Resources' preference for an in-person deposition, that preference is outweighed by the risks posed by the COVID-19 pandemic and the hardship that the Walmart defendants will

likely experience if their lead counsel is unable to be physically present during Ms. Latham's in-person deposition. Consequently, in its discretion, the Court orders that Ms. Latham's deposition take place via remote videoconference.”

B. Tips & Tricks from Participation in Zoom Proceedings and Depositions

1. Working with a 3rd Party Reporter

- a. Who all is needed?
 - i. Reporter
 - ii. Interpreter?
 1. Website portal in same language?
 - iii. Witness
 1. Having cell phone contact number can be important
- b. How do participants join?
- c. Where are participants located?
 - i. Other parties nearby?
- d. What documents will be used?
 - i. Reporter likely needs documents in advance

2. Hosted by The Court

- a. **Every court is different!** Figure out logistics in advance!

3. Items specific to Zoom

- a. Best practices are for the court reporter and the witness (or anyone with a temperamental internet connection) to use a telephone for their AUDIO connection.
 - i. Phone numbers all work in Zoom email listing
- b. Before you start your deposition, organize your exhibits in a folder on your desktop for quick access.
- c. Sharing Exhibits
 - i. Before you share a specific exhibit on Zoom, it needs to be open on your computer
 - ii. If you don't open the exhibit first, you may accidentally share the screen that shows all of your exhibits
- d. Hard Drive space for recordings
 - i. It took 10 minutes to convert a 10 minute, 122MB recording
 - ii. That means you need about 750MB of space on your computer for each hour of video you record

Rule 26. Duty to Disclose; General Provisions Governing Discovery

(a) REQUIRED DISCLOSURES.

(1) *Initial Disclosure.*

(A) *In General.* Except as exempted by Rule 26(a)(1)(B) or as otherwise stipulated or ordered by the court, a party must, without awaiting a discovery request, provide to the other parties:

(i) the name and, if known, the address and telephone number of each individual likely to have discoverable information—along with the subjects of that information—that the disclosing party may use to support its claims or defenses, unless the use would be solely for impeachment;

(ii) a copy—or a description by category and location—of all documents, electronically stored information, and tangible things that the disclosing party has in its possession, custody, or control and may use to support its claims or defenses, unless the use would be solely for impeachment;

(iii) a computation of each category of damages claimed by the disclosing party—who must also make available for inspection and copying as under Rule 34 the documents or other evidentiary material, unless privileged or protected from disclosure, on which each computation is based, including materials bearing on the nature and extent of injuries suffered; and

(iv) for inspection and copying as under Rule 34, any insurance agreement under which an insurance business may be liable to satisfy all or part of a possible judgment in the action or to indemnify or reimburse for payments made to satisfy the judgment.

(B) *Proceedings Exempt from Initial Disclosure.* The following proceedings are exempt from initial disclosure:

(i) an action for review on an administrative record;

(ii) a forfeiture action in rem arising from a federal statute;

(iii) a petition for habeas corpus or any other proceeding to challenge a criminal conviction or sentence;

- (iv) an action brought without an attorney by a person in the custody of the United States, a state, or a state subdivision;
- (v) an action to enforce or quash an administrative summons or subpoena;
- (vi) an action by the United States to recover benefit payments;
- (vii) an action by the United States to collect on a student loan guaranteed by the United States;
- (viii) a proceeding ancillary to a proceeding in another court; and
- (ix) an action to enforce an arbitration award.

(C) *Time for Initial Disclosures—In General.* A party must make the initial disclosures at or within 14 days after the parties' Rule 26(f) conference unless a different time is set by stipulation or court order, or unless a party objects during the conference that initial disclosures are not appropriate in this action and states the objection in the proposed discovery plan. In ruling on the objection, the court must determine what disclosures, if any, are to be made and must set the time for disclosure.

(D) *Time for Initial Disclosures—For Parties Served or Joined Later.* A party that is first served or otherwise joined after the Rule 26(f) conference must make the initial disclosures within 30 days after being served or joined, unless a different time is set by stipulation or court order.

(E) *Basis for Initial Disclosure; Unacceptable Excuses.* A party must make its initial disclosures based on the information then reasonably available to it. A party is not excused from making its disclosures because it has not fully investigated the case or because it challenges the sufficiency of another party's disclosures or because another party has not made its disclosures.

(2) *Disclosure of Expert Testimony.*

(A) *In General.* In addition to the disclosures required by Rule 26(a)(1), a party must disclose to the other parties the identity of any witness it may use at trial to present evidence under Federal Rule of Evidence 702, 703, or 705.

(B) *Witnesses Who Must Provide a Written Report.* Unless otherwise stipulated or ordered by the court, this disclosure must be accompanied by a written report—prepared and signed by the witness—if the witness is one retained or specially employed to provide expert testimony in the case or one whose duties as the party's employee regularly involve giving expert testimony. The report must contain:

- (i) a complete statement of all opinions the witness will express and the basis and reasons for them;

- (ii) the facts or data considered by the witness in forming them;
- (iii) any exhibits that will be used to summarize or support them;
- (iv) the witness's qualifications, including a list of all publications authored in the previous 10 years;
- (v) a list of all other cases in which, during the previous 4 years, the witness testified as an expert at trial or by deposition; and
- (vi) a statement of the compensation to be paid for the study and testimony in the case.

(C) *Witnesses Who Do Not Provide a Written Report.* Unless otherwise stipulated or ordered by the court, if the witness is not required to provide a written report, this disclosure must state:

- (i) the subject matter on which the witness is expected to present evidence under Federal Rule of Evidence 702, 703, or 705; and
- (ii) a summary of the facts and opinions to which the witness is expected to testify.

(D) *Time to Disclose Expert Testimony.* A party must make these disclosures at the times and in the sequence that the court orders. Absent a stipulation or a court order, the disclosures must be made:

- (i) at least 90 days before the date set for trial or for the case to be ready for trial; or
- (ii) if the evidence is intended solely to contradict or rebut evidence on the same subject matter identified by another party under Rule 26(a)(2)(B) or (C), within 30 days after the other party's disclosure.

(E) *Supplementing the Disclosure.* The parties must supplement these disclosures when required under Rule 26(e).

(3) *Pretrial Disclosures.*

(A) *In General.* In addition to the disclosures required by Rule 26(a)(1) and (2), a party must provide to the other parties and promptly file the following information about the evidence that it may present at trial other than solely for impeachment:

- (i) the name and, if not previously provided, the address and telephone number of each witness—separately identifying those the party expects to present and those it may call if the need arises;

(ii) the designation of those witnesses whose testimony the party expects to present by deposition and, if not taken stenographically, a transcript of the pertinent parts of the deposition; and

(iii) an identification of each document or other exhibit, including summaries of other evidence—separately identifying those items the party expects to offer and those it may offer if the need arises.

(B) *Time for Pretrial Disclosures; Objections.* Unless the court orders otherwise, these disclosures must be made at least 30 days before trial. Within 14 days after they are made, unless the court sets a different time, a party may serve and promptly file a list of the following objections: any objections to the use under Rule 32(a) of a deposition designated by another party under Rule 26(a)(3)(A)(ii); and any objection, together with the grounds for it, that may be made to the admissibility of materials identified under Rule 26(a)(3)(A)(iii). An objection not so made—except for one under Federal Rule of Evidence 402 or 403—is waived unless excused by the court for good cause.

(4) *Form of Disclosures.* Unless the court orders otherwise, all disclosures under Rule 26(a) must be in writing, signed, and served.

(b) DISCOVERY SCOPE AND LIMITS.

(1) *Scope in General.* Unless otherwise limited by court order, the scope of discovery is as follows: Parties may obtain discovery regarding any nonprivileged matter that is relevant to any party's claim or defense and proportional to the needs of the case, considering the importance of the issues at stake in the action, the amount in controversy, the parties' relative access to relevant information, the parties' resources, the importance of the discovery in resolving the issues, and whether the burden or expense of the proposed discovery outweighs its likely benefit. Information within this scope of discovery need not be admissible in evidence to be discoverable.

(2) *Limitations on Frequency and Extent.*

(A) *When Permitted.* By order, the court may alter the limits in these rules on the number of depositions and interrogatories or on the length of depositions under Rule 30. By order or local rule, the court may also limit the number of requests under Rule 36.

(B) *Specific Limitations on Electronically Stored Information.* A party need not provide discovery of electronically stored information from sources that the party identifies as not reasonably accessible because of undue burden or cost. On motion to compel discovery or for a protective order, the party from whom discovery is sought must show that the information is not reasonably accessible because of undue burden or cost. If that showing is made, the court may

nonetheless order discovery from such sources if the requesting party shows good cause, considering the limitations of Rule 26(b)(2)(C). The court may specify conditions for the discovery.

(C) *When Required*. On motion or on its own, the court must limit the frequency or extent of discovery otherwise allowed by these rules or by local rule if it determines that:

(i) the discovery sought is unreasonably cumulative or duplicative, or can be obtained from some other source that is more convenient, less burdensome, or less expensive;

(ii) the party seeking discovery has had ample opportunity to obtain the information by discovery in the action; or

(iii) the proposed discovery is outside the scope permitted by Rule 26(b)(1).

(3) *Trial Preparation: Materials*.

(A) *Documents and Tangible Things*. Ordinarily, a party may not discover documents and tangible things that are prepared in anticipation of litigation or for trial by or for another party or its representative (including the other party's attorney, consultant, surety, indemnitor, insurer, or agent). But, subject to Rule 26(b)(4), those materials may be discovered if:

(i) they are otherwise discoverable under Rule 26(b)(1); and

(ii) the party shows that it has substantial need for the materials to prepare its case and cannot, without undue hardship, obtain their substantial equivalent by other means.

(B) *Protection Against Disclosure*. If the court orders discovery of those materials, it must protect against disclosure of the mental impressions, conclusions, opinions, or legal theories of a party's attorney or other representative concerning the litigation.

(C) *Previous Statement*. Any party or other person may, on request and without the required showing, obtain the person's own previous statement about the action or its subject matter. If the request is refused, the person may move for a court order, and Rule 37(a)(5) applies to the award of expenses. A previous statement is either:

(i) a written statement that the person has signed or otherwise adopted or approved; or

(ii) a contemporaneous stenographic, mechanical, electrical, or other recording—or a transcription of it—that recites substantially verbatim the person's oral statement.

(4) Trial Preparation: Experts.

(A) Deposition of an Expert Who May Testify. A party may depose any person who has been identified as an expert whose opinions may be presented at trial. If Rule 26(a)(2)(B) requires a report from the expert, the deposition may be conducted only after the report is provided.

(B) Trial-Preparation Protection for Draft Reports or Disclosures. Rules 26(b)(3)(A) and (B) protect drafts of any report or disclosure required under Rule 26(a)(2), regardless of the form in which the draft is recorded.

(C) Trial-Preparation Protection for Communications Between a Party's Attorney and Expert Witnesses. Rules 26(b)(3)(A) and (B) protect communications between the party's attorney and any witness required to provide a report under Rule 26(a)(2)(B), regardless of the form of the communications, except to the extent that the communications:

(i) relate to compensation for the expert's study or testimony;

(ii) identify facts or data that the party's attorney provided and that the expert considered in forming the opinions to be expressed; or

(iii) identify assumptions that the party's attorney provided and that the expert relied on in forming the opinions to be expressed.

(D) Expert Employed Only for Trial Preparation. Ordinarily, a party may not, by interrogatories or deposition, discover facts known or opinions held by an expert who has been retained or specially employed by another party in anticipation of litigation or to prepare for trial and who is not expected to be called as a witness at trial. But a party may do so only:

(i) as provided in Rule 35(b); or

(ii) on showing exceptional circumstances under which it is impracticable for the party to obtain facts or opinions on the same subject by other means.

(E) Payment. Unless manifest injustice would result, the court must require that the party seeking discovery:

(i) pay the expert a reasonable fee for time spent in responding to discovery under Rule 26(b)(4)(A) or (D); and

(ii) for discovery under (D), also pay the other party a fair portion of the fees and expenses it reasonably incurred in obtaining the expert's facts and opinions.

(5) Claiming Privilege or Protecting Trial-Preparation Materials.

