CHAPTER 12: HEALTH CARE PROVIDER LIENS

In Arizona, an action is not assignable in whole or in part prior to the entry of judgment. ***Harleysville Mut. Ins. Co. v. Lea***, 2 Ariz. App. 538, 541, 410 P.2d 495, 498 (1966) (injured party cannot assign his personal injury recovery to insurer to reimburse medical payments made). In addition, an insurer cannot be subrogated to the proceeds of the insured's personal injury action. ***Allstate Ins. Co. v. Druke***, 118 Ariz. 301, 303, 576 P.2d 489, 491 (1978); ***State Farm Fire & Cas. Co. v. Knapp***, 107 Ariz. 184, 185, 484 P.2d 180, 181 (1971). Where a policy creates "an interest in any recovery against a third party for bodily injury[,] [s]uch an arrangement, if made or contracted for prior to settlement or judgment, is the legal equivalent of an assignment and therefore unenforceable." ***Allstate***, 118 Ariz. at 303, 576 P.2d at 492.

Exceptions to the general rule against subrogation and assignment exist. For example, under A.R.S. § 20-259.01, an insurer has a right of subrogation and the right to sue for reimbursement of payments made in the name of the insured against any uninsured motorist liable to the insured for personal injury. A.R.S. § 20-259.01(I). In addition, health care providers in Arizona who render treatment to injured persons resulting from the fault of another and, in some limited circumstances, the health insurers who pay for the medical treatment, may have a right of subrogation (reimbursement) against the injured person's tort recovery. The mechanism by which these rights are secured is referred to as a medical or health care provider lien.

This chapter focuses on the following health care provider liens:

1. Statutory health care providers liens pursuant to A.R.S. § 33-931;
2. Arizona Health Care Cost Containment System (AHCCCS) – Arizona Medicaid liens;
3. ERISA liens; and
4. Medicare's right of reimbursement.

STATUTORY HEALTH CARE PROVIDER LIENS (A.R.S. § 33-931 ET SEQ.)

Pursuant to A.R.S. § 33-931, health care providers who treat injured persons arising from the fault of another are entitled to a lien against the injured person's tort recovery for the reasonable and customary charges of the treatment rendered. The purpose of allowing health care provider liens is to "lessen the burden on hospitals and other medical providers imposed by non-paying accident cases." ***LaBombard v. Samaritan Health Sys***., 195 Ariz. 543, 548 ¶ 18, 991 P.2d 246, 251 (Ct. App. 1998).

The lien created under this statute attaches solely to proceeds the injured party receives; the health care provider may not pursue an action to enforce its lien directly against the injured party. In addition, statutory health care provider liens apply only to third-party tort recoveries; first party underinsured and uninsured motorist proceeds and liens and/or claims for subrogation by health insurance companies are specifically exempt. A.R.S. § 33-931 ("except health insurance and underinsured and uninsured motorist coverage as defined in section 20-259.01").

Perfection Requirement

To be valid and enforceable, a lien pursuant to this statute must be perfected in compliance with A.R.S. § 33-932. To perfect a lien under § 33-932, the lien holder must record, before or within 30 days of the first date of service in the county where the treatment was rendered, a lien setting forth the following information:

1. The name and address of the patient;
2. The name and address of the health care provider;
3. The name and address of the executive officer or agent of the health care provider, if any;
4. The dates or range of dates of services and treatment received;
5. The amount claimed due;
6. The name of those alleged to be responsible for paying the damages, i.e., the tortfeasor and the tortfeasor's insurance company; and
7. Whether the treatment has been terminated or will be continued.

A.R.S. § 33-932(A)-(B). In addition to timely recordation, A.R.S. § 33-932 requires the lien holder to send a copy of the lien via first class mail to all named persons within 5 days of recordation. A.R.S. § 33-932(C).

In ***Premier Physicians Grp., PLLC, v. Navarro***, 240 Ariz. 193, 197-98, 377 P.3d 988, 992-93 (Ct. App. 2016), the Arizona Supreme Court held that A.R.S. § 33-932(A) clearly requires non-hospital providers to record liens before services are first rendered—or within thirty days thereafter. A health care provider must therefore strictly comply with the statutory recording requirements to perfect a medical lien.

"Treatment Continuing"

Liens that are recorded with "treatment continuing" language are valid for the final amount billed as opposed to the amount listed on the lien. *See* A.R.S. § 33-932(B). There is no requirement to re-record with the final amount billed.

