A Rock and a Hard Place

Medicare Compliance in First-Party Claims

By Erin Collins and Shannon Metcalf

Insurers continue to face conflicting positions when complying with obligations under insurance contracts and Medicare laws.

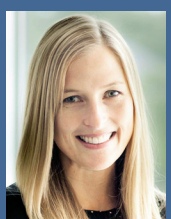
Insurers have an obligation to comply with federal Medicare laws. Insurers also have a first-party duty of good faith to their insureds to follow the terms of the insurance policy and treat their insureds fairly. Due to recent increased enforcement efforts of the government coupled with aggressive bad faith filings by insureds, these competing duties have placed insurers between a rock and a hard place. This article provides a background of this dilemma faced by insurers, advice for avoiding lawsuits when finalizing claims involving Medicare beneficiaries, and suggestions for posturing these lawsuits for dismissal.

Obligations of Insurers Under the Federal Medicare Laws vs. State Laws

The MSP—The "Rock"

As a general rule, the Medicare Secondary Payer Act (MSP) prohibits Medicare from making medical payments if a "primary plan" has the responsibility to pay for such treatment. 42 U.S.C. §1395y(b). A primary plan is an insurance plan (liability, workers' compensation, auto liability and no-fault) covering an injured individual, and a "primary payer" is an entity responsible for making payments under the primary plan. 42 U.S.C. §1395(y)(b)(2). In situations where a primary payer has not made a medical payment and is not expected to make the payment promptly, the MSP permits Medicare to pay for the injured individual's medical treatment, with the understanding that such payment is conditioned upon reimbursement once the primary payer's responsibility for that payment is demonstrated. *Id.* These payments by Medicare are known as "conditional payments."

The MSP specifically requires primary plans to "reimburse the appropriate Trust Fund for any payment made by [Medicare] if it is demonstrated that [the] primary plan has or had a responsibility to make payment with respect to such item or service." *Id.* The statute further explains that a primary plan's "responsibility" for payment can be demonstrated by a judgment, a payment made towards a compromise settlement, waiver or release (regardless of whether there has been a determination of liability),



■ Shannon Metcalf is a partner in the Charlotte, North Carolina, office and Erin Collins is an associate in the Wilmington, North Carolina, office of Hedrick, Gardner, Kincheloe & Garofalo, LLP. Their practices focus on civil litigation, workers' compensation and Medicare Secondary Payer Act compliance. Both authors are members of DRI, the North Carolina Association of Defense Attorneys, and the National Alliance of Medicare Set-Aside Professionals.

or by "other means." *Id.* Accordingly, in a situation where Medicare has made one or more conditional payments and a payment from the primary payer to the injured Medicare beneficiary is made through settlement, judgment, award, med-pay, PIP or other payment, the federal statutes require Medicare to be reimbursed for its conditional payment(s). The federal regulations indicate the primary payer must either pay Medicare as directed in the final demand letter, or must pay the entity designated to receive the repayment if "responsibility" is shown in a manner other than the receipt of a demand letter from Medicare. 42 C.F.R. §411.22. If the beneficiary or other party receives a primary payment, the beneficiary or other party must reimburse Medicare within 60 days. 42 C.F.R. §411.24(h). The provision concerning most primary payers is found in 42 C.F.R. §411.24(i) and provides "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." This provision has encouraged the implementation of policies that require insurance claim handlers to confirm Medicare has been or will be reimbursed prior to disbursing contractual insurance payments.

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State Bad Faith Laws—"The Hard Place"

State laws addressing bad faith vary in scope. Generally these laws preclude insurance companies from delaying payment to an insured claimant for any reason once the insurer's obligation to pay has been established. *See*, *e.g.*, N.C. Gen. Stat. §58-63-15. This means if an insurer delays payment or attaches limitations on a contractual payment, the insurer could be sued for bad faith or unfair settlement practices in certain cases and jurisdictions. Often the insurer will delay payment when an insured claimant is a Medicare beneficiary because the insurer is uncomfortable paying a Medicare-eligible claimant directly without knowing that Medicare will be reimbursed. An insured claimant in this situation may argue that the insurer is protecting itself from exposure under 42 C.F.R. 411.24(i) at the expense of the claimant's contractual right under the insurance policy. Insured claimants will make these assertions and file lawsuits more often when their insurers unilaterally decide how to handle the Medicare reimbursement issues without involvement from the claimants or their counsel.

