NEW YORK STATE BAR ASSOCIATION

TRIAL LAWYERS SECTION

6.0 MCLE Credits

Under New York's MCLE rule, this program has been approved for a total of 6.0 MCLE credits consisting of 2.0 credits in Skills, 3.0 in Professional Practice and 1.0 in Ethics for all attorneys, both experienced and newly admitted.

Summer Meeting

Niagara-On-The-Lake, Ontario, Canada

August 4 – 7, 2019

Queens Landing Hotel
155 Byron Street

www.nysba.org/TRIASU19

Summer Meeting 2019

Trial Lawyers Section

August 4 - 7, 2019

Niagara-On-The-Lake
Ontario, Canada

Thank You! This program is made possible by the generous donation of time and expertise by members and volunteers. Thank you to our volunteers—and to you, for choosing NYSBA Programs.

This program is offered for educational purposes. The views and opinions of the faculty expressed during this program are those of the presenters and authors of the materials, including all materials that may have been updated since the books were printed or distributed electronically. Further, the statements made by the faculty during this program do not constitute legal advice.

MCLE INFORMATION

Program Title: **Trial Lawyers Section Summer Meeting 2019**
Date/s: August 4-7, 2019 Location: Niagara-On-The-Lake, Ontario, Canada

Evaluation: https://nysba.co1.qualtrics.com/jfe/form/SV_8CyamzTFJTkzwlT
This evaluation survey link will be emailed to registrants following the program.

Total NY Credits: 6.0

Credit Category:
3.0 Areas of Professional Practice
1.0 Ethics and Professionalism
2.0 Skills

This course is approved for credit for **both** experienced attorneys and newly admitted attorneys (admitted to the New York Bar for less than two years). Newly admitted attorneys participating via recording or webcast should refer to www.nycourts.gov/attorneys/cle regarding permitted formats.

Attendance Verification for New York MCLE Credit

In order to receive MCLE credit, attendees must:

1) **Sign in** with registration staff
2) Complete and return a **Form for Verification of Presence** (included with course materials) at the end of the program or session. For multi-day programs, you will receive a separate form for each day of the program, to be returned each day.

Partial credit for program segments is not allowed. Under New York State Continuing Legal Education Regulations and Guidelines, credit shall be awarded only for attendance at an entire course or program, or for attendance at an entire session of a course or program. Persons who arrive late, depart early, or are absent for any portion of a segment will not receive credit for that segment. The Form for Verification of Presence certifies presence for the entire presentation. Any exceptions where full educational benefit of the presentation is not received should be indicated on the form and noted with registration personnel.

Program Evaluation

The New York State Bar Association is committed to providing high quality continuing legal education courses, and your feedback regarding speakers and program accommodations is important to us. Following the program, an email will be sent to registrants with a link to complete an online evaluation survey. The link is also provided above.

ADDITIONAL INFORMATION AND POLICIES

Recording of NYSBA seminars, meetings and events is not permitted.

Accredited Provider

The New York State Bar Association's **Section and Meeting Services Department** has been certified by the New York State Continuing Legal Education Board as an accredited provider of continuing legal education courses and programs.

Credit Application Outside of New York State

Attorneys who wish to apply for credit outside of New York State should contact the governing body for MCLE in the respective jurisdiction.

MCLE Certificates

MCLE Certificates will be emailed to attendees a few weeks after the program, or mailed to those without an email address on file. **To update your contact information with NYSBA**, visit www.nysba.org/MyProfile, or contact the Member Resource Center at (800) 582-2452 or MRC@nysba.org.

Newly Admitted Attorneys—Permitted Formats

Newly admitted attorneys (admitted to the New York Bar for less than two years) may not be eligible to receive credit for certain program credit categories or formats. For official New York State CLE Board rules, see www.nycourts.gov/attorneys/cle.

Tuition Assistance

New York State Bar Association members and non-members may apply for a discount or scholarship to attend MCLE programs, based on financial hardship. This discount applies to the educational portion of the program only. Application details can be found at www.nysba.org/SectionCLEAssistance.

Questions

For questions, contact the NYSBA Section and Meeting Services Department at SectionCLE@nysba.org, or the NYSBA Member Resource Center at (800) 582-2452 (or (518) 463-3724 in the Albany area).

SCHEDULE OF EVENTS

Sunday, August 4

2:00 – 6:00 p.m.	**Registration** – Queens Landing Hotel Lobby
3:00 – 5:00 p.m.	**Executive Committee Meeting** – Loyalist Room
6:30 – 7:30 p.m.	**Welcome Cocktail Reception** – Tiara Terrace
7:30 p.m.	Dinner on Your Own

Monday, August 5

7:00 – 9:30 a.m.	**Breakfast Buffet**– Tiara Dining Room Included in meeting fee for all registered attorneys and registered spouses/guests
8:00 – 9:00 a.m.	**Executive Committee Meeting** – Imperial Ballroom A *Breakfast will not be served* at the meeting.
8:00 a.m. – 12:00 p.m.	**Registration** – Imperial Ballroom Foyer
9:00 a.m. – 12:00 p.m.	**GENERAL SESSION** – Imperial Ballroom B
9:00 – 9:10 a.m.	**Trial Lawyers Section Welcome** Kevin J. Sullivan, Esq. Section Chair
9:10 – 10:00 a.m.	**Ethics Update For Trial Lawyers** *(1.0 in Ethics)*
Speaker:	**Sharon Stern Gerstman, Esq.** Former President, New York State Bar Association Magavern, Magavern, Grimm, LLP | Buffalo
10:10 – 10:20 a.m.	Refreshment Break – Sponsored by **PRECISION LIEN RESOLUTION**
10:20 – 11:10 a.m.	**New York Practice and CPLR Update** *(1.0 Areas of Professional Practice)*
Speaker:	**Hon. Shirley Troutman** Appellate Division, Fourth Department | Buffalo
11:10 a.m. – 12:00 p.m.	**Where Are We with Medicare, Medicaid, and Lien Resolution** *(1.0 Areas of Professional Practice)*
Speaker:	**Paul K. Isaac, Esq.** Precision Lien Resolution | Buffalo
1:00 – 5:15 p.m.	**GOLF AT LEGENDS ON THE NIAGARA - BATTLEFIELD COURSE, 9172 WILLOUGHBY DRIVE, NIAGARA FALLS, ONTARIO** Golf Architect Douglas Carrick created a truly unique course that challenges every level of golfer. The Course features a nice mix of wide, links style holes with generous undulating fairways and greens bound by dense forest and brush. **$125.00 per person.** Fee includes: transportation, greens fees, golf cart and box lunch. **Preregistration required**. ***Meet in lobby to car pool to course at 12:30 p.m. sharp.***
2:00 p.m.	**NIAGARA-ON-THE-LAKE TROLLEY WINE COUNTRY TOUR** Enjoy a leisurely tour through the town of Niagara-on-the-Lake aboard a trolley. Experience Canada's most celebrated wineries and award-winning wines. Discover the local history of Niagara-on-the-Lake: "The Prettiest Town in Canada"as we travel along the area's scenic wine route and visit two local wineries. Must be 21 and older. Trolley will pick-up right in front of the hotel. Tour length is 3 hours. Fee is **$65.00 per person**. **Preregistration is required**.
7:00 – 10:00 p.m.	**Cocktail Reception & Dinner** – The Jade Room, Tiara Dining Room **Preregistration required.**

SCHEDULE OF EVENTS

Tuesday, August 6

7:00 – 9:30 a.m.	**Breakfast Buffet**– Tiara Dining Room Included in meeting fee for all registered attorneys and registered spouses/guests
8:30 a.m. – 12:00 p.m.	**Registration** – Imperial Ballroom Foyer
9:00 a.m. – 12:00 p.m.	**GENERAL SESSION –** Imperial Ballroom B
9:00 – 9:10 a.m.	Program Introduction Kevin Sullivan, Chair
9:10 – 10:00 a.m.	**Evidence Issues for Trial Attorneys** *(1.0 in Skills)*
Speaker:	**Hon. Thomas P. Franczyk** University at Buffalo School of Law Buffalo
10:00 – 10:10 a.m.	Refreshment Break – Sponsored by **LEXITAS - DEITZ NATIONWIDE COURT REPORTING**
10:10 – 11:00 a.m.	**Understanding the Labor Law – Construction Site Accidents** *(1.0 Areas of Professional Practice)*
Speaker:	**David R. Adams, Esq.** Hurwitz & Fine, P.C. Buffalo
11:00 – 11:50 a.m.	**Focus Groups - How to Deal with Case Issues** *(1.0 Skills)*
Speaker:	**Richard A. Hall, IV, Esq.** Dolce Panepinto, P.C. Buffalo
2:00 – 5:00 p.m.	**SHAW THEATRE FEST MATINEE: *GETTING MARRIED*** **The Royal George Theater, 85 Queen Street** On the eve of the wedding, the bride and groom realize what marriage is all about. So, of course, the wedding is off. Or is it? A timeless, laugh-out-loud Shaw comedy about marriage. For ages 14 & over. Theatre is approx. 10 minute walk from hotel. **Preregistration required. Tickets: $80.00 each.**

SCHEDULE OF EVENTS

6:30 – 10:00 p.m.

Reception and Dinner – Ravine Vineyard Estate Winery, 1366 York Road, St. David's, Ontario
For five generations the Lowrey family has grown grapes in the soil of one of the oldest commercial vineyards in Niagara-on-the-Lake. Enjoy a real farm-to-table experience featuring their wines and dishes made from organic ingredients sourced from their garden. Ravine is a place steeped in time and heritage. **Shuttle departs from the hotel at 6:15 p.m. sharp. Preregistration required.**

Wednesday, August 7

Checkout

THINGS TO DO

Shaw Theatre Festival

(800) 511-7429 / www.shawfest.com

The Shaw Festival brings great theatre to life in the heart of Niagara Wine Country. One of the world's finest theatre companies, the Shaw Festival is celebrated for its vivid and exhilarating productions of plays by Bernard Shaw and his contemporaries (1856-1950), and plays about the period of Shaw's lifetime. Join us Tuesday, August 6 for a 2 p.m. matinee of Getting Married at the Royal George Theatre. Purchase tickets using the meeting registration form.

Niagara Historical Society Museum
THE PAST IS PRESENT HERITAGE FESTIVAL

(905) 468-3912/ www.niagarahistorical.museum

Monday, August 5, the Museum at 43 Castlereagh St. will host a "treasurers" sale, historic demonstrations, heritage activities, food, live music and more! Free admission from 11 a.m. to 4 p.m.

Fort George National Historic Site

(905) 468-4257 / www.pc.gc.ca

Fort George located on the west side of the mouth of the Niagara River in Niagara-on-the-Lake, offers a fascinating and thought provoking experience by allowing visitors to be immersed in a very important part of the history of Canada, the War of 1812. Open seven days a week, 10 am to 5 pm.

During the war, the Niagara River was a vital water transportation route between Lake Ontario and Lake Erie. The Niagara frontier was the scene of many battles, including the ferocious Battle of Fort George, which saw the British attempt to defend against a much larger American force, supported by the U.S. navy. During the battle, in May 1813, Fort George was nearly destroyed by American cannon fire and was consequently captured days later. It was retaken in December of that same year by the British who went on to capture the American Fort Niagara in a daring night assault.

With the construction of Fort Mississauga in 1814 (now also a National Historic Site), Fort George was abandoned and allowed to fall into ruins soon after the war. Fort George, was designated a National Historic Site in 1921 and restored in the late 1930's.

Knowledgeable, costumed staff help bring the story of the fort and surrounding area to life with fascinating tales of real Canadian heroes. Dramatic tales of nation shaping events unfold within the walls of the fort. Children can try the hands-on fun of becoming soldiers in the 41st Regiment by trying on soldiers' redcoats, and learning to march and drill with wooden muskets.

Niagara Falls

Niagara Falls is approximately 30 to 45 minutes by car from Niagara-on-the-Lake. Enjoy spectacular views of the falls from a beautiful park on the edge of the Niagara River.

During the Summer, **you can easily get from Niagara Falls to Niagara-on-the-Lake with the WEGO** orange line shuttle, offered from May 5th until October 29th. The cost for a one way ticket is $7.00 for an adult and $5.00 for a child. The shuttle runs every 60 minutes from 11:00 am until 6:00 p.m. from Fort George to the Floral Clock where you transfer to the Niagara Parks Green Line bus. Tickets can be purchased with the correct change from the bus driver. **To see the full schedule visit the WE GO** website or visit the Niagara Parks website to **view the Shuttle Schedule. Bus line map also available at** www.wegoniagarafalls.com/pdf/wego-route-map.pdf

Hornblower Niagara Cruises (Canada)

(905) 642-4272 / www.niagaracruises.com

The legendary boat tour of Niagara Falls takes place aboard new state-of-the-art catamaran boats. The **"Voyage To The Falls"** promises an unforgettable thrill of a lifetime journey in the Great Gorge, past the American Falls, Bridal View Falls and into the very heart of the mighty Horseshoe Falls for an up-close and personal experience of the thundering water, awesome power and amazing mist of magnificent Niagara Falls! Boats depart every 15 minutes and begin each day with the Early Morning Sunrise Tour. This experience includes access to Hornblower Landing and extraordinary Falls viewing. Accessible view WEGO Green Line Bus.

Maid of the Mist (USA)

(905) 358-5781 / www.maidofthemist.com

Debuting in 1846, the Maid of the Mist is North America's oldest tourist attraction. For the 129th year in a row the iconic boats are setting sail through Niagara Falls. A raincoat is provided free with admission to help keep you dry from the mist and spray. Water rushes all around as you "soak" in the excitement and explore the roar of the Falls.

Casinos – gambling is available at 3 casinos in Niagara Falls. The Fallsview Casino and Casino Niagara in Niagara Falls, Canada or the Seneca Niagara Casino in Niagara Falls, New York.

Skylon Tower, Canada – the Skylon Tower offers visitors an outstanding view from indoor and outdoor observation decks reached by an exterior glass-enclosed "yellow bug elevator". Enjoy the 52 second ride and the view of the falls, the Great Gorge, the Niagara wine district and see skylines of Buffalo, New York and Toronto.

For more information on the numerous activities available at Niagara-on-the-Lake go to:
www.niagaraonthelakeinfo.com and for the surrounding area, visit: www.niagaraparks.com

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Lawyer Assistance Program 800.255.0569

Q. What is LAP?

A. The Lawyer Assistance Program is a program of the New York State Bar Association established to help attorneys, judges, and law students in New York State (NYSBA members and non-members) who are affected by alcoholism, drug abuse, gambling, depression, other mental health issues, or debilitating stress.

Q. What services does LAP provide?

A. Services are **free** and include:

- Early identification of impairment
- Intervention and motivation to seek help
- Assessment, evaluation and development of an appropriate treatment plan
- Referral to community resources, self-help groups, inpatient treatment, outpatient counseling, and rehabilitation services
- Referral to a trained peer assistant – attorneys who have faced their own difficulties and volunteer to assist a struggling colleague by providing support, understanding, guidance, and good listening
- Information and consultation for those (family, firm, and judges) concerned about an attorney
- Training programs on recognizing, preventing, and dealing with addiction, stress, depression, and other mental health issues

Q. Are LAP services confidential?

A. Absolutely, this wouldn't work any other way. In fact your confidentiality is guaranteed and protected under Section 499 of the Judiciary Law. Confidentiality is the hallmark of the program and the reason it has remained viable for almost 20 years.

Judiciary Law Section 499 Lawyer Assistance Committees Chapter 327 of the Laws of 1993

Confidential information privileged. The confidential relations and communications between a member or authorized agent of a lawyer assistance committee sponsored by a state or local bar association and any person, firm or corporation communicating with such a committee, its members or authorized agents shall be deemed to be privileged on the same basis as those provided by law between attorney and client. Such privileges may be waived only by the person, firm or corporation who has furnished information to the committee.

Q. How do I access LAP services?

A. LAP services are accessed voluntarily by calling **800.255.0569** or connecting to our website **www.nysba.org/lap**

Q. What can I expect when I contact LAP?

A. You can expect to speak to a Lawyer Assistance professional who has extensive experience with the issues and with the lawyer population. You can expect the undivided attention you deserve to share what's on your mind and to explore options for addressing your concerns. You will receive referrals, suggestions, and support. The LAP professional will ask your permission to check in with you in the weeks following your initial call to the LAP office.

Q. Can I expect resolution of my problem?

A. The LAP instills hope through the peer assistant volunteers, many of whom have triumphed over their own significant personal problems. Also there is evidence that appropriate treatment and support is effective in most cases of mental health problems. For example, a combination of medication and therapy effectively treats depression in 85% of the cases.

Personal Inventory

Personal problems such as alcoholism, substance abuse, depression and stress affect one's ability to practice law. Take time to review the following questions and consider whether you or a colleague would benefit from the available Lawyer Assistance Program services. If you answer "yes" to any of these questions, you may need help.

1. **Are my associates, clients or family saying that my behavior has changed or that I don't seem myself?**
2. **Is it difficult for me to maintain a routine and stay on top of responsibilities?**
3. **Have I experienced memory problems or an inability to concentrate?**
4. **Am I having difficulty managing emotions such as anger and sadness?**
5. **Have I missed appointments or appearances or failed to return phone calls? Am I keeping up with correspondence?**
6. **Have my sleeping and eating habits changed?**
7. **Am I experiencing a pattern of relationship problems with significant people in my life (spouse/parent, children, partners/associates)?**
8. **Does my family have a history of alcoholism, substance abuse or depression?**
9. **Do I drink or take drugs to deal with my problems?**
10. **In the last few months, have I had more drinks or drugs than I intended, or felt that I should cut back or quit, but could not?**
11. **Is gambling making me careless of my financial responsibilities?**
12. **Do I feel so stressed, burned out and depressed that I have thoughts of suicide?**

There Is Hope

CONTACT LAP TODAY FOR FREE CONFIDENTIAL ASSISTANCE AND SUPPORT

The sooner the better!

1.800.255.0569

NEW YORK STATE BAR ASSOCIATION

Join Our Section

☐ As a NYSBA member, **PLEASE BILL ME $40 for Trial Lawyers Section dues.** (law student rate is $15)

☐ I wish to become a member of the NYSBA (please see Association membership dues categories) and the Trial Lawyers Section. **PLEASE BILL ME for both.**

☐ I am a Section member — please consider me for appointment to committees marked.

Name _____

Address _____

_____

City _____ State _____ Zip _____

The above address is my ☐ Home ☐ Office ☐ Both

Please supply us with an additional address.

Name _____

Address _____

City _____ State _____ Zip _____

Office phone (_____) _____

Home phone (_____) _____

Fax number (_____) _____

E-mail address _____

Date of birth _____ /_____ /_____

Law school _____

Graduation date _____

States and dates of admission to Bar: _____

Please return this application to:
MEMBER RESOURCE CENTER,
New York State Bar Association, One Elk Street, Albany NY 12207
Phone 800.582.2452/518.463.3200 • FAX 518.463.5993
E-mail mrc@nysba.org • www.nysba.org

Join a Trial Lawyers Section Committee(s)

Please designate the committee(s) in which you would like to participate. Space limits may apply.

___ Appellate Practice (TRIA1100)
___ Arbitration and Alternatives to Dispute Resolution (TRIA1200)
___ Commercial Collections (TRIA4200)
___ Construction Law (TRIA3000)
___ Continuing Legal Education (TRIA1020)
___ Criminal Law (TRIA3300)
___ Diversity (TRIA4100)
___ Employment Law (TRIA3700)
___ Family Law (TRIA4000)
___ Lawyers Professional Liability and Ethics (TRIA3800)
___ Legal Affairs (TRIA2900)
___ Legislation (TRIA1030)
___ Medical Malpractice (TRIA2200)
___ Membership (TRIA3200)
___ Motor Vehicle Law (TRIA3400)
___ No Fault Law (TRIA3500)
___ Real Property Law (TRIA3900)
___ Trial Advocacy Competition (TRIA2700)
___ Website (TRIA4400)
___ Workers Compensation (TRIA3600)

2019 ANNUAL MEMBERSHIP DUES

Class based on first year of admission to bar of any state. Membership year runs January through December.

ACTIVE/ASSOCIATE IN-STATE ATTORNEY MEMBERSHIP	
Attorneys admitted 2011 and prior	$275
Attorneys admitted 2012-2013	185
Attorneys admitted 2014-2015	125
Attorneys admitted 2016 - 3.31.2018	60
ACTIVE/ASSOCIATE OUT-OF-STATE ATTORNEY MEMBERSHIP	
Attorneys admitted 2011 and prior	$180
Attorneys admitted 2012-2013	150
Attorneys admitted 2014-2015	120
Attorneys admitted 2016 - 3.31.2018	60
OTHER	
Sustaining Member	$400
Affiliate Member	185
Newly Admitted Member*	FREE

DEFINITIONS

Active In-State = Attorneys admitted in NYS, who work and/or reside in NYS
Associate In-State = Attorneys not admitted in NYS, who work and/or reside in NYS
Active Out-of-State = Attorneys admitted in NYS, who neither work nor reside in NYS
Associate Out-of-State = Attorneys not admitted in NYS, who neither work nor reside in NYS
Sustaining = Attorney members who voluntarily provide additional funds to further support the work of the Association
Affiliate = Person(s) holding a JD, not admitted to practice, who work for a law school or bar association
*Newly admitted = Attorneys admitted on or after April 1, 2018

NYSBA

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Ethics Update for Trial Lawyers

Sharon Stern Gerstman, Esq.
Former President, New York State Bar Association
Magavern, Magavern, Grimm, LLP
Buffalo

NEW YORK STATE BAR ASSOCIATION
TRIAL LAWYERS SECTION
August 5, 2019

ETHICS UPDATE FOR TRIAL LAWYERS

Sharon Stern Gerstman
Magavern Magavern Grimm LLP

Note: Text of NYSBA Opinions may be found here: https://www.nysba.org/Ethics/

I. Issues Regarding Firm Name

Rule 7.5(b) provides:

"A lawyer in private practice shall not practice under a trade name, a name that is misleading as to the identity of the lawyer or lawyers practicing under such name, or a firm name containing names other than those of one or more of the lawyers in the firm, except that the name of a professional corporation shall contain 'PC' or such symbols permitted by law, the name of a limited liability company or partnership shall contain 'LLC,' 'LLP' or such symbols permitted by law and, if otherwise lawful, a firm may use as, or continue to include in its name the name or names of one or more deceased or retired members of the firm or of a predecessor firm in a continuing line of succession. Such terms as 'legal clinic,' 'legal aid,' 'legal service office,' 'legal assistance office,' 'defender office' and the like may be used only be qualified legal assistance organizations, except that the term 'legal clinic' may be used by a lawyer or law firm provided the name of a participating lawyer or firm is incorporated therein. A lawyer or law firm may not include the name of a nonlawyer in its firm name, nor may a lawyer or law firm that has a contractual relationship with a nonlegal profession or nonlegal professional service firm pursuant to Rule 5.8 to provide legal and other professional services on a systematic and continuing basis include in its firm name the name of the nonlegal professional service firm or any individual nonlegal professional affiliated therewith. A lawyer who assumes a judicial, legislative or public executive or administrative post or office shall not permit the lawyer's name to remain in the name of a law firm or to be used in professional notices of the firm during any significant period in which the lawyer is not actively and regularly practicing law as a member of the firm and, during such period, other members of the firm shall not use the lawyer's name in the firm name or in professional notices of the firm."

Rule 7.5(e) provides:

"A lawyer or law firm may utilize a domain name for an internet web site that does not include the name of the lawyer or law firm provided:

(1) All pages of the web site clearly and conspicuously include the actual name of the lawyer or law firm;
(2) The lawyer or law firm in no way attempts to engage in the practice of law using the domain name;
(3) The domain name does not imply an ability to obtain results in a matter;
(4) The domain name does not otherwise violate these Rules.

The comments to Rule 7.5 include further elucidation regarding the use of domain names, giving examples of proper domain names (for law firm Able and Baker, could use www.ableandbaker.com, www.ab.com, www.ablelaw.com, www.realestatelawyers.com, etc.) and giving examples of some improper usages (PI lawyers can't use www.win-your-case.com or

www.settleformore.com) which might run afoul of (e)(3), and underscoring that any advertising cannot be strictly under the domain name, that the name of the firm must be conspicuous as well.

Two recent NYSBA opinions deal with firm names.

In NYSBA Opinion 1167, May 9, 2019, the Committee decided a question about the use of the lawyer's middle name, as the latest of a long line of questions about use of parts of a lawyer's name. The Committee decided that it was permissible to use the lawyer's middle and last name as the firm name, even if the middle name sounded like another last name and the consumer might think the firm had two lawyers. E.g., if the lawyer's name was Marie Wilson Jones, the firm could be called Wilson Jones. The committee likened it to one that permitted the use of the lawyer's last name and middle initials (NYSBA 1003, 2014), and distinguished the opinion on this issue from previous ones that forbade the practice under just the lawyer's first name (NYSBA Opinion 1152, 5/17/2018). Also forbidden are a contraction of initials or parts of a lawyer's first, middle, and/or last name (NYSBA Opinions 948 and 920, 2012), and a English translation of the lawyer's actual last name (NYSBA Opinion 1138, 2017).

In NYSBA Opinion 1168, May 13, 2019, the Committee decided a question about the use of the seller's firm name after sale. The purchaser was someone who worked as a contract attorney in the firm. However, the seller was going to continue to practice law in the state, albeit quite some distance away. The Committee first opined that the sale was ethical under Rule 1.17 which allows the sale of a private practice by a retiring attorney in that Rule 1.17 defines retirement as the cessation of the private practice of law in the geographic area (defined as the county and city and any contiguous county or city). Second, the committee found that use of a retired lawyer's name in the firm name was permissible, and decided to use the Rule 1.17 definition of retired rather than the OCA definition. The committee did opine, however, that they may not have decided the same way had the purchaser not been affiliated with the firm prior to purchase. The Committee also noted that two opinions (Opinions 148 and 850) were modified in light of the opinion in 1168.

II. Issues Regarding End of Representation/Missing Client

In NYSBA Opinion 1163, March 11, 2019, the Committee answered a tricky inquiry involving a missing client. In the facts presented, the lawyer had negotiated a settlement for the client, sent the terms of settlement to the client with a letter which provided that the representation was concluded. There was a subsequent issue regarding the settlement, and the opposing party brought a motion. The lawyer tried to contact the client by phone, email and mail without success. The lawyer asked the Committee to define his duties regarding disclosure of the end of the representation, disclosure that the client could not be found, answering the opposing motion, and moving to formally withdraw.

An obligation to make a motion to withdraw, continues to exist until a stipulation of discontinuance is filed. If there is no stipulation of discontinuance, the lawyer must make the motion. However, in preparing the motion to withdraw, the lawyer must be careful not to disclose any client confidences (perhaps including his disappearance), unless ordered by the court to do so. NYSBA Opinion 1057 (2015) requires the lawyer to cite "professional considerations" as the reason for terminating the representation. NYSBA Opinion 787 (2005) discusses the steps an attorney must take when a client is missing.

If a stipulation has already been filed, the lawyer may disclose that the representation of the client is terminated, and then the lawyer has no obligation regarding the motion.