Special Rules for Hospitals and Ambulance Companies

Hospitals and ambulance companies are not required to name the tortfeasor and his/her insurance company as described above. *See* A.R.S. § 33-932(A)(6). In addition, hospitals and ambulance companies are not required to record within 30 days of when service is first rendered.

Rather, a hospital or ambulance company need only record 30 days before either the date the settlement or judgment is agreed to or the date the settlement or judgment proceeds are paid, in order to have a valid enforceable lien. A.R.S. § 33-932(D). Finally, hospital liens take priority over all other liens authorized by A.R.S. § 33-931, but not as to other forms of recovery, such as AHCCCS. *See* A.R.S. § 33-931(D).

Enforcement

A perfected statutory health care provider lien is enforceable against the patient's recovery, the liable tortfeasor, or the tortfeasor's insurance company for two years after judgment/settlement. *See* A.R.S. § 33-934(A)-(B)*; see also* ***Midtown Med. Grp., Inc. v. Farmers Ins. Grp.***, 235 Ariz. 593, 595 ¶ 12, 334 P.3d 1252, 1254 (Ct. App. 2014). Although A.R.S. § 33-934 permits a lien holder to pursue its lien against the patient's recovery, it does not permit a lien holder to pursue the patient beyond the amount of tort recovery, i.e., to reach the patient's personal assets. ***Blankenbaker v. Jonovich***, 205 Ariz. 383, 387 ¶ 18, 71 P.3d 910, 914 (2003). Moreover, the lien holder is only entitled to recover the "customary charges" for reasonable and necessary medical treatment. *See* A.R.S. § 33-931(A); 33-934(B).

Not Enforceable Against Wrongful Death Recoveries

A statutory health care provider lien is not applicable to wrongful death recoveries. ***Gartin v. St. Joseph's Hosp. & Med. Ctr.***, 156 Ariz. 32, 36, 749 P.2d 941, 945 (Ct. App. 1988). The lien is enforceable only against a recovery of medical expenses by the decedent's estate. *See* A.R.S. § 12-613 ("In an action for wrongful death . . . [t]he amount recovered in such action shall not be subject to the debts or liabilities of the deceased, unless the action is brought on behalf of the decedent's estate.").

Health Care Providers Who Accept AHCCCS and/or Medicare Benefits

Health care providers who accept AHCCCS and/or Medicare benefits are prohibited from pursuing a "balance billing lien" for the difference between the billed charges and the AHCCCS and/or Medicare payment. *See* ***Ansley v. Banner Health Network***, 248 Ariz. 143, 152 ¶ 35, 459 P.3d 55, 64 (2020) (holding that federal law preempts Arizona's lien statute that allowed recovery for difference between Medicaid reimbursement and hospital's actual costs because Medicaid participation is limited to "providers who accept, as payment in full, the amounts paid by the agency plus any deductible, coinsurance or copayment required by the plan to be paid by the individual"); *see also* ***Lizer v. Eagle Air Med. Corp.***, 308 F. Supp. 2d 1006, 1009 (D. Ariz. 2004); 42 U.S.C. § 1396a(a)(25)(C); 42 C.F.R. § 447.15. *But see* ***Grunwald v. Scottsdale Healthcare Hospitals***, 252 Ariz. 141, 146 ¶ 20, 499 P.3d 329, 334 (Ct. App. 2021) (a hospital may pursue balance billing liens against the tort recoveries of plaintiffs enrolled in private health care insurance).

Defenses to Enforcement

A defendant in a lien enforcement action cannot argue that it is not liable for the underlying accident giving rise to the lien. *See* A.R.S. § 33-934(B). The only available defenses to a lien enforcement action are: (1) that the charges sought are erroneous or exceed the customary charges; and/or (2) that the care or treatment was not reasonable, medically necessary, or causally related to the event giving rise to the underlying claim. *Id.* The lien holder has the burden to prove the charges were "usual and customary" and that the care or treatment was reasonable, necessary, and causally related to the underlying claim. Consequently, when defending an action to enforce a lien, it is important to determine first whether the treatment was reasonable and necessary, and second whether the charges sought are truly customary. If not, it might be possible to negotiate a reduction on those grounds.