Courts' Analyses of this Dilemma

There are two unpublished opinions in different jurisdictions addressing the interplay between bad faith and the MSP, and each held in favor of the insurer. In *Wilson v. State Farm Mutual Automobile Insurance Company*, the western district court of Kentucky addressed this issue in the context of an uninsured motorist (UM) claim. 795 F. Supp. 2d 604 (W.D. Ky. 2011). Wilson filed suit claiming State Farm acted in bad faith by delaying payment of his claim. Both Wilson and State Farm moved for summary judgment, and the district court denied Wilson's motion and granted State Farm's.

Wilson was in an accident while driving a vehicle insured by State Farm. The tortfeasor was uninsured, and Wilson made a claim against the UM portion of his policy. Wilson had significant medical bills, some of which were paid by Medicare. State Farm agreed to pay the $50,000.00 policy limits, but did not initially disburse the proceeds so that it could attempt to determine the value of Medicare's lien. Wilson, however, refused to allow communication between State Farm and Medicare about the case and requested prompt disbursement of the full policy limits. He also offered to agree to hold State Farm harmless from any claim made by Medicare. Despite the offer, State Farm decided to wait for Medicare's determination of the value of its lien before issuing separate checks to Medicare and Wilson.

In Kentucky, "it is an unfair claims settlement practice" if a party fails to attempt "in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear." Ky. Rev. Stat. Ann. §304.12-230(6). Wilson filed suit against State Farm claiming in part that its delay of the settlement payment constituted bad faith under Ky. Rev. Stat. Ann. §304.12-230. Two months later, State Farm learned the value of the Medicare lien and paid both Medicare and Wilson the next day.

In granting State Farm's motion for summary judgment, the court acknowledged Wilson had primary responsibility to repay Medicare, but stated State Farm was absolutely liable to Medicare if Wilson did not satisfy the lien, citing 42 C.F.R. 411.24(i). The court further recognized State Farm's potential obligation "to protect Medicare's lien under the Medicare Secondary Payer Act and its corresponding regulations." *Id.* at 607. The court ultimately held that State Farm's consideration of these obligations was reasonable and stated that there were "sound reasons to try to determine the amount of [the lien] and take reasonable precautions to protect itself from overpayment." *Id.* In response to Wilson's argument that State Farm was acting with self-interest, the court stated "[w]hile it may serve defendant's self interest to comply with federal law, such action was not bad faith especially when plaintiff apparently refused to cooperate with defendant's attempts to pay the claim more quickly." *Id.*

In *Porter v. Farmers Insurance Company*, the northern district court of Oklahoma, ruled in a similar manner. 2012 WL 256014 (N.D. Okla. 2012). In that case, Porter was allegedly involved in an accident with a phantom driver on April 22, 2007, and made a claim under his UM policy with Farmers Insurance Company. On December 24, 2009, Farmers agreed to pay Porter $25,000.00 in UM statutory benefits, but due to a potential claim by Medicare and a child support lien, the proceeds were not paid until November 4, 2011. Porter filed an action against Farmers on February 24, 2010, for breach of contract and

bad faith. Farmers moved for summary judgment on the bad faith claim.

The evidence of record demonstrated communication between counsel for Porter and Farmers regarding the Medicare conditional payment amount as well as efforts by Porter's counsel to obtain the final demand amount. The parties learned by letter dated July 15, 2011, that Medicare had not made payment related to the "October 1, 2009" "date of incident" and was closing its file. Since Medicare cited the date of incident incorrectly, the parties continued to communicate with Medicare to confirm that Medicare did not have a conditional payment reimbursement request related to the April 22, 2007, accident. The parties submitted a request for clarification to Medicare in July 2011, but Medicare responded by referring to its July 15, 2011, correspondence.