III. Issues Regarding Client Files

NYSBA Opinion 1164 (March 21, 2019) concerns what the lawyer is to do when a client requests not only the return of a document, but the destruction of all copies of the document. Recognizing that, as a general rule, an attorney may have an interest in maintaining (at his or her own expense) a copy of a client's file, the Committee determined that the attorney may comply with such a request, if there is a reason for the client's insistence of the destruction of the document, and that the attorney may condition such a destruction upon the client providing a release and hold harmless agreement.

Opinion 1164 cites back to NYSBA Opinion 1142 (2018) which gives general parameters regarding the return of files that are stored in electronic form. This comprehensive opinion culls from other opinions and cases and provides a good outline for the storage and maintenance of client files and related issues. These principles include:

1. Except for certain documents that must be kept in the original (wills, deeds, original contracts, promissory notes), documents may be kept in any form, including electronic form, on microfilm, or in cloud-based storage.

2. As a general rule, a former client is entitled to his or her client file, and the lawyer must promptly deliver the file upon request.

3. Fees for copying or assembling the file may be charged to the client provided a) the client hasn't already been charged for the cost of assembling the file under the retainer agreement; b) the copies to be charged are for the client's benefit, not the lawyer's. Where the client is entitled to return of his or her documents, a copy kept by the lawyer is for the lawyer's benefit and cannot be charged to the client.

4. Where the file is exclusively electronic, the lawyer may deliver the file in electronic form or allow access to the electronic file from the cloud. If the client cannot access the file in electronic form, the lawyer must make every effort to provide the file in a

form that the client can access. If the client requests that the documents be printed out, the lawyer may charge for the reasonable costs of doing so.

IV. Issues Regarding Fee Divisions

During the past year, the Committee on Professional Ethics issued two opinions regarding the sharing of legal fees with a party who is not a lawyer licensed to practice in New York. In NYSBA Opinion 1159 (December 14, 2018), the Committee considered the circumstances that fees may be split with a deceased lawyer's estate.

Consider the following case:

Lawyer A is the sole owner of a law firm which handles plaintiff's personal injury cases on contingent fee. He hires Lawyer B as an associate to work on the files. Lawyer A dies unexpectedly, without a succession plan. Lawyer B continues to work on the files, and also brings in new cases. Lawyer A's estate continues to hold the interest in the firm, and eventually dissolves the firm. Lawyer B starts her own firm and all of the clients of Lawyer A's firm sign new retainers with Lawyer B. The Estate has demanded a share of the fees for the cases which originated with Lawyer A's firm.

1. Can the Lawyer B continue to work in the firm while the Estate owns it?
2. Can Lawyer B pay the Estate any portion of the fees?

The Committee says yes to both questions, limited to Rule 5.4 (d)(1) and (a)(2).

Rule 5.4(d) prohibits a lawyer from practicing in a firm which is owned (in whole or in part) or controlled by a non-lawyer. Rule 5.4(d)(1) provides an exception where the firm is owned by the representative of the lawyer's estate, for a reasonable time during the estate administration.

Rule 5.4(a) generally prohibits the sharing of a fee with a non-lawyer, or working in a law firm which is owned by a non-lawyer. There are three exceptions in Rule 5.4(a):

"(1) an agreement by a lawyer with the lawyer's firm or another lawyer associated in the firm may provide for the payment of money, over a reasonable period of time after the lawyer's death to the lawyer's estate or to one or more specified persons.

"(2) a lawyer who undertakes to complete unfinished legal business of a deceased lawyer may pay to the estate of the deceased lawyer that portion of the total compensation that fairly represents the services rendered by the deceased lawyer.

"(3) a lawyer or law firm may compensate a nonlawyer employee or include a nonlawyer employee in a retirement plan based in whole or in part on a profit-sharing arrangement."

In the case given, there is no succession plan and so no agreement as contemplated by Rule 5.4(a)(1). However, Lawyer B can provide to the estate "that portion of the total compensation that fairly represents the services" by Lawyer A. Any fee in excess of this amount would be prohibited.

In NYSBA 1160 (January 2, 2019), the Committee considered a situation where the New York lawyer wishes to affiliate in some manner with a lawyer who is licensed to practice in a state other than New York, but is admitted to practice before the federal courts in New York. [This is possible for cases like bankruptcy or tax where the underlying law and procedure is federal.] The proposed arrangement does not include federal cases in which both attorneys would work. It was explained that the contemplated arrangement would ease referrals of clients to each other. While the Committee acknowledged that there can be affiliations and partnerships of lawyers across multiple jurisdictions, based upon each lawyer practicing only in the jurisdictions(s) in which he or she is licensed. Here, the lawyer's admission to the Federal District Court is not the equivalent of the license to practice. Sharing of fees between attorneys cannot be a pure "referral fee" with the referring attorney maintaining no responsibility. Rule 1.5(g). The problem with the proposed affiliation is that when the non-licensed attorney receives a portion of a fee earned by the licensed lawyer, either he or she is not maintaining any responsibility or he or she is engaged in the unlawful practice of law. The former would run afoul of Rule 1.5(g), and the latter runs afoul of Rule 5.5(b), which provides that "A lawyer shall not aid a nonlawyer in the unauthorized practice of law.

Interestingly, the Committee had previously permitted a fee split between a lawyer practicing in another state, who refers his client to the lawyer in New York, so long as the lawyer in the other state remains responsible, without defining the way the out of state lawyer would remain responsible. NYSBA Opinion 864 (2011). However, this was a one time referral, not an

affiliation. Presumably, the out of state attorney could be admitted on the case pro haec vice, or could remain responsible for issues which are entail provisions of law in the client's home state.

In ABA Formal Opinion 487, the Standing Committee on Ethics and Professional Responsibility outlined the steps that a lawyer who is replacing another lawyer in representation of the client on a contingent fee should take to inform the client that the fee may be split with the former attorney. The Committee based this opinion on Rules 1.5(b) and (c) which require the lawyer to inform the client as to general rates of fees in Rule 1.5(b) and how the fee is to be computed in Rule 1.5(c), and recommended that this explanation be made in the original agreement with the client, although it permitted a later separate agreement.

The Committee also commented on the role of the successor attorney in addressing the predecessor's claim to a portion of the fee. The successor's work may include an assessment of the legitimacy of the claim to the fee or to an assessment of the amount of the fee earned. The successor has a duty to hold the fee in trust under Rule 1.15 until the division is concluded.

V. Issues Regarding Social Media

On May 11, 2017, the NYSBA Commercial and Federal Litigation Section issued its updated "Social Media Ethics Guidelines." It may be accessed here: http://www.nysba.org/workarea/DownloadAsset.aspx?id=77534

These guidelines provide an extensive review of many topics of interest to trial lawyers including Attorney Competence, Attorney Advertising, Furnishing Legal Advice through Social Media, Use of Evidence from Social Media, Communicating with Clients Regarding Social Media, Jurors and Social Media, and Communicating with a Judicial Officer Through Social Media.

Part 5, "Communicating with Clients," is excerpted below.

Since its dissemination, the Court of Appeals has decided ***Forman v. Henkin***, 30 N.Y.3d 656 (2018), which provided that normal discovery rules would apply to the discoverability of social media postings, and that any discovery request must be "reasonably likely to yield relevant evidence."

The following are the guidelines and some explanatory material from the NYSBA Commercial and Federal Litigation Section "Social Media Ethics Guidelines" (2017), Part 5:

5. Communicating with Clients:

Guideline No. 5.A: Removing Existing Social Media Information

"A lawyer may advise a client as to what content may be maintained or made non-public on her social media account, including advising on changing her privacy and/or security settings. A lawyer may also advise a client as to what content may be "taken down" or removed, whether posted by the client or someone else. However, the lawyer must be cognizant of preservation obligations applicable to the client and/or matter, such as a statute, rule, regulation, or common law duty relating to the preservation of information, including legal hold obligations. Unless an appropriate record of the social media content is preserved, a party or nonparty may not delete information from a social media account that is subject to a duty to preserve."

There is a duty to ensure that potentially relevant information is preserved, but there is no obligation to show the material to the public, and the lawyer may advise his or her client to "privatize" the information. This guideline is based upon N.Y.C.L.A. Formal Opinion 745 (2013), NCSBA Formal Opinion 2014-5; Phila.Bar Ass'n Opinion 2014-5, FBA Opinion 14-1 (2015, as revised 2016).

Guideline No. 5.B.: Adding New Social Media Content

"A lawyer may advise a client with regard to posting new content on social media, as long as the proposed content is not known to be false by the lawyer. A lawyer also may not 'direct or facilitate the client's publishing of false or misleading information that may be relevant to a claim.'"

The advice can include reviewing the material before posting, advising that there be no postings, and advising the client on the discoverability of social media postings. PBA Opinion 2014-300.

Guideline No. 5.C.: False Media Statements

"A lawyer is prohibited from proffering, supporting, or using false statements if she learns from a client's social media posting that a client's lawsuit involves the assertion of material false factual statements or evidence supporting such a conclusion and if proper inquiry of the client does not negate that conclusion."

See Rule 3.1(a).

Guideline No. 5.D: A Lawyer's Use of Client-Provided Social Media Information

"A lawyer may review a represented person's non-public social media information provided to the lawyer by her client, as long as the lawyer did not cause or assist the client to: (i) inappropriately obtain non-public information from the represented person; (ii) invite the represented person to take action without the advice of his or her lawyer; or (iii) otherwise overreach with respect to the represented person."

The client may communicate with a represented party, but the lawyer must be careful not to assist the client to seek confidential information inappropriately, or participate in the communication. Rule 4.2(b).

The lawyer must also be cautious if the client plans to "friend" the represented person. Some ethical opinions allow that the client send a "friend" request or "follow" the person, and provide the information to the lawyer, but the lawyer cannot direct the client to do so. NHBA Opinion 2012-13/05. ABA Opinion 11-461 (2011) permits the lawyer to give substantial assistance including subjects to be addressed and review of potential correspondence between the client and the represented party.

Guideline No. 5E: Maintaining Client Confidences and Confidential Information

"Subject to the attorney-client privilege rules, a lawyer is prohibited from disclosing client confidences and confidential information relating to the legal representation of a client, unless the client has provided informed consent. Social media activities and a lawyer's website or blog must comply with these limitations.

"A lawyer should also be aware of potential risks created by social media services, tools or practices that seek to create new user connections by importing contacts or connecting platforms. A lawyer should understand how the service, tool or practice operates before using it and consider whether any activity places client information and confidences at risk.

"Where a client has posted an online review of the lawyer or her services, the lawyer's response, if any, shall not reveal confidential information relating to the representation of the client. Where a lawyer uses a social media account to communicate with a client or otherwise store client confidences, the lawyer shall make reasonable efforts to prevent the inadvertent or unauthorized disclosure or use of, or unauthorized access to, such an account."

This guideline requires safeguards to protect client information as required by Rule 1.9. Regarding the response to online reviews, see PBA Opinion 2014-300, Texas State Bar Opinion 662, and DC Bar Ethics Opinion 370.

VI. Issues Regarding Litigation Funding

What started as a source of emergency funding for plaintiffs has blossomed into a multi-billion dollar industry. There are several ethical issues which can be raised regarding various forms of funding, including plaintiff loans for non-litigation costs, client loans for litigation costs, and attorney loans for litigation costs.

Case 1: Plaintiff is injured in an automobile accident, which has prevented him from working. Plaintiff retains you to represent him. Defendant has $100,000 coverage and you have demanded the policy, but there has been only a $25,000 offer, so you put the case in suit. Plaintiff complains that he has bills to pay and limited money and no ability to borrow from friends or family or to put any more on his credit card. He has seen the late night advertisements by SqueezeDry Funding and asks you if he should borrow from SqueezeDry or someone else.

(a) Suppose you know a funding source (SmoothOperator) that gives better terms that SqueezeDry? Can you refer Plaintiff to them?

Rule 1.7(a)(2) (see page 17) and 1.8(a) (see page 18) put limitations on business relationships between lawyers and clients. If you have any ownership interest in SmoothOperator, you cannot refer Plaintiff as it would constitute making a loan to the Plaintiff which is prohibited under 1.8(e) and you cannot take a share of Plaintiff's cause of action under 1.8(i). NYSBA Opinion 666(1994)

If SmoothOperator is owned by a member of your family, you are also prohibited from referring the Plaintiff: NYSBA Opinion 855 (2011) regarding ownership by lawyer's spouse; ***In Re Cellino,*** 21 AD3d 229 (4th Dept. 2005) regarding ownership by lawyer's cousin; ***S.D. v. St. Luke's Cornwall***

Hospital, 63 Misc.3d 384 (2019) regarding ownership by lawyer's brother. At very least, full disclosure and compliance with Rule 1.8(a) would be required.

If you have a relationship with SmoothOperator, other than ownership, you may be able to refer Plaintiff to them, with full disclosure and Plaintiff's informed consent. Rule 1.8(a) controls and requires three steps: (1) the transaction has to be fair to the client and set out in writing that can be easily understood by the client; (2) the client is advised in writing that he or she should consider independent legal advice and be given an adequate opportunity to do so; (3) the client gives informed consent of both the terms of the transaction, the lawyer's role, and whether the lawyer is representing the client in the transaction. A business relationship which triggers Rule 1.8(a) includes receipt of a referral fee or like benefit, prior representation of SmoothOperator [***Leon v. Martinez,*** 84 NY2d 83 (1994), and even a long history with SmoothOperator.

(b) Suppose Plaintiff tells you that he can't hold out any longer and you must either settle for the $25,000 or he's going to go to SqueezeDry for a loan. What do you do? Are you sure your advice is in Plaintiff's best interests and not your own? If Plaintiff goes to SqueezeDry and borrows $25,000, are there any conflicts of interest as you negotiate a settlement or push to go to trial?

(c) Do you help your client negotiate with the ALF supplier? Are there terms of the agreement that are in your best interests but not your client's?

(d) Suppose SqueezeDry or SmoothOperator requires that Plaintiff turn over all papers including attorney's work product and confidential information? Or suppose SqueezeDry or SmoothOperator require Plaintiff not to change law firms without their permission?

Informed consent regarding these risks and alternative provisions may be necessary and are certainly preferable. There are Ethics Opinions from other states that require informed consent regarding waiver of the attorney-client privilege or regarding the sharing of attorney work product. One opinion requires the lawyer to inform the ALF supplier in writing that the client, not the funding company, retains the right to control the litigation.

Case #2: Plaintiff claims medical malpractice against a number of doctors and a hospital. Under the retainer agreement, the attorney retains the right to ask the client for payment of disbursements as a condition for the attorney to proceed in the case. After the completion of discovery, there is an offer of settlement, that the attorney advises the Plaintiff to consider but Plaintiff refuses. Attorney tells the Plaintiff that he must advance the litigation costs, or else the attorney will move to withdraw. Plaintiff goes to Love Litigation, Inc. to borrow the money for litigation costs.

(a) What are Attorney's obligations? What if there is a relationship between Attorney and LoveLitigation, Inc.? What if Plaintiff is suing as PNG of injured child?

See ***S.D. v. St. Luke's Cornwall Hospital***, 63 Misc.3d 384 (Sup.Ct. Orange Co. 2019).

Case #3: You are commencing product liability actions against a pharmaceutical company, claiming failure to warn of a dangerous side effect of a drug. You think you can attract a lot of plaintiffs, but you don't have sufficient capital to finance what will likely be a lengthy case. You seek a loan from Lawyer Savior, Inc., secured by your office's fixtures and accounts receivable. Interest rate is at fair market value for this type of loan. The retainer agreement is for a contingent fee with the pay back of all disbursements.

(a) Can you pass along the interest you paid on the loan? How about a surcharge?

Rule 1.5(a) Reasonableness of Fee; Rule 1.8(a) Requirement of Informed Consent

Other Issues:

Legislation (Disclosure, Consumer Protection)
Disclosure to a Mediator or Arbitrator
Actions on behalf of an infant or AIP

VII. Other Issues Regarding Conflicts in Representation

Case #4: Mother is driver in automobile rear-ended by Defendant. Mother is injured, as are her two daughters who are back seat passengers. The daughters are 18 and 16 at the time of the accident. The three of them come to see you to represent them. What do you do?

Case #5: You represent defendants in automobile cases for XYZ Insurance Co. They send you a case to represent the owner (and policy holder) and her boyfriend driver. Owner was not in the car at the time of the accident. What do you do?

Case #6: You represent two injured passengers in the same car. You sue both drivers. You learn that the total insurance coverage will not be sufficient to compensate both passengers. What do you do?

Rule 1.7: Conflict of interest: current clients.

(a) Except as provided in paragraph (b), a lawyer shall not represent a client if a reasonable lawyer would conclude that either:

(1) the representation will involve the lawyer in representing differing interests; or
(2) there is a significant risk that the lawyer's professional judgment on behalf of a client will be adversely affected by the lawyer's own financial, business, property or other personal interests.

(b) Notwithstanding the existence of a concurrent conflict of interest under paragraph (a), a lawyer may represent a client if:

(1) the lawyer reasonably believes that the lawyer will be able to provide competent and diligent representation to each affected client;
(2) the representation is not prohibited by law;
(3) the representation does not involve the assertion of a claim by one client against another client represented by the lawyer in the same litigation or other proceeding before a tribunal; and
(4) each affected client gives informed consent, confirmed in writing.

Rule 1.8: Current Clients: Specific Conflict of Interest Rules

(a) A lawyer shall not enter into a business transaction with a client if they have differing interests therein and if the client expects the lawyer to exercise professional judgment therein for the protection of the client, unless:

(1) the transaction is fair and reasonable to the client and the terms of the transaction are fully disclosed and transmitted in writing in a manner that can be reasonably understood by the client;

(2) the client is advised in writing of the desirability of seeking, and is given a reasonable opportunity to seek, the advice of independent legal counsel on the transaction; and

(3) the client gives informed consent, in a writing signed by the client to the essential terms of the transaction and the lawyer's role in the transaction, including whether the lawyer is representing the client in the transaction.

……

(e) While representing a client in connection with contemplated or pending litigation, a lawyer shall not advance or guarantee financial assistance to the client, except that:

(1) a lawyer may advance court costs and expenses of litigation, the repayment of which may be contingent on the outcome of the matter;

(2) a lawyer representing an indigent or pro bono client may pay court costs and expenses of litigation on behalf of the client; and

(3) a lawyer, in an action in which an attorney's fee is payable in whole or in part as a percentage of the recovery in the action, may pay on the lawyer's own account court costs and expenses of litigation. In such case, the fee paid to the lawyer from the proceeds of the action may include an amount equal to such costs and expenses incurred.

(f) A lawyer shall not accept compensation for representing a client, or anything of value related to the lawyer's representation of the client, from one other than the client unless:

(1) the client gives informed consent;

(2) there is no interference with the lawyer's independent professional judgment or with the client-lawyer relationship; and

(3) the client's confidential information is protected as required by Rule 1.6

(g) A lawyer who represents two or more clients shall not participate in making an aggregate settlement of the claims of or against the clients, absent court approval, unless each client gives informed consent in a writing signed by the client. The lawyer's disclosure shall include the

existence and nature of all the claims involved and the participation of each person in the settlement.

……

(i) A lawyer shall not acquire a proprietary interest in the cause of action or subject matter of litigation the lawyer is conducting for a client, except that the lawyer may:

(1) acquire a lien authorized by law to secure the lawyer's fee or expenses; and

(2) contract with a client for a reasonable contingent fee in a civil matter subject to Rule 1.5(d) or other law or court rule.

Rule 1.9: Duties to Former Clients

(a) A lawyer who has formerly represented a client in a matter shall not thereafter represent another person in the same or a substantially related matter in which that person's interests are materially adverse to the interests of the former client unless the former client gives informed consent, confirmed in writing.

See, ***Keller v. Kruger***, 41 Misc.3d 1204(A) (Sup.Ct. Kings Co. 2013); defense lawyer cannot represent both owner and operator if there is any issue of permissive use.

Pasquis v. Osorio, 58 Misc.3d 1204(A) (Sup.Ct. Kings Co. 2017); attorney disqualified from representing either of driver and passenger in same car

Shelby v. Blakes, 129 AD3d 823 (2d Dept 2015) and ***Quinn v. Walsh***, 18 AD3d 638 (2d Dept. 2005) where attorney represented both driver and passenger in rear ender, attorney precluded from collecting any attorneys fees.

Key v. Arrow Limo, Inc., 44 Misc.3d 1213(A) (Sup.Ct. Kings Co. 2014); mother driver cannot be PNG, mother and adult passenger cannot settle; attorney disqualified

Marinozzi v. Sanders, 37 Misc.3d 1225(A) (Sup. Ct. Orange Co. 2012); while opposing party lacks standing to move to disqualify, court can disqualify sua sponte. Defense attorney cannot represent both doctor and nurse midwife in medical malpractice action, disqualified from representing any.

Ethics Update for Trial Lawyers

Sharon Stern Gerstman, Esq.
Magavern Magavern Grimm LLP
August 5, 2019

Issues Regarding Litigation Funding

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New York Practice and CPLR Update

Hon. Shirley Troutman
Appellate Division, Fourth Department
Buffalo

CPLR UPDATE

August 2019

Hon. Shirley Troutman
Associate Justice
Supreme Court of the State of New York
Appellate Division
Fourth Department

PERSONAL JURISDICTION (CPLR 301)

General Rule:

A defendant must be "at home" for a court to have general jurisdiction.

A court must have jurisdiction over a person to adjudicate the person's rights or obligations (*see* ***Pennoyer v Neff***, 95 US 714, 725 [1877]). A state court may assert general jurisdiction over a person—i.e., it may hear any claims involving the person—if the person maintains such a systematic and continuous presence in the state that he, she, or it is essentially at home there (*see* ***Goodyear Dunlop Tires Operations, S.A. v Brown***, 564 US 915, 919 [2011]). If the person is not "at home" in the state, the court may nonetheless exercise specific jurisdiction—i.e., adjudicate a specific controversy—if there

is a sufficient affiliation between the state and the controversy (*see id.*).

In the seminal case of ***Daimler AG v Bauman***, the United States Supreme Court concluded that a foreign company does not become subject to the general jurisdiction of a state, i.e. it is not "at home there," merely because its wholly-owned subsidiary operates there and has contacts with the state (*see* 571 US 117, 136 [2014]). The Court suggested that in most cases, a company is "at home" only where it is incorporated or has its principal place of business (*see id.* at 137).

Recent Development:

Merely registering to do business in New York State and appointing an agent for service is insufficient to confer jurisdiction by consent.

In ***Aybar v Aybar***, the Second Department considered whether a New York resident, injured in a car crash in Virginia, could invoke a New York court's jurisdiction and sue Ford Motor Company (a Delaware

corporation with a principal place of business in Michigan) and Goodyear Tire & Rubber Co. (an Ohio corporation with a principal place of business in Ohio) (*see* 169 AD3d 137, 139-140 [2d Dept 2019]). Applying *Daimler*, the court held that a New York court lacked general jurisdiction over the companies because—even though they had operated in New York for decades and had a retail presence here—they were incorporated and had their principal places of business elsewhere (*see id.* at 144). Perhaps more significantly, the court determined that by registering to do business in New York and appointing an agent for service of process here, the defendant companies did not consent to the general jurisdiction of the state (*see id.* at 165-170). In doing so, the court questioned whether the Court of Appeals case ***Bagdon v Philadelphia & Reading Coal & Iron Co.*** (217 NY 432 [1916]) and its progeny, which would seem to allow the exercise of jurisdiction based upon registration to do business and appointment of an agent, is still good law after *Daimler* (*see Aybar*, 169 AD3d at 170).

The most compelling criticism of *Daimler*—and much of the Supreme Court's jurisprudence since ***Citizens United v FEC*** (558 US 310 [2010])—is that it applies the rights of natural persons to corporate persons. Indeed, arguably *Daimler's* reasoning amounts to little more than saying that because a natural person may have only one domicile, a corporate person may have only one domicile (*see* 571 US at 137). Not only is this reasoning ahistorical—the rights of the person were historically regarded as *natural* rights whereas the rights of the corporation were regarded as conferred by the state—it ignores an obvious difference between natural and corporate persons. A natural person may be present in only one place at one time, but a corporate person may be present in several places. To its credit, the court recognized this fact, noting that there were two "homes" for corporations, i.e. place of incorporation and principal place of business (*see Daimler*, 571 US at 137). Nevertheless, the Court reasoned that "[a] corporation that operates in many places can scarcely be deemed at home in all of them" (*id.* at 139 n 20).

Two recent decisions are worth noting. In ***AlbaniaBEG Ambient Sh.p.k. v Enel S.p.A***., the First Department rejected the notion that *Daimler* should control in proceedings to recognize or enforce foreign judgments (*see* 160 AD3d 93, 101 [1st Dept 2018]). And in ***BRG Corp. v Chevron U.S.A., Inc.***, the Fourth Department held that a corporation does not become subject to the personal jurisdiction of the state merely because it bears successor liability to a corporation that itself was subject to personal jurisdiction in New York (*see* 163 AD3d 1495, 1496 [4th Dept 2018]).

General Rule:

An exercise of personal jurisdiction must comport with due process.

Although a court may have a basis to exercise personal jurisdiction over a defendant, it must nonetheless ensure that doing so comports with constitutional notions of due process, particularly notice and an opportunity to be heard (*see* ***Mullane v Cent. Hanover Bank & Tr. Co.***, 339 US 306, 313 [1950]).

Recent Development:

In foreclosure proceedings, there is no jurisdiction over heirs without notice.

An old but still interesting issue is the extent to which an *in-rem* proceeding must comport with constitutional notions of notice and due process vis a vis the persons touched by it (*see generally Pennoyer*, 95 US 714). In ***Matter of Foreclosure of Tax Liens***, the Second Department held that although a property tax foreclosure proceeding was an in-rem proceeding, the foreclosing authorities could not proceed where the owner of the property had died and an administrator had not been substituted, inasmuch as doing so would deprive the heirs of notice of the proceeding (*see* 165 AD3d 1112, 1120 [2d Dept 2018]).

General Rule:

An exercise of specific jurisdiction requires an affiliation between the state and the underlying controversy.

As mentioned, for a state court to exercise specific jurisdiction over a person, there must be an affiliation between the state and the events giving rise to the litigation (*see Goodyear*, 564 US at 919; *see also* ***Bristol-Myers Squibb Co. v Superior Ct. of California, San Francisco County***, 137 S Ct 1773, 1781 [2017]). Moreover, the exercise of specific jurisdiction over the defendant must comport with notions of due process, in other words, "the nonresident generally must have 'certain minimum contacts . . . such that the maintenance of the suit does not offend 'traditional notions of fair play and substantial justice' " (***Walden v Fiore***, 571 US 277, 283 [2014], quoting ***International Shoe Co. v. Washington***, 326 U.S. 310, 316 [1945]).

New York's long-arm statute provides that a non-domiciliary's conduct may expose it to the state's personal jurisdiction if the non-domiciliary: (1) transacts business here or supplies goods and services here; (2) commits a tort here, (3) commits a tort outside of the state causing injury to a person or property in the state, if the tortfeasor does business here, derives substantial revenue here, or

should reasonably expect the act to have consequences here and derives substantial revenue from interstate commerce, or (4) owns, uses, or possesses real property in the state (*see* CPLR 302 [a]).

Recent Developments:

There are limits on long-arm jurisdiction.