RESOLVING STATUTORY HEALTH CARE PROVIDERS LIENS

The Common Fund Doctrine

Even if the treatment was reasonable and the charges customary, health care providers pursuing a lien under A.R.S. § 33-931 are required to reduce the lien by an amount that represents a pro-rata share of the legal expenses incurred in securing the tort recovery. ***LaBombard v. Samaritan Health Sys.***, 195 Ariz. 543, 548-49 ¶ 22, 991 P.2d 246, 251-52 (Ct. App. 1998). The purpose of the "common fund doctrine," as it is often called, is to "ensure fairness to the successful litigant, who might otherwise receive no benefit because his recovery might be consumed by the expenses . . ." *Id.* For example, a litigant who recovers $50,000 and faces a health care provider lien in the amount of $20,000 can argue, under the common fund doctrine, that the lien should be reduced by a proportionate share of the attorneys' fees and legal expenses incurred in securing the judgment. Assuming for purposes of this example that the attorneys' fees are 25% of the settlement, and the expenses incurred were $5,000, the total "cost" associated in securing the judgment is $17,500, or 35% of the settlement amount. The lien holder is then asked to reduce its lien by the same percentage, which in this case would be a reduction of $7,000.

Does a "Released" Health Care Provider Lien Resolve the Debt?

In ***Blakenbaker v. Jonovich***, 205 Ariz. 383, 388 ¶ 19, 71 P.3d 910, 915 (2003), the court held that even in the absence of a perfected health care provider lien, the provider could pursue the patient directly, under a contract theory, for the amount owed. In ***Pain Management Clinic v. Preese***, 229 Ariz. 364, 275 P.3d 1284 (Ct. App. 2012), the court of appeals took that analysis one step further. There, the clinic released a lien when the patient told them that there was no source of recovery from the tortfeasor. Despite the lien release filed by the clinic stating that the lien had been "released in full having been compromised or paid," the clinic was permitted to recover from the patient. *Id.* at 365-66 ¶¶ 7-8, 275 P.3d at 1285-86. The court held that "the language in the Release did not constitute a waiver of Pain Management's right to payment on the debt obligation." *Id.* at 366 ¶ 8, 275 P.3d at 1286. Therefore, a health care provider may be able to seek full reimbursement despite having released a health care provider lien. However, that action can only be taken against the patient. Nothing in this decision allows a health care provider to sue the tortfeasor and/or her insurer for the debt. A health care provider's only recourse against a tortfeasor and/or her insurer for the repayment of medical expenses is through the enforcement of a valid, perfected health care provider lien pursuant to A.R.S. § 33-931.

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) LIENS (A.R.S. § 36-2915 ET SEQ.)

Under federal law, every state that participates in the Medicaid program is required to enact statutes to provide for the reimbursement of expenses paid on behalf of Medicaid beneficiaries. *See* 42 U.S.C. § 1396a(a)(25)(B), (H). Arizona participates in the federal Medicaid program through AHCCCS, the State agency that provides medical care and treatment to the indigent. Under A.R.S. § 36-2915(A), AHCCCS is entitled to pursue a lien against "any third party or . . . monies payable from accident insurance, liability insurance, workers' compensation, health insurance, medical payment insurance, underinsured coverage, uninsured coverage or any other first or third party source."

Perfection Requirement

To perfect a lien pursuant to A.R.S. § 36-2915(B), the AHCCCS lien holder must record, within 60 days from either the date of hospital discharge or the first date of service, in the county in which the injuries were incurred, a lien setting forth the following:

1. The name and address of the injured person;
2. The name and address of the administration;
3. The dates of service and treatment;
4. The amount charged; and
5. The names and addresses of those alleged to be responsible for the injuries giving rise to treatment and their insurance carriers.

In addition, the AHCCCS lien holder must, within 5 days of recordation, mail a copy of the lien to the patient and each person or entity alleged to be responsible for the damages and their insurance carriers. A.R.S. § 36-2915(B).

Alternative Recovery Under A.R.S. § 12-962

An AHCCCS lien holder that fails to properly record its lien as required by § 36-2915(B) may still recover the expenses paid on behalf of the plan beneficiary under § 12-962. However, recovery under A.R.S. § 12-962 is limited to only third party proceeds. *See* ***Arizona Health Care Cost Containment Sys. v. Bentley***, 187 Ariz. 229, 234, 928 P.2d 653, 658 (Ct. App. 1996) (noting that AHCCCS's lien rights under A.R.S. § 36-2915 do not preempt AHCCCS recovery under A.R.S. § 12-962); ***Arizona Dep't of Admin. v. Cox***, 222 Ariz. 270, 278 ¶ 35 n.6, 213 P.3d 707, 715 n.6 (Ct. App. 2009) (noting that A.R.S. § 12-962 does not permit the state to recover anything other than what is recovered from the third party).