(A) *Information Withheld.* When a party withholds information otherwise discoverable by claiming that the information is privileged or subject to protection as trial-preparation material, the party must:

(i) expressly make the claim; and

(ii) describe the nature of the documents, communications, or tangible things not produced or disclosed—and do so in a manner that, without revealing information itself privileged or protected, will enable other parties to assess the claim.

(B) *Information Produced.* If information produced in discovery is subject to a claim of privilege or of protection as trial-preparation material, the party making the claim may notify any party that received the information of the claim and the basis for it. After being notified, a party must promptly return, sequester, or destroy the specified information and any copies it has; must not use or disclose the information until the claim is resolved; must take reasonable steps to retrieve the information if the party disclosed it before being notified; and may promptly present the information to the court under seal for a determination of the claim. The producing party must preserve the information until the claim is resolved.

(c) PROTECTIVE ORDERS.

(1) *In General.* A party or any person from whom discovery is sought may move for a protective order in the court where the action is pending—or as an alternative on matters relating to a deposition, in the court for the district where the deposition will be taken. The motion must include a certification that the movant has in good faith conferred or attempted to confer with other affected parties in an effort to resolve the dispute without court action. The court may, for good cause, issue an order to protect a party or person from annoyance, embarrassment, oppression, or undue burden or expense, including one or more of the following:

(A) forbidding the disclosure or discovery;

(B) specifying terms, including time and place or the allocation of expenses, for the disclosure or discovery;

(C) prescribing a discovery method other than the one selected by the party seeking discovery;

(D) forbidding inquiry into certain matters, or limiting the scope of disclosure or discovery to certain matters;

(E) designating the persons who may be present while the discovery is conducted;

(F) requiring that a deposition be sealed and opened only on court order;

(G) requiring that a trade secret or other confidential research, development, or commercial information not be revealed or be revealed only in a specified way; and

(H) requiring that the parties simultaneously file specified documents or information in sealed envelopes, to be opened as the court directs.

(2) *Ordering Discovery.* If a motion for a protective order is wholly or partly denied, the court may, on just terms, order that any party or person provide or permit discovery.

(3) *Awarding Expenses.* Rule 37(a)(5) applies to the award of expenses.

(d) TIMING AND SEQUENCE OF DISCOVERY.

(1) *Timing.* A party may not seek discovery from any source before the parties have conferred as required by Rule 26(f), except in a proceeding exempted from initial disclosure under Rule 26(a)(1)(B), or when authorized by these rules, by stipulation, or by court order.

(2) Early Rule 34 Requests.

Time to Deliver. More than 21 days after the summons and complaint are served on a party, a request under Rule 34 may be delivered:

(i) to that party by any other party, and

(ii) by that party to any plaintiff or to any other party that has been served.

(B) When Considered Served. The request is considered to have been served at the first Rule 26(f) conference.

(3) *Sequence.* Unless the parties stipulate or the court orders otherwise for the parties' and witnesses' convenience and in the interests of justice:

(A) methods of discovery may be used in any sequence; and

(B) discovery by one party does not require any other party to delay its discovery.

(e) SUPPLEMENTING DISCLOSURES AND RESPONSES.

(1) *In General.* A party who has made a disclosure under Rule 26(a)—or who has responded to an interrogatory, request for production, or request for admission—must supplement or correct its disclosure or response:

(A) in a timely manner if the party learns that in some material respect the disclosure or response is incomplete or incorrect, and if the additional or corrective information has not otherwise been made known to the other parties during the discovery process or in writing; or

(B) as ordered by the court.

(2) *Expert Witness.* For an expert whose report must be disclosed under Rule 26(a)(2)(B), the party's duty to supplement extends both to information included in the report and to information given during the expert's deposition. Any additions or changes to this information must be disclosed by the time the party's pretrial disclosures under Rule 26(a)(3) are due.

(f) CONFERENCE OF THE PARTIES; PLANNING FOR DISCOVERY.

(1) *Conference Timing.* Except in a proceeding exempted from initial disclosure under Rule 26(a)(1)(B) or when the court orders otherwise, the parties must confer as soon as practicable—and in any event at least 21 days before a scheduling conference is to be held or a scheduling order is due under Rule 16(b).

(2) *Conference Content; Parties' Responsibilities.* In conferring, the parties must consider the nature and basis of their claims and defenses and the possibilities for promptly settling or resolving the case; make or arrange for the disclosures required by Rule 26(a)(1); discuss any issues about preserving discoverable information; and develop a proposed discovery plan. The attorneys of record and all unrepresented parties that have appeared in the case are jointly responsible for arranging the conference, for attempting in good faith to agree on the proposed discovery plan, and for submitting to the court within 14 days after the conference a written report outlining the plan. The court may order the parties or attorneys to attend the conference in person.

(3) *Discovery Plan.* A discovery plan must state the parties' views and proposals on:

(A) what changes should be made in the timing, form, or requirement for disclosures under Rule 26(a), including a statement of when initial disclosures were made or will be made;

(B) the subjects on which discovery may be needed, when discovery should be completed, and whether discovery should be conducted in phases or be limited to or focused on particular issues;

(C) any issues about disclosure, discovery, or preservation of electronically stored information, including the form or forms in which it should be produced;

(D) any issues about claims of privilege or of protection as trial-preparation materials, including—if the parties agree on a procedure to assert these claims after production—whether to ask the court to include their agreement in an order under Federal Rule of Evidence 502;

(E) what changes should be made in the limitations on discovery imposed under these rules or by local rule, and what other limitations should be imposed; and

(F) any other orders that the court should issue under Rule 26(c) or under Rule 16(b) and (c).

(4) *Expedited Schedule*. If necessary to comply with its expedited schedule for Rule 16(b) conferences, a court may by local rule:

(A) require the parties' conference to occur less than 21 days before the scheduling conference is held or a scheduling order is due under Rule 16(b); and

(B) require the written report outlining the discovery plan to be filed less than 14 days after the parties' conference, or excuse the parties from submitting a written report and permit them to report orally on their discovery plan at the Rule 16(b) conference.

(g) **SIGNING DISCLOSURES AND DISCOVERY REQUESTS, RESPONSES, AND OBJECTIONS.**

(1) *Signature Required; Effect of Signature*. Every disclosure under Rule 26(a)(1) or (a)(3) and every discovery request, response, or objection must be signed by at least one attorney of record in the attorney's own name—or by the party personally, if unrepresented—and must state the signer's address, e-mail address, and telephone number. By signing, an attorney or party certifies that to the best of the person's knowledge, information, and belief formed after a reasonable inquiry:

(A) with respect to a disclosure, it is complete and correct as of the time it is made; and

(B) with respect to a discovery request, response, or objection, it is:

(i) consistent with these rules and warranted by existing law or by a nonfrivolous argument for extending, modifying, or reversing existing law, or for establishing new law;

(ii) not interposed for any improper purpose, such as to harass, cause unnecessary delay, or needlessly increase the cost of litigation; and

(iii) neither unreasonable nor unduly burdensome or expensive, considering the needs of the case, prior discovery in the case, the amount in controversy, and the importance of the issues at stake in the action.

(2) *Failure to Sign*. Other parties have no duty to act on an unsigned disclosure, request, response, or objection until it is signed, and the court must strike it unless a signature is promptly supplied after the omission is called to the attorney's or party's attention.

(3) *Sanction for Improper Certification*. If a certification violates this rule without substantial justification, the court, on motion or on its own, must impose an appropriate sanction on the signer, the party on whose behalf the signer was acting,

or both. The sanction may include an order to pay the reasonable expenses, including attorney's fees, caused by the violation.

NOTES

(As amended Dec. 27, 1946, eff. Mar. 19, 1948; Jan. 21, 1963, eff. July 1, 1963; Feb. 28, 1966, eff. July 1, 1966; Mar. 30, 1970, eff. July 1, 1970; Apr. 29, 1980, eff. Aug. 1, 1980; Apr. 28, 1983, eff. Aug. 1, 1983; Mar. 2, 1987, eff. Aug. 1, 1987; Apr. 22, 1993, eff. Dec. 1, 1993; Apr. 17, 2000, eff. Dec. 1, 2000; Apr. 12, 2006, eff. Dec. 1, 2006; Apr. 30, 2007, eff. Dec. 1, 2007; Apr. 28, 2010, eff. Dec. 1, 2010; Apr. 29, 2015, eff. Dec. 1, 2015.)

NOTES OF ADVISORY COMMITTEE ON RULES—1937

Note to Subdivision (a). This rule freely authorizes the taking of depositions under the same circumstances and by the same methods whether for the purpose of discovery or for the purpose of obtaining evidence. Many states have adopted this practice on account of its simplicity and effectiveness, safeguarding it by imposing such restrictions upon the subsequent use of the deposition at the trial or hearing as are deemed advisable. See Ark.Civ.Code (Crawford, 1934) §§606–607; Calif.Code Civ.Proc. (Deering, 1937) §2021; 1 Colo.Stat. Ann. (1935) Code Civ.Proc. §376; Idaho Code Ann. (1932) §16–906; Ill. Rules of Pract., Rule 19 (Ill.Rev.Stat. (1937) ch. 110, §259.19); Ill.Rev.Stat. (1937) ch. 51, §24; 2 Ind.Stat. Ann. (Burns, 1933) §§2–1501, 2–1506; Ky.Codes (Carroll, 1932) Civ.Pract. §557; 1 Mo.Rev.Stat. (1929) §1753; 4 Mont.Rev.Codes Ann. (1935) §10645; Neb.Comp.Stat. (1929) ch. 20, §§1246–7; 4 Nev.Comp.Laws (Hillyer, 1929) §9001; 2 N.H.Pub.Laws (1926) ch. 337, §1; N.C.Code Ann. (1935) §1809; 2 N.D.Comp.Laws Ann. (1913) §§7889–7897; 2 Ohio Gen.Code Ann. (Page, 1926) §§11525–6; 1 Ore.Code Ann. (1930) Title 9, §1503; 1 S.D.Comp.Laws (1929) §§2713–16; Tex.Stat. (Vernon, 1928) arts. 3738, 3752, 3769; Utah Rev.Stat. Ann. (1933) §104–51–7; Wash. Rules of Practice adopted by the Supreme Ct., Rule 8, 2 Wash.Rev.Stat. Ann. (Remington, 1932) §308–8; W.Va.Code (1931) ch. 57, art. 4, §1. Compare [former] Equity Rules 47 (Depositions—To be Taken in Exceptional Instances); 54 (Depositions Under Revised Statutes, Sections 863, 865, 866, 867—Cross-Examination); 58 (Discovery—Interrogatories—Inspection and Production of Documents—Admission of Execution or Genuineness).

This and subsequent rules incorporate, modify, and broaden the provisions for depositions under U.S.C., Title 28, [former] §§639 (Depositions *de bene esse*; when and where taken; notice), 640 (Same; mode of taking), 641 (Same; transmission to court), 644 (Depositions under *dedimus potestatem* and *in perpetuum*), 646 (Deposition under *dedimus potestatem*; how taken). These statutes are superseded insofar as they differ from this and subsequent rules. U.S.C., Title 28, [former] §643 (Depositions; taken in mode prescribed by State laws) is superseded by the third sentence of Subdivision (a).

Rule 30. Depositions by Oral Examination

(a) WHEN A DEPOSITION MAY BE TAKEN.

(1) *Without Leave.* A party may, by oral questions, depose any person, including a party, without leave of court except as provided in Rule 30(a)(2). The deponent's attendance may be compelled by subpoena under Rule 45.

(2) *With Leave.* A party must obtain leave of court, and the court must grant leave to the extent consistent with Rule 26(b)(1) and (2):

(A) if the parties have not stipulated to the deposition and:

(i) the deposition would result in more than 10 depositions being taken under this rule or Rule 31 by the plaintiffs, or by the defendants, or by the third-party defendants;

(ii) the deponent has already been deposed in the case; or

(iii) the party seeks to take the deposition before the time specified in Rule 26(d), unless the party certifies in the notice, with supporting facts, that the deponent is expected to leave the United States and be unavailable for examination in this country after that time; or

(B) if the deponent is confined in prison.

(b) NOTICE OF THE DEPOSITION; OTHER FORMAL REQUIREMENTS.

(1) *Notice in General.* A party who wants to depose a person by oral questions must give reasonable written notice to every other party. The notice must state the time and place of the deposition and, if known, the deponent's name and address. If the name is unknown, the notice must provide a general description sufficient to identify the person or the particular class or group to which the person belongs.