On October 20, 2011, Farmers issued payment of the UM proceeds and included "Medicare" as a payee on the settlement check. The parties then agreed to participate in a phone conference with Medicare on October 31, 2011. During the telephone conference, Medicare represented that it was not asserting a subrogation claim arising from the April 22, 2007, accident. On November 14, 2011, Farmers re-issued the settlement check to Porter.

In Oklahoma, "an insurer's refusal to pay is not unreasonable or in bad faith when there is a legitimate dispute concerning coverage," and "the decisive question is whether the insurer had a good faith belief, at the time its performance was requested, that it had justifiable reason for withholding payment under the policy." *Id.* at 16. Accordingly, the *Porter* court stated that "[w]here an insurer has demonstrated a reasonable basis for its actions, bad faith cannot exist as a matter of law," and the insurer is entitled to summary judgment. *Id.* In granting Farmer's motion for summary judgment, the district court reviewed the MSP and the regulations and stated "given (1) the harsh nature of laws and regulations governing reimbursement of Medicare [the court here was referring to the possibility that the insurer could end up paying the same bill three times—once to the plaintiff and again to Medicare with double damages]; and (2) the confusion surrounding [plaintiff's counsel's] communications with Medicare, Farmer's conduct was reasonable." *Id.* at 20.

Preventing Extra-Contractual Lawsuits in First-Party Claims

Medical Payments Coverage/PIP

Medical payment ("med pay") and PIP provisions usually require prompt payment or reimbursement for claim-related medical expenses upon receipt of documentation that the expenses were "incurred." For example, a typical medical payments provision states:

> We will pay reasonable expenses incurred for necessary medical and funeral services because of "bodily injury": 1. Caused by accident; and 2. Sustained by an "insured." We will pay only those expenses incurred for services rendered within 3 years from the date of the accident.

See Volume 1 of *Miller's Standard Insurance Policies Annotated*, 2012, p. 7. In a situation where the insurer receives a claim for payment under a med pay or PIP provision and also learns that Medicare has made medical payments related to the claim, the insurer arguably has both a duty under the insurance policy to pay for the medical expenses "incurred" and also has an obligation under federal law to reimburse or to ensure that Medicare is reimbursed for its conditional payments. This scenario places the insurer between the proverbial "rock and a hard place."

To avoid litigation, the insurer should implement policies to determine Medicare eligibility promptly. Notice should be provided to Medicare's Coordination of Benefits Contractor (COBC) after eligibility is determined to trigger a conditional payment investigation. Step-by-step instructions for providing notice can be found at www.msprc.info. A claim closure form should be sent to the Medicare Secondary Payer Recovery Contractor (MSPRC) and a final demand letter should be requested once the insured claimant completes treatment or the medical expenses reach or exceed the insurance coverage for med pay or PIP. The earlier Medicare is notified of the claim, the sooner the parties will be able to obtain Medicare's final demand for reimbursement. It is often necessary to follow up with Medicare to confirm Medicare has complete information to provide the parties with the conditional payment reimbursement amount.

The insurer should also advise the insured claimant regarding the parties' obligations to protect Medicare and attempt to work out an arrangement with the insured claimant or the claimant's attorney to ensure Medicare will be reimbursed for any claim-related conditional payments.

The insurer should communicate with Medicare and the insured claimant frequently, document communications, and act promptly and early to prevent bad faith claims.

If the insurer anticipates a delay in payment due to Medicare concerns, the insurer should attempt to make the "delayed payment" a part of the arrangement to finalize the contractual payment. Ultimately, the insurer should communicate with Medicare and the insured claimant frequently, document communications, and act promptly and early to prevent bad faith claims as a result of med pay or PIP claims involving Medicare beneficiaries.

Additionally, insurers should use caution before including Medicare's name on the check for a contractual payment, and should generally avoid this practice unless the parties have expressly agreed to that payment arrangement. *See Tomlinson v. Landers*, 2009 WL 2496531 (M.D. Fla. 2009) (denying the defendant's motion to enforce the settlement agreement since there was not a meeting of the minds on all essential terms, in part because the insurer included Medicare's name on the settlement check without first obtaining consent from the plaintiff to do so). Including Medicare's name on the check also adds a condition to the contractual payment since Medicare itself must endorse the check for it to have value. In practice, this

added, unanticipated condition on a contractual payment can give rise to claims for bad faith and unfair settlement practices against the insurer/primary payer.