Enforcement

Under A.R.S. § 36-2916(B), the AHCCCS lien holder may enforce its lien against the patient, the tortfeasor, or the tortfeasor's insurance company. Alternatively, should the AHCCCS lien holder choose to pursue its right of subrogation under A.R.S. § 12-962, it may do so by initiating a direct action against the tortfeasor or the AHCCCS beneficiary's tort recovery, or by intervening in an existing third party personal injury action brought by the AHCCCS beneficiary. A.R.S. § 12-962(B).

Priority and Statute of Limitations

AHCCCS liens pursuant to A.R.S. § 36-2915 have priority over liens by the Department of Economic Security ("DES"), the counties, statutory health care provider liens pursuant to A.R.S. § 33-931, and claims against a third party payor. A.R.S. § 36-2915(F). An AHCCCS lien holder has two years from the date of judgment or settlement to pursue its lien rights. A.R.S. § 36-2916(B).

Resolving AHCCCS Liens

To determine whether an AHCCCS lien exists, one should begin by determining the third-party administering entity. In rare circumstances will a lien be filed on behalf of AHCCCS itself. In Arizona, common AHCCCS entities include Mercy Care Plan and APIPA, among others.

An AHCCCS lien holder is required to reduce its lien if, after considering the following factors, it determines that the reduction provides a settlement of the claim that is fair and equitable:

1. The nature and extent of the person's injury or illness;

2. The sufficiency of insurance or other sources of indemnity available to the person; and

3. Any other factor relevant to determining a fair and equitable settlement under the circumstances of a particular case.

A.R.S. § 36-596.01(I). Note, however, that 15 days after being put on notice of a settlement, the AHCCCS lien amount becomes final and cannot be amended. A.R.S. § 36-2915(G).

An AHCCCS lien holder is not required to reduce the federal portion of the benefits paid, which can account for up to 30%. ***Eaton v. Arizona Health Care Cost Containment Sys.***, 206 Ariz. 430, 435 ¶ 20, 79 P.3d 1044, 1049 (Ct. App. 2003). The only exception to this rule occurs when a plaintiff recovers less than the full value of his/her claim, in which case the AHCCCS lien holder is entitled to recover only a pro-rata share of what it paid on behalf of the injured person, less a deduction for litigation expenses consistent with the "common fund doctrine." ***Southwest Fiduciary, Inc. v. Arizona Health Care Cost Containment Sys. Admin.***, 226 Ariz. 404, 411 ¶ 28, 249 P.3d 1104, 1111 (Ct. App. 2011); *see also* ***Arkansas Dep't of Health & Human Servs. v. Ahlborn***, 547 U.S. 268, 284-85 (2006) (Medicaid's share of a settlement may not exceed the portion of the settlement that represents medical expenses.). Additionally, an AHCCCS provider's lien is enforceable only against the Medicaid beneficiary's tort settlement/judgment. ***Wos v. E.M.A. ex rel. Johnson***, 568 U.S. 627, 632 (2013).

ERISA LIENS

Most private (non-governmental) health plans are organized under the Employee Retirement Income Security Act (ERISA), 29 U.S.C. §§ 1001 *et seq.* ERISA itself does not create any lien or subrogation rights for ERISA health plans. Rather, the scope and extent of each specific plan's lien rights are dictated by the provisions of the Summary Plan Description adopted and incorporated as part of the plan. *See* ***CIGNA Corp. v. Amara***, 563 U.S. 421, 436 (2011) (terms must be part of the plan to be enforceable). Consequently, it is critical to obtain these documents to fully understand the extent of each specific plan's lien rights.

Obtaining Plan Documents

ERISA grants a plan beneficiary the right to make a written request and receive certain specified documentation from the plan administer. *See* 29 U.S.C. § 1024(b)(4). The failure to provide this information within 30 days can result in the imposition of a penalty of up to $100 per day for

each day of noncompliance. *See* 29 U.S.C. § 1132(c)(1)(B). Note, however, that only the ERISA plan administrator, not the subrogation company or health insurer, is subject to the $100 per day penalty for late production of requested plan documents. Thus, it is important to always request plan documents from the plan administrator, even if you also request plan documents from the subrogation company or health insurer.

Perfection Requirement

ERISA plan liens have no perfection requirements. The lien automatically arises upon the payment of benefits under the plan for accident related treatment.