The reach of long-arm jurisdiction is a perennial issue. In ***Williams v Beemiller***, the Court of Appeals affirmed the Fourth Department in holding that a New York court could not exercise personal jurisdiction over a firearm merchant who sold a gun in Ohio that was eventually resold on the black market and used to shoot the plaintiff in New York (*see* 2019 NY Slip Op 03656, at *2-3 [2019]). The Court held that doing so would offend notions of due process, and therefore did not address whether the exercise of jurisdiction would comport with the long-arm statute (*see id.* at *3 n 2). However, in a lengthy concurring opinion, Judge Feinman concluded that the firearm merchant's conduct would not have satisfied any of the bases for long-arm jurisdiction (*see id.* at *4-9).

In ***Glazer v Socata, S.A.S.***, the Fourth Department held that a French airplane servicer could not be subject to New York long-arm jurisdiction with respect to litigation involving a plane departing Rochester and crashing near Jamaica, where the sole basis for jurisdiction was that the servicer had contracted with the plane's manufacturer to provide warranty service in New York, but had never actually done so (*see* 170 AD3d 1685, 1687 [4th Dept 2019]).

In ***Gottlieb v Merrigan***, the Third Department held that a Massachusetts law firm would not be subject to the jurisdiction of New York courts where the law firm's sole contacts with the state were to send responsive correspondence to its client's medical providers in New York, to make limited contact with a New York trust, and to send certain emails to plaintiff's counsel (*see* 170 AD3d 1316, 1318 [3d Dept 2019]).

SUBJECT MATTER JURISDICTION

General rule:
Supreme Court is the court of general jurisdiction.

Although there are more than a dozen types of courts in New York State, the only court with general jurisdiction is the Supreme Court (*see* NY Const. art. VI, § 7).

Recent Developments:

In certain instances an action must be brought in Supreme Court.

The issue of general jurisdiction does not often surface, but a trio of recent cases shows that courts and litigants must be mindful of it.

In ***Caffrey v North Arrow Abstract & Settlement Servs., Inc.***, the Second Department held that the Supreme Court erred in transferring an action in equity to the Civil Court, which has jurisdiction only of actions in law, and further erred—upon retransfer to Supreme Court—in adopting the findings of facts and conclusions rendered by the Civil Court (*see* 160 AD3d 121, 134 [2d Dept 2018]).

In ***Guendjian v Reardon***, the Third Department held that it lacked original subject matter jurisdiction to entertain an Article 78 proceeding to review a determination by the Industrial Board of Appeals. Except in limited circumstances, an Article 78 proceeding must be brought in Supreme Court. The Appellate Division lacks original jurisdiction (*see* 170 AD3d 1288, 1289 [3d Dept 2019]).

In ***Richmond v Cohen***, the Second Department in a proceeding to compel a Supreme Court justice to dismiss an action held that it lacked subject matter jurisdiction of the action insofar as asserted against two attorneys (*see* 168 AD3d 1064, 1065 [2d Dept 2019]).

VENUE (CPLR ARTICLE 5)

General Rule:

Venue is Now Proper Where the Events Occurred.

Effective October 2017, venue continues to be proper in any county where a party resided upon commencement, but now is also proper in a county in which a substantial part of the events or omissions giving rise to the claim occurred (*see* CPLR 503 [a]).

Recent Development:

Occurrence-based venue takes hold.

Appellate courts have begun to apply that rule. For example, in ***Marrero v Mamkin***, the Second Department held that the trial court erred in changing venue where the plaintiffs—who lived in a different state but were injured in motor vehicle accident in Queens County—had initially laid venue in Queens County, rather than Richmond County where the defendant resided (*see* 170 AD3d 1159, 1160 [2d Dept 2019]).

General Rule:

In actions involving real property, venue is proper in the county where the real property is located (*see* CPLR 507)

Recent Developments:

CPLR 507 applies to real property only.

CPLR 507 does not often receive appellate attention, but last year it did. In ***Patiwana v Shah***, the Second Department held that a plaintiff seeking a declaration of its ownership interest in an LLC could not rely on CPLR 507 to use the county where the LLC was located to lay venue (*see* 162 AD3d 1059, 1060 [2d Dept 2018]).

In ***Tower Broadcasting, LLC v Equinox Broadcasting Corp.***, the Fourth Department held that venue is not proper in the county where a broadcasting tower is located, because a broadcasting tower is considered a trade fixture and should be considered personal property (*see* 160 AD3d 1435, 1436 [4th Dept 2018]).

General Rule:

Defendant serves demand to change venue, and then moves within 15 days; plaintiff may consent within five days of the demand.

The court may, upon motion, change venue where the county designated was improper, where an impartial trial cannot be had in the proper county, or where a change of venue will promote the convenience of material witnesses and the ends of justice (*see* CPLR 510; *cf.* ***Rowland v Slayton***, 169 AD3d 1474, 1475 [4th Dept 2019] [affirming denial of motion to change venue from Monroe County to Steuben County, where movant failed to show that witnesses—who resided in Steuben County where accident occurred—would be inconvenienced by litigating in Monroe County]).

A defendant seeking to change venue must first serve a written demand on the plaintiff before he or she may file a motion (*see* CPLR 511 [b]). Thereafter, "the defendant may move to change the place of trial within fifteen days after service of the demand, unless within

five days after such service plaintiff serves a written consent to change the place of trial to that specified by the defendant" (*id.*).

Recent Development:

Defendant need not wait five days to file a motion.

The Third Department held that although the statute gives the plaintiff five days to consent to the change, the defendant need not wait the full five days before filing his or her motion. Rather, the five-day period operates as a time limit for the plaintiff only (*see* ***Aaron v Steele***, 166 AD3d 1141, 1143 [3d Dept 2018]).

DISCLOSURE

General Rule:

Disclosure is broadly permitted.

Parties must disclose "all matter material and necessary in the prosecution or defense of an action" (CPLR 3101 [a]).

Recent Developments:

Courts have refined disclosure rules.

In what is sure to become a seminal case, the Court of Appeals in ***Forman v Henkin*** held that the rule of broad disclosure applies to social media accounts, such as Facebook profiles (*see* 30 NY3d 656, 664 [2018]). But recognizing that Facebook accounts contain large amounts of private and irrelevant material, a court faced with a dispute concerning the scope of social media discovery should: (1) consider the nature of the event giving rise to the litigation and whether relevant material will be found on the Facebook account; and (2) balance the utility of the information against the privacy

concerns of the owner to tailor a discovery order accordingly (*see id.* at 665).

In ***Rickard v New York Cent. Mut. Fire Ins. Co.***, the Fourth Department disavowed ***Lalka v ACA Ins. Co.*** (128 AD3d 1508 [4th Dept 2015]), which held that documents are per se protected from discovery where in a claim file created after commencement of an action to recover supplementary underinsured motorist benefits where there had been no denial of coverage (*see* 164 AD3d 1590, 1591 [4th Dept 2018]).

In ***Norddeutsche Landesbank Girozentrale v Tilton***, the First Department held that where a party is entitled to disclosure of tax returns, it may also be entitled to underlying financial information, such as information contained in Form K-1, where that information is material and necessary (*see* 165 AD3d 447, 448 [1st Dept 2018]).

In ***Liberty Petroleum Realty, LLC v Gulf Oil, L.P.***, the First Department adopted a rule developed by the Second Department

which requires that, before a party may depose the attorney of an opponent, it must show that the information sought is both material and necessary, and that there is good cause for the deposition, in order to rule out the possibility that the deposition is being used for tactical reasons (*see* 164 AD3d 401, 406 [1st Dept 2018]).

In ***Brito v Gomez***, the First Department held that a plaintiff in a personal injury action does not in asserting a claim for lost earnings put at issue injuries to those parts of the body not the subject of the pending litigation, even though such information might be useful in determining the amount of lost wages attributable to the events giving rise to the litigation (*see* 168 AD3d 1, 6 [1st Dept 2018]).

General Rule:

In med-mal cases, a medical expert's identity may be kept confidential.

Generally, a party must upon request identify the experts he or she intends to call as a witness at trial and must disclose, inter alia, the

expert's qualifications and a summary of the grounds for his or opinion (*see* CPLR 3101 [d] [1] [i]). However, in medical malpractice cases the party may omit the names of its medical experts (*see id.*). Courts have been open to issuing protective orders to prevent disclosure of additional information that could be used to reveal the expert's identity (*see Morris v Clements*, 228 AD2d 990, 991 [3d Dept 1996]).

Recent Development:

Only the names of an expert may be withheld in medical malpractice cases.

Technology, however, is testing the limits of that protection. In ***Kanaly v DeMartino***, the plaintiff disclosed some materials regarding her expert's education and qualifications, but withheld several details, arguing that an advanced software program had become available allowing experts to be identified with only a few pieces of data (*see* 162 AD3d 142, 147 [3d Dept 2018]). The Third Department recognized that, under the existing rule, the plaintiff had

satisfied her burden of showing that more detailed disclosure was not required because it could be used to reveal the expert's identity (*see id.* at 150). Accordingly, the court ruled in the plaintiff's favor and held that she was entitled to a protective order (*see id.* at 152-153). However, it took this opportunity to "reassess[] [its] current standard" (*id.* at 150). The court determined that advancements in technology had neutered the statute, making it so that in any case a party could refuse to disclose most qualifications of his or her expert because any such disclosure might be used to reveal the expert's identity (*see id.* at 150-152). The Third Department then announced that going forward, the statute would be applied as written, and the only information a party will be entitled to withhold is the medical expert's name (*see id.* at 151).

General Rule:

Protective orders are available to prevent unreasonable prejudice.

The court may at any time issue a protective order "to prevent unreasonable annoyance, expense, embarrassment, disadvantage, or other prejudice to any person or the courts" (*see* CPLR 3103 [a]).

Recent Development:

The President of the United States is not immune from disclosure.

In a case that has national implications, the First Department in ***Zervos v Trump*** considered whether a reality television star's defamation suit against another reality television star, the latter of whom is currently serving as President, should be stayed or dismissed based on notions of executive immunity (*see* 94 NYS3d 75, 77 [1st Dept 2019]). The First Department held that neither the Supremacy Clause nor notions of executive immunity shielded the President from litigation for his pre-election and non-official conduct (*see generally id.*). Nonetheless, the court suggested that protective orders be employed to minimize the impact on the President's performance of his official duties (*see id.* at 87).

General Rule:

A representative is allowed at an IME.

In a personal injury action where the plaintiff puts his or her physical condition at issue, the defendant may require that the plaintiff submit to an independent medical examination (*see* CPLR 3121 [a]). The plaintiff is entitled to have a representative present at the examination (*see* ***Parsons v Hytech Tool & Die***, 241 AD2d 936, 936 [4th Dept 1997]).

Recent Development:

Notes of plaintiff's representative taken at an IME are conditionally privileged.

In a case of first impression, the First Department held that the notes of a plaintiff's representative, taken during the IME examination, constituted material prepared in anticipation of litigation which enjoy a conditional privilege from disclosure (*see* ***Markel v Pure Power Boot Camp, Inc.***, 171 AD3d 28, 31-32 [1st Dept 2019]).

MOTIONS TO DISMISS & FOR SUMMARY JUDGMENT

General rule:

Certain defenses are waived if not asserted in an answer or pre-answer motion.

Before serving a responsive pleading, a party may move to dismiss a cause of action for eleven reasons set forth in statute (*see* CPLR 3211 [a]). Crucially, several bases for dismissal are waived if not asserted in a pre-answer motion or answer (*see* CPLR 3211 [e]), including the invocation of an affirmative defense (*see* CPLR 3211 [5]). Similarly, a defendant will waive the defense of a lack of personal jurisdiction if he or she moves to dismiss without raising the issue or fails to raise lack of personal jurisdiction in the responsive pleading (*see* CPLR 3211 [e]). Several bases for dismissal, such as a lack of subject matter jurisdiction, failure to state a cause of action, and lack of a necessary party, are not waived (*see* CPLR 3211 [a] [2], [7], [10]).

Recent Development:

A lack of standing may be waived.

A lack of standing will be waived if not asserted in a pre-answer motion or answer (*see* ***US Bank N.A. v Nelson***, 169 AD3d 110, 116 [2d Dept 2019]; *see also* ***Forcucci v Board of Educ. of Hamburg Cent. Sch. Dist.***, 151 AD3d 1660, 1660 [4th Dept 2017]).

In ***Matter of Associated Gen. Contrs. of NYS, LLC v New York State Thruway Auth.***, the trial court dismissed a CPLR article 78 petition sua sponte for lack of standing. The Fourth Department wrote: " '[U]se of the [sua sponte] power of dismissal must be restricted to the most extraordinary circumstances' " (159 AD3d 1560, 1560 [4th Dept 2018]). Because lack of standing is not a jurisdictional defect, dismissal here was an improvident exercise of discretion.

Nonetheless, in ***Dawes v State***, the Third Department repeated that although a defense may be waived if not raised by pre-answer motion or answer, a court may grant leave to assert the defense in an

amended pleading, absent undue prejudice or surprise (*see* 167 AD3d 1099, 1100 [3d Dept 2018]).

General Rule:

A motion to dismiss is made upon the pleadings, while a motion for summary judgment is made based upon evidence.

A motion to dismiss is made upon the pleadings, whereas the motion for summary judgment is made upon evidence (*see* ***Nonnon v City of New York***, 9 NY3d 825, 827 [2007]; ***Rovello v Orofino Realty Co.***, 40 NY2d 633, 635 [1976]). On a motion to dismiss for failure to state a cause of action, the court must accept the facts alleged in the complaint as true and deny the motion unless no reasonable view of the facts would entitle the plaintiff to recovery (*see* ***219 Broadway Corp. v Alexander's, Inc.***, 46 NY2d 506, 509 [1979]). On a motion for summary judgment, the movant must establish that there is no dispute as to any material fact and that he or she is entitled to judgment as a matter of law (*see* ***Friends of Thayer Lake LLC v Brown***, 27 NY3d 1039, 1043 [2016]). Notably, upon hearing a motion to

dismiss, a party may submit evidence that could be considered upon summary judgment, and the court may on notice to the parties treat the motion as one for summary judgment (*see* CPLR 3211 [c]). Moreover, a party may generally move for summary judgment at any time after issue has been joined (*see* CPLR 3212 [a]). However, the court may deny the motion, or allow further discovery, where it appears that the facts essential to justify opposition may exist but cannot then be stated (*see* CPLR 3212 [f]).

Recent Developments:

Premature motions for summary judgment are disfavored.

In the premises liability case ***Reid v City of New York***, the First Department determined that the defendants' motion for summary judgment was properly denied as premature because it was brought before defendants had "provided full responses to discovery demands pertinent to the issues of ownership, control and maintenance of the premises" (*see* 168 AD3d 447, 448 [1st Dept 2019]).

Similarly, in the premises liability case ***Beck v. City of Niagara Falls***, the Fourth Department held that the defendant's motion for summary judgment was premature "because discovery, including the depositions of the parties involved in the incident, had not been completed . . . and plaintiffs, in opposing defendant's cross motion as premature pursuant to CPLR 3212 (f), made the requisite evidentiary showing to support the conclusion that facts essential to justify opposition may exist but could not then be stated" (169 AD3d 1528, 1529 [4th Dept 2019], *amended on rearg*, 97 NYS3d 546 [4th Dept 2019]).

The Fourth Department further elucidated the standard, reasoning that the party opposing summary judgment as premature must "make an evidentiary showing supporting the conclusion that facts essential to justify opposition may exist but cannot then be stated . . . [and] must demonstrate that the discovery sought would produce evidence sufficient to defeat the motion . . . and that facts essential . . . were in the movant's exclusive knowledge and possession and

could be obtained by discovery" (***Weiss v Zellar Homes, Ltd.,*** 169 AD3d 1491, 1493 [4th Dept 2019]).

A defendant who has a case-ending defense, such as one founded upon documentary evidence, can assert such a defense upon a motion to dismiss. However, by making a pre-discovery motion for summary judgment, the defendant may take advantage of a more favorable standard of review. In the recent slip-and-fall case of ***Bartlett v City of New York***, the City of New York moved for summary judgment on the ground that it did not own the area where the accident occurred. The City enjoyed a standard of review more favorable than if it had moved to dismiss, which it could have done. Although there had been no discovery, "plaintiff failed to demonstrate that discovery might lead to relevant evidence [with respect to] ownership or control of the accident site" (169 AD3d 629, 630 [2d Dept 2019]).

Where Are We with Medicare, Medicaid, and Lien Resolution

Paul K. Isaac, Esq.
Precision Lien Resolution
Buffalo

I. MANAGING MEDICARE CONDITIONAL PAYMENTS (MEDICARE "LIENS")

A. AN OVERVIEW OF MEDICARE

- Medicare is a federally funded health insurance program for qualified individuals 65 and older, or for certain individuals who have received Social Security Disability benefits for 24 months. It is also available for individuals who have been diagnosed with end-stage renal disease or Lou Gehrig's disease (ALS).

- Under the Medicare Secondary Payer (MSP) Act, Medicare is a secondary payer when payment has been made or can reasonably be expected to be made by a "Primary Plan." A primary plan is a worker's compensation law or policy, liability insurance (including self-insureds), and no-fault insurance. 42 U.S.C. §1395y(b)(2)(A).

- Liability insurance, including self-insured entities, means "insurance that provides payment based on legal liability for injury or illness or damage to property. It includes, but is not limited to, automobile liability insurance, ***uninsured motorist insurance, underinsured motorist insurance***, homeowner's liability insurance, malpractice insurance, product liability insurance, and general casualty insurance." 42 CFR §411.50(b).

- If a Primary plan has not, or cannot be reasonably expected to make payment promptly, Medicare may make a "conditional payment" on behalf of the primary plan. 42 USC §1395y(b)(2)(B)(i).

- Conditional payments are conditioned upon reimbursement from the primary plan, or an entity that receives payment from a primary plan (e.g., a beneficiary or attorney), if the primary plan has or had a responsibility to pay for those same items and services. Responsibility for payment is 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 Medicare-covered items or services], or by other means," i.e., a settlement. 42 U.S.C. §1395y(b)(2)(B)(ii).

- If reimbursement of the conditional payments is not made, the MSP creates a cause of action against a primary plan or an entity which has received payment from a primary plan, for double damages, i.e., double the amount owed. 42 U.S.C. § 1395y(b)(2)(B)(iii).

- There is also a "private cause of action" for double damages if repayment is not made. 42 USC §1395y(b)(3)(A).

- Insurance companies have an obligation to report to Medicare certain events and information pursuant to Section 111 of Medicare Medicaid SCHIP Extension Act (MMSEA), known as Mandatory Insurer Reporting (MIR or Section 111). No-Fault and Worker's Compensation companies must report to Medicare when they have taken on the responsibility to pay for medicals, known as Ongoing Responsibility for Medicals (ORM), and when that obligation ends, either because a policy limit has exhausted, no further accident-related treatment is required, or because of a worker's compensation settlement that releases medicals. Liability insurance companies must likewise report when a settlement has occurred, called Total Payment Obligation to the Claimant (TPOC).

B. MEDICARE LIEN RESPONSIBILITIES

- Medicare is authorized to seek recovery directly against the primary plan (insurer or self-insured), or against the entity receiving the primary payment, "including a beneficiary, provider, supplier, physician, attorney, State agency or private insurer that has received a primary payment." 42 CFR §411.24(g).

- The following cases demonstrate exposure for both sides relative to reimbursement of Medicare conditional payments: *Merrifield v. United States*, 2008 U.S. Dist. LEXIS 25877 (D. N.J. Mar. 31, 2008) (exposure to plaintiff); *United States v. Harris*, 2009 U.S. Dist. LEXIS 23956 (N.D. W. Va. 2009) (exposure to plaintiff's counsel); and *U.S. v. Stricker*, 524 Fed. Appx. 500 (11th Cir. Ala. 2013) (exposure to insurers).

- Once a Final Demand is issued, the Medicare beneficiary has 60 days from the date the Demand letter was issued, including the date of issue, to repay Medicare before interest begins to accrue. 42 CFR 411.24(h).

- Interest continues to accrue during any appeal or challenge after the Demand is issued. There is no tolling of interest for challenges to the conditional payment amount.

- If the Medicare debt is not resolved within 120 days from the date of the Demand, the debt is referred to the United States Department of Treasury for collection or offset of the beneficiary's other Social Security Benefits. Prior to CMS referring the debt to the Treasury, an "Intent to Refer" letters will be issued to the beneficiary and authorized representatives.

- Section 111 Mandatory Insurer Reporting is the only affirmative obligation imposed upon insurance companies in the MSP Act. Although it holds insurance companies responsible to reimburse Medicare, it holds Medicare beneficiary plaintiffs and their attorneys equally responsible.

- However, it is incumbent upon the Medicare beneficiary plaintiff and his or her attorney to be in control of the Medicare reimbursement process. This means being in contact with the Medicare contractor, the Benefits Coordination and Recovery Center (BCRC), and obtaining accurate conditional payment information.

- The BCRC will only communicate with the Medicare beneficiary and those that the beneficiary specifically authorizes. It is therefore incumbent upon the attorney to keep track of the conditional payments, ensure their accuracy, and make sure Medicare is paid on time.

C. MANAGING THE BCRC CONDITIONAL PAYMENT FILE

(From www.cms.gov):

The BCRC:

- Is responsible for the collection and maintenance of the MSP information in CMS' systems.

- Develops and researches MSP occurrences, as appropriate. (Sources include: Identification of a pending NGHP claim by a beneficiary or his or her attorney or other representative, by an insurer or other entity, through claims processing information, through the Initial Enrollment Questionnaire [IEQ] completed by new beneficiaries, etc. Identification may also occur through MMSEA Section 111 reporting.)

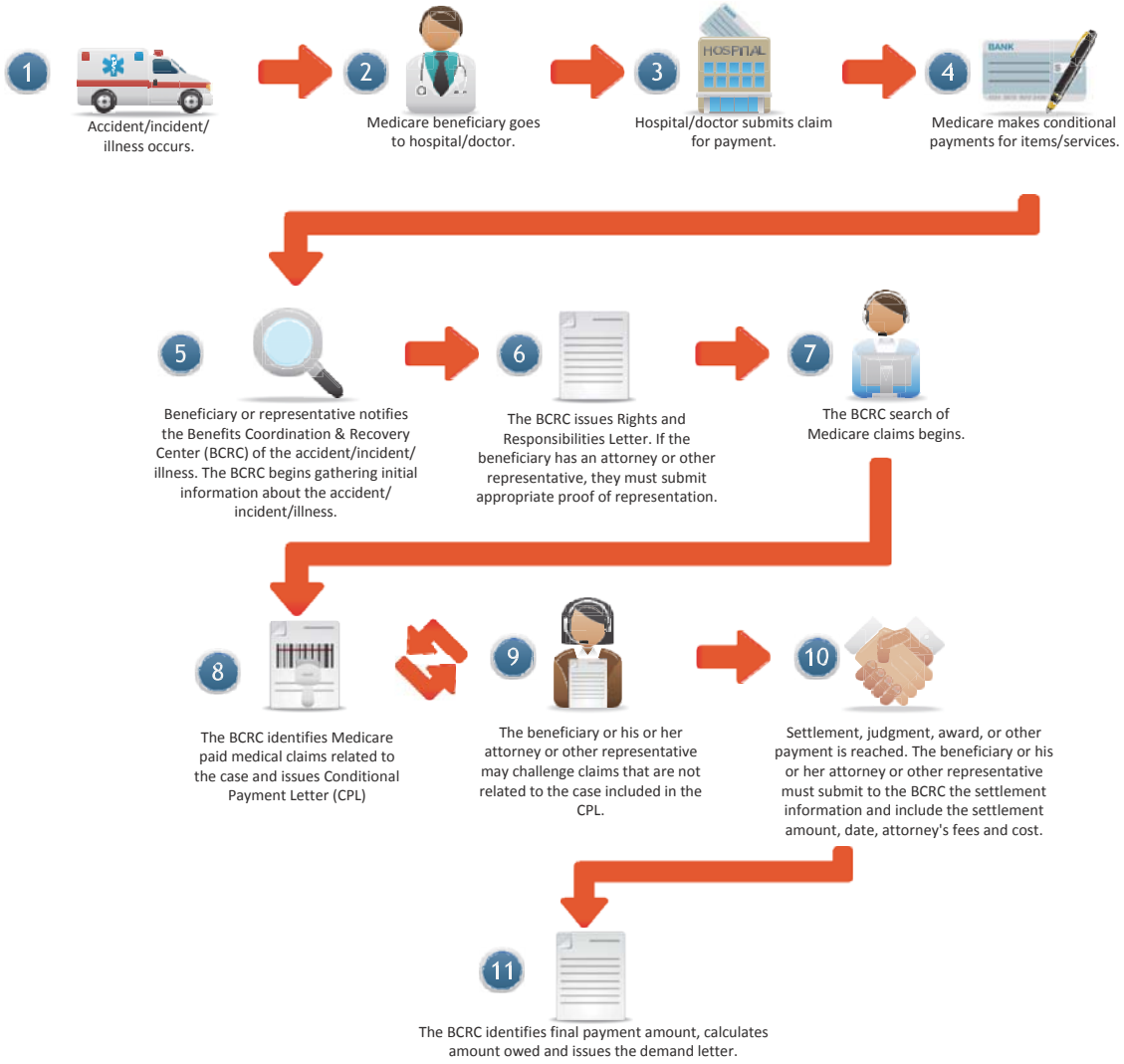
- Updates data in CMS' systems regarding MSP occurrences (terminations, changes in effective dates, address changes, etc).

- Contacting the BCRC is always the first step for interacting with Medicare if you have a pending liability claim.

- **Phone**: 1-855-798-2627

- **Fax**: 1-405-869-3309

- **Address**: NGHP, P.O. Box 138832, Oklahoma City, OK 73113



Overview of the Beneficiary NGHP Recovery Process

Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Workers' Compensation Cases

10.01.2015

COB&R Coordination of Benefits and Recovery

NGHP Correspondence Cover Sheet

Beneficiary's Name _____

HIC#: _____

Date of Incident: _____

Case ID#:_____*(can be found on Rights and Responsibilities letter)*

This cover sheet is for your use when mailing or faxing in correspondence to the Benefits Coordination & Recovery Center (BCRC). Please retain a COPY of this cover sheet for any future correspondence. The information above will ensure accuracy when handling your case documentation.

Please indicate the type of correspondence you are submitting to the BCRC to facilitate routing. Check all that apply:

- ☐ Check
- ☐ Settlement information
- ☐ Retainer agreement or other authorization documentation
- ☐ Other _____

Note: A Conditional Payment Letter is sent automatically, as soon as the information is available. Separate requests for initial Conditional Payment Amounts will not make Conditional Payment information available sooner.

In order to accurately associate claims to your case, please include a description of the injury. (i.e.: Knee, Physical Therapy, Slip and Fall, Lumbar Injury...)