Uninsured/Underinsured Motorist Coverage

A typical uninsured or underinsured motorist insurance clause is as follows:

> We will pay compensatory damages which an "insured" is legally entitled to recover from the owner or operator of an "uninsured motor vehicle" because of "bodily injury" or "property damage" 1. Sustained by an "insured"; and 2. Caused by an accident.

See Volume 1 of *Miller's Standard Insurance Policies Annotated*, 2012, p. 9. As with med pay claims, upon determining the insured claimant is Medicare-eligible, the parties should immediately provide notice to the COBC and request conditional payment information from the MSPRC. Uninsured motorist (UM) carriers and underinsured motorist (UIM) carriers are subrogated to the rights of tortfeasors and, therefore, liability and medical causation defenses are typically considered and asserted when proper. Accordingly, UM and UIM claims are often "settled" like liability claims and, therefore, a "final settlement detail" document should be sent to the MSPRC to obtain a final demand letter when a UM or UIM claim is "settled" with a Medicare beneficiary. The Strengthening Medicare and Repaying Taxpayers Act of 2011 ("the SMART Act") was recently passed and is anticipated to speed up the parties' ability to obtain a final demand amount from Medicare in these situations. The SMART Act will also allow parties in some situations to obtain a final demand letter from Medicare prior to finalizing settlement. *See* information on the SMART Act at http://www.govtrack.us/congress/bills/112/hr1845/text.

The insurer should communicate its preferences or requirements to the other side at the beginning of negotiations, and again confirm the option for reimbursement as a term of the final settlement.

Insurers should always discuss a proposed arrangement for reimbursing Medicare when negotiating the terms for resolution of a UM or UIM claim. Counsel for claimants often prefer that the insurer issue the entire lump sum amount to their law office trust account to be held until the final demand letter from Medicare is received and satisfied. Another option is for the insurer to withhold payment until the final demand is received from Medicare, and then issue a check directly to Medicare for the full reimbursement amount and a second check for the remainder of the lump sum amount to insured claimant or the claimant's attorney. Regardless of the option selected, the insurer should communicate its preferences or requirements to the other side at the beginning of negotiations, and again confirm the option for reimbursement as a term of the final settlement. Additionally, when possible, insurers should communicate often with Medicare and the insured claimant regarding the progress of the conditional payment investigation and document all communications with correspondence to the insured claimant or the attorney.

Judgments

The insurer has a contractual obligation to its insured to satisfy properly any part of a judgment against the insured covered by the insurance contract. If the judgment is not satisfied, the defendant/insured could be subject to personal liability, and the insurer could be subject to breach of contract or a bad faith lawsuit. Accordingly, insurers must promptly pay judgments in compliance with the applicable rules of civil procedure.

In most jurisdictions, the money owed under the judgment may be paid to the clerk of court, or the judgment may be "settled" by sending a check to the plaintiff or plaintiff's attorney. Courts have not addressed whether an insurer's payment of a judgment to a clerk of court would alleviate exposure for the insurer under 42 C.F.R. §411.24(i); however, it is anticipated the judgment payment will be classified as a "payment" to the plaintiff since the clerk is simply serving as a conduit for the funds. If the insurer elects to settle the judgment, and pays the judgment amount directly to the plaintiff's attorney, the insurer should consider sending a letter acknowledging the insurer's contractual obligation to make the payment and reminding the plaintiff and his or her attorney that 42 C.F.R. §411.24(h) imposes responsibility on the plaintiff to ensure that Medicare is fully reimbursed for any related conditional payments within 60 days. The plaintiff and his or her attorney also should be reminded of Medicare's right of action to recover its payments from any entity, including a beneficiary or attorney, receiving a primary payment in the event Medicare is not timely reimbursed. *See* 42 C.F.R. §411.24(g).