Enforcement

Actions to enforce an ERISA lien are governed by 29 U.S.C. § 1132, and can be brought by the Secretary, a participant, beneficiary, or fiduciary. 29 U.S.C. § 1132(a).

Formerly, provisions in ERISA plans providing for lien/subrogation and reimbursement from personal injury settlements were void and unenforceable in the Ninth Circuit. *See, e.g.*, ***Westaff (USA) Inc. v. Arce***, 298 F.3d 1164, 1167 (9th Cir. 2002); *see also* ***Great-West Life & Annuity Ins. Co. v. Knudson***, 534 U.S. 204 (2002). ***Knudson*** and ***Westaff*** held that because ERISA's enforcement statutes allow only equitable relief, an ERISA plan could not bring an action to enforce its lien rights against the plan beneficiary. In 2006, however, the U.S. Supreme Court ruled in ***Sereboff v. Mid Atlantic Medical Services, Inc.***, 547 U.S. 356, 363 (2006), that an action by an ERISA plan for reimbursement of medical expenses paid on behalf of the plan beneficiary is a form of "equitable relief" under 29 U.S.C. § 502(a)(3). *Sereboff* expressly abrogated the decision in *Westaff* and distinguished *Knudson* on the grounds that the Knudsons' funds were in trust, whereas the Sereboffs' funds were in their own possession and control. *Sereboff* thus provided a means by which an ERISA plan could enforce its lien rights against personal injury tort recoveries.

After *Sereboff*, an ERISA plan has a valid enforceable lien if the subrogation provision in the plan documents (the Summary Plan Description) includes the following language:

1. The fund "specifically identifie[s] a particular fund, distinct from the [plan beneficiaries'] general assets," i.e., the tort recovery;

2. The funds sought belong in "good conscience" to the plan; and

3. The plan specifically identifies the particular share of the fund to which the plan is entitled.

An ERISA lien is unenforceable if it fails to meet any of the above requirements. ***Popowski v. Parrott***, 461 F.3d 1367, 1371 n.4 (11th Cir. 2006). Additionally, as set forth above, it is not enough that the subrogation provision complies with *Sereboff.* The Summary Plan Description must be appropriately incorporated into the health care plan. *See Amara*, 563 U.S. at 436.

Resolving ERISA Liens

Assuming the ERISA plan contains a valid, enforceable subrogation provision, the terms of the plan will dictate the extent of, and limitations on, the plan's recovery. ***US Airways, Inc. v. McCutchen***, 569 U.S. 88, 101 (2013) (plan's clear terms will be enforced). This includes the equitable defenses, if any, that are available to the plan beneficiary. Where the plan is silent as to equitable defenses, i.e., the common-fund and make-whole doctrines, such defenses should arguably be available. *Id.* at 102-05.

Statute of Limitations

As with other aspects of ERISA liens, the Plan language may define the statute of limitations to bring a subrogation claim. In the absence of any such language, state law controls:

> ERISA itself does not contain a statute of limitations applicable to Plaintiffs' claims. Therefore, the Court must borrow "the most analogous state statute of limitations." When borrowing a state statute of limitations, the task is to apply "the local time limitation *most analogous* to the case at hand." In other words, the issue is not which state statute of limitations is a "perfect" fit for the federal claim, but which statute of limitations is the closest fit. And when picking the closest fit, a federal court must "accept[] the state's interpretation of its own statutes of limitations."

Blood Sys., Inc. v. Roesler, 972 F. Supp. 2d 1150, 1154 (D. Ariz. 2013) (emphasis and alteration in original) (citations omitted).

In Arizona, two statutes of limitations could apply: either the six year statute governing written contracts, or the one year statute governing breach of a written employment contract. *See* A.R.S. § 12-548, A.R.S. § 12-541(3). In *Blood Systems*, the Arizona district court applied the one year employment contract statute of limitations because the employment contract between Blood Systems and the employee included additional compensation in the form of paying for medical care in return for the employee's continued employment. 972 F. Supp. 2d at 1155. The district court further noted the one year limitations period for an employee to sue for benefits after a claim has been denied. Although a claim for benefits and a claim for subrogation are different, the court suggested it was fair to apply the same limitations period for both the Plan and the participant, and "[a] one-year limitations period after settlement is ample time for an ERISA plan[] to bring claims against its participant." *Id.* at 1157 & n.7.