_____

_____

_____

_____

Submit correspondence to the BCRC address listed below:

Liability Insurance, No-Fault Insurance, Workers' Compensation:

NGHP
PO Box 138832
Oklahoma City, OK 73113

Proof of Representation
Liability Insurance (Including Self-Insurance), No-Fault Insurance, or Workers' Compensation

Where to find Information on "Proof of Representation" vs. "Consent to Release"

Please refer to the PowerPoint document on this website titled: "Rules and Model Language for 'Proof of Representation' vs. 'Consent to Release' for Medicare Secondary Payer Liability Insurance (Including Self-Insurance), No-Fault Insurance, or Workers' Compensation" for detailed information on:

- **When to use a "proof of representation" document vs. a "consent to release" document,**
- Appropriate content for both documents,
- Use of attorney retainer agreements as proof of representation if certain criteria are met,
- The need for appropriate documentation when there are two layers of representatives involved (examples: attorney 1 refers a case to attorney 2; the beneficiary's guardian hires an attorney to pursue a liability insurance claim) or when a beneficiary's representative signs a "consent to release" document on the beneficiary's behalf,
- What liability insurers (including self-insurers), no-fault insurers, and workers' compensation entities must have in order to obtain conditional payment information, and
- Use of agents by insurers' or workers' compensation.

General

Proof of representation is required in order for the Benefits Coordination & Recovery Center (BCRC) to communicate with and provide information to a Medicare beneficiary's representative. Once the BCRC has the appropriate documentation, it can communicate with the representative and act upon requests made by the representative on behalf of the beneficiary. This includes furnishing conditional payment information and/or a recovery demand letter as well as addressing questions regarding the specific claims included in the conditional payment information, appeal requests or waiver of recovery requests.

Model Language

See attached. Use of the model language is not required, but any documentation submitted as a "Proof of Representation" document must include the information the model language requests.

Where to Submit Proof of Representation:

Liability Insurance, No-Fault Insurance, Workers' Compensation:
NGHP
PO Box 138832
Oklahoma City, OK 73113
Fax: (405) 869-3309

PROOF OF REPRESENTATION

The language below should be used when you, the Medicare beneficiary, want to inform the Centers for Medicare & Medicaid Services (CMS) that you have given another individual the authority to represent you and act on your behalf with respect to your claim for liability insurance, no-fault insurance, or workers' compensation, including releasing identifiable health information or resolving any potential recovery claim that Medicare may have if there is a settlement, judgment, award, or other payment. You are not required to use this model language, but proof of representation must include the information provided in this model language. Your representative must also sign that he/she has agreed to represent you. This model language also makes provisions for the information your representative must provide.

Type of Medicare Beneficiary Representative (Check one below and then print the requested information):

( ) Individual other than an Attorney:
( ) Attorney*
( ) Guardian*
( ) Conservator*
( ) Power of Attorney*

Name: _____
Relationship to the Medicare Beneficiary: _____
Firm or Company Name: _____
Address: _____
_____
_____
Telephone: _____

* Note -- If you have an attorney, your attorney may be able to use his/her retainer agreement instead of this language. (If the beneficiary is incapacitated, his/her guardian, conservator, power of attorney etc. will need to submit documentation other than this model language.) Please visit http://go.cms.gov/cobro for further instructions.

Medicare Beneficiary Information and Signature/Date:

Beneficiary's Name (please print exactly as shown on your Medicare card):

Beneficiary's Health Insurance Claim Number (number on your Medicare card):

Date of Illness/Injury for which the beneficiary has filed a liability insurance, no-fault insurance or workers' compensation claim: _____

Beneficiary Signature:_____ Date signed: _____

Representative Signature/Date:

Representative's Signature:_____ Date signed: _____

[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:

D. MEDICARE SECONDARY PAYER RECOVERY PORTAL

(The following can be found on the CMS Website)

Medicare Secondary Payer Recovery Portal

The Medicare Secondary Payer Recovery Portal (MSPRP) is a web-based tool designed to assist in the resolution of liability insurance, no-fault insurance, and workers' compensation Medicare recovery cases. The MSPRP gives you the ability to access and update certain case specific information online.

CMS has made available a curriculum of computer-based training (CBT) courses for the MSPRP. These courses provide in-depth training on use of the MSPRP. You can access or download these CBTs from the **Dynamic List** on this page. Please see the *MSPRP Curriculum* for a complete listing of the courses and their descriptions. If you have any questions or feedback on this material, please click the Training Feedback link.

MSPRP Features & Benefits:

The MSPRP provides you with the following features and related benefits:

1. Submit Beneficiary Proof of Representation, Beneficiary Consent to Release or Insurer Letter of Authority documentation

2. Request conditional payment information:

- Obtain current conditional payment amount
- Request a copy of a current conditional payment letter
- Request a final conditional payment amount for a case that is approaching settlement

3. Dispute claims included in a conditional payment letter:

- View the claims listed on the conditional payment letter and dispute unrelated claims
- Upload documentation to support the claim dispute

4. Submit case settlement information:

- Input settlement information and upload a copy of the settlement documentation

5. Multi-Factor Authorization (MFA) and Identity Proofing

- Request access to view unmasked claims data. Individuals requesting this access must complete the ID Proofing and Multi-Factor Authentication (MFA) process.

Note: Only those actions that are applicable to the case will be available.

How to Access the MSPRP

Beneficiaries will access the MSPRP through the MyMedicare.Gov Web site. They will login to their MyMedicare account via the MyMedicare.gov Web site. This Web site can be accessed from the link: My Medicare.Gov. The beneficiary will enter their established Login ID and Password for that application in the Secure Sign In section of the web page. After they successfully login to the MyMedicare.Gov site and enter the MSP section, they can access the MSPRP in two different ways:

- Click the **[Case ID]** in the "Payment Details" box on the MyMedicare page of the case they would like to access.
- Click the **[Go to MSPRP]** button.

Insurers and attorneys will access the MSPRP using the following MSPRP Application link: https://www.cob.cms.hhs.gov/MSPRP. Please note that registration must occur before access to the MSPRP is permitted. Additionally, you must complete the Identity Proofing and Multi-Factor Authentication process on the MSPRP if you wish to request access to unmasked claims data. See the MSPRP User Guide and the *Remote Identity Proofing (RIDP) - Multifactor Authentication (MFA) on the Medicare Secondary Payer Recovery Portal (MSPRP) Frequently Asked Questions* in the Downloads section below.

E. TIPS FOR DEALING WITH THE BCRC AND RESOLVING CONDITIONAL PAYMENTS

- Start early. Do not wait until settlement to start the process. Best case scenario for receiving information back from Medicare after initial case reporting is about 2 weeks. Very often it takes at least a month. By starting early you can be more confident that you know where you stand with Medicare prior to settlement.

- An advantage to starting early is the availability of disputing Medicare's conditional payments. A dispute may be submitted as many times as you wish prior to settlement and the issuance of a Final Demand Letter.

- Typically in cases where the lien amount consumes a disproportionate amount of the plaintiff's net recovery, a compromise may be requested from the CMS Regional Office, not from the BCRC.

- Be aware of the plaintiff's treatment history. If the conditional payment amount seems lower than it should be, make sure all of the plaintiff's treatment is included on the Payment Summary. If something is missing, it may only come up when a Final Demand is requested, leading to a much higher than anticipated reimbursement demand. CMS does not give much credence to the attorney's detrimental reliance on conditional payment letters which are labeled "interim" and subject to change.

II. MEDICARE ADVANTAGE PLANS (MAPS)

A. MEDICARE ADVANTAGE GENERALLY—PART C OF THE MEDICARE ACT.

In 1997, the Medicare Advantage Program (hereinafter "MA"), Part C of the Medicare Act, was created as an alternative to the government Medicare program. Under the Medicare Advantage Program, enrollees have the option of receiving their Medicare insurance from private insurers instead of direct benefits from the federal government.

B. STATUTES AND REGULATIONS

The Medicare Secondary Payer (MSP) Act provides that Medicare is secondary to other insurers, called primary plans: group health plans, workers compensation plans, liability insurance policies and plans, and no-fault insurance. See 42 U.S.C. § 1395y(b)(2)(A). Medicare makes conditional payments, i.e., it pays for services and if it later learns that those services are covered by a primary plan, the primary plan (or an entity that receives payment from a primary plan) must reimburse Medicare for those services. See 42 U.S.C. § 1395y(b)(2)(B).

1. The Medicare Advantage Secondary Payer Statute

The Medicare Advantage (MA or Part C) statute includes its own provision regarding the role of an MA plan as secondary payer. The MA statute's secondary payer provision, at 42 U.S.C. § 1395w-22(a)(4), states that:

> 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.

2. The Medicare Advantage Secondary Payer Regulations

On January 28, 2005, the Medicare Advantage regulations were amended. The Secretary of Health and Human Services, in respect for the basic rule that Medicare does not pay for services to the extent that Medicare is not the primary payer, adopted 42 CFR § 422.108 which provides for the secondary payer responsibilities of a MA plan:

(a) Basic rule. CMS does not pay for services to the extent that Medicare is not the primary payer under section 1825(b) of the Act and part 411 of this chapter.

(b) Responsibilities of the MA organization. The MA organization must, for each MA plan—

(1) Identify payers that are primary to Medicare . . . ;

(2) Identify the amounts payable by those payers; and

(3) Coordinate its benefits to Medicare enrollees with the benefits of the primary payers, including reporting, on an ongoing basis, information obtained related to requirements in paragraphs (b)(1) and (b)(2) of this section in accordance with CMS instructions.

(c) Collecting from other entities. The MA organization may bill, or authorize a provider to bill, other individuals or entities for covered Medicare services for which Medicare is not the primary payer, as specified in paragraphs (d) and (e) of this section.

(d) Collecting from other insurers or the enrollee. If a Medicare enrollee receives from an MA organization covered services that are also covered under State or Federal workers' compensation, any no-fault insurance, or any liability insurance policy or plan, including a self-insured plan, the MA organization may bill, or authorize a provider to bill any of the following—

(1) The insurance carrier, the employer, or any other entity that is liable for payment for the services under section 1862(b) of the Act and part 411 of this chapter.

(2) The Medicare enrollee, to the extent that he or she has been paid by the carrier, employer, or entity for covered medical expenses.

Finally, 42 CFR § 422.108(f) states that:

The rules established under this section supersede any State laws, regulations, contract requirements, or other standards that would otherwise apply to MA plans. A State cannot take away an MA organization's right under Federal law and the MSP regulations to bill, or to authorize providers and suppliers to bill, for services for which Medicare is not the primary payer. The MA organization 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 CFR § 422.108(f).

3. MSP Private Cause of Action for Double Damages

There have been a number of cases in both state and federal courts that have considered the issue of whether there is a federal cause of action providing for MA plans to enforce their rights under the Medicare Advantage statutes, the MSP Act, and the accompanying regulations.

C. MEDICARE ADVANTAGE REIMBURSEMENT: CASE LAW

1. *Care Choices HMO v. Engstrom*, 330 F.3d 786 (6th Cir. 2003)

In this case, the private insurer was not a Medicare Advantage plan, but rather a Medicare-substitute HMO. The HMO sought reimbursement from a plaintiff who recovered a settlement in a third-party liability action. The U.S. Court of Appeals for the Sixth Circuit considered whether the applicable statute, 42 U.S.C. § 1395mm(e)(4), contains a private right of action in federal court. The court found no such right and held:

> Reading the statute as a whole, it is clear that Section 1395mm(e)(4) is intended to permit Medicare-substitute HMOs to create a right of reimbursement for themselves in the context of their own insurance agreements with Medicare beneficiaries. The statute does not confer any affirmative rights to reimbursement, much less contain an implied right of action. . . . If an HMO chooses to include such a provision in its insurance policy, its remedy would be based on a standard insurance contract claim and not on any federal statutory right.

Care Choices is frequently cited in cases deciding the issue of a private right of action for MA plans. Although the plan in *Care Choices* was not an MA plan, the issues raised and the statutory language in 42 U.S.C. § 1395mm(e)(4) are essentially the same as the issues raised in the context of MA plans and the statutory language in the MA statute, 42 U.S.C. § 1395w-22(a)(4). Thus, *Care Choices* continues to be favorably cited.

2. *Nott v. Aetna U.S. Healthcare, Inc.*, 303 F. Supp. 2d 565 (E.D. Pa. 2004)

Here, the Federal District Court for the Eastern District of Pennsylvania considered whether a Medicare Advantage plan's right to assert subrogation against an enrollee's tort recovery arose under the Medicare Advantage statute. The court noted that the language of the statutory provision, 42 U.S.C. § 1395w-22(a)(4), does not create a federal scheme for the civil enforcement of an MA plan's subrogation rights.

Rather, the Act only authorizes, but does not require, the private insurer to include subrogation provisions in the insurance contract. This permissive language, along with the absence of an express remedial provision, is evidence of Congress's intent not to create an explicit right of action for private MA plans. Thus, if the MA plan includes a subrogation provision in the insurance policy, the right to subrogation remains a private contractual right which may be enforced in state court.

NOTE: It is important to note that this case may have been rendered irrelevant by the recent Third Circuit decision in *In re Avandia* that is discussed below. *Nott*, along with *Care Choices*, is frequently cited in cases holding that there is no express or implied federal right of action for Medicare Advantage plans to enforce their rights of subrogation and/or reimbursement. *In re Avandia* held that an MA plan may bring an action under 42 U.S.C. §1395y(b)(3)(A) of the MSP Act. *In re Avandia* concluded that *Nott* only considered 42 U.S.C. Sections 1395mm(e)(4) and 1395w-22(a)(4), and did not consider 1395y(b)(3)(A). Therefore, *Nott* was irrelevant to its decision. Although not explicitly overruled, *Nott* has no real impact in the Third Circuit because *In re Avandia* held that there is another federal avenue of relief for MA plans, through the private cause of action under 42 U.S.C. § 1395y(b)(3)(A).

3. *Primax Recoveries, Inc. v. Yarmosh,* Case No. 3: 03CV01931, 2006 U.S. Dist. LEXIS 98858 (D. Conn. 2006)

In this case, Primax, as the subrogation and collection agent for a Medicare Advantage plan, sued in federal court to enforce its right of subrogation and reimbursement. Here, the Federal District Court for the District of Connecticut agreed with the reasoning in *Care Choices* and concluded that there was no express or implied private right of action in the statutes to allow a Medicare Advantage plan to sue in federal court. It noted that the Second Circuit had not addressed the issue, but the *Care Choices* decision relied on the same standard to determine whether there is an implied cause of action that is applicable in the Second Circuit. "This court agrees with the *Care Choices* court that there is no private cause of action for a Medicare+ Choice HMO under the Medicare+ Choice statute, 42 U.S.C. § 1395mm(e)(4)." Primax, 2006 U.S. Dist. LEXIS 98858 at *13.

The MA plan in this case also argued that the MSP Act itself, in 42 U.S.C. §1395y(b)(2)(B)(ii) entitled it to sue in federal court. That provision, however, only authorizes the United States to bring a lawsuit in federal court. The statute does not expressly grant a cause of action to any entity other than the United States. The court found the language of the statute clear and unambiguous, dismissed the MAO's federal action, and allowed them to replead in state court under a state contract law claim.

4. *Konig v. Yeshiva,* 12-CV-467, (E.D. N.Y. March 30, 2012)

Here, the District Court in the Eastern District of New York found that MA plans do not have a right of action under the Medicare laws. "Although the Medicare statute clearly authorizes the government to bring an action to enforce its subrogation rights under its own Medicare insurance

contracts, see 42 U.S.C. § 1395y(b)(2)(B)(iii), the statute does not expressly accord private MAP providers the same right." Konig, 12-CV-467, at 5. The court noted that "every court" to address the issue has found that the laws also fail to create an implied cause of action.

In *Konig*, the MA plan argued that the corresponding regulation, at 42 CFR § 422.108(f), provides that Medicare Advantage Plan organizations (MAO) exercise the same right to recover as the Secretary, and therefore this places them in the same shoes as the government, thereby granting them the power to bring a private right of action. The court disagreed, stating that the reasoning is faulty. The court reasoned that "[l]anguage in a regulation may invoke a private right of action that Congress through statutory text created, but it may not create a right that Congress has not." Id. at 5, fn. 2 (citing *Alexander v. Sandoval*, 532 U.S. 275, 291 (2001)). Since there is nothing in the Medicare statutes that creates a cause of action, then the parties cannot fashion one by invoking the regulations. The Medicare laws offer no private right of action—express or implied—to MA plans to enforce any claimed subrogation rights.

5. *In re Avandia Marketing, Sales Practices and Products Liability Litigation*, 685 F.3d 353 (3d Cir. 2012)

The U.S. Court of Appeals for the Third Circuit, in *In Re Avandia*, came to a different conclusion than every previous decision. The lower court decision in this case, in U.S. District Court for the Eastern District of Pennsylvania, ruled in line with previous decisions that an MA plan does not have a private right of action in federal court, and the MA plan is limited to state court to enforce the subrogation terms in the insurance contract.

The plan argued that the MSP Act itself, even without reference to the Medicare Advantage statutes, is broad enough to include a Medicare Advantage plan within the parties that may bring a private right of action for double damages under 42 U.S.C. § 1395y(b)(3)(A). The private cause of action statute states:

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).

The Court here agreed, and reversed the lower court's ruling. The Third Circuit concluded that an MAO has the same right to recover as the Medicare Trust Fund. The Medicare statute has two separate causes of action. When the Medicare Trust Fund makes a conditional payment and the primary payer does not reimburse it, the United States may bring suit pursuant to § 1395y(b)(2)(B)(iii). Also, there is a private right of action with no particular plaintiff specified under § 1395y(b)(3)(A) any time a primary payer fails to make required payments.

Even though the MSP Act was enacted before Part C, private Medicare risk plans were authorized at the time. The Court felt that Congress was aware that private Medicare providers existed; and had Congress intended to prevent them from suing under the private cause of action provision, Congress could have done so explicitly.

The MA plan here did not argue that the MA secondary payer provision provides a cause of action through its reference to the MSP Act, but it argued that the language of the MSP Act itself is broad enough to encompass an MA plan, regardless of the existence of 42 U.S.C. §1395w-22(a)(4). The Court concluded that there is nothing in the text or legislative history of the MA secondary payer provision that demonstrates a congressional intent to deny MA plans access to the MSP private cause of action.

The Court disregarded the decisions of *Care Choices HMO v. Engstrom*, and *Nott v. Aetna U.S. Healthcare, Inc*. In both decisions, the Court noted that the question of whether a Medicare Advantage plan could have brought suit as a private actor directly under the MSP Act under 42 U.S.C. 1395y(b)(3)(A) was neither raised nor addressed. Therefore, those decisions were irrelevant.

The Court found nothing in the text or the legislative history of the statute to imply that Congress did not intend to facilitate recovery for MA plans in the same fashion as that of traditional Medicare, and found the text of the statute to be clear and unambiguous.

Even if the statute was ambiguous as to whether an MA plan has the same rights as traditional Medicare in the MSP Act, the Chevron defense would apply to reach the same conclusion. The Supreme Court in Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837 (1984) established a test to determine when a court should defer to the interpretation of a statute embodied in a regulation enacted by the federal agency charged with implementing the statute.

CMS regulations state that an "MA organization 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). The court found that the plain language of the regulation suggests that the Medicare Act treats MA plans the same way it treats the Medicare Trust Fund for purposes of recovery from any primary payer. So, deference to the agency's interpretation in the regulations suggests that there is a private cause of action under the MSP Act for MA plans:

The language of the MSP private cause of action is broad and unrestricted and therefore allows any private plaintiff with standing to bring an action. Since private health plans delivered Medicare services prior to the 1980 passage of the MSP Act, Congress was certainly aware that private health plans might be interested private parties when it drafted the cause of action, and it did not exclude them from that provision's ambit. That decision is logically consistent because affording MAOs access to the private cause of action for double damages comports with the broader policy goals of the MA program. Further, even if we were to find the statutory text to be ambiguous on the issue, Chevron deference to CMS regulations, which grant MAOs parity with traditional Medicare, would require us to find in favor of [the MAO] here.

6. *Potts v. Rawlings Company, LLC,* No. 11 Civ. 9071 (S.D.N.Y. September 25, 2012).

In this case, a class of Medicare Part C beneficiaries challenged the collection activities of various collection agents who had worked on behalf of MA Plans. They argued that the plans' claims arise under state contract law and the New York anti-subrogation statute (General Obligations Law § 5-335), and not under the Medicare Act.

Here, the court held that the issue of whether a MA plan has a private cause of action to pursue reimbursement is irrelevant. The issue is that the Medicare Act expressly pre-empts state law, and thus General Obligations Law § 5-335 does not apply:

> First, that the Medicare Act does not create a private right of action for MA organizations is not at all clear, as there is a split of authority on the issue. Second, given the broad express preemption clause in the Medicare Act, whether there is a private right of action for MA organizations is immaterial to the question whether GOL § 5-335 is preempted.
> . . .
> Because Plaintiffs' claims, in essence, are claims seeking the retention of benefits, they arise under the Medicare Act, and Plaintiffs were obligated to exhaust their administrative remedies before bringing this action. Thus, the Court is without subject matter jurisdiction to consider those claims.

7. *Trezza v. Trezza*, 2012 N.Y. Slip. Op. 09048 (N.Y. App. Div. 2d Dept. 2012)

In a reversal of arguments as to the enforceability of claims for reimbursement of Medicare Advantage Plans, on December 26, 2012 [*argued September 21, 2012*] the New York State Appellate Division, Second Judicial Department has reversed the lower court's decision in the appeal of the matter of the Kings County Supreme Court decision of *Trezza v. Trezza*, 32 Misc 3d 1209[A], 2011 NY Slip Op 51237[U] (Sup Ct, Kings County).

The Second Department held that: "General Obligations Law §5-335, insofar as applied to Medicare Advantage organizations under Part C, is preempted by federal law since it would impermissibly constrain contractual reimbursement rights authorized under the "Organization as secondary payer" provisions of the Medicare Act."

By way of relevant background, Janine Trezza was injured in a motor vehicle accident while riding in a vehicle operated by her husband. Oxford Health Plus, the Medicare Advantage plan, paid $37,787.64 in medical expenses for plaintiff's accident-related injuries. Plaintiff received a settlement of $75,000.00 out of which Oxford Health Plus claimed entitlement to reimbursement of $37,787.64.

The Supreme Court, Kings County, granted the plaintiff's motion to extinguish the purported lien and/or claim for reimbursement based upon the following reasoning:

> Courts have held that because the Medicare Act did not establish a federal scheme for the civil enforcement of HMO subrogation rights, it did not create a private cause of action (*Nott, 303 F.Supp.2d at 570*; *See also Care Choices HMO v. Engstrom, 330 F.3d 786, 789 [6th Cir. 2003]).* The Medicare Act therefore does not create a statutory right of reimbursement; instead, it allows HMOs to include subrogation rights in its contracts with beneficiaries (*Nott, 303 F.Supp.2d at 570*). Because "the Medicare Act permits, but does not mandate, HMO insurers to contract for subrogation rights" (*id. at 571*), subrogation in this context remains a state contract law issue (*id. at 572*; *Care Choices, 330 F.3d at 790*).

In a matter of first impression before the Appellate Division, the Court further examined the preemptive effect the Medicare Act may have on General Obligation Law §5-335.

In its analysis, the Appellate Division observed:

> Thus, the Medicare Act provides that Medicare Advantage organizations may create a right of reimbursement for themselves in their insurance agreements with Medicare insureds. Moreover, "[t]he standards established under [Part C] shall supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency) with respect to [Medicare Advantage] plans which are offered by [Medicare Advantage] organizations under [Part C]" (42 USC § 1395w-26[b][3]), and "[a] State cannot take away [a Medicare Advantage] organization's right under Federal law and the MSP regulations to bill, or to authorize providers and suppliers to bill, for services for which Medicare is not the primary payer" (42 CFR 422.108[f]).
>
> Yet General Obligations Law § 5-335 would prohibit Medicare Advantage organizations from exercising the contractual right to reimbursement in that it would constrain contractual reimbursement rights where the insured entered into a personal injury settlement. In other words, General Obligations Law § 5-335, which, insofar as at issue here, clearly does not constitute a licensing law or a law relating to plan solvency, would, in the context of such personal injury settlements, "take away [a Medicare Advantage] organization's right under Federal law and the MSP regulations to bill, or to authorize providers and suppliers to bill, for services for which Medicare is not the primary payer" in contravention of the federal regulations enabled by 42 USC § 1395w-26(b)(1) (42 CFR 422.108[f]).

The Court noted that although Medicare Advantage plans had no "statutory right of reimbursement" as used in General Obligations Law § 5-335, the Medicare Act expressly pre-empted the application of § 5-335.

The Court concluded that "because General Obligations Law § 5-335 is expressly preempted by the Medicare Act, the Supreme Court erred in granting the plaintiff's motion to extinguish the purported lien and/or claim for reimbursement based on that section."

Although the decision reinstated the claim of reimbursement of the Medicare Advantage Plan against the settlement proceeds, it did not preclude other arguments to attack the validity and amount of the purported claim.

As such, this case should not be considered a windfall for Medicare Advantage-type Plans in asserting liens and/or claims for reimbursement from personal injury settlements. As in cases involving ERISA self-insured type plans, the language in the plan should be examined in each particular case to ascertain grounds to attack the amounts claimed in addition to other arguments and defenses.

8. *Parra v. Pacificare of Arizona, Inc.*, 715 F.3d 1146 (9th Cir. 2013)

The Ninth Circuit recently issued a similar opinion. In this case, the Ninth Circuit held that the Medicare Advantage statute itself does not create a cause of action for MA plans and the MSP Act's private cause of action did not apply to MA plans.

Regarding the MA statute, the court held that: "On its face, the MAO Statute does not purport to create a cause of action. Rather, it simply describes when MAO coverage is secondary to other insurance, and permits (but does not require) a MAO to include in its plan provisions allowing recovery against a primary plan."

Likewise, it found that the regulation at 42 CFR § 422.108(f) adds nothing to a MAO's claim to a private right of action because language in a regulation cannot create a right that Congress has not created by statute. The Private Cause of Action statute was intended to allow private parties to vindicate wrongs occasioned by the failure of primary plans to make payments, not plaintiff beneficiaries. The court went on to distinguish the Third Circuit's *In re Avandia* case (discussed below), as there the plan sought recovery directly against the third-party tortfeasors and not the Plaintiffs.

9. *Collins v. Wellcare Healthcare Plans, Inc.*, No. 13-6759 L(3) (E.D. LA 2014).

Wellcare, a MAO, made payments for Collins' medical bills as a result of a motor vehicle accident. Collins seeks declaratory judgment as to Wellcare's subrogation and reimbursement rights in regards to Collins' personal injury settlement. Wellcare then removed the case to federal court on diversity jurisdiction.

Wellcare first argued that Collins was required to exhaust administrative remedies before seeking declaratory judgment, and thus the court should dismiss Collins' claim. The court determined

that Collins' claim did "arise under" Medicare because it was essentially a claim to retain benefits by arguing that MSP did not apply. *See Eihnorn*, 2014 WL 4385912. Therefore, Collins' case did arise under Medicare, and exhaustion was required.

Wellcare also argued that as a MAO, it was entitled to reimbursement through the MAO or MSP statutes. The court failed to make a determination on whether the MAO statute created a specific right of reimbursement, or only created the right to charge such reimbursement in their contracts, but did acknowledge the circuit split. The Court did, however, determine that the MSP statute was broad enough to include MAOs.