(2) *Producing Documents.* If a subpoena duces tecum is to be served on the deponent, the materials designated for production, as set out in the subpoena, must be listed in the notice or in an attachment. The notice to a party deponent may be accompanied by a request under Rule 34 to produce documents and tangible things at the deposition.

(3) *Method of Recording.*

(A) *Method Stated in the Notice.* The party who notices the deposition must state in the notice the method for recording the testimony. Unless the court orders otherwise, testimony may be recorded by audio, audiovisual, or stenographic means. The noticing party bears the recording costs. Any party may arrange to transcribe a deposition.

(B) *Additional Method.* With prior notice to the deponent and other parties, any party may designate another method for recording the testimony in addition to that specified in the original notice. That party bears the expense of the additional record or transcript unless the court orders otherwise.

(4) *By Remote Means.* The parties may stipulate—or the court may on motion order—that a deposition be taken by telephone or other remote means. For the purpose of this rule and Rules 28(a), 37(a)(2), and 37(b)(1), the deposition takes place where the deponent answers the questions.

(5) *Officer's Duties.*

(A) *Before the Deposition.* Unless the parties stipulate otherwise, a deposition must be conducted before an officer appointed or designated under Rule 28. The officer must begin the deposition with an on-the-record statement that includes:

(i) the officer's name and business address;

(ii) the date, time, and place of the deposition;

(iii) the deponent's name;

(iv) the officer's administration of the oath or affirmation to the deponent;
and

(v) the identity of all persons present.

(B) *Conducting the Deposition; Avoiding Distortion.* If the deposition is recorded nonstenographically, the officer must repeat the items in Rule 30(b)(5)(A)(i)–(iii) at the beginning of each unit of the recording medium. The deponent's and attorneys' appearance or demeanor must not be distorted through recording techniques.

(C) *After the Deposition.* At the end of a deposition, the officer must state on the record that the deposition is complete and must set out any stipulations made by the attorneys about custody of the transcript or recording and of the exhibits, or about any other pertinent matters.

(6) *Notice or Subpoena Directed to an Organization.* In its notice or subpoena, a party may name as the deponent a public or private corporation, a partnership, an association, a governmental agency, or other entity and must describe with reasonable particularity the matters for examination. The named organization must

designate one or more officers, directors, or managing agents, or designate other persons who consent to testify on its behalf; and it may set out the matters on which each person designated will testify. Before or promptly after the notice or subpoena is served, the serving party and the organization must confer in good faith about the matters for examination. A subpoena must advise a nonparty organization of its duty to confer with the serving party and to designate each person who will testify. The persons designated must testify about information known or reasonably available to the organization. This paragraph (6) does not preclude a deposition by any other procedure allowed by these rules.

(c) EXAMINATION AND CROSS-EXAMINATION; RECORD OF THE EXAMINATION; OBJECTIONS; WRITTEN QUESTIONS.

(1) *Examination and Cross-Examination.* The examination and cross-examination of a deponent proceed as they would at trial under the Federal Rules of Evidence, except Rules 103 and 615. After putting the deponent under oath or affirmation, the officer must record the testimony by the method designated under Rule 30(b)(3)(A). The testimony must be recorded by the officer personally or by a person acting in the presence and under the direction of the officer.

(2) *Objections.* An objection at the time of the examination—whether to evidence, to a party's conduct, to the officer's qualifications, to the manner of taking the deposition, or to any other aspect of the deposition—must be noted on the record, but the examination still proceeds; the testimony is taken subject to any objection. An objection must be stated concisely in a nonargumentative and nonsuggestive manner. A person may instruct a deponent not to answer only when necessary to preserve a privilege, to enforce a limitation ordered by the court, or to present a motion under Rule 30(d)(3).

(3) *Participating Through Written Questions.* Instead of participating in the oral examination, a party may serve written questions in a sealed envelope on the party noticing the deposition, who must deliver them to the officer. The officer must ask the deponent those questions and record the answers verbatim.

(d) DURATION; SANCTION; MOTION TO TERMINATE OR LIMIT.

(1) *Duration.* Unless otherwise stipulated or ordered by the court, a deposition is limited to 1 day of 7 hours. The court must allow additional time consistent with Rule 26(b)(1) and (2) if needed to fairly examine the deponent or if the deponent, another person, or any other circumstance impedes or delays the examination.

(2) *Sanction.* The court may impose an appropriate sanction—including the reasonable expenses and attorney's fees incurred by any party—on a person who impedes, delays, or frustrates the fair examination of the deponent.

(3) *Motion to Terminate or Limit.*

(A) *Grounds.* At any time during a deposition, the deponent or a party may move to terminate or limit it on the ground that it is being conducted in bad faith or in a manner that unreasonably annoys, embarrasses, or oppresses the deponent or party. The motion may be filed in the court where the action is pending or the deposition is being taken. If the objecting deponent or party so demands, the deposition must be suspended for the time necessary to obtain an order.

(B) *Order.* The court may order that the deposition be terminated or may limit its scope and manner as provided in Rule 26(c). If terminated, the deposition may be resumed only by order of the court where the action is pending.

(C) *Award of Expenses.* Rule 37(a)(5) applies to the award of expenses.

(e) REVIEW BY THE WITNESS; CHANGES.

(1) *Review; Statement of Changes.* On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) *Changes Indicated in the Officer's Certificate.* The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

(f) CERTIFICATION AND DELIVERY; EXHIBITS; COPIES OF THE TRANSCRIPT OR RECORDING; FILING.

(1) *Certification and Delivery.* The officer must certify in writing that the witness was duly sworn and that the deposition accurately records the witness's testimony. The certificate must accompany the record of the deposition. Unless the court orders otherwise, the officer must seal the deposition in an envelope or package bearing the title of the action and marked "Deposition of [witness's name]" and must promptly send it to the attorney who arranged for the transcript or recording. The attorney must store it under conditions that will protect it against loss, destruction, tampering, or deterioration.

(2) *Documents and Tangible Things.*

(A) *Originals and Copies.* Documents and tangible things produced for inspection during a deposition must, on a party's request, be marked for identification and attached to the deposition. Any party may inspect and copy them. But if the person who produced them wants to keep the originals, the person may:

(i) offer copies to be marked, attached to the deposition, and then used as originals—after giving all parties a fair opportunity to verify the copies by comparing them with the originals; or

(ii) give all parties a fair opportunity to inspect and copy the originals after they are marked—in which event the originals may be used as if attached to the deposition.

(B) *Order Regarding the Originals.* Any party may move for an order that the originals be attached to the deposition pending final disposition of the case.

(3) *Copies of the Transcript or Recording.* Unless otherwise stipulated or ordered by the court, the officer must retain the stenographic notes of a deposition taken stenographically or a copy of the recording of a deposition taken by another method. When paid reasonable charges, the officer must furnish a copy of the transcript or recording to any party or the deponent.

(4) *Notice of Filing.* A party who files the deposition must promptly notify all other parties of the filing.

(g) FAILURE TO ATTEND A DEPOSITION OR SERVE A SUBPOENA; EXPENSES. A party who, expecting a deposition to be taken, attends in person or by an attorney may recover reasonable expenses for attending, including attorney's fees, if the noticing party failed to:

(1) attend and proceed with the deposition; or

(2) serve a subpoena on a nonparty deponent, who consequently did not attend.

NOTES

(As amended Jan. 21, 1963, eff. July 1, 1963; Mar. 30, 1970, eff. July 1, 1970; Mar. 1, 1971, eff. July 1, 1971; Nov. 20, 1972, eff. July 1, 1975; Apr. 29, 1980, eff. Aug. 1, 1980; Mar. 2, 1987, eff. Aug. 1, 1987; Apr. 22, 1993, eff. Dec. 1, 1993; Apr. 17, 2000, eff. Dec. 1, 2000; Apr. 30, 2007, eff. Dec. 1, 2007; Apr. 29, 2015, eff. Dec. 1, 2015.)

NOTES OF ADVISORY COMMITTEE ON RULES—1937

Note to Subdivision (a). This is in accordance with common practice. See U.S.C., Title 28, [former] §639 (Depositions *de bene esse*; when and where taken; notice), the relevant provisions of which are incorporated in this rule; Calif.Code Civ.Proc. (Deering, 1937) §2031; and statutes cited in respect to notice in the *Note to Rule 26(a)*. The provision for enlarging or shortening the time of notice has been added to give flexibility to the rule.

Note to Subdivisions (b) and (d). These are introduced as a safeguard for the protection of parties and deponents on account of the unlimited right of discovery given by Rule 26.

336 F.R.D. 206

United States District Court, D. Nevada.

Sean SWENSON, Plaintiff(s),

v.

GEICO CASUALTY
COMPANY, Defendant(s).

Case No.: 2:19-cv-01639-JCM-NJK

Signed August 19, 2020

Synopsis

Background: Insured brought action against automobile liability insurer, alleging breach of contract arising from insurer's failure pay policy limit for underinsured motorist benefits under his policy. Insurer moved for protective order to prevent insured from taking depositions by remote means.

The District Court, Nancy J. Koppe, United States Magistrate Judge, held that defendant failed to make particularized showing of need to support issuance of protective order.

Motion denied.

Attorneys and Law Firms

*207 Ashley Marie Ganier, Bradley S. Mainor, Joseph J. Wirth, Mainor Wirth, LLP, Las Vegas, NV, for Plaintiff.

Wade M. Hansard, Jonathan W. Carlson, Renee Maxfield, McCormick, Barstow, Sheppard, Wayte & Carruth, LLP, Las Vegas, NV, for Defendant.

Order

[Docket No. 42]

Nancy J. Koppe, United States Magistrate Judge

Pending before the Court is Defendant's motion for protective order. Docket No. 42. Plaintiff filed a response in opposition. Docket No. 43. Defendant filed a reply. Docket No. 44. The motion is properly resolved without *208 a hearing.

See Local Rule 78-1. For the reasons discussed below, Defendant's motion for protective order is hereby **DENIED**.

I. BACKGROUND

The instant action arises from an insurance dispute.¹ On July 19, 2017, a nonparty driver struck and injured Plaintiff. Plaintiff incurred medical expenses totaling \$39,460.24. His treating physician also recommended a surgery costing \$109,750. Plaintiff received the \$50,000 policy limit from the nonparty driver's insurance carrier and, on May 14, 2018, Plaintiff demanded the \$100,000 policy limit for underinsured motorist benefits under his policy with Defendant GEICO.

¹ This background section is derived largely from United States District Judge James C. Mahan's order resolving Defendant's motion to dismiss. Docket No. 36. As such, citations will generally not be provided herein.

Roughly two weeks after receiving Plaintiff's demand, GEICO requested a recorded statement, which Plaintiff gave on June 20, 2018. When Plaintiff gave his recorded statement, a GEICO claims adjuster indicated that an independent medical examination ("IME") was necessary and also requested Plaintiff's diagnostic studies. Plaintiff claims GEICO "failed to follow through with obtaining the diagnostic studies." Plaintiff provided at least one of his diagnostic studies to GEICO on October 1, 2018. On October 8, 2018, Plaintiff scheduled the IME with Dr. Daniel Lee, which he attended on November 26, 2018.

After attending the IME, Plaintiff followed up with GEICO regarding his claim several times. On December 21, 2018, the adjuster informed Plaintiff that GEICO had received Dr. Lee's report. GEICO offered plaintiff \$5,000 based on Dr. Lee's opinion that Plaintiff was misdiagnosed. Plaintiff alleges that disregarding his treating physician's surgery recommendation and offering \$5,000 was unreasonable. Plaintiff sent GEICO and Dr. Lee a rebuttal report. Plaintiff then followed up with GEICO regarding his claim. GEICO's \$5,000 offer did not change.

On May 21, 2019, Plaintiff brought suit in state court for claims of breach of contract, breach of the implied covenant of good faith and fair dealing, and violations of Nevada's Unfair Claims Practices Act. Docket No. 1-1.² On September 19, 2019, the case was removed to federal court. Docket No. 1. On November 1, 2019, the Court entered a scheduling order setting a discovery cutoff of March 23, 2020. Docket No. 18.

The discovery cutoff has been extended three times and is currently set for September 28, 2020. Docket No. 37.