Two years later, the Arizona district court applied the six year contract statute of limitations in ***JDA Software Inc. v. Berumen***, 2015 WL 12941860 (D. Ariz. Jan. 8, 2015). The court reasoned that the Plan Document was not an employment contract between the employer and employee, but rather a contract between JDA Software as the Plan administrator and the employee as the Plan participant, even though the Plan administrator was also the employer. Nothing in the Plan Document governed, or even related to, the participant's rights or responsibilities as an employee, or the nature, conditions, or duration of the employment. *Id*. at *3. The court further reasoned that, in Arizona, if there is a doubt as to which of two limitations periods should apply, courts generally apply the longer. *Id.* at *4.

MEDICARE'S RIGHT OF REIMBURSEMENT: PART A & B COVERAGE

Medicare provides health insurance and medical benefits for the following:

- People aged 65 or older;
- People under 65 who have been receiving Social Security Disability Income (SSDI) for 24 continuous months; or
- People of any age with End-Stage Renal Disease (ESRD).

Once an individual becomes eligible for Medicare Part A (which covers hospital care) and Part B (which covers physician care), he or she can opt to enroll in a Part C, a Medicare Advantage Plan. Medicare's right to reimbursement with respect to payments made under Part A & B plans are distinct from the reimbursement rights that apply to payments made under Part C. Thus, this section addresses them separately.

Medicare Secondary Payer Act of 1980

Medicare's lien rights are governed by the Medicare Secondary Payer (MSP) Act of 1980, codified at 42 U.S.C. § 1395y(b)(2)(B)(ii). Prior to the enactment of the MSP Act, Medicare was the "primary payer" of medical bills for its beneficiaries and could not seek reimbursement. The MSP Act now provides that Medicare is the "secondary payer" of medical bills after primary health care insurance, workers' compensation, automobile insurance coverage and other liability plans. To facilitate the coordination of treatment and benefits, however, Medicare often pays the medical expenses of its beneficiaries up front as a "conditional payment." 42 U.S.C. § 1395y(b)(2)(B). Medicare is then entitled to reimbursement of the conditional payment from the beneficiary's primary plan.

Perfection Requirement

No formal perfection requirements exist for Medicare to have a valid enforceable lien. Rather, the right of reimbursement arises upon Medicare's issuance of a conditional payment on behalf of the beneficiary. Note that Medicare's rights to recover from tortfeasors' insurance policies under the MSP Act are essentially rights of subrogation, even though Medicare's rights are referred to as a lien.

Enforcement

Medicare may initiate an action to enforce its liens against all those involved in the personal injury action, including the plaintiff and his or her attorney, the tortfeasor, and the insurance carrier. *See* 42 U.S.C. § 1395y(b)(2)(B)(iii). Through the Strengthening Medicare and Repaying Taxpayers ("SMART") Act, Medicare has three (3) years from the date it learns of the settlement/recovery to enforce its lien rights. The time limit runs from the date the settlement is reported to CMS as part of the Medicare reporting requirements.

Resolving Medicare Liens

Resolving and negotiating Medicare liens requires an understanding of the Medicare claims process through which Medicare formally asserts its right of reimbursement. Following is a brief description of the procedure in place at the time of this writing. For the most current information on the Medicare claims process, visit **www.cms.gov**.[4]

Medicare pursues its right of reimbursement through the Benefits Coordination & Recovery Center (BCRC). Whenever a Medicare beneficiary initiates a personal injury action, a claim is opened with the BCRC. Upon receipt of the claim, the BCRC issues a Rights and Responsibilities letter, setting forth Medicare's right of reimbursement and the beneficiary's responsibility to report information to Medicare in conformance with the claims process. A Conditional Payment letter is issued 65 days later and sets forth an itemized list of expenses that Medicare claims it paid on behalf of the beneficiary for the subject accident or incident. If any of the charges listed are disputed, i.e., because they are not accident related, the BCRC will review the dispute and may issue a revised Conditional Payment Letter.

Once the case is settled or judgment entered, a Final Settlement Detail is submitted which lists the date and amount of the settlement, and any attorneys' fees and costs incurred. The BCRC then issues a Final Lien Demand letter which formally sets forth the amount Medicare is seeking in reimbursement. Medicare is required to, at a minimum, reduce its lien by a pro-rata share of the attorneys' fees and costs incurred in securing the judgment. 42 C.F.R. § 411.37.

The beneficiary has 60 days from the receipt of the Final Demand letter to pay the amount due before interest and penalties begin accruing, unless an administrative remedy is pending. *See* ***Haro v. Sebelius***, 747 F.3d 1099, 1109 (9th Cir. 2014) (holding that the Secretary could not pursue collection action against a Medicare beneficiary while an administrative remedy was pending).