After it was determined that MAOs had a private right of action generally, the court decided whether Wellcare's claim satisfied the requirements of the MSP to enforce a private cause of action. The main issue was whether tort settlements were considered primary plans for purposes of paragraph (1) and (2)(A) of 42 U.S.C. §1395(y)(3)(A). The court deferred to other circuit holdings that this cause of action included tort settlements, and not just group health plans as set out in paragraph (1). Furthermore, the court held that Wellcare was indeed making conditional payments even though it did not know of any other primary payers. *See* 42 C.F.R. §411.21.

Lastly, assessing double damages was inappropriate for this case because Collins placed the settlement funds into a trust account pending a determination of Wellcare's rights.

10.*Humana Med. Plan, Inc. v. W. Heritage Ins. Co.*, No. 15-11436, 1:12-cv-20123-MCG (11th Cir. Aug. 8, 2016).

Ms. Reale was the injured plaintiff in a personal injury case against Hamptons West Condominium Association. Hamptons West was insured by Western Heritage Insurance Company. Humana paid medical bills for Ms. Reale's injuries, as a Medicare Advantage plan; it paid $19,155.41 in expenses. Humana requested reimbursement while the personal injury suit was still pending.

Ms. Reale and Western Heritage agreed to settle the personal injury claim for $115,000.00. Ms. Reale represented in the Release that there was no Medicare lien, and she also agreed to indemnify and hold harmless defendant and its insurance company.

Humana first attempted to sue Ms. Reale and her attorney in federal district court seeking reimbursement. The district court initially dismissed Humana's complaint for lack of subject matter jurisdiction, but it later vacated that order after Humana moved to correct the order. However, prior to the hearing to consider Humana's motion, Humana voluntarily dismissed its action against Ms. Reale and her attorney.

At this time, Western Heritage had still not tendered the settlement check to plaintiff because Western Heritage demanded that Humana be included as a payee on the settlement check. The state court ordered that Western Heritage tender the check without Humana as payee, but also ordered Ms. Reale's attorney to hold $19,155.41 in trust, pending resolution of the dispute on the claimed lien. Ms. Reale then sued Humana in state court seeking a declaration as to the amount

owed. The state court applied Florida law regarding collateral indemnity and subrogation and concluded that Humana was only entitled to $3,685.03. On appeal by Humana, Ms. Reale's case was dismissed for lack of jurisdiction by the Florida appellate court, determining that only upon exhaustion of the administrative process does the Medicare Act provide for federal judicial review, and it expressly preempts state law. *See* 42 U.S.C. §§ 1395w-22(g)(5) and 1395w-26(b)(3), respectively.

Still unpaid, and perhaps motivated by double damages, Humana then sued the liability carrier, Western Heritage, for failure to reimburse, arguing that the Medicare Secondary Payer Act's private cause of action provision allows a suit for double damages when an insurance company fails to reimburse a Medicare Advantage plan. (Note that this double damages provision is found nowhere within the wording of the Medicare Advantage statute, 42 U.S.C. §§ 1395w-21, et.seq.)

The district court agreed with Humana, and followed the Third Circuit's decision in *In re Avandia Mktg., Sales Practices & Prods. Liab. Litig.*, 685 F.3d 353 (3rd Cir. 2012).

Circuit Judge William Pryor authored a brief but thoughtful and logical dissent which concluded that the majority ignored key words in the statutes, such as "Secretary" and "Trust Fund." Under the Medicare Secondary Payer Act, only the Secretary of Health and Human Services may make conditional payments, which are conditioned on reimbursement to the Medicare Trust Fund.

However, the majority decision is now controlling in the Eleventh Circuit, which will no doubt further embolden collection agents in their attempts to collect on behalf of private insurance companies providing Medicare Advantage coverage.

D. Liability of Plaintiff's Attorney

The case law cited above clearly establishes that various courts throughout the country have held plaintiff Medicare beneficiaries and primary plans liable for double damages.

Medicare Advantage plans have also sued the plaintiff's attorney in these cases where the plan is not reimbursed. The Eastern District of Virginia, in *Humana v. Paris Blank, LLP*, 187 F.Supp.3d 676 (E.D. Va. 2016), held that "regulation dictates that MAOs 'exercise the same rights to recovery 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). CMS has promulgated regulations identifying attorneys as an entity from which recovery may be sought under the MSP law by the Secretary. *See id.* § 411.24(g). Accordingly, Plaintiff may maintain suit against Defendants for recovery of conditional payments." *Paris Blank*, 187 F.Supp.3d at 682-83.

In this case's aftermath, plaintiff's attorney has been sued by Medicare Advantage plans in cases throughout the country, in addition to plaintiffs themselves. *See, e.g., Humana Health Benefit Plan of Louisiana, Inc. v. Falcon*, 3:17-cv-00596-JWD-EWD (M.D. La., Complaint filed August 30, 2017); *Humana Ins. Co. v. Pelham*, 4:17-cv-00374-RH-CAS (N.D. Fla., Complaint

filed August 18, 2017); *United Healthcare Ins. Co. v. Kardoulis*, 1:16-cv-735 (E.D.N.Y., Complain filed February 11, 2016).

E. Where Do We Stand In New York?

Take advantage of the unsettled nature of the law while you still can. In New York State, the most problematic case law regarding MAP reimbursement rights is from the Third and Eleventh Circuits and not binding authority. In fact, the cases closest to home do have some favorable elements. *Konig v. Yeshiva* is an obvious one. *Potts* and *Trezza* have held that New York's anti-subrogation statute, NY General Obligations Law § 5-335 is preempted by the Medicare Act. However, even *Trezza* states that the reimbursement right itself is limited, i.e., there must be language in the contract giving it such rights.

Keep in mind that MAP reimbursement is not a matter of settled law in the State of New York. Barring that, a Medicare Advantage plan's best case scenario for recovery is only that which traditional Medicare has, and nothing more. Therefore, all applicable challenges that might have been made in the regular Medicare context, including an automatic reduction for the costs of litigation, must be applied in the Medicare Advantage context.

III. MEDICARE SET-ASIDES (MSAs)

A. What is the Basis for an MSA?

- The MSP Act's General Rule states that Medicare may not make payment for any medical items and services "to the extent that payment has been made . . . 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." 42 U.S.C. §1395y(b)(2)(A).
- The MSP General rule makes clear that in the event there has been a payment by a primary plan, Medicare shall not pay for any items or services.
- The risk that the MSP imposes for future medicals incurred after the date of a liability insurance settlement is clear, i.e., that Medicare will not cover accident-related medical treatment costs after the date of a liability settlement.
- The question becomes: to what extent must the parties to a settlement ensure that Medicare does not cover future accident-related medical expenses, and who bears the responsibility to protect Medicare's future interests?
- The Medicare Set-Aside—the creation of a separate bank account that a Medicare beneficiary utilizes solely to privately pay for accident-related and otherwise Medicare-covered treatment occurring after the date of a settlement—has emerged as Medicare's preferred method that Medicare beneficiaries utilize to protect Medicare's future interests in a settlement.
- That said, there is no statute or regulation which mandates the use of a MSA in any case.

B. MSAs in Worker's Compensation Cases

1. In worker's compensation cases, when the carrier settles with the claimant to extinguish the carrier's future obligations in exchange for a lump sum payment to the claimant, the need to protect Medicare's future interests is clear. In this situation, it is unequivocally a shifting of the burden of medical care from the carrier to the Medicare Trust Fund. Medicare cannot pay for medical care in a situation where there has been a payment from a worker's compensation carrier. Therefore, there is a clear need to protect the Medicare Trust Fund.

2. While there is no requirement for an MSA in a worker's compensation case, CMS has promulgated thresholds for cases in which it will review an MSA allocation:
    - The claimant is currently a Medicare beneficiary and the total settlement amount is greater than $25,000;

- The claimant has a "reasonable expectation" of Medicare enrollment within 30 months of the settlement date and the anticipated total settlement amount for future medical expenses and disability/lost wages over the life or duration of the settlement agreement is expected to be greater than $250,000.

3. CMS Memorandum dated May 11, 2011: Submission of a WCMSA proposal to CMS for review and approval is a recommended process. There are no statutory or regulatory provisions requiring that a WCMSA proposal be submitted to CMS for review. However, if an entity chooses to use the WCMSA review process, CMS requests that it comply with the established policies and procedures referenced on its Web site. Claimants, employers, carriers, and their representatives should be encouraged regularly to monitor this dedicated workers' compensation Web site for changes in policies and procedures.

C. MSAs in Liability Cases

1. In liability cases, the burden-shifting for the payment of medicals is much less clear than in worker's compensation cases.

2. On May 25, 2011, a CMS memorandum reiterated that there was no requirement for a MSA, but that: "The law requires that the Medicare Trust Funds be protected from the payment for future services whether it is a Worker's Compensation or liability case. There is no distinction in the law." It specifies distinct roles/responsibilities for the plaintiff Medicare beneficiary and his/her counsel, and for defendants and their carriers.

3. CMS Memo September 29, 2011: "Where the beneficiary's treating physician certifies in writing that treatment for the alleged injury has been completed as of the date of the settlement, and that future medical items and/or services for that injury will not be required, Medicare considers its interest, with respect to future medicals for that particular settlement, satisfied." See the Stalcup Memorandum which is included in its entirety below.

4. Proposed Regulations for Liability MSAs. There was advanced notice of proposed rulemaking to promulgate rules related to Liability MSAs. After a very active comment period, CMS withdrew the proposed rules on August 1, 2013. It is important to note that at the time, CMS proposed several different options to protect Medicare's future interests. All of those options were the plaintiff Medicare beneficiary's responsibility to address.

5. On June 8, 2016, CMS made the following announcement: "The Centers for Medicare and Medicaid Services (CMS) is considering expanding its voluntary Medicare Set-Aside Arrangements (MSA) amount review process to include the

review of proposed liability insurance (including self-insurance) and no-fault insurance MSA amounts. CMS plans to work closely with the stakeholder community to identify how best to implement this potential expansion. CMS will provide future announcements of the proposal and expects to schedule town hall meetings later this year. Please continue to monitor CMS.gov for additional updates."

6. On February 3, 2017, it was announced that CMS systems would be updated effective October 1, 2017. "Medicare does not make claims payment for future medical expenses associated with a settlement, judgment, award, or other payment because payment "has been made" for such items or services through use of LMSA or NFMSA funds." Department of Health and Human Services, Centers for Medicare & Medicaid Services, MLN Matters, N*ew Common Working File (CWF) Medicare Secondary Payer (MSP) Type for Liability Medicare Set-Aside Arrangements (LMSAs) and No-Fault Medicare Set-Aside Arrangements* (NFMSAs), MLN Matters, (Feb. 3, 2017).

   The existence of a LMSA or NFMSA fund will now be incorporated into Medicare's Common Working File (CWF) shared file system. And all of the claims related to the liability and no fault files will be denied, with instructions that payment is to be made from the LMSA or NFMSA fund.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Division of Financial Management and Fee for Service OP!rations, R!Qion VI

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May 25, 2011

This specific handout was prepared as a service to the public and is not intended to grant rights or impose obligations. It may contain certain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. Readers are encouraged to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. It is intended to provide consolidated guidance to those attomeys, insurers, etc., working liability, no fault and general third party liability cases for any Medicare beneficiary residing in Oklahoma, Texas, New Mexico, Louisiana and Arkansas and is not to be considered a CMS official statement of policy.

If the Medicare beneficiary involved in your case is not a resident of one of these states, please contact the appropriate Centers for Medicare & Medicaid Services' (CMS) Medicare Secondary Payer Regional Office (MSP RO). If you do not have that information please contact Sally Stalcup (contact infom1ation below) for that infmmation.

Medicare's interests must be protected; however, CMS does not mandate a specific mechanism to protect those interests. The law does not require a "set-aside" in any situation. The law reguires that the Medicare Trust Funds be rotected from a ment for future services whether it is a Workers' Compensation or liability case. There IS no istmctwn m the aw.

Set-aside is our method of choice and the agency feels it provides the best protection for the program and the Medicare beneficiary.

Section l862(b)(2)(A)(ii) of the Social ::->ecurity, Act [42 USC 1395 y(b)(2)], precludes Medicare payment for services to the extent that payment has been made or can reasonably be expected to be made promptly under liability insurance. This also governs Workers' Compensation. 42 CFR 411.50 defines the tenn "liability insurance". Anytime a settlement, judgment or award provides funds for future medical services, it can reasonabJy be expected that those monies are available to pay for future services related to what was claimed and/or released in the settlement, judgment. or award. Thus, Medicare should not be billed for future services until those funds are exhausted by payments to providers for services that would otherwise be covered and reimbursable by Medicare. If the settlement, judgment, award .yare not funded there is no reasonable expectation that third party funds are available to pay for those services.

The new provisions for Liability Insurance (including Self-Insurance), No-Fault Insurance, and Workers' Compensation found at 42 U.S.C. 1395y(b)(8) add reporting mles and do not eliminate any existing statutory provisions or regulations. The new provisions do not eliminate CMS' existing processes if a Medicare beneficiary (or his/her representative) wishes to obtain interim conditional payment amount infonnation prior to a settlement, judgment, award, or other payment. The new provisions do NOT require a set-aside when there is a recovery for future medicals, in fact this legislation does not address that subject This legislation is unofficially known as "Mandatory Insurer

Reporting" because it does just and only that. It specifies the entity mandated to report a settlement/judgment/award/recovery to Medicare and addresses specifics of that issue.

There is no formal CMS review process in the liability arena as there is for Worker' Com ensation. However, CMS does expect the funds to e exhausted on otherw1se Medicare covered and otheiWJse reimbursable services related to what was claimed and/or released befote Medicare is ever billed. CMS review is decided on a case by case basis.

The fact that a settlement/judgment/award does not specify payment for future medical services does not mean that they are not funded. The fact that the agreement designates the entire amount for pain and suffering does not mean that future medicals are not funded. The only situation in which Medicare recognizes allocations of liability payments to nonmedical losses is when payment is based on a court of competent jurisdiction's order after their review on the merits of the case. A review of the metits of the case is a revi.ew of the facts of the case to determine whether there are future medicals - not to detennine the proper allocation of funds. If the court of competent jurisdiction has reviewed the facts of the case and determined that there are no future medical services Medicare will accept the Court's designation.

While it is Medicare's position that counsel should know whether or not their recovery provides for future medicals, simply recovers policy limits, etc, we are frequently asked how one would 'know'. Consider the following examples as a guide for determining whether or not settlement funds must be used to protect Medicare's interest on any Medicare covered otherwise reimbursable, case related, future medical services. Does the case involve a catastrophic injury or illness? Is there a Life Care Plan or similar document? Does the case involve any aspect of Workers' Compensation? This list is . by no means all inclusive.

We use the phrase "case related" becaus we consider more than just services related to the actual injury/illness which is the basis of the case. Because the law precludes Medicare payment for services to the extent that payment has been made or can reasonably be expected to be made promptly under liability insurance, Medicare's right of recovery, and the prohibition fi'om billing Medicare for future services, extends to all those services related to what was claimed and/or released in the settlement, judgment, or award. Medicare's payment for those same past services is recoverable and payment for those future services is precluded by Section 1862(b)(2)(A)(ii) ofthe Social Security Act.

"Otherwise covered" means that the funds must be used to pay for only those services Medicare would cover so there is a savings to the Medicare trust funds. For exan1ple, Medicare does not pay for bathroom grab bars, handicapped vans, garage door openers or spas so use of the funds for those items is inappropriate. We include the designation of"othcrwise reimbursable" because Medicare does not pay for services that are not medically necessary even if the specific service is designated as a covered service and Medicare does not pay primary when Group Health Plan insurance has been detem1ined to be the primary payer.

At this time, the CMS is not soliciting cases solely because of the language provided in a general release. CMS does not review or sign off on counsel's determination of the amount to be held to protect the Trust Fw1d in most cases. We do however urge counsel to consider this issue when settling *a* ctt.so;; and recommend that their determination u.s to whctho;;I or not thdr ca;-;c provided recovery funds for future medicals be documented in their records. Should they determine that future services are funded, those dollars must be used to pay for future otherwise Medicare covered case related services.

CMS does .not revi w or sign off on counsel's determination of whether or not there is recovery for future medical serviCes and thus the need to protect the Medicare Trust Funds and *only* in limited cases do they review or sign off on counsel's determination of the amount to be held to protect the Trust Funds.

There is no formal CMS review process in the liability arena as there is for Worker' Compensation, however Regional Offices do review a number of submitted setwaside proposals. On occasions, when the recovery is large enough, or other unusual facts exist within the case, this CMS Regional Office will review the settlement and help make a determination on the amotmt to be available for future services.

We are still asked for written confirmation that a Medicare set-aside is, or is not, required. As we have already covered the "set-aside" aspect of that request we only need to state that IF there was/is funding for otherwise covered and reimbursable future medical services related to what was claimed/released, the Medicare Trust Funds must be protected. If there was/is no such funding, there is no expectation of 3rd party funds with which to protect the Trust Funds. Each attomey is going to have to decide, based on the specific facts of each of their cases, whether or not there is funding for future medicals and if so, a need to protect the Trust Funds. They must decide whether or not there is funding for future medicals. If the answer for plaintiff's counsel is yes, they should to see to it that those funds are used to pay for otherwise Medicare covered services related to what is claimed/released in the settlement judgment award. If the answer for defense counsel or the insurer, is yes they should make sure their records contain documentation of their notification to plaintiff's counsel and the Medicare beneficiary that the settlement does ftmd future medicals which obligates them to protect the Medicare Trust Funds. It will also be part of their report to Medicare in compliance with Section III,Mandatory Insurer Reporting requitements.

Medicare educates about laws/statutes/policies so that individuals can make the best decision possible based on their situation. This is not new or isolated to the MSP provisions. Probably the best example I can give is the 2008 final rule adopting payment and policy changes for inpatient hospital services paid under the Inpatient Prospective Payment System. That final rule also adopted a number of important changes and clarifications to the physician self referral rules sometimes known as the Stark provisions. The physician self-referral law prohibits physicians from referring Medicare and Medicaid patients to certain entities with which the physician or a member of their immediate family has a financial relationship. Exceptions apply. Requests for determinations as to whether or not the physician met the exception criteria, or whether or not their situation was covered by this prohibition poured in. CMS!Medicare did not and continues to make no such determinations. It is the responsibility of the provider to know the specifics of their situation and determine their appropriate course of action.

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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MEMORANDUM

DATE: September 29, 2011

FROM: Acting Director
Financial Services Group
Office of Financial Management

SUBJECT: Medicare Secondary Payer—Liability Insurance (Including Self-Insurance) Settlements, Judgments, Awards, or Other Payments and Future Medicals -- INFORMATION

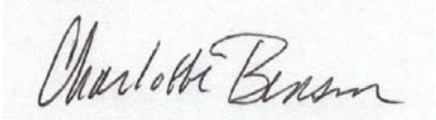
TO: Consortium Administrator for Financial Management and Fee-for-Service Operations

The purpose of this memorandum is to provide information regarding proposed Liability Medicare Set-Aside Arrangement (LMSA) amounts related to liability insurance (including self-insurance) settlements, judgments, awards, or other payments ("settlements").

Where the beneficiary's treating physician certifies in writing that treatment for the alleged injury related to the liability insurance (including self-insurance) "settlement" has been completed as of the date of the "settlement", and that future medical items and/or services for that injury will not be required, Medicare considers its interest, with respect to future medicals for that particular "settlement", satisfied. If the beneficiary receives additional "settlements" related to the underlying injury or illness, he/she must obtain a separate physician certification for those additional "settlements."

When the treating physician makes such a certification, there is no need for the beneficiary to submit the certification or a proposed LMSA amount for review. CMS will not provide the settling parties with confirmation that Medicare's interest with respect to future medicals for that "settlement" has been satisfied. Instead, the beneficiary and/or their representative are encouraged to maintain the physician's certification.

The above referenced guidance and procedure is effective upon publication of this memorandum.



Charlotte Benson

IV. MEDICAID LIENS

A. The Federal Anti-Lien Statute [42 U.S.C. § 1396p(a)(1)]:

(a) Imposition of lien against the property of an individual on account of medical assistance rendered to him under a State plan.

(1) No lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan, except —

(A) in circumstances not relevant to personal injury cases].

B. New York Anti-Lien Statute [NY Soc Serv Law §§ 369(2)(a), 369(2)(c)]

2. (a) Notwithstanding any inconsistent provision of this chapter or other law, no lien may be imposed against the property of any individual prior to his or her death on account of medical assistance paid or to be paid on his or her behalf under this title, except [in cases not relevant to personal injury claims]

. . .

(c) Nothing contained in this subdivision shall be construed to alter or affect the right of a social services official to recover the cost of medical assistance provided to an injured person in accordance with the provisions of section one hundred four-b of this chapter.

C. New York State Social Services Law Section 104-b:

§ 104-b. Liens for public assistance and care on claims and suits for personal injuries.

1. If a recipient of public assistance and care shall have a right of action, suit, claim, counterclaim or demand against another on account of any personal injuries suffered by such recipient, then the public welfare official for the public welfare district providing such assistance and care shall have a lien for such amount as may be fixed by the public welfare official not exceeding, however, the total amount of such assistance and care furnished by such public welfare official on and after the date when such injuries were incurred. In all such cases, notice of the commencement of such an action shall be served upon the public welfare district that has provided or is providing such assistance and care, or upon the department of health.

The commissioner shall endeavor to ascertain whether such person, firm or corporation alleged to be responsible for such injuries is insured with a liability insurance company, as the case may be, and the name thereof.

2. No such lien shall be effective, however, unless a written notice containing the name and address of the injured recipient, the date and place of the accident, and the name of the person, firm or corporation alleged to be liable to the injured party for such injuries, together with a brief statement of the nature of the lien, the amount claimed and

that a lien is claimed upon the said right of action, suit, claim, counterclaim or demand by the public welfare official be served prior to the payment of any moneys to such injured party, by certified with return receipt or registered mail upon such person, firm or corporation, and his or her, its or their attorney, if known, and upon any insurance carrier which has insured such person, firm or corporation against such liability. A copy of the notice of lien shall be mailed to such carrier at least twenty days prior to the date on which such carrier makes a payment to the injured party. Except as against such carrier, the effectiveness of the lien against any other party shall not be impaired by the failure to mail the required notice to such carrier. In addition, a true copy of such notice shall be served by regular mail to the welfare recipient and to his or her attorney, if known. Such mailing shall be deemed to be effective, notwithstanding any inaccuracy or omission, if the information contained therein shall be sufficient to enable those to whom the notice is given to identify the injured recipient and the occurrence upon which his or her claim for damages is based.

3. Upon the service of the notice, as aforesaid, the local public welfare official shall file a true copy thereof in the office of the clerk of the county in which his office is located, and, thereupon the lien of the public welfare official in the amount therein stated shall attach to any verdict, decision, decree, judgment, award or final order in any suit, action or proceeding in any court or administrative tribunal of this state respecting such injuries, as well as the proceeds of any settlement thereof, and the proceeds of any settlement of any claim or demand respecting such injuries prior to suit or action.

4. An amended notice of lien may be served and filed by such public welfare official in the same manner and subject to the provisions of this section governing the notice of lien originally served and filed pursuant to this section.

5. (a) The person, firm, corporation or insurance carrier, having notice that a social services official has served and filed a notice of lien, and intending to make payment on the personal injury claim upon which the lien was filed, shall notify the social services official by certified or registered mail, at least ten days prior to the date such payment is proposed to be made, of the amount and date thereof.

(b) Notwithstanding any inconsistent provision of this section, the social services official shall have the right to serve and file by certified or registered mail, within five days after receipt of such notice, excluding Saturdays, Sundays, and holidays, an amended notice of lien to include the amount of public assistance and care furnished to the recipient after the date such official served and filed the notice of lien or the last previous amendment thereof.

(c) A person, firm, corporation or insurance carrier that fails to give the notice required by paragraph (a) of this subdivision shall be liable to the social services official to the same extent that it would have been liable had such notice been given and the social services official had filed the amended notice of lien provided for in paragraph (b) of this subdivision.

6. Such lien may be enforced by action against those alleged to be liable for such injuries, as aforesaid, by the local public welfare official in any court of appropriate jurisdiction.

7. The aforesaid lien shall be valid and effective, when the notice thereof and the statement are served and filed as aforesaid, and shall continue until released and discharged by the local public welfare official by an instrument in writing and filed in the said county clerk's office, and no release, payment, discharge or satisfaction of any such claim, demand, right of action, suit or counterclaim shall be valid or effective against such lien.

8. The county clerk shall, at the expense of the county, provide a suitable book with proper index, to be called the public welfare lien docket, in which he shall enter the names of the public welfare official and the recipient, the date and place of the accident and the name or names of those alleged to be liable for such injuries, as aforesaid.

9. The provisions of this section to the contrary notwithstanding, the lien herein created shall be subject and subordinate to the lien on the amount recovered by verdict, report, decision, judgment, award or decree, settlement or compromise, of any attorney or attorneys retained by any such injured person to prosecute his claim for damages for personal injuries, having or acquiring by virtue of such retainer a lien on the cause of action of any such injured person, or on the verdict, report, decision, judgment, decree made in, or any settlement or compromise of, any such

action or claim for damages for personal injuries.

10. The provisions of this section to the contrary notwithstanding, the lien herein created shall be subordinate to the lien of any hospital claimed under and to the extent recognized by section one hundred eighty-nine of the lien law, but only for treatment, care and maintenance given, prior to or in excess of the public assistance and care granted by the public welfare official.

11. The provisions of this section shall not be deemed to adversely affect the right of a public welfare official who has taken an assignment of the proceeds of any such right of action, suit, claim, counterclaim or demand, to recover under such assignment the total amount of assistance and care for which such assignment was made.

12. The provisions of this section to the contrary notwithstanding, the lien herein created shall not apply with respect to any claim or benefits payable to the recipients of any form of public assistance or care, part of which is paid for by the government of the United States or any agency thereof when, in the opinion of the commissioner, such lien would jeopardize the continuation of such federal contribution.

13. The provisions of this section to the contrary notwithstanding, the public welfare official may in his discretion release to the injured person an amount not to exceed the cost of two years' maintenance from the lien herein created.

This section shall not apply to any claim or award which is or may be allowed pursuant to the provisions of the workmen's compensation law or the volunteer firemen's benefit law.

14. Any inconsistent provision of this chapter or of any other law notwithstanding, a social services official may not assert any claim under any provision of this chapter to recover payments of public assistance if such payments were reimbursed by child support collections.

D. ***Arkansas Dept. of Health and Human Services v. Ahlborn*, 547 U.S. 268 (2006)**

Ahlborn was a college student who suffered brain damage after she was involved in an automobile accident. She settled with the defendant for $550,000, which represented approximately one-sixth of the full value of her case. The settlement included past and future medical expenses as well as other types of damages. It did not allocate amounts for each type of damage. Arkansas Medicaid argued that it was entitled to the *full* balance of what it had paid in medical expenses – $215,615.30 – from the settlement proceeds. Ahlborn, on the other hand, argued that Medicaid was entitled to only one-sixth of the entire recovery, since she had only settled for one-sixth of what she was entitled to herself.