² Plaintiff initially included the claims adjusters as defendants, but later agreed to dismiss them. *See* Docket No. 29.

The parties are now before the Court on a dispute as to whether depositions should move forward in light of the COVID-19 pandemic or whether such depositions should be stayed for an indefinite period of time until conditions have improved.

II. STANDARDS

“[B]road discretion is vested in the trial court to permit or deny discovery.” *Hallett v. Morgan*, 296 F.3d 732, 751 (9th Cir. 2002); *see also Crawford-El v. Britton*, 523 U.S. 574, 598, 118 S.Ct. 1584, 140 L.Ed.2d 759 (1998).

“The discovery process in theory should be cooperative and largely unsupervised by the district court.” *Sali v. Corona Reg. Med. Ctr.*, 884 F.3d 1218, 1219 (9th Cir. 2018). Nonetheless, a party from whom discovery is sought may move for a protective order to prevent annoyance, embarrassment, oppression, or undue burden or expense. Fed. R. Civ. P. 26(c)(1). The party seeking issuance of a protective order bears the burden of persuasion. *U.S. E.E.O.C. v. Caesars Entm't, Inc.*, 237 F.R.D. 428, 432 (D. Nev. 2006) (citing *Cipollone v. Liggett Grp.*, 785 F.2d 1108, 1121 (3d Cir. 1986)). Such a burden is carried by demonstrating a particular need for protection supported by specific facts. *Id.* To that end, courts “insist[] on a particular and specific demonstration of fact, as distinguished from conclusory statements,” to issue a protective order. *Twin City Fire Ins. Co. v. Employers Ins. of Wausau*, 124 F.R.D. 652, 653 (D. Nev. 1989). Broad allegations of harm, unsubstantiated *209 by specific examples or articulated reasoning, are insufficient. *Caesars Entertainment*, 237 F.R.D. at 432. A showing that discovery may involve some inconvenience or expense is likewise insufficient to obtain a protective order. *Turner Broad. Sys., Inc. v. Tracinda Corp.*, 175 F.R.D. 554, 556 (D. Nev. 1997).³

³ These standards are effectively the same as those applicable to motions to compel discovery, for which the party seeking to avoid discovery bears the burden of persuasion and must make a showing as outlined herein. *See V5 Techs. v. Switch, Ltd.*, 334 F.R.D. 306, 309 (D. Nev. 2019); *see also* Fed. R. Civ. P. 37(a)(5)(B) (upon denying a motion to compel discovery, courts may

instead issue a protective order authorized under Rule 26(c)).

District courts possess “wide discretion to determine what constitutes a showing of good cause and to fashion a protective order that provides the appropriate degree of protection.” *Grano v. Sodexo Mgmt., Inc.*, 335 F.R.D. 411, 414 (S.D. Cal. Apr. 24, 2020). Where grounds for a protective order have been established, courts have a variety of options to rectify the situation, including preventing the discovery or specifying the terms on which the discovery will be conducted. Fed. R. Civ. P. 26(c)(1)(A), (B).

In-person depositions have been standard operating practice,⁴ but the rules also provide courts with the authority to order a deposition to take place by telephone or other remote means if the circumstances so warrant. Fed. R. Civ. P. 30(b)(4). Generally, leave to take depositions by remote means should be granted liberally. *Brown v. Carr*, 253 F.R.D. 410, 412 (S.D. Tex. 2008); *see also Lopez v. CIT Bank, N.A.*, Case No. 15-cv-00759-BLF (HRL), 2015 WL 10374104, at *2 (N.D. Cal. Dec. 18, 2015) (citing case law from within the Ninth Circuit). Analyzing whether to permit remote depositions generally consists of two steps. First, the proponent must advance a legitimate reason for seeking a remote deposition. *Jahr v. IU Int'l Corp.*, 109 F.R.D. 429, 431 (M.D.N.C. 1986). Second, if that foundational showing is made, then the burden shifts to the opposing party to make a “particularized showing” that conducting the deposition by remote means would be prejudicial. *United States v. \$160,066.98 from Bank of Am.*, 202 F.R.D. 624, 629 (S.D. Cal. 2001) (collecting cases).

⁴ To be more precise, in-person depositions have been the standard operating practice in ordinary times. As will be discussed below, “[d]ue to the COVID-19 pandemic, conducting depositions remotely has become the ‘new normal.’” *Grupo Petromex, S.A. de C.V. v. Polymatrix A.G.*, Case No. 16-cv-2401 (SRN/HB), 2020 WL 4218804, at *2 (D. Minn. July 23, 2020) (quoting *In re Broiler Chicken Antitrust Litig.*, Case No. 16-cv-08637, 2020 WL 3469166, at *5 (N.D. Ill. June 25, 2020)).

Courts possess wide discretion in determining the manner for taking depositions, including whether they should take place by remote means. *Learning Res., Inc. v. Playgo Toys Enters. Ltd.*, 335 F.R.D. 536, 537-38 (N.D. Ill. June 16, 2020); *see also Hyde & Drath v. Baker*, 24 F.3d 1162, 1166 (9th Cir. 1994) (addressing discretion with respect to time and place of depositions). As with the Federal Rules of Civil Procedure more generally, courts are mindful to construe Rule 30(b)(4)

in a manner that secures the just, speedy, and inexpensive determination of the case. *See United States v. K.O.O. Constr., Inc.*, 445 F.Supp.3d 1055, 1056-57 (S.D. Cal. May 8, 2020).

III. ANALYSIS

The dispute currently before the Court arises out of Plaintiff's notices for depositions of two claims adjusters and for a Rule 30(b)(6) corporate deponent. Docket Nos. 42-1, 42-2, 42-3. The parties agree that these depositions cannot take place in person right now given the health concerns arising out of the current pandemic, as well as the governmental and personal restrictions in place to curtail the spread of the COVID-19 virus. The parties, however, dispute the proper course to take in light of the inability to conduct in-person depositions at this time. Plaintiff urges that the depositions should move forward by remote means. *See Resp.* at 3. Defendant argues that the depositions should be halted so that they can take place in-person at some future time when the pandemic is no longer an impediment to normal *210 litigation practices. *See, e.g., Mot.* at 6-7. Plaintiff has the better argument.

"The Court is mindful of the unprecedented magnitude of the COVID-19 pandemic and the extremely serious health risks it presents." *United States v. Boatwright*, — F. Supp. 3d —, —, 2020 WL 1639855, at *5 (D. Nev. Apr. 2, 2020). At the same time, mere reference to the pandemic is not a golden ticket that provides the movant admission into the chocolate factory. This general proposition holds true for requests to avoid depositions. "While the court is sympathetic to the challenges facing the legal community during this global pandemic—not unlike the rest of society, attorneys and litigants are adapting to new ways to practice law, including preparing for and conducting depositions remotely." *Newirth v. Aegis Senior Communities LLC*, Case No. 16-cv-03991-JSW (RMI), 2020 WL 4459120, at *1 (N.D. Cal. May 27, 2020). Neither party cites case law from this District, but other courts within the Ninth Circuit routinely highlight remote depositions as an effective and appropriate means to keep cases moving forward notwithstanding pandemic-related restrictions. *See K.O.O. Construction*, 445 F.Supp.3d at 1056-57 (collecting cases); *Grano*, 335 F.R.D. at 414-15 n.5 (collecting cases); *see also Christensen v. Goodman Distrib. Inc.*, Case No. 2:18-cv-02776-MCE-KJN, 2020 WL 4042938, at *5 n.3 (E.D. Cal. July 17, 2020); *Highlander Holdings, Inc. v. Fellner*, Case No. 3:18-cv-1506-AHG, 2020 WL 3498174, at *9 (S.D. Cal. June 29, 2020); *Lundquist v. First Nat'l Ins. Co. of Am.*, Case No. 18-5301 RJB, 2020 WL 3266225, at *2 (W.D. Wash. June 17, 2020); *Jammeh v. HNN Assocs., LLC*, Case No. C19-0629JLR, 2020 WL 3000775,

at *3 n.3 (W.D. Wash. June 4, 2020); *Newirth*, 2020 WL 4459120, at *1; *Jae Props., Inc. v. Amtax Holdings 2001-XX, LLC*, Case No.: 19cv2075-JAH-LL, 2020 U.S. Dist. Lexis 83418, at *4-7 (S.D. Cal. May 12, 2020); *Ogilvie v. Thrifty PayLess Inc.*, Case No. C18-0718JLR, 2020 WL 2630732, at *2 (W.D. Wash. May 12, 2020); *Cavanaugh v. Cty. of San Diego*, Case No. 18cv2557-BEN-LL, 2020 U.S. Dist. Lexis 80792, at *3 (S.D. Cal. May 7, 2020); *In re Outlaw Labs, LP Litig.*, Case No. 19CV840 GPC, 2020 WL 2111920, at *5 n.6 S.D. Cal. May 4, 2020; *Planned Parenthood of Great Nw. and the Haw. Islands v. Wasden*, Case No. 1:18-CV-00555-BLW, 2020 WL 1976641, at *4 (D. Id. Apr. 24, 2020); *Velicer v. Falconhead Capital LLC*, Case No. C19-1505 JLR, 2020 WL 1847773, at *2 (W.D. Wash. Apr. 13, 2020). In short, vague reference to pandemic-related restrictions does not substitute for the required factual showing specifically tailored to the pending case as is necessary to succeed on a motion for protective order, and courts have overwhelmingly endorsed depositions moving forward by remote means during the pandemic.

Given the similarities to the issues presented in this case, the Court finds the recent analysis by United States Magistrate Judge Barbara L. Major to be particularly instructive. *See Grano*, 335 F.R.D. 411. In that case, the plaintiff and one of the defendants sought to move forward with depositions by video, but another defendant resisted by arguing that pandemic-related restrictions warranted delaying depositions outright on the hope that conditions might improve in the short term to allow for in-person depositions. *See id.* at 412-13. The movant attempted to establish undue burden and prejudice by throwing the kitchen sink at the Court:

Sodexo argues that there is good cause for the requested relief because (1) circumstances have changed since the [case management conference] and the worsening of the COVID-19 pandemic has led to additional restrictions on businesses and individuals throughout the country, (2) not granting the relief would unfairly prejudice Sodexo as Sodexo is the only party "that must prepare for depositions with one hand tied behind its back[.]" (3) preparing for and conducting depositions via videoconference "is unworkable[.]" (4) Ms. Almedom requires an interpreter, does not have reliable Wi-Fi access or a device with a camera, and does not have a private space at her place of employment where she can meet, (5) Mr. Bowser's deposition preparation will be document intensive, he is in a vulnerable demographic, and refuses to meet with counsel in person, (6) Ms. *211 Snyder is exceptionally busy right now responding to the COVID-19 pandemic, (7) Sodexo's

lead counsel are all in a vulnerable demographic, (8) “gathering, reviewing, and providing pertinent documents to the witnesses ha[s] become very difficult in the current climate[,]” and (9) conducting depositions via videoconference will be “cumbersome.”

Id. at 413. Judge Major rejected each of these contentions. With respect to the particular logistical objections that video depositions are “unworkable” or “cumbersome,” Judge Major was unmoved given the resources and training available to ensure video depositions proceed with limited inconvenience. *Id.* at 414-15. With respect to the health concerns raised, Judge Major flatly rejected reliance on such concerns because “the remote deposition structure eliminates those concerns.” *Id.* at 415-16 n.4. In short, Judge Major’s decision makes clear that there has been widespread use of video depositions during the pandemic and that video depositions are an effective tool to keep cases moving forward in the current climate. Hence, the motion for protective order was denied and depositions were ordered to move forward by remote means.

The arguments advanced in Defendant’s motion for protective order in this case track closely with the arguments rejected by Judge Major. Defendant’s motion is predicated on assertions that pandemic-related restrictions impede travel and “preclude[] GEICO’s Counsel’s ability to adequately prepare and defend GEICO personnel in person, for and at, their depositions.” Mot. at 3. Without meaningful explanation, the motion then raises the “burden, hardship[,] and inequity” in moving forward with depositions by remote means as doing so would “irreparably harm GEICO’s defenses” and would “unnecessarily place[] lives at risk.” *Id.* at 6. The motion challenges video depositions as “half-measures” that cannot “ever be as effective as in-person” depositions. *Id.* Defendant points to the fact that at least one deponent is in a “high-risk” category and that remote depositions are unsafe in that they would “likely” involve travel to a court reporter’s office. *Id.* at 7. Given these assertions, the motion indicates that the “only logical recourse” is to prohibit video depositions and to instead stop depositions altogether. *Id.* The Court is unpersuaded.