Tender of Funds

The district court in *Haro* held that while the Secretary is precluded from pursuing a collection action against a beneficiary prior to the exhaustion of administrative remedies, attorneys are not precluded from "disbursing undisputed portions of the settlement proceeds to their beneficiary clients." *Id*. at 1195. Under the district court decision, defendants could have considered tendering the full amount of settlement funds to the plaintiff's attorney, conditioned upon the plaintiff's attorney's agreement to retain the disputed portion in trust pending the Medicare lien resolution. But the Ninth Circuit reversed the district court's ruling in January 2014. The Ninth Circuit held "reasonable" the "Secretary's demand that attorneys who have received settlement proceeds reimburse Medicare before disbursing those proceeds to their clients [which] certainly increases the likelihood that proceeds will be available for reimbursement." 747 F.3d at 1117.

[4] The Medicare Claims Processing Manual is available at https://www.cms.gov/regulations-and-guidance/guidance/manuals/internet-only-manuals-ioms-items/cms018912 . (last visited July 16, 2023).

Therefore, in light of *Haro,* defendants might want to consider the conditions of tendering settlement funds in cases involving Medicare beneficiaries. Considerations include:

1. Whether to demand conditional payment information prior to tender;

2. Whether to demand a copy of Medicare's formal demand letter prior to tender;

3. Whether to demand that plaintiff and her counsel hold back of funds (completely or partially) pending the resolution of Medicare's right of reimbursement;

4. Whether to demand proof of satisfaction of Medicare's right of reimbursement as part of the settlement AND a liquidated damages provision for any failure to provide proof of satisfaction; and

5. The extent of the indemnification required of Plaintiff and their lawyer for any failure to satisfy Medicare's right of reimbursement.

The law regarding Medicare's right of reimbursement is ever-changing. We encourage you to contact us with any specific questions you have regarding Medicare's right of reimbursement and the appropriate steps you should take to protect your and/or your client's interests.

MEDICARE ADVANTAGE'S RIGHT OF REIMBURSEMENT: PART C PLANS

Unlike Medicare Part A & B, Medicare Advantage Plans are administered by private insurers and governed by separate statutes. 42 U.S.C. § 1395w-21 *et seq.* These statutes permit, but do not require, a Medicare Advantage Plan to recover against a primary plan, whereas payments made under Part A & B coverage "shall be conditioned" upon reimbursement by a primary plan. *Compare* 42 U.S.C. § 1395y(b)(2)(B)(i) *with* 42 U.S.C. § 1395mm(e)(4). Courts have said this reflects Congress's intent not to give these plans the same reimbursement rights as the Medicare program. *See* ***Care Choices HMO v. Engstrom***, 330 F.3d 786, 789 (6th Cir. 2003); ***Nott v. AETNA U.S. Healthcare, Inc.***, 303 F. Supp. 2d 565, 570 (E.D. Pa. 2004). These courts have further held that Medicare Advantage Plan statutes create a right of reimbursement without providing a remedy to enforce that right. *See* ***Nott***, 303 F. Supp. 2d at 571 ("[W]hile granting statutory permission to include recovery provisions in their contracts, Congress did not create a mechanism for the private enforcement of subrogation rights of Medicare substitute[s]."). Even after the Medicare Advantage statutes were amended in 2005 to give Medicare Advantage Plans the same rights as the Medicare program under 42 U.S.C. § 1395 *et seq*., courts continued to reject Medicare Advantage Plans' attempts to enforce lien rights under federal law.

Parra v. PacifiCare of Arizona, Inc., 715 F.3d 1146, 1154 (9th Cir. 2013), held that the Medicare statutes did not grant a Medicare Advantage Plan a private right of action to enforce its lien rights in federal court and that the Plan had to pursue its claim in state court. It was originally thought that this might not be possible because of the anti-subrogation decision in ***Allstate Ins. Co. v. Druke***, 118 Ariz. 301, 304, 576 P.2d 489, 492 (1978).

In ***Estate of Ethridge v. Recovery Management Systems, Inc.***, 235 Ariz. 30, 39 ¶ 30, 326 P.3d 297, 306 (Ct. App. 2014), however, the court held that the federal statutes authorizing Medicare Advantage Plans preempted any state laws or decisions that precluded a Medicare Advantage Plan private carrier from enforcing its lien/subrogation rights in Arizona state courts. It specifically ruled that *Druke* and its anti-abrogation doctrine were not applicable to Medicare Advantage Plans.