The United States Supreme Court unanimously held that federal Medicaid laws did not authorize Arkansas to recover an amount in excess of Ahlborn's recovery for medical expenses because the federal anti-lien provision affirmatively prohibited such recovery. The federal anti-lien provision allowed Arkansas to recover *only that portion of the settlement that represented past medical expenses*. That amount was equivalent to one-sixth of the recovery. Any recovery beyond that was unauthorized as it was Ahlborn's property.

Justice Stevens of the U.S. Supreme Court made an additional observation in dicta:

> Read literally and in isolation, the anti-lien prohibition contained in §1396p(a) would appear to ban even a lien on that portion of the settlement proceeds that represents payments for medical care. Ahlborn does not ask us to go so far, though; she assumes that the State's lien is consistent with federal law insofar as it encumbers proceeds designated as payments for medical care. Her argument, rather, is that the anti-lien provision precludes attachment or encumbrance of the remainder of the settlement.

Ahlborn, 547 U.S. at 284.

E. ***Wos v. E.M.A.*, 568 U.S. ___ (2013)**

In a more recent decision, *Wos v. E.M.A.*, the Supreme Court held that the Federal Anti-Lien Statute preempted North Carolina's statute. North Carolina's statute created a presumption that in every settlement, one-third of the proceeds represented compensation for past medical expenses. It permitted the state to recover the lesser of this amount or the amount it had actually paid. The United States Supreme Court ruled that this statute was preempted because it allowed for the *possibility* that North Carolina could take a portion of the plaintiff's proceeds that were not for past medical expenses. This was because one-third or the actual amount paid were not necessarily equivalent to or less than the amount the plaintiff received from the settlement for past medical expenses. The court noted that this was unacceptable under *Ahlborn* because a state could not recover from proceeds that were not designated as payment for medical expenses:

> And it is pre-empted for that reason. ***The defect in §108A-57 is that it sets forth no process for determining what portion of a beneficiary's tort recovery is attributable to medical expenses.*** Instead, North Carolina has picked an arbitrary number-one-third-and by statutory command labeled that portion of a beneficiary's tort recovery as representing payment for medical care. Pre-emption is not a matter of semantics. A State may not evade the pre-emptive force of federal law by resorting to creative statutory interpretation or description at odds with the statute's intended operation and effect. *Wos v. E.M.A.*, slip op. at 7 (emphasis mine).

F. **BIPARTISAN BUDGET ACT OF 2018**

On February 9, H.R. 1892 became law: The Bipartisan Budget Act of 2018. Deep within the bill, at Section 53102(b)(1), there is a complete repeal of the Medicaid changes that were included in the 2013 budget bill, which extended the Medicaid lien to reach the entire settlement proceeds effective October 1, 2017. As of that date, Medicaid could arguably collect on 100% of its lien, regardless of the settlement amount, and regardless of whether any part of that settlement included a past medical component. However, that 2013 law was completely repealed, effective

September 30, 2017, negating its effects permanently and retroactively. The Medicaid lien laws therefore remain as they had always been, as described in the sections above.

Precision Resolution's position is that this 2018 repeal of the 2013 amendments, effective retroactive to September 30, 2017, does far more than restore the *Ahlborn* allocation principle. As many of you know, prior to the effective date of the "*Ahlborn* repeal" on October 1, 2017, our office had always taken the position that Medicaid liens cannot exist against the property of a plaintiff. This position is rooted in the unambiguous terminology of the federal ***Anti-Lien Statute (42 U.S.C. § 1396p(a)(1):***

> **No lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan**, except . . .

This is not to say that the Medicaid agency does not have recovery rights, however. We have always argued that the Medicaid right is limited to subrogation by means of "automatic assignment" of the medical component of the case. That is because the Medicaid act also mandates:

> (a) For the purpose of assisting in the collection of medical support payments and other payments for medical care owed to recipients of medical assistance
> (b) under the State plan approved under this title [42 USCS §§ 1396 et seq.], a State plan for medical assistance shall--(1) provide that, as a condition of eligibility for medical assistance under the State plan to an individual who has the legal capacity to execute an assignment for himself, the individual is required—
> (A) ***to assign the State any rights, of the individual or of any other person who is eligible for medical assistance*** under this title [42 USCS §§ 1396 et seq.] and on whose behalf the individual has the legal authority to execute an assignment of such rights, to support (specified as support for the purpose of medical care by a court or administrative order) and ***to any payment from a third party that has a legal liability to pay for care and services available under the plan;*** 42 USCS § 1396k (emphasis added).

In *Ahlborn*, 547 U.S. 268 (2006), when the Arkansas Medicaid agency sought recovery of the entire amount of its lien on a limited recovery, Ms. Ahlborn fought back. In doing so, she acknowledged that Arkansas had a lien, but that it was limited to the "automatically assigned" medical component of the claim. The United States Supreme Court agreed but appeared to want to go further. Justice Stevens wrote for a unanimous Court:

> Read literally and in isolation, the anti-lien prohibition contained in § 1396p(a) would appear to ban even a lien on that portion of the

> settlement proceeds that represents payments for medical care. ***Ahlborn does not ask us to go so far,*** though; she assumes that the State's lien is consistent with federal law insofar as it encumbers proceeds designated as payments for medical care. Her argument, rather, is that the anti-lien provision precludes attachment or encumbrance of the remainder of the settlement. *Ahlborn*, 547 U.S. at 284 (emphasis added).

The *2013* Bipartisan Budget Act therefore not only legislatively overruled *Ahlborn*, but also gutted the plain language and intent of the federal anti-lien statute. Ironically, for a few short months the revised "***Anti-Lien*** statute" actually ***created a lien*** that had previously not existed.

The 2018 repeal of those Medicaid provisions in the 2013 Act not only restored the "*Ahlborn* allocation" but also restored the original congressional intent of the Medicaid Act (Social Security Act) signed into law by President Johnson in 1965 that states, "No lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan." 42 USC § 1396p.

V. "OTHER" LIEN CLAIMS: VETERAN'S ADMINISTRATION, TRICARE, FEDERAL EMPLOYEES

A. VA and Tricare

VA Benefits are administered by the Veterans Health Administration, an agency run by the Department of Veteran Affairs. TRICARE is administered by the Department of Defense.

Enrollment into the VA comprehensive health plan is determined by priority based on severity of the disability, whether or not it was service-connected, and one's income level. In the instance of service-connected disability, the cost of care is generally free. For other priority groups, there may be a copayment required. When a veteran is treated for non-service connected conditions, the VA will bill the veteran's private insurance, if other coverage exists, this includes billing TRICARE. VA will not, however, bill Medicare or Medicaid.

TRICARE is the United States Military's health insurance program, which falls under the Department of Defense. TRICARE covers active and retired service members, including veterans, from any seven of the uniformed services, including those in the National Guard and Reserves if they have been called to active duty for more than 30 consecutive days. Additionally, TRICARE covers spouses, children, and surviving spouses and surviving children.

Eligibility for TRICARE plans are broken into three major categories, and is dependent on the status, age, and location of the member. Active and retired members who live in a TRICARE Prime service area must enroll in the TRICARE Prime plan. Active duty members pay nothing out of pocket while retirees pay annual enrollment fees and copayments.

TRICARE Standard is a voluntary program for those not required to be enrolled in TRICARE Prime. For TRICARE Standard plans there is a nominal deductible and possible cost sharing depending on the location and services. Additionally, TRICARE Standard offers premium-based plans, which are more akin to private healthcare or HMOs.

Finally, TRICARE For Life is for anyone eligible for TRICARE benefits and who is enrolled in Medicare Parts A and B. Medicare's Part B premium is the only cost for TRICARE For Life. TRICARE For Life is secondary to Medicare, and the payer of last resort if there is any other insurance involved.

1. Federal Medical Care Recovery Act

The Federal Medical Care Recovery Act (FMCRA), 42 USC § 2651, authorizes the right of recovery by the United States for medical treatment paid by the federal government in situations where there is "tort liability." This right is independent of the injured person's right to recover. In addition, in third party tort liability situations, the US government has a right to recover the amount of pay that is incurred, or will be incurred, as a result of an armed services

member being injured or disabled and unable to perform active duty. The FMCRA applies to both TRICARE and VA benefit situations when tort liability is involved.

42 U.S.C. § 2651. The Federal Medical Care Recovery Act.

(a) Conditions; exceptions; persons liable; amount of recovery; subrogation; assignment. In any case in which the United States is authorized or required by law to furnish or pay for hospital, medical, surgical, or dental care and treatment (including prostheses and medical appliances) to a person who is injured or suffers a disease, after the effective date of this Act, under circumstances creating a tort liability upon some third person (other than or in addition to the United States and except employers of seamen treated under the provisions of section 322 of the Act of July 1, 1944 (58 Stat. 696), as amended (42 U.S.C. 249)) to pay damages therefor, the United States shall have a right to recover (independent of the rights of the injured or diseased person) from said third person, or that person's insurer, the reasonable value of the care and treatment so furnished, to be furnished, paid for, or to be paid for and shall, as to this right be subrogated to any right or claim that the injured or diseased person, his guardian, personal representative, estate, dependents, or survivors has against such third person to the extent of the reasonable value of the care and treatment so furnished, to be furnished, paid for, or to be paid for. The head of the department or agency of the United States furnishing such care or treatment may also require the injured or diseased person, his guardian, personal representative, estate, dependents, or survivors, as appropriate, to assign his claim or cause of action against the third person to the extent of that right or claim.

…

(d) Enforcement procedure; intervention; joinder of parties; State or Federal court proceedings. The United States may, to enforce a right under subsections (a), (b), and (c)[,] (1) intervene or join in any action or proceeding brought by the injured or diseased person, his guardian, personal representative, estate, dependents, or survivors, against the third person who is liable for the injury or disease or the insurance carrier or other entity responsible for the payment or reimbursement of medical expenses or lost pay; or (2) if such action or proceeding is not commenced within six months after the first day in which care and treatment is furnished or paid for by the United States in connection with the injury or disease involved, institute and prosecute legal proceedings against the third person who is liable for the injury or disease or the insurance carrier or other entity responsible for the payment or reimbursement of medical expenses or lost pay, in a State or Federal court, either alone (in its own name or in the name of the injured person, his guardian, personal representative, estate, dependents, or survivors) or in

conjunction with the injured or diseased person, his guardian, personal representative, estate, dependents, or survivors.

2. Case Law

***United States v. Trammel*, 899 F. 2d 1483 (6th Cir. 1990)**

An active United States Navy member was involved in a motor vehicle accident in Kentucky for which the government provided medical expenses. Kentucky's no-fault laws provide for an abolition of tort liability for the first $10,000.00 in economic loss, but allow for recovery of other non-economic damages. The government then sued the tortfeasor and insurer under the Recovery Act for medical expenses it paid. However, under the FMCRA, the government is only allowed to bring a separate suit against the tortfeasor in situations that create tort liability against the third party. The court therefore held that the FMCRA limits recovery to those circumstances where tort liability is created under state law.

> The government's independent right of recovery, therefore, is not independent in the sense that it is based upon a separate pecuniary loss distinct from Tramell's right of recovery under a state law cause of action in tort. Instead, the FMCRA only confers a right of recovery when a beneficiary is injured by conduct which subjects the third-party actor to tort liability to the beneficiary. In essence, the government stands in the position similar to that of a subrogee to the state law claim of the beneficiary against the tortfeasor…Accordingly, state substantive law is the basis for determining whether tort liability exists for purposes of an FMCRA claim. *Trammel*, at 1487-1488.

***Holbrook v. Anderson Corp.*, 996 F. 2d 1339 (1th Cir. 1993)**

The dependent of an active Navy member suffered injuries after falling out of a window in their apartment building. The plaintiff notified the government of their lawsuit, but the government did not choose to intervene. The district court *sua sponte* modified the settlement agreement to place funds in an escrow account pending satisfaction of the government's lien. The government then moved to intervene and have the escrowed funds released pursuant to the FMCRA. On appeal, the First Circuit took issue with the government asserting its lien against the plaintiff's settlement. It held that reimbursement may not be sought against the injured party themselves.

> All courts which have considered the question have agreed that the statute gives the Unites States an independent right of recovery against the tortfeasor…Thus, the government's right is not extinguished by the injured person's settlement and release with the tortfeasor. Indeed the government's right against the tortfeasor under the Recovery Act is not defeated even by certain restrictions that might bar the injured person's own recovery. There is thus no necessity for the United States to look to the injured party's settlement for compensation.

> If the United States wishes to invoke the Recovery Act to recover its medical payments in this case, we think under the plain language of the statute it must proceed against Andersen and seek to establish Andersen's tort liability. The language of the statutes does not authorize the government to collect under the Recovery Act out of a settlement negotiated between the injured person and the tortfeasor. Nor is there any case law that permits such a recovery absent an express agreement designating for the government a portion of the settlement. *Holbrook*, at 1341 (internal citations omitted).

***Mosey v. United States*, 3 F. Supp. 2d 1133 (D. NV. 1998)**

Mosey received a settlement in her personal injury lawsuit; some of the resulting treatment from the accident was provided at a VA hospital. The VA attempted to recoup its payments from Ms. Mosey's attorney under the FMCRA. Negotiations broke down and Mosey filed a declaratory judgment action to determine what portion of the VA's claim they were entitled to. The parties agreed that the government was entitled to some share of the settlement proceeds, but there was a dispute as to whether the VA's claim should be reduces based on equitable principles.

The court weighed 3 factors: (1) whether the government passively allowed the injured party to bear all the risks and costs of litigation, (2) whether, in the case of settlement, the award obtained reflects a "settlement discount," and (3) the terms of any agreement between the government and the victim, or the tortfeasor and the victim, as to the government's right to reimbursement. The last two factors were inapplicable, so the court balanced only the first factor. It reasoned that since the government passively let Mosey assume the risks and costs of litigation, its share of recovery must be reduced to take into account what it would have had to pay for attorney's fees. So the court analogized the case to the common fund recoveries, federal False Claims Act cases, and hypothetical hiring of attorneys and concluded that it was fair to reduce the government's recovery by 25% to account for attorney's fees.

Cockerham v. Garvin, 768 F. 2d 784 (6th Cir. 1985)

A veteran plaintiff held moneys in escrow for medical treatment received at a VA Hospital, which he received as the result of a settlement with the tortfeasor. Under the Medical Care Recovery Act, 42 UCS § 2651, the VA moved to be awarded reimbursement for the care they provided out of the escrowed funds in the underlying lawsuit. Ultimately the Court of Appeals held that the VA was entitled to the escrow funds, but remanded the case to address the VA's improper standing, and to hold an evidentiary hearing to determine the "reasonable value" of medical services rendered. The Sixth Circuit applied equitable principals to the settlement funds and held:

> In this hearing, the Court should consider the equities of the two parties. Although diligent research reveals no case law on the subject, it is clear that the government should not be reimbursed for the full amount of its claim in this case because it

> passively has allowed the veteran to bear all the risks and costs of pursuing litigation…The settlement agreement which created the fund expressly contemplates "appropriate settlement" between the plaintiff and the government. The government is not suing the tortfeasor. It seeks recovery only as a beneficiary of the fund, and therefore equitable considerations apply. If an insured veteran has accepted a discounted settlement for his claims of wage loss, pain and suffering, loss of future earning potential, and the like, it is not equitable to require full reimbursement for services the government was duty-bound to render. If Cockerham establishes on remand that his settlement was discounted, the government's portion should be reduced accordingly. Cockerham, at 787.

Additionally, the court found that under these circumstances, a six-year statute of limitations under 28 USC § 2415(a) applied. The court acknowledged that when the government seeks recovery directly against the tortfeasor, it involved tort liability, and § 2415(b) would apply for a three-year statute of limitations. However, in this situation, the beneficiary and tortfeasor entered into a settlement agreement, specifically segregating funds for medicals. Thus, the government's action here was based in contracts and the six years limitations period applied.

B. Federal Employees: Federal Employee Health Benefit Act

Most federal employees are provided health benefits through the Federal Employee Health Benefits Act. Benefits are provided through private insurance carriers, and the federal government, along with employees, pay a premium to the carriers. Benefits are administered through the Office of Personnel Management (OPM). There is no statutory right of FEHB plans to assert reimbursement rights.

However, there is a provision which states that the terms of any FEHB contract which relate to the coverage of benefits preempt state law related to health insurance.

> FEHBA Preemption clause 5 U.S.C. §8902(m)(1):
> (1) The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.

The relevant question became: does contract language in these types of plans, which relate to subrogation and reimbursement, "relate to the nature, provision, or extent of coverage or benefits" and thus preempt state law, e.g., New York General Obligations Law §5-335.

The answer had a long and tortured history which was finally resolved by the United States Supreme Court in *Coventry Health Care of Missouri, Inc. v. Nevils*, 581 U.S.___(April 18, 2017. The Court explained that there is an expansive view of Congress' use of the phrase

"relate to." The purpose of the statute also supported the Court's view, reasoning that there is a strong federal interest in uniform administration of the Federal Employee Health Benefits program, free from interference by the individual states.

Going further, the Court held that the statute does not violate the Supremacy Clause because it is the statute itself, not contract provisions, which preempt state law, while also noting that other federal statutes have similar effect and have been held to be valid, such as ERISA and the Federal Arbitration Act.

Ultimately the case was remanded for further proceedings consistent with the opinion.

Contract terms would therefore govern the scope of reimbursement rights in cases involving federal employees.

VI. SELF-FUNDED HEALTH BENEFIT PLANS: ERISA

Any retirement/pension or welfare benefit plan, including a health benefit plan, which is provided through a person's employer, is governed by Employee Retirement Income Security Act of 1974 (ERISA). 29 U.S.C. §1001 et seq. (There are a few exceptions, including any government plan or a church plan). As a federal statute, ERISA has great preemptive force over state laws, specifically anti-recovery and anti-subrogation statutes, which are normally used to bar recovery of settlement proceeds from health insurance providers.

A. SELF-FUNDED HEALTH PLANS VS. INSURED PLANS.

1. The distinction between self-funded ERISA plans and those that are insured ERISA plans is a significant one, as it is part of the determination of whether ERISA preempts state law.

2. Self-funded plans are often created by large employers that are better able to fund a group health and pension plan. The employer uses its own assets, usually in combination with contributions from the employees, to fund the plan. Using this method of funding the plan, the employer bears the risk of loss should the need for benefits to be paid occur. In this scenario, a commercial insurance company simply acts as a claims administrator, bearing no risk for payment of benefits, but processes claims and manages the fund out of which benefits are paid.

3. By contrast, an insured ERISA plan is one where the employer purchases insurance from a commercial insurer to cover the risk of loss should any benefits be paid out. Here, the employer (and employee through a contribution) pay a premium to the insurance company, which is on the risk for payment of benefits.

B. ERISA PREEMPTION

ERISA's express preemption statute consists of three parts, typically called the preemption clause, the savings clause, and the deemer clause:

1. The Preemption Clause:

> Except as provided in subsection (b) of this section, *the provisions of [ERISA] shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan* described in section 1003(a) of this title and not exempt under section 1003(b) of this title.

29 U.S.C. § 1144(a) (emphasis added).

2. The Savings Clause:

> Except as provided in subparagraph (B), *nothing in this subchapter shall be construed to exempt or relieve any person* from any *law of any State which regulates insurance,* banking, or securities.

29 U.S.C. § 1144(b)(2)(A) (emphasis added).

3. The Deemer Clause:

> Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, *shall be deemed to be an insurance company or other insurer,* bank, trust company, or investment company *or to be engaged in the business of insurance* or banking *for purposes of any law of any State purporting to regulate insurance companies, insurance contracts,* banks, trust companies, or investment companies.

29 U.S.C. 1144(b)(2)(B) (emphasis added).

4. *FMC Corp. v. Holliday*, 498 U.S. 52 (1990)

This Supreme Court case decided in 1990 involved a state anti-subrogation statute from Pennsylvania and a self-funded ERISA plan. In interpreting ERISA's preemption scheme, the Court held:

> We read the deemer clause to exempt self-funded ERISA plans from state laws that 'regulate insurance' within the meaning of the saving clause. . . State laws that directly regulate insurance are 'saved' but do not reach self-funded employee benefit plans because the plans may not be deemed to be insurance companies, other insurers, or engaged in the business of insurance for purposes of such state laws. On the other hand, employee benefit plans that are insured are subject to indirect state regulation. An insurance company that insures a plan remains an insurer for purposes of state laws, 'purporting to regulate insurance' after application of the deemer clause [of ERISA]. The insurance company is therefore not relieved from state insurance regulation. The ERISA plan is consequently bound by state insurance regulations insofar as they apply to the plan's insurer.

FMC, 498 U.S. 52, 62 (1990).

In other words, *FMC* created the preemption distinction between self-funded plans, and insured plans. If a plan is self-funded, state laws regulating insurance are preempted, and ERISA applies. For insured plans, any state law which regulates insurance is applicable.

5. New York State General Obligations Law § 5-335.

GOL § 5-335 is New York State's anti-subrogation statute. The statute applies only to settlements, but precludes health insurers from making a claim for subrogation or reimbursement against the settlement proceeds. The statute states:

> Limitation of reimbursement and subrogation claims in personal injury and wrongful death actions. (a) **When a person settles a claim**, whether in litigation or otherwise, against one or more other persons **for personal injuries, medical, dental, or podiatric malpractice, or wrongful death, it shall be conclusively presumed that the settlement does not include any compensation for the cost of health care services, loss of earnings or other economic loss to the extent those losses or expenses have been or are obligated to be paid or reimbursed by an insurer**. By entering into any such settlement, a person shall not be deemed to have taken an action in derogation of any right of any insurer that paid or is obligated to pay those losses or expenses; nor shall a person's entry into such settlement constitute a violation of any contract between the person and such insurer. **No person entering into such a settlement shall be subject to a subrogation claim or claim for reimbursement by an insurer and an insurer shall have no lien or right of subrogation or reimbursement against any such settling person or any other party to such a settlement, with respect to those losses or expenses that have been or are obligated to be paid or reimbursed by said insurer.**

NY CLS Gen. Oblig. § 5-335 (emphasis added).

An "insurer" as is used in GOL §5-335 is defined as:

> As used in section 5-335 of this article, the term "insurer" means any insurance company or other entity which provides for payment or reimbursement of health care expenses, health care services, disability payments, lost wage payments or any other benefits under a policy of insurance or an insurance contract with an individual or group.

NY CLS Gen. Oblig. § 5-101(4).

C. EQUITABLE RELIEF UNDER ERISA.

Under the provisions of ERISA, a civil action may be brought by a member of the plan, or by a fiduciary who administers the plan, to enforce certain rights under ERISA and/or the terms of the benefit plan. ERISA dictates which courts have jurisdiction to hear these actions, and what specific relief may be sought.

1. Section 502(a)(1)(B), 29 U.S.C. §1132(a)(1)(B)

(a) <u>Persons empowered to bring a civil action</u>
A civil action may be brought—
(1) by a participant or beneficiary—
(A) for the relief provided for in subsection (c) of this section, or
(B) o recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

2. Section 502(a)(3), 29 U.C.S. §1132(a)(3).

A civil action may be brought—
(3) by a participant, beneficiary, *or fiduciary*

(A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or

(B) o obtain other ***<u>appropriate equitable relief</u>***
(i) to redress such violations or
(ii) ***<u>to enforce</u>*** any provisions of this subchapter or ***<u>the terms of the plan.</u>***

29 U.S.C. § 1132(a)(3) (emphasis added).

3. *Great-West Life & Annuity Insurance Co. v. Knudson*, 534 U.S. 204 (2002)

Knudson was a plan member who was involved in a motor vehicle accident for which his plan initially paid medical benefits. After Knudson settled his personal injury case against the tortfeasor, the plan filed suit in federal court under §502(a)(3) to seek reimbursement for the medical expenses they paid. Pursuant to the language of 502(a)(3), the plan must obtain reimbursement by seeking "appropriate equitable relief." The Court explained that in order for a reimbursement claim to sound in equitable relief, there must be a constructive trust or an equitable lien, while an action in law (which is not permitted under ERISA's civil enforcement scheme) seeks to impose personal liability on the plan member to reimburse the plan, as a general creditor.

The Court held that in order to obtain appropriate equitable relief, the plan must seek recovery against a particular fund, and that particular fund must be in the possession of the member. In this case, by the time the Plan sued the Knudsons, the settlement proceeds had

already been placed into a special needs trust. Since the funds were not in Knudson's possession, the plan could not properly seek equitable relief.

4. *Sereboff v. Mid-Atlantic Services, Inc.*, 547 U.S. 356 (2006)

Four years after *Knudson* was decided, the Supreme Court decided *Sereboff*. Similar to *Knudson*, Sereboff was injured in a motor vehicle accident and was provided medical benefits through his ERISA plan. The plan filed suit in district court under 502(a)(3) seeking reimbursement after Sereboff received a settlement from the car accident. Through a stipulation by the parties in district court, a portion of the settlement funds were segregated accounting for the medical expenses paid by the plan.

The Supreme Court elaborated on the rules found in *Knudson*, and held that it was the plan language that controlled whether or not the plan was seeking equitable relief. By this the court meant that the recovery language in the plan must specify a specific fund in the member's possession, which the Court stated was separate from the member's general assets, and the particular share of that fund that the plan was entitled to. Here, unlike in *Knudson*, the funds were in a separate fund held by the Sereboffs for which equitable relief could be sought.

5. *U.S. Airways v. McCutchen*, 133 S.Ct. 1537 (April 16, 2013)

In *McCutchen*, the question was presented as to what is means by "appropriate" equitable relief in the statute. The Third Circuit held that appropriate equitable relief meant that any and all equitable defenses could be asserted against a plan seeking reimbursement under the equitable relief provision. However, the U.S. Supreme Court ruled that so long as the plan specifically waives the application of an equitable defense, it is unavailable. The U.S. Supreme Court held:

> US Airways . . . is seeking to enforce the modern-day equivalent of an "equitable lien by agreement." And that kind of lien—as its name announces—both arises from and serves to carry out a contract's provisions. . . . So enforcing the lien means holding the parties to their mutual promises. . . . Conversely, it means declining to apply rules—even if they would be "equitable" in a contract's absence—at odds with the parties' expressed commitments. McCutchen therefore cannot rely on theories of unjust enrichment to defeat US Airways' appeal to the plan's clear terms.
> . . .
> Even in equity, when a party sought to enforce a lien by agreement, all provisions of that agreement controlled. So too, then, in a suit like this one.
> . . .
> The plan, in short, is at the center of ERISA. And precluding McCutchen's equitable defenses from overriding plain contract terms helps it to remain there.

This is a major holding that confirmed that the terms of the plan, contracting away equitable defenses like the made-whole doctrine or common-fund doctrine, were enforceable against the member.

In *McCutchen*, the case was remanded back to the district court for a determination of whether the plan at issue specifically waived the application of the common fund doctrine.

6. *Montanile v. Bd. of Trustees of the Nat'l Elevator Industry Health Benefit Plan*, 136 S.Ct. 651 (January 20, 2016).

In 2016, a major decision was passed down by the Supreme Court analyzing the equitable relief rules established under *Knudson* and *Sereboff*, mainly, what recourse, if any, the plan had when settlement funds were dissipated and no longer in the possession of the plan member. The Court determined that:

> In sum, at equity, a plaintiff ordinarily could not enforce any type of equitable lien if the defendant once possessed a separate, identifiable fund to which the lien attached, but then dissipated it all. The plaintiff could not attach the defendant's general assets instead because those assets were not part of the specific thing to which the lien attached.