The Court begins by analyzing whether there are legitimate reasons for Plaintiff’s desire to take depositions remotely. Legitimate reasons plainly exist. As numerous courts have recognized, “the physical distancing orders related to the current pandemic are a legitimate reason for holding depositions remotely.” *Cavanaugh*, 2020 U.S. Dist. Lexis 80792, at *3; *see also Broiler Chicken*, 2020 WL 3469166, at *7 (finding pandemic conditions justify a request for

conducting depositions remotely and that such reason transcends any particular deposition).

Plaintiff having met the initial burden in the inquiry, the key analytical issue is then whether Defendant has established grounds to prevent the remote depositions. Defendant fails to meet its burden. The overarching problem with Defendant’s position is that it is based on speculation and assumption rather than meaningful explanation supported by a factual showing or legal authority. By way of example, Defendant contends that the deponents’ safety will be at risk because they would be required to travel to a court reporter’s office for the video depositions. Mot. at 7. Defendant presents no citation to legal authority to support the foundation of this argument, which is that the deponent and the court reporter must always be physically present in the same room. The case law is to the contrary. *E.g.*, *Grano*, 335 F.R.D. at 414 n.5 (collecting decisions issued during the pandemic that a deposition will be construed as being conducted “before” an officer so long as the officer is connected to the deposition by remote means; physical presence is not required).⁵ In short, holding depositions remotely *212 entirely “eliminates” the safety concerns identified by Defendant here. *E.g.*, *id.* at 415-16 n.4. Similarly, the motion speculates that remote depositions are cumbersome and are otherwise insufficient substitutes for in-person depositions. *See* Mot. at 5, 6. Defendant presents no citation to legal authority supporting this position,⁶ nor any factual showing supporting this position. Again, the case law is the contrary. *E.g.*, *Grano*, 335 F.R.D. at 414-15; *K.O.O. Construction*, 445 F.Supp.3d at 1056-57 (collecting cases that the need to use voluminous and highly detailed exhibits does not establish prejudice for video deposition).⁷ In short, ample resources exist for counsel to prepare themselves to proceed by video to facilitate the smooth operation of a remote deposition. *E.g.*, *Grano*, 335 F.R.D. at 414-15. Hence, none of the arguments advanced by Defendant is persuasive. Having failed to make a particularized showing of need, Defendant has not met its burden to support issuance of a protective order prohibiting Plaintiff from taking the depositions at issue by remote means.

⁵ Even absent this case law, the motion provides no explanation why the parties could not stipulate that physical presence of the court reporter was unnecessary. *See* Fed. R. Civ. P. 29(a) (giving parties a broad ability to stipulate to deposition procedures).

⁶ The motion points to one case as supporting this argument. *See* Mot. at 5 (citing *Testone v. Barlean’s*

Organic Oils, LLC, Case No. 19-cv-169 JLS, 2020 WL 2838689, at *2 S.D. Cal. May 29, 2020). The reliance on that case, however, is misplaced. Although the parties there had presented competing arguments regarding the appropriateness of video depositions, see *Testone*, 2020 WL 2838689, at *2, the court did not make any findings on the issue because it instead stayed the case to avoid potentially duplicative discovery in the event a pending motion to disqualify counsel was granted, *id.*

7 The Court rejects Defendant's assertion that its preference for in-person depositions constitutes grounds for a protective order. "If the lack of being physically present with the witness were enough prejudice to defeat the holding of a remote deposition, then Rule 30(b)(4) would be rendered meaningless." *Rouviere v. DePuy Orthopaedics, Inc.*, Case No. 1:18-cv-04814 (LJL) (SDA), 2020 WL 3967665, at *4 (S.D.N.Y. July 11, 2020).

The Court notes further Plaintiff's argument that the indefinite timeline proffered in the motion for protective order is problematic. See Resp. at 2. The discovery cutoff has already been extended three times in this case. See Docket Nos. 23, 28, 37. Defendant's motion for protective order seeks to delay the depositions at issue to an unspecified date once "the health and safety concerns due to the pandemic" permit. Mot. at 5. Defendant speculates that this new reality will dawn "most likely [in] only a few months [when] a vaccine becomes available or the number of cases decreases substantially." *Id.* at 6. Defendant provides no basis for its projected timeline, however, and it appears to be based on pure speculation. Cf. *Cavanaugh*, 2020 U.S. Dist. Lexis 80792, at *4. The Court is similarly unable to predict the creation and distribution of an effective vaccine or the ebbs and flows of the spread of the virus in the meantime. Unfortunately, it could well be that pandemic-related restrictions exist for many months to come, in which scenario granting Defendant's motion for protective order would cause extreme delay in this case.⁸ "It is not feasible for the Court to extend deposition deadlines until a time when [depositions] can be safely conducted in person because no one knows when that will occur and there

are alternatives" in that such depositions can be taken now by remote means. *K.O.O. Construction*, 445 F.Supp.3d at 1056-57; see also *Newirth*, 2020 WL 4459120, at *2.⁹ Stated differently, granting Defendant's motion for protective order would run afoul of the mandate to construe the rules in a manner that secures the just, *213 speedy, and inexpensive determination of cases. Fed. R. Civ. P. 1.

8 Assessments from government health officials undermine Defendant's prediction. E.g., *Broiler Chicken*, 2020 WL 3469166, at *8 (collecting such assessments). For example, a chief adviser of the federal government's vaccine program said recently that he was optimistic that a sufficient supply of vaccines for all Americans would be available by the end of 2021 or, possibly, within the first half of 2021. See <https://www.cnn.com/videos/health/2020/07/30/coronavirus-vaccine-timeline-effectiveness-cohen-lead-bts-vpx.cnn> (last viewed August 7, 2020).

9 The Court herein rules only on the arguments presented in the motion that is now pending in this case. Further militating against granting the motion, however, is the fact that Defendant's arguments could be made in nearly every civil case. Accepting Defendant's position would open the door to significant delays in thousands of cases that are currently pending in this courthouse.

Accordingly, Defendant has not met its burden for issuance of a protective order prohibiting Plaintiff from taking depositions by remote means.

IV. CONCLUSION

For the reasons discussed above, Defendant's motion for protective order is **DENIED**.

IT IS SO ORDERED.

All Citations

336 F.R.D. 206, 107 Fed.R.Serv.3d 1035

335 F.R.D. 536
United States District Court,
N.D. Illinois, Eastern Division.

LEARNING RESOURCES, INC., Plaintiff,
v.
PLAYGO TOYS ENTERPRISES LTD.,
Sam's West, Inc., Sam's East, Inc.,
Jet.Com, and Walmart Inc., Defendants.

No. 19-CV-00660
|
Signed June 16, 2020

Synopsis

Background: In copyright infringement action, following copyright owner's notice of in-person deposition, alleged infringers filed motion for entry of an order requiring that deposition be conducted by remote video conference because of health concerns related to the on-going COVID-19 pandemic.

The District Court, Jeffrey Cummings, United States Magistrate Judge, held that health concerns created by the COVID-19 pandemic created good cause for the entry of an order requiring that deposition take place by remote video conference.

Motion granted.

Attorneys and Law Firms

*537 Arthur Gollwitzer, III, Michael Best & Friedrich LLP, Austin, TX, Larry L. Saret, Carolyn E. Isaac, Mircea A. Tipescu, Michael Best & Friedrich LLP, Michael David Bess, Winston & Strawn LLP, Chicago, IL, for Plaintiff.

Richard Z. Lehv, Pro Hac Vice, Fross, Zelnick, Lehrman & Zissu, P.C., New York, NY, Amy T. Adler, William T. McGrath, Davis McGrath LLC, Chicago, IL, for Defendant Playgo Toys Enterprises Ltd.

William T. McGrath, Amy T. Adler, Davis McGrath LLC, Chicago, IL, for Defendants Sam's West, Inc., Sam's East, Inc., Jet.Com, Inc., Walmart Inc.

MEMORANDUM OPINION AND ORDER

Jeffrey Cummings, United States Magistrate Judge

Plaintiff Learning Resources, Inc. filed this copyright infringement action alleging that the Walmart defendants (Walmart Inc., Sam's West, Inc., Sam's East, Inc., and Jet.Com) and Playgo Toys Enterprises Ltd. violated the Copyright Act of 1976, 17 U.S.C. § 101 *et seq.*, by selling play food items intentionally copied from Learning Resources. Learning Resources has noticed the in-person deposition of Ms. Shelley Latham in Fayetteville, Arkansas, for June 30, 2020. Ms. Latham is a Senior Merchant for Toys for the Walmart defendants and was – according to Learning Resources – “the ‘buyer’ of (and executive responsible for) the infringing products in this case.” (Dckt. #101 at 1). The Walmart defendants do not believe that Ms. Latham's deposition should be conducted in-person because of concerns related to the on-going COVID-19 pandemic. Although Playgo agrees that the deposition need not be conducted in-person, Learning Resources insists that it must be. Consequently, the Walmart defendants have filed a motion pursuant to Federal Rules of Civil Procedure 26(c) and 30(b) (4) for the entry of an order requiring that Ms. Latham's deposition be conducted by remote videoconference. The Walmart defendants' motion is granted for the reasons stated below.

I. STANDARD

Federal Rule of Civil Procedure 26(c) provides that this Court may, for good cause, issue an order to protect a party or person from annoyance, embarrassment, oppression, or undue burden or expense. Fed.R.Civ.P. 26(c). This Court is vested with “broad discretion to decide when a protective order is appropriate and what degree of protection is required.” *Shockey v. Huhtamaki*, 280 F.R.D. 598, 600 (D. Kan. 2012). Federal Rule of Civil Procedure 30(b)(4) authorizes this Court in its discretion to order that a deposition “be taken by telephone or other remote means.” Fed.R.Civ.P. 30(b)(4); *Usov v. Lazar*, No. 13 CIV 818, 2015 WL 5052497, at *1 (S.D.N.Y. Aug. 25, 2015); *Graham v. Ocwen Loan Servicing, LLC*, No. 16-80011-CIV, 2016 WL 7443288, at *1 (S.D. Fla. July 1, 2016) (“[C]ourts enjoy wide discretion to control and place appropriate limits on discovery, which includes authorizing depositions to be taken by remote means”). When exercising its discretion, this Court “must ‘balance claims of prejudice and those of hardship and conduct a careful

weighing of the relevant facts.’ ” *538 *Usov*, 2015 WL 5052497, at *1, quoting *RP Family, Inc. v. Commonwealth Land Title Ins. Co.*, No. 10 Civ. 1149, 2011 WL 6020154, at *3 (E.D.N.Y. Nov. 30, 2011).

II. DISCUSSION

The Walmart defendants seek to have Ms. Latham's deposition conducted by remote videoconference based on safety concerns created by the COVID-19 pandemic. In particular, the Walmart defendants' lead counsel (Mr. William McGrath) is in a high-risk category if exposed to COVID-19 due to the fact that he is over 65 years-old. (Dckt. #100-1 at 2). Mr. McGrath's wife and his son-in-law (who lives nearby) are likewise in high risk categories. (*Id.*). The Walmart defendants believe that an unnecessary and unacceptable risk to the health of Mr. McGrath and others will be created if he is forced to fly from Chicago to Arkansas to attend a deposition in a confined room with other counsel (who will travel from New York City and Austin), Ms. Latham, and a court reporter. (*Id.*).

For its part, Learning Resources asserts that “in-person depositions are the norm in American jurisprudence, and a party is well within its rights to cross-examine an adverse witness face-to-face.” (Dckt. #101 at 3). Furthermore, while Learning Resources is “sensitive to health and safety concerns raised by Defendants' counsel”, it asserts that the “conditions on the ground in Arkansas are much different than in Chicago.... because [t]he governor has lifted most aspects of the shut-down orders.... [and] [l]ife in Arkansas is rapidly returning to business a[s] usual.” (*Id.* at 2, 3). Finally, Learning Resources insists that its proposed compromise of having Mr. McGrath attend the deposition by video while a Walmart attorney based in Arkansas attends in person would “address any fairness concerns” raised by the Walmart defendants. (*Id.* at 2).