MEDICARE SET ASIDES

Workers' Compensation Cases

The Medicare statutes specifically mandate that settlement funds in workers' compensation cases earmarked for future medical treatment be "set aside." 42 C.F.R. § 411.46(a). Once those funds are exhausted, Medicare assumes liability for any further medical expenses.

Third Party Liability Cases

Some plaintiffs' lawyers argue that, unlike in the workers' compensation context, no specific statutory language requires a Medicare Set Aside ("MSA") in third party liability cases. While the statutes are not a model of clarity, we believe an MSA is required where the settlement or judgment contemplates the payment of future medical expenses. *See* 42 U.S.C. § 1395y(b)(2)(A)(ii) (as secondary payer, Medicare will not cover items or services for which "payment has been made or can reasonably expected to be made . . . under a[] . . . liability insurance policy or plan (including a self-insured plan."). Medicare recently indicated it would not require or consider the MSA in a third-party liability case where a beneficiary's treating physician certifies in writing that the accident-related injuries have resolved and no further treatment is required. *See* CMS Memorandum: "Medicare Secondary Payor – Liability Insurance (Including Self-Insurance) Settlements, Judgments, Awards, or Other Payments and Future Medicals -- INFORMATION," September 30, 2011.[5] In 2012, CMS proposed a Rule, CMS-6047-P Medicare Secondary Payer and "Future Medicals," that would require MSAs in all third party liability cases where "future medical care is claimed, or the settlement, judgment, award or other payment releases (or has the effect of releasing) claims for future medical care." That Rule was, however, withdrawn in October 2014. In the fall of 2018, CMS issued another notice indicating that it planned to issue proposed rules in September, 2019 to address future medicals, but it does not appear this became law.[6] In light of Medicare's overall mandate that its payments are "secondary" to those that are made, or can be made, by a "primary plan," it is important to consider an MSA in liability settlements where the jury specifically allocates sums for future medical expenses, or where future medical expenses are paid as part of a personal injury settlement.

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[5] https://www.cms.gov/files/document/future-medicals.pdf (last visited July 16, 2023).

[6] https://www.reginfo.gov/public/do/eAgendaViewRule?pubId=201810&RIN=0938-AT85 (last visited July 16, 2023).

Wrongful Death Proceeds

When a liability insurance payment is made in a wrongful death action, Medicare may recover from the payment only if a state statute permits recovery of these medical expenses. *See* Medicare Secondary Payer Manual Chapter 7, § 10.9(a).[7] In Arizona, damages recoverable in a wrongful death action "shall not be subject to debts or liabilities of the deceased, unless the action is brought on behalf of the decedent's estate." A.R.S. § 12-613. Accordingly, in Arizona,

Medicare may only enforce its right of reimbursement against wrongful death proceeds if the claim is brought on behalf of the estate. Medicare cannot enforce its lien against recoveries paid to wrongful death beneficiaries. *Id.*; *see also* ***Gartin v. St. Joseph's Hosp. & Med. Ctr.***, 156 Ariz. 32, 34, 749 P.2d 941, 943 (Ct. App. 1988) (holding that only the estate can make a survival claim for the medical expenses incurred by the decedent before his or her death). This holding was reaffirmed in *Ethridge, supra.*

MEDICARE REPORTING REQUIREMENTS

As of January 1, 2012, all insurers (including no-fault and self-insured policies) are required to report first- and third-party personal injury settlements, verdicts or awards to Medicare whenever Medicare paid medical expenses on behalf of its beneficiary that are compensated as part of the recovery. This change is the result of the implementation of the Medicare, Medicaid, and SCHIP Extension Act of 2007 ("MMSEA"), which effectively shifted the burden to the insurer to put Medicare on notice of settlements so that Medicare can pursue its statutory right of reimbursement. 42 U.S.C. § 1395y(b)(7)-(8). A Registered Reporting Entity ("RRE") that fails to comply can be fined $1,000 per day for failing to report and faces "double damages," i.e., double the amount Medicare paid on behalf of the beneficiary for expenses related to the subject incident.

While it remains unclear whether settlements involving Medicare Advantage Plans must be reported, if in doubt, it is certainly prudent to report any settlement involving a Medicare beneficiary, to avoid the potential imposition of fines and penalties.

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[7] https://www.cms.gov/files/document/chapter-7-msp-recovery.pdf (last visited July 16, 2023).

If you have questions regarding the information in this chapter, please contact the author.

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