Therefore, the Supreme Court held that if the plan member's funds were dissipated and could not be traced to a tangible item, the plan had no recourse against them.

D. WHAT IS THE "AGREEMENT" IN "EQUITABLE LIEN BY AGREEMENT?"

29 U.S.C. § 1024(b)(4) under ERISA mandates that upon written request by the plan member, to the plan administrator, certain plan documents must be furnished to the plan member. Among these documents are the Summary Plan Description (SPD) and the plan document. Under ERISA, these are two different documents, both requirements for a plan. However, in some cases, the terms of the SPD differ from the terms of the plan document. Therefore, it is important to have all documents related to the plan at your disposal when analyzing any claim for reimbursement.

1. *Cigna v. Amara*, 131 S.Ct. 1866 (May 16, 2011)

The Supreme Court was faced with distinguishing the difference between the Plan Document and the SPD. The Court held:

> We cannot agree that the terms of statutorily required plan summaries (or summaries of plan modifications) necessarily may be enforced (under § 502(a)(1)(B)) as the terms of the plan itself.
>
> ***

> Summary documents, important as they are, provide communication with beneficiaries *about* the plan, but that their statements do not themselves constitute the *terms* of the plan for purposes of §502(a)(1)(B).

This holding confirmed that the Plan Document language controlled over the language contained in the SPD.

2. *McCutchen* Continued*:* Remand to the Western District of Pennsylvania.

The Supreme Court remanded this case to determine whether or not the common fund doctrine had been dispensed of by virtue of the plan language.

A very important issue in *McCutchen* was relegated to a footnote, but the issue reappeared in the remand to the district court. The Supreme Court noted that the document at issue in the case was the U.S. Airways SPD. Despite repeated requests for the actual plan document, U.S. Airways did not disclose it until it was specifically requested by the Solicitor General of the United States in preparation for the Supreme Court case. Because the plan document was never in the record before it, the Supreme Court decided the case on the basis of the SPD.

It turned out that the actual plan document had much different reimbursement language than the Summary Plan Description.

When the case was remanded, McCutchen's attorneys moved to amend their Answer, six years after the fact, to add causes of action for breach of the plan's fiduciary duty for failure to disclose the plan document. The motion was granted.

> In *Amara*, the Court found it improper to enforce the terms of the SPD over the plan language reasoning that the syntax of another section of ERISA, § 102(a), which obliges the plan administrators to furnish SPDs and requires that participants and beneficiaries "be advised of their rights and obligations 'under the plan,'" suggests that the information about the Plan provided by the SPDs "is not itself part of the plan." Since *Amara*, courts have agreed that the summary plan provisions, including stipulations not present in the plan certificate, are unenforceable.

The district court then enforced the terms of the plan that were contained in the Plan Document, and not those in the SPD.

E. REQUESTING AND REVIEWING PLAN DOCUMENTS

ERISA requires certain documents to be furnished to the plan member upon written request to the designated plan administrator. 29 U.S.C. § 1024(b)(4). Failure by the plan

administrator to furnish the requested documents within 30 days of receipt of the request can result in a penalty of $110.00 per day that the administrator is in breach. 29 U.S.C. § 1132(c)(1) and 29 CFR § 2575.502c-1.

1. Requesting all relevant documents.

The following form letter can be used to request all relevant documentation, and was provided by Professor Roger Baron of the University of South Dakota School of Law.

Date

(Name of Plan Administrator – should be set forth in SPD)
Plan Administrator for_____Medical Plan
Street address
City, State, Zip Code

CERTIFIED MAIL: Return Receipt Requested

Dear Mr./Ms.,

My name is_____. Pursuant to my right as a participant and beneficiary of _____ Plan, I respectfully request copies of the following materials:

Copies of the Summary Plan Description (SPD) and other Plan Documents relating to my health insurance coverage for the years (year preceding date of injury through current year);

Copies of the Plan Document relating to my health coverage for the years (year preceding date of injury through current year);

Administrative Services Contract between (Employer/Plan) and (Plan Insurer(s)/Claims Administrator) for the years (year preceding date of injury through current year);

Copies of all contracts including, but not limited to: Insurance contracts, Stop Loss Contracts, Health Insurance Contracts, Insurance Intermediary Services Contracts, and Administrative Services Contracts related to_____Medical Plan serving (insert name of state or region encompassing client) participants for the years (year preceding date of injury through current year);

Amendments to the Plan Documents for_____Medical Plan (including, but not limited to the Summary Plan Description) for the years (year preceding date of injury through current year);

Copies of the SMM (Summary of Material Modifications) statements for the years (year preceding date of injury through current year);

Copies of form 5500, including all attached schedules, filed with the U.S. Department of Labor for the years (year preceding date of injury through current year).

Please forward these materials to my attorney, Mr./Mrs._____, (street address), (city), (state), (zip code).

Thank you.

_____ (signature)
(Name of Participant/Beneficiary – Printed)
Plan Participant
Plan Beneficiary

2. *Popowski v. Parrott*, 461 F.3d 1367 (11th Cir. 2006).

Following the decision in *Sereboff*, the Eleventh Circuit applied the equitable relief test to two different plans. The plans contained the following reimbursement language:

United Distributors Plan:

> In any event, the Plan has a lien on any amount recovered by the Covered Person whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full.
>
> The Covered Person…must repay to the Plan the benefits paid on his or her behalf out of the recovery made from the third party or insurer.

Mohawk Plan:

> If, however, the Covered Person receives a settlement, judgment, or other payment related to the accidental injury or illness from another person, firm, corporation, organization or business entity paid by, or on behalf of, the person or entity who allegedly caused the injury or illness, the Covered Person agrees to reimburse the Plan in full and in first priority, for any medical expenses paid by the Plan relating to the injury or illness.

The Eleventh Circuit held that the United Plan required repayment to be made *out* of the settlement proceeds, thereby identifying a particular fund to which reimbursement is sought. By contrast, the Mohawk Plan did not require payment to be made from the settlement itself, but instead made the receipt of settlement proceeds a triggering event that would enable the Plan to seek reimbursement. Under this interpretation, the Mohawk Plan did not identify a particular fund because once a settlement was reached, the member was free to reimburse the plan out of any assets.

3. Form 5500

This document is an annual report about the funding, administration, and participation of the plan, which is required to be annually submitted to the U.S. Department of Labor. The "plan funding arrangement" should be noted, and contain a "Schedule A" for every insurance contract which is associated with the plan. The information contained therein may be useful in determining whether a health plan is self-funded, either through a trust or the employer's general assets, or by insurance.

F. JURISDICTION

In cases brought by ERISA plans as plaintiffs to enforce a lien or reimbursement right, the United States District Courts have exclusive jurisdiction. However, when a participant or beneficiary of an ERISA plan brings a claim under Section 502(a)(1)(B) "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan," there is concurrent jurisdiction with the state courts:

> Except for actions under subsection (a)(1)(B) of this section, the district courts of the United States shall have exclusive jurisdiction of civil actions under this subchapter brought by the Secretary or by a participant, beneficiary, fiduciary, or any other person referred to in section 1021(f)(1) of this title. **State courts of competent jurisdiction and district courts of the United States shall have concurrent jurisdiction of actions under paragraphs (1)(B) and (7) of subsection (a) of this section**. 29 U.S.C. §1132(e) (emphasis added).

In a case in the Northern District of New York, *In re Boisseau*, 2017 U.S. Dist. LEXIS 11964, 2017 WL 395124 (N.D.N.Y. January 30, 2017), a case involving an ERISA lien was remanded to state court using the "probate exception" to federal jurisdiction. This was a case in which the ERISA plan participant sued the plan in state court to vacate the asserted lien on the proceeds of a medical malpractice and wrongful death settlement. The Northern District made it a point to acknowledge that the plan participant ("Petitioner") made repeated requests to obtain plan information and failed to receive a satisfactory response:

> Petitioner sent repeated requests to the Plan seeking information in order to ascertain the validity of the lien. After failing to receive a satisfactory response from the Plan, Petitioner filed a petition in the Oswego County Surrogate's Court under section 1809 of the Surrogate's Court Procedure Act seeking to vacate the lien. As a result, on April 1, 2016, the Surrogate's Court issued an order to show cause as to why the lien should not be dismissed. The

> Plan responded by removing the action to this Court, asserting federal question jurisdiction under ERISA, and Petitioner moved to remand.

In re Boisseau, 2017 U.S. Dist. LEXIS at *2-3. The Northern District then applied the probate exception to federal jurisdiction, noting that the exception has two purposes, as outlined by the United States Supreme Court:

> (1) it "reserves to state probate courts the probate or annulment of a will and the administration of a decedent's estate" and (2) it "precludes federal courts from endeavoring to dispose of property that is in the custody of a state probate court." This case falls squarely within the scope of the second application of the probate exception because it necessarily involves the Court's interference with a res in the custody of the state probate court. As Petitioner makes clear, "[t]he res of Mr. Boisseau is subject exclusively to the jurisdiction of the Oswego County Surrogate's Court. . . . Any claim against the settlement proceeds is a claim against his estate."

Id. at *8 (internal citations omitted).

Evidence Issues for Trial Attorneys

Hon. Thomas P. Franczyk
University at Buffalo School of Law
Buffalo

EVIDENCE PRESENTATION

Thomas P. Franczyk

New York State Bar Association, Trial Lawyers Section

Niagara-on-the-Lake, Ontario, Canada

Tuesday August 6th, 2019

EXPERT WITNESSES: ADMISSIBILITY OF OPINION TESTIMONY OF BIOMECHANICAL ENGINEERS WITH RESPECT TO CAUSATION OF SERIOUS INJURY IN LOW-SPEED, REAR-END, AUTO ACCIDENT CASES.

Although the use of biomechanical engineers (BME) in personal injury cases is hardly a recent phenomenon, (see, for example, Martell v Chrysler Corp. 186 AD2d 1049 (4thdep't 1992), trial courts across the state still seem to be all over the road in deciding whether opinion testimony regarding the forces involved in multi-car motor vehicle accidents and whether they were sufficient to cause the plaintiff's claimed injuries should be admitted into evidence. Some courts (see, for example, Clemente v Blumenberg 183 Misc 2d 923 Sup Ct Richmond County [1999}, Garner v Baird 27 Misc 3d Sup Ct NY County [2009]), have concluded that the scientific principles and methodologies underlying such testimony were not shown to have met the Frye "general acceptance" test (Frye v US 293 F2d 1013 [DC Cir 1923]), while other courts (see, for example, Shah v Rahman 167 Ad3d 671 [2d dep't 2018]), Cornell v 360 W 51st St Realty 22 NY3d 762 [2014], determined that the principles, even if generally accepted, were not properly applied to the case at hand, or that the foundation for admissibility was otherwise lacking. (See Imran v R. Barclay Monuments Inc 167 AD3d 99 [2d Dept 2018], Pascocello v Jibone 161 AD3d 516 [1st dep't 2018]).

In Federal Court, the trial judge assumes the role of evidentiary gatekeeper under FRE 702 and determines whether the principles underlying the expert opinion are grounded in good science that has been reliably applied to the case at hand. In doing so, the court assesses whether the principles and methodologies have been published and peer-reviewed, tested with replicable results and have an acceptable error rate. General acceptance under Frye is, at best, an ancillary consideration. The court will also consider whether the expert's opinion was the product of independent study or conducted in anticipation of litigation. (See also Kumho Tire v Carmichael 526 US 137 [1997]).

While some courts may allow a BME to testify generally about the displacement of energy and changes in speed (Delta V), caused by multi-vehicle impacts, (Clemente v Blumenberg supra, Neat v Pfeffer 2013 NY Slip Op 32207 Sup Ct NY County), they may not allow the expert to give an opinion whether the forces involved in the collision in question were sufficient to cause the plaintiff's injuries if there is too great an analytical gap between the data upon which the expert relies and the conclusion offered. See Cornell v 360 West 51st St Realty LLC 22 NY3d 762 [2006], People v Brooks 31 NY3d 929 [2018]). Such a gap can occur, for example, where crash-test studies upon which the expert bases the opinion fail to account for certain variables (e.g. make, model, age, size, weight, condition of the vehicles, road

conditions, angle of impact, age, gender, physical health, height, weight of the occupant), peculiar to the case at hand. Others challenge the studies as fundamentally flawed for any number of reasons including the crash participants' bias, awareness of the test objectives and knowledge that they will be subject to a low-speed impact.

Courts also diverge on whether a BME who is not a medical doctor (in the United States or elsewhere), should be allowed to give an opinion on the injury causation question. In Gates v Longdon 120 Ad3d 980 (4th dep't 2001) and in Santo v Nicolos 24 MIsc 3d (Sup Ct Bronx County 2009), the courts said no, and in Vargas v Sabri 115 Ad3d 505 (1st dep't 2014), Valentino v Grossman 283 Ad2d 571 (2d dep't 2001), and Plate v Palisade Plate Film Delivery Corp 39 AD3d 835 (2d dep't 2007), the courts did not find the lack of medical training to be a bar to an opinion that the forces of the accident were insufficient to have caused the plaintiff's injuries. Conversely, in Torres v Hickman 162 AD3d 821 (2d dep't 2018), the court held that the trial court properly precluded an orthopedic surgeon from opining that the accident "imparted a tremendous amount of energy" because he was not a biomechanical engineer and did not quantify the degree of force involved.

The first question to ask in determining whether a Frye hearing is even warranted is whether the expert is relying on new or novel scientific principles, theories or methodologies in forming an opinion (as opposed to personal experience, observation or testing, in which case Frye does not even come in to play. People v Oddone 22 NY3d 369 [2013]. See also People v Brooks supra and People v Wesley 83 NY2d 417 [1994]). If so, then the opponent of such evidence bears the initial burden of demonstrating (by more than unsupported say-so), that the underlying principles upon which the expert relied have not gained general acceptance in the relevant scientific community. (See Saulpaugh v Kraft 5 A3d 934 [3d dep't 2004]). If this threshold has been met, the burden then shifts to the proponent to establish by a preponderance of the evidence that the proposed testimony is based on generally accepted principles. (See Garner v Baird supra, DeMeyer v Advantage Auto 9 Misc 3d 303 [Sup Ct Wayne County 2003], Styles v GM 20 AD3d 328 [1st dep't 2005]). General acceptance cannot be established by conclusory claims of the expert but rather, by scientific writings, peer reviewed articles, independent studies that have used the same methodology and yielded the same results, judicial opinions and those of other experts. (See Parker v Mobil Oil Corp 7 NY3d 434 [2006]).

Once general acceptance has been established, the proponent must also demonstrate that the principles were properly applied to the case on trial. These are foundational matters of relevance and reliability that apply to all expert testimony. (See Shah v Rahman 167 AD3d 671 [2d dep't 2018]). Moreover, the application of the principles and data (from relevant studies) to the case at hand must be established by more than the "ipse dixit" (unsupported word) of the expert. (Cornell v 361 West 51st St Realty LLC supra, 22 NY3d at 781 , citing GE Co v Joiner 527 US 136, 146 [1997]).

In an article entitled "The Use of Biomechanical Engineers in Motor Vehicle Accident Trials" appearing in the February 2016 edition of the New York State Bar Journal, Kings County Supreme Court Justice Debra Silber (also a Fellow of the Advanced Science and Technology Adjudication Center), concluded , based upon a review of published court decisions, that trial courts may be analyzing the admissibility of biomechanical expert testimony with respect to injury causation under Frye when they should probably be doing so by assessing whether the expert has properly related the underlying principles to the facts of the given case. Noting that trial court decisions statewide reflect a fairly even split for and against admissibility, the author notes that while "there is no doubt that the testimony of a biomechanical

engineer is based on scientific principles or procedures which have been sufficiently established to have gained general acceptance in the particular field… the court must still make a determination that the processes and methods employed by the expert in formulating the opinion adhered to accepted standards of reliability within the field."

In Judge Silber's view, there should no longer be any doubt but that biomechanical engineers are proper witnesses in motor vehicle accident cases at least insofar as explaining the forces and speed changes involved in an accident are concerned. Whether or not a BME should be allowed to opine on the causation question seems to depend, as noted above, on the Department in which the case is tried. The need for Frye hearings in the first instance, however, appears to be on the wane. In Shah v Rahman supra, the Second Department held that the trial court did not err in denying the plaintiff's request for a Frye hearing where the court had previously determined in a different case involving the same expert that his testimony was based on generally accepted scientific principles and there was a sufficient foundation to show that they were appropriately applied in this case. (Citing inter alia, People v LeGrand 8 NY3d 449 [2007], and Vargas v Sabri supra. See also People v Foster-Bey 158 AD3d 641 [2d Dept 2018] where court said that a judge may rely on findings of another court that certain DNA testing procedures were not a novel scientific techniques requiring a Frye hearing).

Some lawyers argue that conclusions drawn from crash test studies are based on faulty premises that there is a threshold level of force below which a person will not sustain injury and that the absence of demonstrable damage to a vehicle equates with no physical injury.

Lawyers may also challenge the notion that the forces imposed upon a vehicle during an accident can accurately be determined by examining photographs of damage and evaluating repair bills. Some also take issue with the studies themselves, pointing to things like inadequate sample sizes, biased participants, forewarning of impact, use of crash test dummies that cannot replicate the reaction of a live human being, and test conditions that do not fairly represent real-life accidents.

Another avenue of attack is the failure of studies to account for important variables including the age, gender, height, weight, physical health of the occupant, his/her body and head position in the vehicle at the time of impact, the make, model, age and condition of the vehicles, their position and angle of impact, the condition of the seat, headrest and position of the occupants in relation to them, the weather and road conditions and the movement of the vehicles post impact. (See article: "Defense Biomechanical Experts," by Daniel G. Kagan Esq. of Maine Law Firm, Berman and Simmons).

Others challenge the notion that low-speed, rear-end collisions with little or no vehicular damage translate to no physical injury, suggesting that the initial body movement upon impact is not that of the head and neck but rather that of the torso moving forward (with G forces pulling the head downward) as the result of forces transmitted through the frame and seat of the vehicle. Moreover, even in low speed impacts with little or no hyperextension, the rapid change in velocity combined with both vertical and horizontal movement can cause torque and compression resulting in injury. (See article: "Low Speed Impacts: Does No Property Damage Equal No Injuries?" by Paul Godlewski Esq of Scheibel, Goetz and Seiber of Minnesota , submitted for the Trial Lawyers Section of the Florida Bar Association, February, 2000).

Lawyers seeking to disabuse juries of the "no vehicle damage equals no physical injury" assumption, may also focus on vehicular and human factors that, in their view, are too varied and complex to replicate in staged accidents that seek to reduce the concept of causation to a simple matter of Delta V. They look to things like individual susceptibility and tolerance to injury based, as noted above, on characteristics such as age, gender, physical condition, position and angle of the body and head vis-à-vis the seat- back headrest, their characteristics and spring rate, the movement of the occupant's head and body (ramping), whether the occupant was wearing a seat belt, what the occupant was wearing, whether the head and torso accelerated at different rates. They may also suggest that it is more appropriate to focus on the peak Delta V based on the sudden change in velocity rather than on an average Delta V and to consider the initial jarring of the cervical spine in relation to the entire spine upon impact. (Kagan article, supra). Such challenges may be beyond the expertise of a biomechanical engineer and may be better directed to a medical professional.

In the case of Imran v R. Baranay Monuments 167 AD3d 992 (2d dep't 2018), the court affirmed the trial court's decision to set aside a jury verdict in favor of the defendant (based on lack of serious injury), because the opinion of the defense BME was based on an insufficient foundation and the crash tests used to calculate Delta V were too dissimilar to this accident. Here, the plaintiff was a passenger in the lead car of a four-car collision who sustained injuries of the cervical spine, lumbar spine and knees.

At the trial on damages (following summary judgment on liability granted to the plaintiff), the defense called a BME who relied upon photographs and repair estimates of the plaintiff's vehicle (Honda CRV), and of the second car in line (a Ford Focus), to determine that the Delta v was five to seven miles-per-hour. He then used different crash tests to determine what happens to occupants involved in impacts of similar speeds. He concluded that the impact from the Ford to the CRV was not enough to have caused the plaintiff's injuries.

The Second Department held that the foundation for the opinion was lacking for failure to calculate the forces exerted by all four vehicles instead of just the first two in line. Further, the crash tests upon which the expert relied were not sufficiently similar to this one including the use of crash test dummies that differed in weight from the plaintiff. So, it was foundation (or the lack thereof) and not Frye that carried the day for the plaintiff.

Similarly. In Shah v Rahman supra, the court held that where the trial judge had already found the underlying science to be generally accepted, it need not reinvent the wheel and litigate the question anew. There, at the conclusion of the damages trial, the court, without conducting a Frye hearing, allowed the defense expert to testify that the forces involved in the accident could not have caused the plaintiff's injuries. In the court's view, the only issue was one of foundation, in particular, whether the accepted scientific methods were properly applied to the facts of the case. (See also Pascocello v. Jibone 161 AD3d 516 [1st dep't 2018] where the court affirmed the trial court's decision to exclude opinion testimony because it was based on photographs for which an inadequate foundation had been established (citing, inter alia, Hambsch v New York City Transit Authority 63 NY2d 723 [1984]).

CASES PRECLUDING BME TESTIMONY:

Clemente v. Blumenberg 183 Misc 2d 923 (Sup Ct, Richmond County 1999)

In this rear-end, two-car MVA case, the court precluded the defense BME from testifying that the impact to the plaintiff's vehicle could not have caused the plaintiff's herniated and bulging discs because the data and methodology used by the expert were not shown to have general acceptance in the relevant scientific community. Also, the expert's theory and methodology of determining the change in velocity by comparing the damage (as shown by photos and repair bills), to the subject vehicles with test vehicles damaged in low-speed, rear-end crash studies was deemed to lack acceptance or validity in the field of engineering or physics.

Facts: The plaintiff, a 40-year-old female driving a 1996 GMC Jimmy, was hit from behind by the 17-year-old male defendant who was driving an Astro Mini-Van. The plaintiff testified that she was slowing down to make a turn when she was hit and the defendant said that he hit her at 25 miles per hour when she was standing still (but the impact caused no vehicular advancement). The jury found the defendant 73% liable and the plaintiff 27% liable.

During the damages phase, the plaintiff called a treating neurologist who attributed her injuries (L4-L5 disc herniation and bulging disc at L5-S1) to the accident.

A defense orthopedic surgeon and radiologist (neither of whom examined the plaintiff or reviewed her MRI until trial) testified that the plaintiff had pre-existing disc degeneration and that her injuries were not caused by the accident.

The defense then proffered a well-credentialed biomechanical engineer (MS degree, Diplomate in his field) who mainly prepared reports for the Insurance industry and who previously testified for the defense in trials and other proceedings, and who studied Physiology, to testify about 1. The forces generated in an auto accident, 2. The human body's reaction to such forces, 3. The types of injuries that can result from such forces, and 4. Whether the forces involved in this accident could have caused the plaintiff's injuries.

Methodology: The expert calculated the change in velocity (Delta V) of the plaintiff's vehicle at impact (to determine the forces exerted upon the plaintiff's body) by examining photos and repair records of the damage to her vehicle and compared them to repair bills for 13 SUVs (one of which was the same year, make, and model as the plaintiff's) that were damaged in crash tests involving a backward impact into a flat barrier at 5 miles per hour. The average repair bill was $882.00, and reportedly none of the drivers was injured. Since the plaintiff's auto repair bill was $860.40, the expert concluded that the change in velocity of the plaintiff's vehicle at impact was also 5 miles per hour. Relying on "data and studies" finding that rear end impacts under six miles per hour do not yield long term serious injuries, the expert concluded that the plaintiff's injuries could not have been caused by this impact.

The Court said:

1. The defendant's cited literature/studies were not reliable because:

a. they involved participants who were associated with the authors or their sponsors, and who were aware of the purpose of the tests and the fact of impending impact,
b. the sample size (5 - -10 “volunteers”) was too small to be statistically significant,
c. it was improper to bootstrap data from other studies using different control variables and methodologies to bolster their findings,
d. the use of crash test dummies in some of the tests could not be properly related to the effects of the collisions on a live human body.

2. The studies relied on also failed to account for the dynamics of this accident inasmuch as the plaintiff testified that her vehicle was in motion when hit from behind and the defendant testified (incredibly) that he struck the plaintiff’s stationary vehicle at 25 miles per hour but didn’t cause it to move forward on impact.

Ruling: The expert may opine as to the general formula of forces involved in rear end accidents if based on facts in evidence but may not offer an opinion on causation because the Frye test was not met and the data and methodology, as noted above, were flawed.

Side Note:: The court in Clemente engaged in a lengthy discussion about the New York (Frye) rule in comparison to FRE 701 which relegates the ‘general acceptance’ criterion to one of several factors that a trial court must apply as “evidentiary gatekeeper” in determining whether the expert’s testimony is based on valid, reliable science and is relevant (i.e., applicable) to the case at hand.

Some of the measuring sticks for reliability include whether the principles and methodology have been published, tested (with replicable results), peer-reviewed, and found to have an acceptable error rate. (See Daubert v. Merrill Dow Pharmaceuticals Inc. 509 US 579 [1993]).

On remand, the 9th Circuit added the criterion of whether the expert’s opinion was the product of research that was independent rather than conducted in preparation for litigation. (See also Kumho Tire v. Carmichael 526 US 137 [1991], which extended the Daubert “scientific” analysis to matters of “technical” knowledge such as engineering.)

Santo v. Nicolos 24 Misc 3d 999 (Sup. Ct. Bronx County 2009)

The court precluded the defendant’s biomechanical engineer from testifying in this rear-end impact MVA trial that the physical forces resulting from the collision could not have caused the plaintiff’s injuries (torn meniscus, lumbar injury) because the expert could not cite any studies articles, journals, or other scientific literature that utilized his methodology (examining photos and repair records of the impacted vehicle, assessing the weight, dimension, and center of gravity of the vehicles) to determine the change in velocity, severity and direction of force, and its effect on the plaintiff’s movement in the vehicle.

The court also noted that the expert WAS NOT A DOCTOR.

The court, noting Frye, observed that in order for scientific testimony to be admitted, the procedures and results underlying the science must be shown to be generally accepted as reliable in the scientific community. (See also, Styles v. General Motors 20 AD3d]1st dep’t 2005]) The most common way to demonstrate such acceptance is to cite peer-reviewed literature in the field indicating that independent

studies have been conducted using this methodology, that the results have been duplicated, and that the studies were conducted on a statistically significant number of subjects. (Sounds a lot like Daubert) Anecdotal information alone is insufficient to meet this test.

The court also observed that the proffered expert opinion must properly relate existing data, studies, and literature to the case at hand and be connected by something more than the "ipse dixit" (i.e., unsupported say-so) of the expert. Where the expert cites no literature at all, the court should not allow the opinion. See also Cumberbatch v. Blanchette 35 AD3d 307 [1st dep't 2004], Marsh v Smith 12 AD3d 307 [1st dep't 2004]).