1. COVID-19 related health concerns provide “good cause” for a remote videoconference deposition under the circumstances of this case

As other courts have recognized, “[t]he President of the United States has declared a national emergency due to the spread of the COVID-19 virus, and the Centers for Disease Control have noted that the best way to prevent illness is to minimize person-to-person contact.” *Sinceno v. Riverside Church in City of New York*, No. 18-CV-2156 (LJL), 2020 WL 1302053, at *1 (S.D.N.Y. Mar. 18, 2020). To protect Court personnel, the bar, and the public against

the severe risks posed by COVID-19, federal courts around the country – including the Western District of Arkansas where Fayetteville is located – have authorized video teleconferencing for a number critical criminal proceedings that had previously been conducted in person and imposed a moratorium on various other court proceedings. *See, e.g.*, Western District of Arkansas, Admin. Order 2020-3 Use of Video Teleconferencing and Telephone Conferencing During Course of the Covid-19 Pandemic (dated 3/31/20); Western District of Arkansas, Admin. Order 2020-5 Court Operations During the COVID-19 Pandemic (dated 5/21/20). These restrictions, as Learning Resources acknowledges, remain in effect through the present day. (*Id.*; Dckt. #101 at 3 n.3).

The general concern over the risks posed by COVID-19 are heightened in this case for three reasons. First, the Walmart defendants' lead counsel, Mr. McGrath, and members of his family are in a high risk category if exposed to COVID-19. Second, counsel for the parties will be traveling to Arkansas from three areas that have either been COVID-19 “hot spots” (namely, New York City and Chicago) or where COVID-19 hospitalization rates are currently on the rise (Austin). *See* “Austin enters Stage 4 COVID-19 risk-based level after a spike in hospitalizations,” KVUE ABC (June 14, 2020) available at: <https://www.kvue.com/article/news/health/coronavirus/austin-texas-covid19-risk-level-4-hospitalizations-coronavirus/269-8eacb5c4-d441-47d5-a902-3aba79b93317>. Finally, notwithstanding the fact that the governor of Arkansas has lifted most aspects of the shut-down orders,¹ “Northwest Arkansas (where *539 Fayetteville is located) is experiencing a surge in community spread of the [COVID-19] virus ... and has witnessed a significant increase in the number of hospitalized individuals with COVID-19.” *See* “Washington Regional official: COVID-19 spike in NWA” is a “serious public health emergency,” ABC 4029 News (June 11, 2020) available at: <https://www.4029tv.com/article/washington-regional-official-covid-19-spike-in-nwa-is-a-serious-public-health-emergency/32831055>.

¹ As the Southern District of New York recently observed, “[t]he fact that certain jurisdictions are beginning to relax their restrictions, a process based in part on political or economic considerations, does not mean that community spread has ceased or that individuals need not be concerned about potential exposure.” *Joffe v. King & Spalding, LLP*, No. 17 Civ. 3392 (VEC) (SDA), Order (6/4/20) (Dckt. #239 at 6) [hereinafter “*Joffee Order*”].

For these reasons, the Court finds that the health concerns created by the COVID-19 pandemic create “good cause” for the entry of an order requiring that Ms. Latham’s deposition take place by remote videoconference under the circumstances in this case.² *See, e.g., In re RFC & ResCap Liquidating Tr. Action*, No. 013CV3451SRNHB, 444 F.Supp.3d 967, 971 (D. Minn. Mar. 13, 2020) (“[u]nder the circumstances, COVID-19’s unexpected nature, rapid spread, and potential risk establish good cause for remote testimony”); *Joffe Order* (“Plaintiff’s proposal requires counsel or witnesses to travel across state lines from disparate places of origin, congregate for several hours in a confined space, and then disperse back to their homes.... The burden on witnesses, in the form of potential exposure and infection for them and their families, needs no further elaboration. Indeed, for essentially those same reasons, the Court has not resumed in-person proceedings.”); *SAP, LLC v. EZCARE Clinic, Inc.*, No. CV 19-11229, 2020 WL 1923146, at *2 (E.D. La. Apr. 21, 2020) (“This court will not require parties to appear in person with one another in the midst of the present pandemic.”).

² The Court’s holding in this case is not tantamount to a finding that concerns raised regarding COVID-19 will *always* suffice to support the entry of an order requiring a remote videoconference deposition. *Cf. Manley v. Bellendir*, No. 18-CV-1220-EFM-TJJ, 2020 WL 2766508, at *3 & n.10 (D. Kan. May 28, 2020) (finding that a remote videoconference deposition was not warranted where defendant asserted that “due to Plaintiff’s past substance abuse, his in-person deposition [wa]s necessary to keep Plaintiff focused and efficiently conduct the deposition,” “Defendant’s need and ability to safely depose Plaintiff in person with the precautions outlined by Defendant outweigh[ed] Plaintiff’s general concerns regarding COVID-19,” and plaintiff’s counsel failed to substantiate her suggestion that she was in a high risk group for contracting the virus).

2. The frustration of Learning Resources’ intent to question Ms. Latham in person does not create prejudice sufficient to overcome the risks created by COVID-19 under the circumstances here

Ms. Latham is seemingly an important witness given her role as the Walmart defendants’ “buyer” of the allegedly infringing products in this case. It is certainly understandable that Learning Resources would like to question her face-to-face and this Court recognizes that “a party’s ability to observe a deponent in person does have value.” *Usov*, 2015 WL 5052497, at *2. Nonetheless, “remote depositions are a presumptively valid means of discovery” even

without the in-person interaction (*Id.* (internal quotation marks omitted)), and many courts have held that remote videoconference depositions offer the deposing party a sufficient opportunity to evaluate a deponent’s nonverbal responses, demeanor, and overall credibility. *See, e.g., Id.*, at *2; *Sec. & Exch. Comm’n v. Aly*, 320 F.R.D. 116, 119 (S.D.N.Y. 2017); *Tangtiwatanapaibul v. Tom & Toon Inc.*, No. 117CV00816LGSKHP, 2017 WL 10456190 at *3 (S.D.N.Y. Nov. 22, 2017); *Graham*, 2016 WL 7443288 at *2; *Shockey*, 280 F.R.D. at 602; *Gee v. Suntrust Mortgage, Inc.*, No. 10-CV-01509 RS NC, 2011 WL 5597124 at *3 (N.D. Cal. Nov. 15, 2011).

Moreover, the cases cited by Learning Resources are inapposite and do not support the proposition that remote videoconference deposition would be inappropriate in this case. Two of the cases³ concern whether the *540 deponent should be deposed either in-person or through a telephone deposition – which is a clearly less desirable method than taking a deposition through a remote videoconference. *See, e.g., Shockey*, 280 F.R.D. at 602 (the “disadvantages of telephonic depositions ... do not apply at all, or to the same degree, when the depositions are to be taken via videoconference”); *United States v. One Gulfstream G-V Jet Aircraft*, 304 F.R.D. 10, 17 n.4 (D.D.C. 2014) (“[T]elephonic depositions are disfavored because it is impossible to see the witness’s demeanor, watch what documents the witness is reviewing, or monitor who else the witness is talking with”). In the third case, the Seventh Circuit recognized that it was generally more desirable to present testimony at trial in-person rather than through videoconferencing but nonetheless affirmed the district court’s decision to force a plaintiff inmate to testify at trial by videoconferencing rather than in-person as he had sought to do. *Perotti v. Quinones*, 790 F.3d 712, 721-25, 729 (7th Cir. 2015).

³ *Mattar v. Cmty. Mem’l Hosp.*, No. 1:04CV95, 2005 WL 6486402 at *1-2 (N.D. Ind. Feb. 18, 2005); *In re: The TJX Companies, Inc., Fair & Accurate Credit Transactions Act (FACTA) Litig.*, No. 07-MD-1853-KHV, 2008 WL 717890, at *2 (D. Kan. Mar. 17, 2008); *see also Clayton v. Velociti, Inc.*, No. 08-2298-CM/GLR, 2009 WL 1033738, at *5 (D. Kan. Apr. 17, 2009) (citing *TJX* for the proposition that “nothing in the Federal Rules of Civil Procedure requires the Court to order that depositions be taken telephonically”).

3. Learning Resources' proposal that the Walmart defendants hire additional counsel to represent Ms. Latham at her in-person deposition is unreasonable

Learning Resources asserts that the risk to Mr. McGrath can be averted if the Walmart defendants retain additional counsel in Arkansas to represent Ms. Latham in-person while Mr. McGrath attends the deposition by video. (Dckt. #101 at 2-3). Learning Resources' counsel asserts that Walmart has retained the same local law firm to represent three of its witnesses whom he has deposed within the last fifteen months and it can follow the same procedure in this case. (*Id.*). While the Walmart defendants do not challenge this representation, they do argue that requiring them to “engage additional local counsel unfamiliar with the case to be physically present while Mr. McGrath appears remotely would unnecessarily deprive Walmart of the effective assistance of its current counsel.” (Dckt. #100, at 2). The Court agrees. The fact that Walmart voluntarily chose to retain local counsel to represent its witnesses of unspecified importance in other unspecified cases does not automatically mean that it would be fair to order it to retain local counsel in this case. Moreover, as stated above, Ms. Latham appears to be an important witness and an attorney should be thoroughly conversant with the issues in this case to properly represent her during her deposition. It is unreasonable to expect the Walmart defendants to hire new counsel – even counsel who have previously represented Walmart in other litigation – and incur the expense and effort to get them fully up to speed in the next couple of weeks

when the option of conducting Ms. Latham's deposition by videoconference is available.

In sum: while the Court is sympathetic to Learning Resources' preference for an in-person deposition, that preference is outweighed by the risks posed by the COVID-19 pandemic and the hardship that the Walmart defendants will likely experience if their lead counsel is unable to be physically present during Ms. Latham's in-person deposition. Consequently, in its discretion, the Court orders that Ms. Latham's deposition take place via remote videoconference. The Court further orders that the Walmart defendants bear any additional costs that are created by use of the videoconferencing format. *See, e.g., Graham*, 2016 WL 7443288, at *2 (imposing videoconferencing costs on the party who successfully moved to have the deposition conducted by videoconference); *Tangtiwatanapaibul*, 2017 WL 10456190 at *4 (same).

CONCLUSION

For these reasons, the Walmart defendants' motion to require deposition by remote means [Dckt. #100] is granted.

All Citations

335 F.R.D. 536

End of Document

© 2021 Thomson Reuters. No claim to original U.S. Government Works.

**Country Lawyer:
Abraham Lincoln and
the Art of Persuasion**

Presented By:

**David J. Rebein, Attorney
Rebein Brothers PA**

COUNTRY LAWYER: ABRAHAM LINCOLN
AND THE ART OF PERSUASION

David J. Rebein
Rebein Brothers
810 Frontview - P.O. Box 1147
Dodge City, KS 67801
620.227.8126 tel.
620.227.8451 fax
David@rbr3.com
www.rbr3.com

~WHY LINCOLN~

As advocates we are constantly trying to persuade. Trying to get the judge, the jury, or the other side to see our view of the case. There are seminars on advocacy, but many are war stories about the big verdict or the complex case. How does that relate to us in rural Kansas? Our cases are often small, and they might take a hearing or two to conclude. We are in front of the same judges and against the same attorneys every day. It is here where Lincoln might teach us something. He was the consummate country lawyer. He took cases big and small. He drew contracts, wills and defended criminal cases and boundary disputes and argued cases on appeal. He handled mortgage foreclosures and collected debts. For 4 months a year he travelled to the 8 small counties in his judicial district. He was, in fact, much like us.

We can look to Lincoln for proof that if you want something bad enough, you can achieve it. Lincoln, over the course of 25 years of practice became an able lawyer but you would not know it by his resume. He had about a year of formal education. He was self-taught. He had an intense desire to better himself and, over time, he built a practice and a reputation. Do you flinch because you didn't go to a name law school or graduate at the top of your class? Lincoln didn't even go to law school. Do you hesitate because of a lack of confidence? Lincoln was socially awkward and lacking in social graces. A fellow lawyer remarked: "When I first knew him his attire and physical

habits were on a plane with an ordinary farmer. His hat was shapeless, his boots had no acquaintance with blacking-- his clothes had not been introduced to the whisk broom-- his carpet bag was well-worn and dilapidated-- his umbrella was substantial, but of a faded green, well worn, with the knob gone-- and his outer garment was a circular blue cloak which he wore for at least 10 years.