Insurers do not have any guarantee the plaintiff or his or her attorney will actually reimburse Medicare when a judgment payment is made. Although this concept is troubling, insurers do not have many options when a judgment is entered against their insured. Courts may ultimately deem it unjust to hold an insurer responsible for conditional payments not reimbursed where the insurer had a mandatory obligation to pay within a certain period. For now, however, the federal regulations indicate there is a risk for insurers in these situations.

Another option is to address the conditional payment reimbursement issue with the judge at a pretrial conference and request that any final order provide specifics regarding the reimbursement of conditional payments to Medicare. Whether these efforts will be successful will likely depend on the jurisdiction, the forum of the hearing or trial, and the presiding judge.

Strategies for Handling Bad Faith Claims Once a Lawsuit Has Been Filed

Dispositive motions should be strongly considered when a plaintiff files a bad faith or unfair and deceptive settlement practice lawsuit as a result of an insurer's Medicare compliance efforts. Summary judgment may be appropriate when the insurer's

obligations under the MSP conflict with its obligations under state laws, or if suit is filed solely as a result of the insurer's attempt to protect Medicare's interest while finalizing an insurance claim.

Federal Preemption

Federal law generally preempts a conflicting state law. There are three situations in which a state law will be preempted: 1) when a federal law directly states that it preempts state law; 2) when Congress occupies the field by "regulating so pervasively that there is no room left for the states to supplement federal law"; and 3) when state law is actually in conflict with federal law (known as "conflict preemption"). *Cox v. Shalala*, 112 F.3d 151 (4th Cir. 1997). In *Cox*, the Fourth Circuit concluded the MSP preempted the North Carolina (NC) Wrongful Death Statute, which only allowed health care providers to recover $1,500.00 from wrongful death proceeds. The court opined the state statute was directly contrary to the MSP, which provides that Medicare has the right to receive full reimbursement for its conditional payments. The court explained it was "faced with a clear 'conflict preemption' situation because compliance with the NC Wrongful Death Act's $1,500 limitation on a health care provider's right to recover a decedent's medical expenses and Medicare's secondary payer provisions is a 'physical impossibility' and because the NC Wrongful Death Act is directly contrary to Medicare's secondary payer provisions." *Id.* at 154.

Similarly, Medicare successfully advanced a preemption argument in *Myers v. Central Ins. Cos.*, No. 1:08-CV-96, 2009 WL 77258 (District Court of Indiana, Jan. 8, 2009). There, the Secretary of the Department of Health and Human Services (Medicare) filed a motion for summary judgment after the plaintiff filed a declaratory judgment action against the defendant-lienholders, including Parkview Memorial Hospital and Medicare, to determine how to allocate funds received in an insurance settlement arising from a motor vehicle accident. *Id.* at 1. The tortfeasor was uninsured and the plaintiff's uninsured motorist carrier paid its $100,000.00 policy limits. *Id.* The plaintiff underwent medical treatment and incurred medical expenses of approximately $78,770.40 with the defendant Parkview Hospital, Inc. ("Parkview"). *Id.* Parkview filed a notice of a hospital lien for the medical services and claimed that its net share of settlement proceeds was $46,257.28 under the Indiana lien statute. *Id.*

In addition, Medicare made conditional payments to Parkview and other providers in an amount of approximately $46,227.88 and requested reimbursement for its conditional payments in the amount of $30,629.34 under the MSP. *Id.* The plaintiff hired an attorney and entered into a contingent fee arrangement, agreeing to pay his attorney one third of the total settlement amount or approximately $33,333.33. *Id.* Accordingly, the total amount of insurance proceeds, $100,000.00, was insufficient to satisfy the attorney's fee, Parkview's lien and Medicare's conditional payment reimbursement request. Medicare filed a motion for summary judgment, claiming that it had a "superior claim" and "first right" to the insurance payment. *Id.* at 2. Parkview also filed a motion for summary judgment, claiming it had a hospital lien in place, which was a superior claim and which gave it the first right to the insurance payment.