When Lincoln was on the circuit, he lived a nomadic life. He had no clerk, no stenographer, no library, no system or method of business. He carried his papers in his hat or his coat pocket. The judge and the lawyers travelled together by horse and by buggy and often shared a table in a tavern and slept several to a bed at night.

And yet this awkward and shy man was regarded as a great advocate and, of course, went on to bigger and better things. What can Abraham Lincoln teach us today?

~AUTHENTICITY~

The trial lawyers of Lincoln's day were orators. They were theatrical. They could drip with sarcasm and scorn or call upon the saints and the prophets. They were entertainers. By contrast, Lincoln was conversational. He was self-deprecating. His language was plain, and it was said that he was able to almost climb into the box with the jury. He was not afraid to identify with his client. He was authentic and therefore credible.

It is often said that, in order to be persuasive, you should simply be yourself. This is true, but especially true if you are your best self. Be prepared, be organized, be professional. If you are prepared, organized and professional, you will be more relaxed, and if you are relaxed, you will be your best self.

In order to persuade, one must be credible. Credibility only comes from a real desire to seek the truth. The jury must know, that while you are an advocate, your fidelity to the truth comes

first. One of the first judgments that a jury will make is whether you believe in the case. Why should a jury care about the outcome if you don't? The jury will be looking to see how you treat your client and the witnesses. They will look at your level of preparation as evidence of whether you really care. If you don't care enough about the case to prepare, then why should they? Caring is contagious.

You must not only care about the case, you must care about the client. You most effectively demonstrate caring by getting to know the client. Get to know their past and their families and their dreams. Demonstrating a depth of knowledge about the client and their life is just another way of showing that you care.

~RESPECT FOR THE AUDIENCE AND THE DECISION MAKER~

Lincoln may have been shy and awkward, but he was unfailingly gracious. He is often described as kind. We can be gracious and respectful too.

Every presentation in court has an audience. When you stand to argue, or to question a witness, or display an exhibit, demonstrate a respect for the audience. Make sure that everything is easily understood. Your language should be simple, clear, and free of legalese. Make sure that the jury and court can see and hear. Show a professional deference to everyone in the courtroom, including the court reporter, the witnesses and opposing counsel. Respect the jury's time. Be on time, be prepared. Don't fumble around. Make your points and then sit down.

Listening is an underappreciated skill. Listening is related to caring. Really listen in voir dire. Really listen to witnesses. Being ready to depart from your notes and follow up. A surprise answer has won many a case. There is a power in listening, really listening can yield surprising results.

~STORY TELLING~

Lincoln was a renowned storyteller. Often at night, Judge Davis would call on Lincoln to regale the audience with the story of the days events.

To persuade, you must first engage, and nothing engages a human being like a story. Do we not get caught up in a song? Are we not inspired by a movie? Are we not changed by a novel? Joseph Campbell, in his landmark book, “The Hero With A Thousand Faces”, makes the case for a universal story. This story crossed cultures and centuries. It is as old as Homer and as new as Star Wars. The story of the ‘hero’s journey’ is the idea of a call to adventure and undergoing trial and overcoming obstacles enroute to an outcome that benefits everyone. This fits so perfectly the journey that a jury will take. They are called away from their everyday jobs, they accept a difficult assignment, jurors are asked to make an important decision and then they return to their lives. Our job is to find the theme within the case that will guide their decision. Every case is different but common themes are safety, responsibility and greed. Finding the theme is a process and the use of focus groups is often a good way to decide what theme at trial will move a jury.

~PREPARATION~

Lincoln was always prepared. His style was brief and stripped down, but he always had a plan.

Organizing the evidence is important. Once a theme is discovered, the evidence is culled so that the presentation at all times fits the theme. It is well known that decisions are made emotionally and then logic is applied to justify a decision hat has already been made. A jury can be moved to take action by emotion, but they must have substance at hand to take action. For example, a jury might be enraged by an accident caused by a drunk driver, but they will still need evidence of injuries, including past medical, future medical, lost wages, etc. to arrive at a final

decision. Both types of evidence must be offered early as studies show that jurors have largely made up their minds by the conclusion of voir dire, opening statements and the first witness.

The beauty of a good theme is that it reinforces a jury's initial impression throughout the trial from direct to cross, to closing. Repetition is necessary and a good thing. Repetition is bearable if it is interesting, creative and subtle.

~HONESTY~

Lincoln detested the name "honest Abe". He preferred, even as President, to be called simply "Lincoln". His reputation for honesty was, however, well-deserved. As you might imagine, in the life of the circuit, everyone knew which lawyers were truth tellers and which could not be trusted. Lincoln was often against a lawyer in the morning and co-counsel with him in the afternoon.

We live by our words, actions, and promises. We can't escape. We can have the reputation of a truth teller or the reputation of someone who bears watching.

~OUR BETTER ANGELS~

Lincoln lived in a time when life was hard. Most people were uneducated. Yet, his approach was to look for the best in people and to ask the jury to rise to the occasion. The case is important and so the jury's job is important. This optimistic view endeared Lincoln to others and made his argument persuasive. People can tell if you are engaged and, if you are, you can inspire. A diarist left his impression of Lincoln at Cooper's Union, "When Lincoln rose to speak, I was greatly disappointed. He was tall, how tall, and so angular and awkward that I had, for an instant, a feeling of pity for so ungainly a man. However, as Lincoln warmed up, his face lighted up as with an inward fire; the whole man was transfigured. I forgot his clothes, his personal appearance, and his

individual peculiarities. Presently, forgetting myself, I was on my feet, yelling like a wild Indian, cheering for this wonderful man.”

~KNOWING THE COURT AND THE JURY~

Lincoln knew his audience. While, hopefully, we don’t have to share a bed with opposing counsel, we can make sure we know the terrain. How does the judge like to take up motions? How does the court reporter prefer to receive exhibits? When does the court like to take breaks? We should know as much in advance as we can about the Court.

~THE CIRCUIT: THE ULTIMATE FOCUS GROUP~

Lincoln was constantly trying out arguments on friends and acquaintances. He was informed as to the reputation of parties and witnesses. We too can focus group our cases and try out our themes. Always asking the question; how is this going to play?

~MASTERY~

Persuasion is an art. As trial lawyers we are on the path toward mastery. We never arrive. But we do get better.

"The Memo That Started It All" by Christopher Vogler
([link to original site here](#))

From time to time people ask me for a copy of the original seven-page memo that was the foundation of THE WRITER'S JOURNEY. For many years I lost track of the original version and could only offer to send people the longer versions that evolved later, or point them to my book, where the memo was embedded in the first chapter, but they weren't satisfied with these solutions, apparently believing there was something almost magical about that original terse, blunt statement of my beliefs. They had to have the "legendary seven-pager" which I had called "A PRACTICAL GUIDE TO THE HERO WITH A THOUSAND FACES", but I was never able to lay hands on the original short version. Until now, that is.

After upheavals of home and office, and sifting through many files and boxes, I have finally come across the raw, original text of The Memo, and I offer it here to you, with the hopes it will have some of the magical effect on you that people attribute to it. But first, I'd like to share some of the context around the creation of this little document.

It was written in the mid-1980s when I was working as a story consultant for Walt Disney Pictures, but I had discovered the work of mythologist Joseph Campbell a few years earlier while studying cinema at the University of Southern California. I was sure I saw Campbell's ideas being put to work in the first of the Star Wars movies and wrote a term paper for a class in which I attempted to identify the mythic patterns that made that film such a huge success. The research and writing for that paper inflamed my imagination and later, when I started working as a story analyst at Fox and other Hollywood studios, I showed the paper to a few colleagues, writers and executives to stimulate some discussion of Campbell's ideas which I found to be of unlimited value for creating mass entertainment. I was certainly making profitable use of them, applying them to every script and novel I considered in my job.

Eventually I arrived at Disney where a strong corporate culture and a string of hits were being created by executives Michael Eisner and Jeffrey Katzenberg. Memos were a big part of that corporate identity, a means of persuasively communicating concepts and attitudes, and all of us who worked at Disney at that time had to learn the memo art form, following the example of Katzenberg, an absolute master.

I suppose the discipline of writing succinct development notes, story coverage and research memos kindled in me a desire to express the exciting ideas I had found in Campbell in a clear, concise way. I wanted to once and for all get them down as creative principles, a set of reliable building blocks for constructing stories, a set of tools for troubleshooting story problems.

So I took time off from my story analyst job and spent a week in New York City with David McKenna, a good friend I'd met years ago while doing theatre in San Antonio in my Air Force days. We'd followed parallel paths in film and theatre, and eventually converged as story analysts and consultants. He is a great film buff and a good guy to bounce ideas off of, and together we shook out the details of the Hero's Journey as it seemed to apply to movies. We worked out terminology and discussed scenes from films in every genre to demonstrate the variations of the Hero's Journey pattern. We wore out his VCR looking at old movie clips. At the end of this intense phase I went back to L.A. and pounded out the seven-page memo, sending the first copy to McKenna.

I gave copies of The Memo to my story analyst friends and to key Disney executives including Ricardo Mestres of Hollywood Pictures and David Hoberman of Touchstone, both divisions of Disney. "Interesting," was all that most people said, at first. But I knew, I sensed somehow, I

was on to something. I had the vision that copies of The Memo were like little robots, moving out from the studio and into the jetstream of Hollywood thinking all on their own. Fax machines had just been invented and I envisioned copies of The Memo flying all over town, and that's exactly what happened.

Feedback started coming in that suggested I had hit a nerve. I heard young executives buzzing about it, telling their friends about it. It became the "I have to have it" document of the season at talent agencies and in studio executive suites like that of Dawn Steel at Paramount. And in the sincerest form of compliment, it was promptly plagiarized. One instance was right under my nose in the studio. A junior executive had taken off my title page and substituted his own name as author, and then submitted it to Jeffrey Katzenberg, who read it and pronounced it a very important document at a meeting of his development execs, making it required reading for the entire staff.

Fortunately someone at that table had already read The Memo and knew I was the true author. I heard about it on the studio grapevine within minutes and immediately sent off a letter to Mr. Katzenberg, asserting myself as the author of The Memo and requesting deeper involvement in story development. He called me right away and put me to work with Disney's Feature Animation division, where I began doing research and development work on THE LION KING and many other projects. When I arrived I found The Memo had preceded me, and the animators were already outlining their story boards with Hero's Journey stages.

The Memo served as a handout when I began teaching story analysis at the UCLA Extension Writers' Program. And that's when it began to grow, as I developed the ideas more fully and added more examples. Eventually I included material about the archetypes and soon there was enough material to contemplate a book, and thus THE WRITER'S JOURNEY was born from a humble seven-page acorn.

But people continue to attribute special importance or powers to the original seven-pager, especially those who had been around when its impact was first felt. At one point, a museum dedicated to screenwriting requested a copy for a display of what they considered the milestone documents and books in the history of the craft. And so I give you The Memo, thus releasing many more little robots to distribute these ideas far and wide, to influence movies, computer game design, or whatever field where they may be useful.

"A Practical Guide to Joseph Campbell's The Hero with a Thousand Faces"
by Christopher Vogler © 1985

"There are only two or three human stories, and they go on repeating themselves as fiercely as if they had never happened before."

Willa Cather

INTRODUCTION

In the long run, one of the most influential books of the 20th century may turn out to be Joseph Campbell's THE HERO WITH A THOUSAND FACES.

The book and the ideas in it are having a major impact on writing and story-telling, but above all on movie-making. Filmmakers like John Boorman, George Miller, Steven Spielberg, George Lucas, and Francis Coppola owe their successes in part to the ageless patterns that Joseph Campbell identifies in the book.

The ideas Campbell presents in this and other books are an excellent set of analytical tools.

With them you can almost always determine what's wrong with a story that's floundering; and you can find a better solution almost any story problem by examining the pattern laid out in the book.

There's nothing new in the book. The ideas in it are older than the Pyramids, older than Stonehenge, older than the earliest cave painting.

Campbell's contribution was to gather the ideas together, recognize them, articulate them, and name them. He exposes the pattern for the first time, the pattern that lies behind every story ever told.

Campbell, now 82, is a vigorous lover of mythology and the author of many books on the subject. For many years he has taught, written, and lectured about the myths of all cultures in all times. THE HERO WITH A THOUSAND FACES is the clearest statement of his observations on the most persistent theme in all of oral traditions and recorded literature – the myth of the hero.

In his study of world hero myths Campbell discovered that they are all basically the same story – retold endlessly in infinite variations. He found that all story-telling, consciously or not, follows the ancient patterns of myth, and that all stories, from the crudest jokes to the highest flights of literature, can be understood in terms of the hero myth; the "monomyth" whose principles he lays out in the book.

The theme of the hero myth is universal, occurring in every culture, in every time; it is as infinitely varied as the human race itself; and yet its basic form remains the same, an incredibly tenacious set of elements that spring in endless repetition from the deepest reaches of the mind of man.

Campbell's thinking runs parallel to that of Swiss psychologist Carl Jung, who wrote of the "archetypes: -- constantly repeating characters who occur in the dreams of all people and the myths of all cultures.

Jung suggested that these archetypes are reflection of aspects of the human mind – that our personalities divide themselves into these characters to play out the drama of our lives.

He noticed a strong correspondence between his patients' dream or fantasy figures and the common archetypes of mythology, and he suggested that both were coming from a deeper source, in the "collective unconscious" of the human race.

The repeating characters of the hero myth such as the young hero, the wise old man or woman, the shape-shifting woman or man, and the shadowy antagonist are identical with the archetypes of the human mind, as revealed in dreams. That's why myths, and stories constructed on the mythological model, strike us as psychologically true.

Such stories are true models of the workings of the human mind, true maps of the psyche. They are psychologically valid and realistic even when they portray fantastic, impossible, unreal events.

This accounts for the universal power of such stories. Stories built on the model of the hero myth have an appeal that can be felt by everyone, because they spring from a universal source in the collective unconscious, and because they reflect universal concerns. They deal with the child-like but universal questions: Who am I? Where did I come from? Where will I go when I die? What is good and what is evil? What must I do about it? What will tomorrow be like? Where did yesterday go? Is there anybody else out there?

The idea imbedded in mythology and identified by Campbell in *THE HERO WITH A THOUSAND FACES* can be applied to understanding any human problem. They are a great key to life as well as being a major tool for dealing more effectively with a mass audience.

If you want to understand the ideas behind the hero myth, there's no substitute for actually reading Campbell's book. It's an experience that has a way of changing people. It's also a good idea to read a lot of myths, but it amounts to the same thing since Campbell is a master storyteller who delights in illustrating his points with examples from the rich storehouse of mythology.

Campbell gives a condensed version of the basic hero myth in chapter IV, "The Keys", of *THE HERO WITH A THOUSAND FACES*. I've taken the liberty of amending the outline slightly, trying to reflect some of the common themes in movies, illustrated with examples from contemporary films. I'm re-telling the hero myth in my own way, and you should feel free to do the same. Every storyteller bends the myth to his or her own purpose. That's why the hero has a thousand faces.

THE STAGES OF THE HERO'S JOURNEY

1.) The hero is introduced in his/her ORDINARY WORLD.

Most stories ultimately take us to a special world, a world that is new and alien to its hero. If you're going to tell a story about a fish out of his customary element, you first have to create a contrast by showing him in his mundane, ordinary world. In *WITNESS* you see both the Amish boy and the policeman in their ordinary worlds before they are thrust into alien worlds – the farm boy into the city, and the city cop into the unfamiliar countryside. In *STAR WARS* you see Luke Skywalker being bored to death as a farm boy before he tackles the universe.

2.) The CALL TO ADVENTURE.

The hero is presented with a problem, challenge or adventure. Maybe the land is dying, as in the King Arthur stories about the search for the Grail. In *STAR WARS*, it's Princess Leia's holographic message to Obi Wan Kenobi, who then asks Luke to join the quest. In detective stories, it's the

hero being offered a new case. In romantic comedies it could be the first sight of that special but annoying someone the hero or heroine will be pursuing/sparring with.

3.) The hero is reluctant at first. (REFUSAL OF THE CALL.)

Often at this point the hero balks at the threshold of adventure. After all, he or she is facing the greatest of all fears – fear of the unknown. At this point Luke refuses Obi Wan's call to adventure, and returns to his aunt and uncle's farmhouse, only to find they have been barbecued by the Emperor's stormtroopers. Suddenly Luke is no longer reluctant, and is eager to undertake the adventure. He is motivated.

4.) The hero is encouraged by the Wise Old Man or Woman. (MEETING WITH THE MENTOR.)

By this time many stories will have introduced a Merlin-like character who is the hero's mentor. In JAWS it's the crusty Robert Shaw character who knows all about sharks; in the mythology of the Mary Tyler Moore Show, it's Lou Grant. The mentor gives advice and sometimes magical weapons. This is Obi Wan giving Luke his father's light saber.

The mentor can go so far with the hero. Eventually the hero must face the unknown by himself. Sometimes the Wise Old Man/Woman is required to give the hero a swift kick in the pants to get the adventure going.

5.) The hero passes the first threshold. (CROSSING THE THRESHOLD.)

The hero fully enters the special world of the story for the first time. This is the moment at which the story takes off and the adventure gets going. The balloon goes up, the romance begins, the spaceship blasts off, the wagon train gets rolling. Dorothy sets out on the Yellow Brick Road. The hero is now committed to his/her journey and there's no turning back.

6.) The hero encounters tests and helpers. (TESTS, ALLIES, ENEMIES.)

The hero is forced to make allies and enemies in the special world, and to pass certain tests and challenges that are part of his/her training. In STAR WARS the cantina is the setting for the forging of an important alliance with Han Solo and the start of an important enmity with Jabba the Hutt. In CASABLANCA Rick's Café is the setting for the "alliances and enmities" phase and in many Westerns it's the saloon where these relationships are tested.

7.) The hero reaches the innermost cave. (APPROACH TO THE INMOST CAVE.)

The hero comes at last to a dangerous place, often deep underground, where the object of the quest is hidden. In the Arthurian stories the Chapel Perilous is the dangerous chamber where the seeker finds the Grail. In many myths the hero has to descend into hell to retrieve a loved one, or into a cave to fight a dragon and gain a treasure. It's Theseus going to the Labyrinth to face the Minotaur. In STAR WARS it's Luke and company being sucked into the Death Star where they will rescue Princess Leia. Sometimes it's just the hero going into his/her own dream world to confront fears and overcome them.

8.) The hero endures the supreme ORDEAL.

This is the moment at which the hero touches bottom. He/she faces the possibility of death, brought to the brink in a fight with a mythical beast. For us, the audience standing outside the cave waiting for the victor to emerge, it's a black moment. In STAR WARS, it's the harrowing moment in the bowels of the Death Star, where Luke, Leia and company are trapped in the giant trash-masher. Luke is pulled under by the tentacled monster that lives in the sewage and is held down so long that the audience begins to wonder if he's dead. IN E.T., THE EXTRATERRESTRIAL, E. T. momentarily appears to die on the operating table.

This is a critical moment in any story, an ordeal in which the hero appears to die and be born again. It's a major source of the magic of the hero myth. What happens is that the audience has been led to identify with the hero. We are encouraged to experience the brink-of-death feeling with the hero. We are temporarily depressed, and then we are revived by the hero's return from death.

This is the magic of any well-designed amusement park thrill ride. Space Mountain or the Great Whiteknuckler make the passengers feel like they're going to die, and there's a great thrill that comes with surviving a moment like that. This is also the trick of rites of passage and rites of initiation into fraternities and secret societies. The initiate is forced to taste death and experience resurrection. You're never more alive than when you think you're going to die.

9.) The hero seizes the sword. (SEIZING THE SWORD, REWARD)

Having survived death, beaten the dragon, slain the Minotaur, her hero now takes possession of the treasure he's come seeking. Sometimes it's a special weapon like a magic sword or it may be a token like the Grail or some elixir which can heal the wounded land.

The hero may settle a conflict with his father or with his shadowy nemesis. In RETURN OF THE JEDI, Luke is reconciled with both, as he discovers that the dying Darth Vader is his father, and not such a bad guy after all.

The hero may also be reconciled with a woman. Often she is the treasure he's come to win or rescue, and there is often a love scene or sacred marriage at this point. Women in these stories (or men if the hero is female) tend to be shape-shifters. They appear to change in form or age, reflecting the confusing and constantly changing aspects of the opposite sex as seen from the hero's point of view. The hero's supreme ordeal may grant him a better understanding of women, leading to a reconciliation with the opposite sex.

10.) THE ROAD BACK.

The hero's not out of the woods yet. Some of the best chase scenes come at this point, as the hero is pursued by the vengeful forces from whom he has stolen the elixir or the treasure.. This is the chase as Luke and friends are escaping from the Death Star, with Princess Leia and the plans that will bring down Darth Vader.

If the hero has not yet managed to reconcile with his father or the gods, they may come raging after him at this point. This is the moonlight bicycle flight of Elliott and E. T. as they escape from "Keys" (Peter Coyote), a force representing governmental authority. By the end of the movie Keys and Elliott have been reconciled and it even looks like Keys will end up as Elliott's step-father.

11.) RESURRECTION.

The hero emerges from the special world, transformed by his/her experience. There is often a replay here of the mock death-and-rebirth of Stage 8, as the hero once again faces death and survives. The Star Wars movies play with this theme constantly – all three of the films to date feature a final battle scene in which Luke is almost killed, appears to be dead for a moment, and then miraculously survives. He is transformed into a new being by his experience.

12.) RETURN WITH THE ELIXIR

The hero comes back to the ordinary world, but the adventure would be meaningless unless he/she brought back the elixir, treasure, or some lesson from the special world. Sometimes it's just knowledge or experience, but unless he comes back with the elixir or some boon to mankind, he's doomed to repeat the adventure until he does. Many comedies use this ending, as

a foolish character refuses to learn his lesson and embarks on the same folly that got him in trouble in the first place.

Sometimes the boon is treasure won on the quest, or love, or just the knowledge that the special world exists and can be survived. Sometimes it's just coming home with a good story to tell.

The hero's journey, once more: The hero is introduced in his ORDINARY WORLD where he receives the CALL TO ADVENTURE. He is RELUCTANT at first to CROSS THE FIRST THRESHOLD where he eventually encounters TESTS, ALLIES and ENEMIES. He reaches the INNERMOST CAVE where he endures the SUPREME ORDEAL. He SEIZES THE SWORD or the treasure and is pursued on the ROAD BACK to his world. He is RESURRECTED and transformed by his experience. He RETURNS to his ordinary world with a treasure, boon, or ELIXIR to benefit his world.

As with any formula, there are pitfalls to be avoided. Following the guidelines of myth too rigidly can lead to a stiff, unnatural structure, and there is the danger of being too obvious. The hero myth is a skeleton that should be masked with the details of the individual story, and the structure should not call attention to itself. The order of the hero's stages as given here is only one of many variations – the stages can be deleted, added to, and drastically re-shuffled without losing any of their power.

The values of the myth are what's important. The images of the basic version – young heroes seeking magic swords from old wizards, fighting evil dragons in deep caves, etc. – are just symbols and can be changed infinitely to suit the story at hand.

The myth is easily translated to contemporary dramas, comedies, romances, or action-adventures by substituting modern equivalents for the symbolic figures and props of the hero story. The Wise Old Man may be a real shaman or wizard, but he can also be any kind of mentor or teacher, doctor or therapist, crusty but benign boss, tough but fair top sergeant, parent, grandfather, etc. Modern heroes may not be going into caves and labyrinths to fight their mythical beasts, but they do enter and innermost cave by going into space, to the bottom of the sea, into their own minds, or into the depths of a modern city.

The myth can be used to tell the simplest comic book story or the most sophisticated drama. It grows and matures as new experiments are tried within its basic framework. Changing the sex and ages of the basic characters only makes it more interesting and allows for ever more complex webs of understanding to be spun among them. The essential characters can be combined or divided into several figures to show different aspects of the same idea. The myth is infinitely flexible, capable of endless variation without sacrificing any of its magic, and it will outlive us all.