For purposes of its motion for summary judgment, Medicare argued that Indiana's Hospital Lien Statute, which gave Parkview the right to recover the insurance policy proceeds, conflicted with the MSP and cited *Cox* in support of its federal preemption argument. *Id.* at 5. The court concluded that Indiana's hospital lien statute conflicted with the MSP since it gave Parkview the right to the same insurance proceeds that the MSP gave to Medicare. *Id.* at 5. The court stated "Parkview is attempting to use the Indiana Hospital Lien Statute as a vehicle to move Parkview in front of Medicare for [the plaintiff's] insurance benefit. This conflicts with the MSP and is not allowed." *Id.* at 6. The court ultimately granted Medicare's motion for summary judgment on the basis of federal preemption and due to the deference owed to CMS in its construction of the MSP. *Id.* The Court also denied Parkview's motion. *Id*; *see also Potts v. The Rawlings Co., LLC*, No. 11 Civ. 9071, 2012 WL 4364451 (S.D.N.Y. Sept. 25, 2012) (applying federal preemption in the Medicare Advantage context).

In practice, a federal preemption argument can be made if a plaintiff brings a lawsuit under a state "bad faith," "unfair settlement practices," or similar state statute as a result of the insurance company's delay of payment due to Medicare reimbursement concerns. Under those circumstances, the insurer and its attorney should consider arguing pursuant to *Cox* and *Myers* that the plaintiff's causes of action under the state bad faith/unfair settlement practices laws are in fatal conflict with the MSP, and therefore, are preempted. To posture a case for dismissal based on federal preemption, the insurer should develop evidence supporting the insurer's position that the delay of payment is solely related to the insurance company's efforts to protect Medicare's right of reimbursement. Evidence of timely communication with Medicare and good faith efforts to determine the conditional payment reimbursement amount will help support this argument.

Summary judgment may be appropriate when the insurer's obligations under the MSP conflict with its obligations under state laws.

Protection of Everyone's Interest

In response to the "self-interest" argument presented in the *Wilson* case discussed above, insurers and their counsel should argue that the protection of Medicare's right of reimbursement is in everyone's best interest since the repayment of conditional payments is an obligation of the beneficiary, the attorneys, and anyone receiving a primary payment, in addition to the insurer. In fact, the Medicare beneficiary (or her or his attorney who receives the payment) is initially charged with the responsibility of reimbursing Medicare within 60 days. 42 C.F.R. §411.24(h).

Although the insurer is obligated to reimburse Medicare in the event the beneficiary does not reimburse Medicare for its conditional payments, Medicare has the

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right under the federal regulations and the MSP to pursue recovery from *any* party receiving the primary payment, even the claimant/beneficiary's attorney. In *United States v. Harris*, Medicare invoked this provision and filed a complaint against the claimant's attorney (Paul Harris) for a declaratory judgment and money damages, requesting reimbursement for conditional payments after Mr. Harris allegedly received a primary payment from a liability insurer and disbursed the payment without confirming Medicare had been fully reimbursed. 334 F. Supp. 569 (NDWV 2009). The court granted the government's motion for summary judgment, acknowledging the government's right to seek recovery directly from the claimant's attorney as an entity receiving the primary payment. The court held that Mr. Harris' failure to pursue an administrative appeal of the final demand letter precluded him from challenging CMS' reimbursement determination. *Id.* at 4. The *Harris* case serves as a reminder that ensuring that Medicare is reimbursed out of an insurer's "primary payment" protects all of the parties, including the claimant's counsel.

These defenses will be strongest if the insurer's claim files contain documentation of prompt notice to Medicare, communication with the insured claimant regarding the insurer's Medicare concerns, and efforts to follow up with Medicare so as to not prolong the already lengthy process of obtaining conditional payment information.

Conclusion

Insurers continue to face conflicting positions when complying with obligations under insurance contracts and Medicare laws. Parties should be proactive in claims involving Medicare beneficiaries, and dispositive motions should be strongly considered when insured claimants pursue bad faith or unfair settlement practices claims as a result of an insurer's Medicare compliance efforts. Penalties or punitive measures against insurers under these circumstances are inappropriate and inconsistent with the intent behind the MSP. FD