Garner v. Baird 27 Misc 3d 123 (NYC Civil Ct 2010):

Court held that once the plaintiff, in a Frye hearing on motion to preclude the defendant's biomechanical expert from testifying that the forces of the accident were insufficient to have caused the plaintiff's injury (torn meniscus), made a prima facie showing that the expert's theories and methodology are not generally accepted, the BURDEN shifted to the defendant to demonstrate by a preponderance of the evidence that the proposed testimony was based on generally accepted scientific principles, and that the witness was properly qualified in his area of expertise. (see also DeMeyer v. Advantage Auto 9Misc 3d 303 [Sup. Ct. Wayne Cty 2005], once the opponent makes a threshold showing that the particular theory, principle, or methodology has not gained general acceptance, i.e., is a novel theory, the burden shifts to the proponent to establish otherwise).

In Saulpaugh v. Kraft 5 AD3d 934 (3d dep't 2004), the court noted that the ultimate burden of proving general acceptance rests upon the proponent of the expert testimony, and conclusory statements of such acceptance (absent evidence of peer-reviewed controlled studies, clinical data, relevant literature) are insufficient to meet the burden.

In Garner supra, the defendant's expert, a Professor of Mechanical Engineering and Applied Mechanics with no medical training (though reportedly able, based on training, to review structural injuries to the human body), testified at the hearing that he used "vehicle stiffness parameters" obtained from the results of crash tests performed by the National Highway Traffic Safety Authority (NHTSA) to determine that the maximum force imposed upon the plaintiff's knee as a result of the accident was 500 lbs (compared to 1000 lbs from walking). Consequently, in his opinion, the forces of the impact were insufficient to have caused the plaintiff's injury.

The Court held that the defense failed to meet the Frye test as there was no evidence of general acceptance of the expert's methodology to determine velocity of the vehicles upon impact. (Citing, inter alia, People v. Wesley 83 NY2d 417 [1994]) In particular, the expert failed to cite any studies to support the conclusion that a back seat passenger in a motor vehicle whose knee hits the car door on impact could not have suffered a torn meniscus. The Court also noted that the expert WAS NOT A DOCTOR.

Gates v. Longdon 120 AD3d 980 (4thdep't 2014)

In this rear-impact MVA case, the defendant, relying upon an affidavit from a biomechanical engineer, moved for summary judgment, contending that the plaintiff did not suffer a serious injury as a result of the accident. The plaintiff cross-moved for summary judgment on negligence. The trial court denied the defendant's motion with respect to both theories of injury (permanent consequential and significant limitation), and granted the plaintiff's cross motion.

On appeal, the Fourth Department: reversed the trial court's determination with respect to the permanent consequential injury, affirmed with respect to significant limitation, and held that the trial court properly denied the defendant's motion with respect to causation because the defendant's expert, NOT BEING A MEDICAL DOCTOR, lacked the requisite skill, training, education, knowledge, and experience to offer a reliable opinion on the issue. (Citing, inter alia, Matott v. Ward 48 NY2d 455 [1979])

But see Cardin v. Christie 283 AD2d 978 (4th dep't 2001) where the Fourth Department found that the Trial Court did not abuse its discretion in allowing the defendant's expert on injury causation analysis to offer an opinion that the impact of the collision was insufficient to cause the plaintiff's alleged injury. (It's not clear from the decision whether that expert was also an MD).

In Cardin, the jury in this rear-end auto accident case found for the defendant, accepting the defense argument that the plaintiff stopped suddenly without warning or use of signals. The trial court denied the plaintiff's motion for judgment as a matter of law since the jury's verdict was not "utterly irrational", and denied the motion to set aside the verdict since the plaintiff failed to establish that the verdict could not have been reached by any fair interpretation of the evidence.

CASES ADMITTING BIOMECHANICAL EXPERT TESTIMONY

Martell v. Chrysler Corp. 186 AD2d 1059 (4th dep't 1992)

In this product liability case arising from the plaintiff's claim of a defective seatbelt, the Appellate Division rejected the plaintiff's argument that she was improperly denied an opportunity to develop the nature and extent of her injuries (in the liability phase), where the plaintiff's biomedical expert testified about the plaintiff's injury, and the plaintiff's entire medical history was received into evidence.

Cocca v. Conway 283 AD2d 787 (3d dep't 2001) Here, the Court held that the defense complied with CPLR 3101(d) by informing the plaintiff in discovery that its two non-medical experts (a mechanical engineer and a biomechanical engineer) would testify based on principles of biomechanical analysis (pertaining to tolerance, limits of flexion/extension of the cervical spine and how it is affected by forces of impact) and accident reconstruction that the accident was of insufficient magnitude to have caused the plaintiff's injuries.

The Court also found that the plaintiff's claim that the experts' theories lacked general acceptance in the scientific community was unpreserved inasmuch as the plaintiff never requested a Frye hearing.

Facts: the plaintiff's vehicle was hit on the rear passenger side by the defendant's station wagon, which was towing a trailer. An MRI showed Herniated discs as C6 – C7 with nerve root impingement. The plaintiff's family physician and orthopedic surgeon testified that the accident either caused the plaintiff's injuries or exacerbated a previously asymptomatic condition.

The defense orthopedic surgeon concluded, after reviewing the plaintiff's medical records, that she has a history of tendonitis in her left shoulder and a shoulder injury dating back over 20 years with periodic complaints of tenderness, tingling, and numbness in her arms. More recently, she complained of stiffness in her neck and left shoulder. She was described as having probable degenerative disc disease of the neck and lumbosacral sine. According to this doctor, the plaintiff's injuries were not caused by this accident nor did it aggravate a previously non-symptomatic condition.

The defense also called a neurologist who reached a similar conclusion.

Valentine v. Grossman 283 AD2d 571 (2d dep't 2001)

The trial court erred in excluding the testimony of the defense's second biomechanical expert (that the G forces, i.e., acceleration x weight of this accident, were insufficient to cause the plaintiff's herniated disc) on relevancy grounds. (The trial court ruled that while the scientific method of relying on studies calculating G forces in crash tests involving live subjects was valid, the expert's opinion was not relevant because the G force in this accident was estimated [by the defendant's first biomechanical engineer] at 3.6 Gs, consistent with crash tests involving dummies and cadavers, when crash tests involving live subjects was 3.2Gs, which a second expert claimed was an insignificant difference.)

The Second Department held that the testimony was relevant because it tended to make the defendant's claim of no causation to be more probable than not. (Presumably, the reliability and weight to be accorded such testimony would have been for the jury to determine.) The AD remanded for a new trial on damages (the trial court having earlier granted summary judgment for plaintiff on liability).

Mitchell v. Brown 43 AD3d 1009 (2d dep't 2007)

The trial court, in this rear impact collision case (where the plaintiff's vehicle was propelled into another car in oncoming traffic), erred in summarily disallowing the defendant's expert (licensed professional engineer) from testifying without first conducting a Frye hearing where the plaintiff, as an alternative to outright preclusion, moved for a Frye hearing.

Pre-trial, the court granted the plaintiff's motion (unopposed by the defense) for summary judgment that the defendant's negligence was the sole proximate cause of the accident. The plaintiff also moved to preclude the defendant's engineer from testifying at the trial on damages. The court reserved until trial and then summarily disallowed the expert at trial. (See also Abramson v. Quickway 56 AD3d 702 [2d dep't 2008], error to preclude expert without conducting a Frye hearing when it is requested.)

In contrast, see Vargas v. Sabri 115 AD3d (1st dep't 2014) where the First Department held that the trial court "did not improvidently exercise its discretion" in denying the plaintiff's request for a Frye hearing to determine the admissibility of the defendant's biomechanical expert.

In that case, the plaintiff challenged the expert's qualifications for lack of medical training and the fact that it conflicted with the opinion of the defense orthopedic expert. The court held that the expert's lack of medical training (not really a Frye issue), did not disqualify him from testifying about the mechanics of injury (citing Colarossi v. CR Bard Inc 113 AD3d [1st dep't 2014]) or offering an expert opinion that the forces of the accident were insufficient to cause the plaintiff's injuries. Moreover, the fact of any conflict with the orthopedic doctor's opinion when to the weight rather than to admissibility of the engineer's testimony. (Citing Willliams v. Halpern 25 AD3d 461 [1st dep't 2006]) And, to the extent that the plaintiff claimed that the studies upon which the expert relied were unreliable, the court was unpersuaded because the plaintiff failed to set forth the basis for their alleged unreliability.

(NOTE: Just as claims by the expert of "general acceptance" in the scientific community must be supported by evidence (e.g., peer-reviewed studies), so too must challenges to such studies be more than conclusory.)

Plate v. Palisade Film Delivery Corp. 39 AD3d 835 (2d dep't 2007)

The trial court erred in determining that the defendant's biomechanical engineer was not qualified to testify whether the force of the impact of the rear impact collision could have caused the plaintiff's spinal injuries or exacerbated preexisting injuries to the plaintiff's cervical spine (from two prior MVAs within the past four years resulting in discectomies). Such testimony, in the Court's view, could have affected the amount of damages awarded. Moreover, any claim that the expert was "not a specialist" in a relevant field of science went to the weight rather than the admissibility of the testimony (citing Borawski v. Huang 34 AD3d 409 [2d dep't 2006]).

The trial court granted judgment as a matter of law as to causation and serious injury at the close of proof. The jury then awarded the plaintiff $2 million in damages. On appeal, the Court said that judgment as a matter of law should only be granted when "there is no rational process by which a jury could base a finding for the non-moving party", and only after viewing the evidence in the light most favorable to that party. (CPLR 4401)

Shifrel v. Singh 61 AD3d 401 (1st dep't 2009)

In this case, the plaintiff sustained a torn rotator cuff (per MRI) as a result of a rear end impact into his stopped vehicle caused by the defendant's vehicle. The plaintiff underwent surgery followed by seven weeks of physical therapy.

At trial, the plaintiff's doctor attributed his injury (described as acute and not degenerative) to the accident. The defendant only called a biomechanical engineer who testified that based on the weight of the vehicles and speed at impact, it was unlikely that the plaintiff's shoulder would have made contact with the steering wheel.

The jury found for the plaintiff on his 90/180 claim (but not for permanent consequential or significant limitation) and awarded him $5,000.00 for past pain and suffering. ($0.00 for future pain and suffering)

On appeal, the Court upheld the verdict as to liability and no award for future pain and suffering, but vacated the award for past pain and suffering as unreasonable. The court directed the defendant to either stipulate to a $50,000.00 damages award or have a new trial.

Gaona-Garcia v. Gould 31 Misc3d 1237A (Sup. Ct. Bronx County 2011)

In this case, Supreme Court denied the plaintiff's motion to preclude the testimony of the defense biomechanical engineer/accident reconstructionist, concluding that these disciplines "have been found to be generally accepted in the scientific community."

In a good discussion of the trial court's role under Frye, the court said that its "gate-keeping" function is NOT to engage in its own independent, unbridled review of an expert's methodology and conclusions but, rather, to ensure that it does not rely on an expert's testimony REGARDING A NOVEL PROCEDURE/METHODOLOGY/THEORY unless it has been found to be generally accepted in the relevant scientific community as leading to reliable results. (Citing Marsh v. Smith 12 AD 3d 37 [1st dep't 2004] There, the trial court was deemed to have gone too far in making a judicial finding of reliability rather than relying on what the experts in the field generally had to say.)

Query: whether the court's approach in Marsh was more akin to what is required by Daubert supra and FRE 702? And how is this different from the foundational analysis that a trial court must engage in when determining whether studies relied on by the expert yield conclusions that can properly be related to the facts of a given case? The former inquiry, it seems, has to do with general acceptance (i.e., reliability) of the underlying scientific principles and methodology, while the latter pertains to the relevance of the opinion offered (i.e. its relatability to the facts of the case at hand).

So, under Frye, the trial judge's function is NOT to make an independent determination whether the expert's methodology is reliable, but to see whether there is CONSENSUS IN THE SCIENTIFIC COMMUNITY as to its reliability. In short, the court's role is limited to determining whether the expert's deductions are based on principles that are sufficiently established to have gained general acceptance.

Noting that New York courts (e.g., Plate v. Palisade supra, Cardin v. Christie supra) have long found biomechanical engineers to be qualified to render opinions on whether the forces involved in an accident can cause injuries, the Court in Gould rejected the plaintiff's claim that the expert's theories were novel, lacking in general acceptance, and unreliable The court was also unpersuaded by the plaintiff's argument that the expert (who was also licensed to practice medicine in England) should be precluded because he was not a licensed MD in the USA. That factor, in the court's view, was a matter of weight, not admissibility (citing Borawski v. Huang supra. See also, Kwon v. Martin 19 AD3d 664 [2d dep't 2005]).

NEW YORK RULE ON EXPERT WITNESSES

(See New York Unified Court System Guide to the Rules of Evidence [Rule 7.01] at NYCOURTS.GOV)

1. A person qualified as an expert by knowledge, skill, experience, training or education may testify to an opinion (or information concerning scientific, technical, medical or other specialized knowledge when:
   a. the subject matter is beyond the knowledge or understanding, (or will dispel misconceptions), of the typical finder of fact; and
   b. the testimony will help the (fact) finder…to understand the evidence or determine a fact in issue, especially when the facts cannot be stated or described in such a manner as to enable the (fact) finder to form an accurate judgement about the subject matter.

2. Where the subject matter of the testimony is NOT based on the PERSONAL TRAINING or EXPERIENCE of the witness (People v Oddone 22 NY3d 369 [2013]), but rather is based on SCIENTIFICALLY DEVELOPED procedures, tests or experiments, it must be (or have been) established that: a. there is GENERAL ACCEPTANCE within the relevant scientific community of the validity of the theory or principle underlying the procedure, test or experiment; b. there is general acceptance…that the procedure, test or experiment is RELIABLE and PRODUCES ACCURATE RESULTS; and c. the particular procedure, test or experiment was conducted in such a way as to yield an accurate result. (See Frye v US 293 F. 1013 [DC Cir 1923; People v Brooks 31 NY3d 939 [2018]; People v Wesley 83 NY2d 417 [1994]).

3. Opinion testimony that meets the above criteria is admissible even if it embraces the ultimate issue to be decided by the fact finders. (See, for example, People v Rivers 18 NY3d 222 [2011]; Fire investigator allowed to opine that the pour pattern of accelerant on stairs was consistent with arson.

4. An expert NEED NOT express a conclusion with certainty but need only DEMONSTRATE A DEGREE OF CONFIDENCE in the conclusion sufficient to satisfy ACCEPTED STANDARDS OF RELIABILITY in the expert's field. (See Matott v Ward 48 NY2d 455 [1979]).

5. a. Unless the court orders otherwise, questions calling for an expert's opinion NEED NOT be in hypothetical form. The expert MAY BASE an opinion of FACTS IN THE RECORD or KNOWN TO THE WITNESS, and …MAY STATE an opinion or reasons WITHOUT FIRST SPECIFYING THE DATA upon which it is based; HOWEVER, an expert who relies on FACTS WITHIN PERSONAL KNOWLEDGE that are NOT CONTAINED in the record IS REQUIRED to TESTIFY TO THOSE FACTS (before) rendering the opinion.

   c. An expert may also rely on OUT-OF-COURT MATERIAL if :
      i. It is of a kind ACCEPTED IN THE PROFESSION AS RELIABLE in forming a professional opinion, provided there is evidence (beyond the witness' say-so), establishing the reliability of (such) material. (See People v Sugden 35 NY 2d 453 [1974]; Hambsch v NYC Transit Authority 63 NY2d 723 [1984]). Note that just because the opinion may come in if this foundation is met, that does not mean the out-of-court material (i.e. hearsay) upon which it is based will be admitted into evidence.

      ii. It comes from a witness who is subject to full cross examination by the opposing party.

(The remaining sections on the right of confrontation and lack of criminal responsibility in criminal cases have been excluded from this discussion).

RECENT EXPERT WITNESS CASES

Demaille v State 166 AD3d 1405 (3d dep't 2018): Expert testimony is necessary to establish that medical care provided fell below the proper standard of care and caused the plaintiff's condition.

In this case, the plaintiff alleged that the State provided inadequate care (slow to order tests and perform follow-up care and provide proper medication), in response to his complaints of bodily pain when he was an inmate in a correctional facility. In addition to his own testimony, he offered medical records which documented his complaints and indicated that the defendant sometimes delayed in performing tests and arranging follow-up consultations.

Noting that the medical records said nothing about the appropriate standard of care in treating the plaintiff's complained-of conditions (back, ear and head pain), the Court of Claims dismissed the complaint for lack of expert medical testimony regarding the proper standard of care and the nature of the defendant's deviation therefrom.

Galluccio v Grossman 161 Ad3d 1049 (2d dep't 2018): Expert witness must be qualified in the appropriate specialty.

In this medical malpractice action, the plaintiff alleged negligent failure by the emergency room physician to properly diagnose and treat her septic wrist joint. In reply to the defense motion for summary judgment, the plaintiff submitted an affidavit from a doctor who was board certified in internal medicine and infectious diseases. However, since there was no indication that this expert had any training in emergency medicine or did anything to acquaint himself with the standard of care for this specialty, the affidavit was insufficient to raise a triable issue of fact.

O'Connor v Kingston Hospital 166 AD3d 1401 (3d dep't 2018): RN was deemed properly qualified to testify based on 35 years of experience (treating patients with bed sores) and from review of medical records (which she claimed were not accurate), that the defendant exacerbated the plaintiff's sores by: using the wrong kind of skin cream, conducting an improper examination, failing to flip the patient every two hours to relieve pressure, not ordering an air mattress and failing to properly evaluate the patient's risk of bed sores. In the court's view, this witness was sufficiently qualified based on experience and did not exceed the limits of her expertise in offering her opinions regarding the defendant's negligent care of the plaintiff.

Vergine v Phillips 167 AD3d 1319 (3d dep't 2018): In this MVA case, the court allowed the plaintiff to amend his bill of particulars (to include a claim of PTSD alleged to have been caused by the accident) upon the sworn affidavit of a licensed clinical social worker whom the court found competent to render such an opinion, (not unlike a psychiatrist, neuropsychologist or psychologist).

Hokenson v Sears Roebuck 159 AD3d 1501 (4th dep't 2018): in this products liability case, the court found the plaintiff's response insufficient to defeat the defendant's summary judgment motion because the plaintiff's expert (an occupational health and safety consultant), demonstrated no experience with or personal knowledge of the ladder from which the plaintiff fell, nor did he show any knowledge or experience with the design or manufacture of ladders generally. (Citing Stever v HSBC Bank 82 AD3d 1680 [4th dep't 2011]).

Mosley v EHJ, LLC 159 AD3d 434 (1st dep't 2018): In this personal injury action, the court held that the plaintiff's expert's opinion lacked a proper basis where the expert relied on a report of a post-accident

MRI comparing the plaintiff's spinal stenosis to the most recent pre-accident MRI which was NOT admitted into evidence. The expert also did not review the plaintiff's pre-accident medical records.

Al-Kabyle v Ali 159 AD3d 477 (1st dep't 2018): Affidavit of defense handwriting expert expressing virtual certainty that the signature on a consent form was from the same person who signed several exemplars was insufficient to support summary judgment where the expert's affidavit failed to describe the exemplars nor were they submitted with the affidavit.

Colucci v Stuyvesant Plaza 157 AD3d 1095 (3d dep't 2018): Expert affidavit was deemed insufficient to establish causation (of toxic mold) because it was conclusory in nature.

See also Humphrey v Riley 163 AD3d 313 (3d dep't 2018): Conclusory, speculative expert medical affidavit without a stated factual basis deemed insufficient to defeat defense motion for summary judgment.

Matter of Chin Chuan Wang 162 AD3d 447 (1st dep't 2018): In this will contest, the will proponent argued that the objector's expert opinion should not have been allowed because it was based, in part, on conversations with the objector about the decedent's mental capacity. The court rejected that argument, holding that a psychiatrist's opinion may be received even though it is partially based on inadmissible hearsay provided it is of a kind that is generally accepted in the profession as reliable in forming opinions, or comes from a witness who is subject to cross examination.

Tornatore v Cohen 162 AD3d 1503 94th dep't 2018): In this (chiropractic) malpractice case, the court allowed the plaintiff's life-care specialist to state an opinion about the plaintiff's future medical needs even though it was partially based on hearsay conversations with the plaintiff's treating physician. Noting that the expert also relied on a review of medical records, recommendations of other treatment providers, an interview of the plaintiff, research and analysis of costs, the court found that there was a sufficient basis for the opinion of which the hearsay was but a link in the chain of data.

Matter of New York City Asbestos Litigation (Juno) 32 NY3d 1116 (2018): In this case, the plaintiff's decedent, an auto mechanic, allegedly contracted mesothelioma from exposure to asbestos while working with the defendant/auto manufacturer's contaminated products.

The trial court set aside a verdict for the plaintiff for failing to establish that his mesothelioma was the result of exposure to a sufficient quantity of asbestos in products sold/distributed by the defendant. The First Department affirmed the lower court's order and agreed that the plaintiff's expert failed to provide at least some quantitative scientific expression of the level of exposure to toxins in the defendant's products that was sufficient to cause this disease. The Court of Appeals affirmed, concluding that the

evidence was insufficient as a matter of law to establish that exposure to the defendant's products was a proximate cause of the plaintiff's condition. (Citing Parker v Mobil Oil Corp 16 AD3d 648 [2006]; Cornell v 51st St Realty LLC 22 NY3d 762[2006]).

Kubera v Bartholomew 167 AD3d 1477 (4th dep't 2018): In this medical malpractice action the court, finding that an expert may not rely on disputed facts when rendering an opinion, held that the defendants failed to meet their burdern (in context of summary judgment), with respect to medical proof because they relied solely on symptoms documented in medical records (of Medicor and BMH) which were significantly different from those allegedly reported to the other defendants and whch the plaintiff manifested prior to surgery.

Romano v Stanley 90 NY2d 444 (1997): Expert must explain how facts relied upon support the opinion.

In this Dram Shop case, the plaintiff's expert testified that the decedent driver must have been visibly intoxicated at the defendant's bar where she had drinking about four hours before the fatal accidernt. The expert referenced the deceased's BAC (.33%) and the otherwise normal appearance of her liver but did not explain how these factors supported the opinion offered. The court, therefore, found the opinion to be inadmmissible because it was speculative.

A FEW MORE FRYE CASES

Brouard v Convery 59 Misc3dd 233 (Sup St Suffolk County 2018): In this MVA case, the court declined the plaintiff's request to take judicial notiice of the general acceptance of diffusion tensor imagaing (DTI), and granted the defendant's cross motion to preclude expert testimony on the subject because DTI was not shown to be generally accepted in the field of neurology as the standard in treatment of patients suffering from minor traumatic brain injury.

The court pointed out that general acceptance can be shown through scientific or legal writings, judicial opinions or opinions from other experts in the field. In this case, the court found that a "white paper" (an authoritative report that summarizes a complex subject and advances the author's point of view), which was supported by members of the scientific community, concluded that while neuroimaging techniques such as DTI showed encouraging results in group comparison analyses, there was not enough evidence to support the routine clinical use of advanced neural imaging for individual diagnosis and prognosis.

In contrast, see Redish v Adler 2018 NY Slip Op 50565(U) (Sup Ct Bronx County) where the court rejected the defendant's motion to preclude the plaintiff's experts from testifying that extracorpeal membrane oxygenation (ECMO) and high frequency oscillatory ventilation (HFOV) was the standard of care for treating asthmatic patients and that the failure to do so amounted to a deviation from the proper

standard of care. (In this case, the plaintiff alleged that defendant was negligent in treating her asthma attack by failing to provide or transfer her to a facility that provided these modes of treatment).

The court noted that ECMO and HFOV therapies had sufficient support in the medical community and that the fact that there were differing opinions justified denying the defendant's motion.

DB v Montefiore Medical Center 162 AD3d 478 (1st dep't 2018): In this medical malpractice case, the court held that the lower court record was insufficient to allow it to determine whether the medical opinion offered by the plaintiff's expert (that the plaintiff's injuries were caused by hypoxic ischemia brought on by intercranial presssure), was based upon theories that enjoyed general acceptance in the medical community.

A FEW WORDS (AND CASES) ON HEARSAY

Hearsay is an out-of-court statement made by a declarant (usually but not always someone other than the witness on the stand) which is offered to prove the truth of what it asserts. A statement can be verbal, ("the street was wet,") written ("Dear Fred: I cut you out of my will,"), or non-verbal conduct, (hit-and-run victim points in a westerly direction in reponse to officer's question, "which way did he go?"), but to constitute hearsay, it must be assertive in natiure (i.e. it seeks to advance some factual proposition that is capable of being proven or disproven)…1. The condtion of the street; 2. Fred's status under the will; 3. The driver's direction of travel).

Therefore, statements that are not intended as an assertion (e.g. questions that inquire and commands that direct others to do or not do something) are generally considered not to qualify as hearsay. Therefore, their admissibility as non-hearsay turns on other factors such as relevance to material issues in the case.

In New York courts, hearsay is not admissible unless it falls within an exception to the rule against hearsay (e.g. present sense impression, excited utterance, statement for diagnosis and treatment, business record, statement of a party-opponent, declarant against interest). The burden of establishing the existence of an exception falls upon the proponent of the statement but if it is not offered for its truth, it is not excluded by the hearsay rule. (See New York Unified Court System Guide to Rules of Evidence [Rule 8.00-8.01] NYCOURTS.GOV).

Paquay v Cup of Tea 165 AD3d 964 (2d dep't 2018): In this construction accident case, the court found the plaintiff's deposition testimony (that he was told that the roof collapsed because the third-floor ceiling beams had been cut) was insufficent to raise a triable issue of fact because it was based on inadmissible hearsay.

Davis v Eab-Tab Enterprises 166 AD3d 1449 (3d dep't 2019): In this case where an issue was whether a worker was an employee as alleged in the verified complaint, the court held that this qualified as a judicial admission even though the complaint was superceded by an amended pleading.

Moskowitz v Tory Burch 161 AD3d 525 (1st dep't 2018): In this breach of contract case, the court held that a report prepared by a party's agent to assess damages and recommend a course of action was admissble as an admission of a party opponent.

Matter of State Farm Fire and Casualty Insurance Co v Jackson 165 AD3d 518 (1st dep't 2018): On a motion to stay arbitration, the court held that the testimony of the respondent driver and of his passenger who were hit by a hit-and-run driver, was admisibile as a present sense impression because their testimony was corroborated by photographs of the license plate of the runaway vehicle that they showed to the responding officer.

In contrast, see Gomes v Pearson Capital 159 AD3d 480 (2d dep't 2018) where the palintiff's statement that he fell from a scaffold was not corroborated by independent evidence. The statement also did not qualify as an excited utterance as there was no evidence offered that the plaintiff was still under the stress of excitement of a startling event when he spoke to his foreman.

A present sense impression is a statement which describes or explains an event or condition as the declarant is perceiving it, as It unfolds or immediately thereafter. It will be admitted (whether or not the declarant is available as a witness), as long as there is evidence independent of the statement that supports both the accuracy of the statement and the fact that it was made contemproaneously or immediately after the event in question. (See NY Rule 8.29, Guide to New York Evidence).

An excited utterance is a statement about a startling or exciting event of a participant in or oberver to the event (whether available as a witness or not), which is made under the stress of nervous excitement resulting from the event and was not the product of studied reflection and possible fabrication. (See Rule 8.17, Guide to New York Evidence).

Both present sense impressions and excited utterances must be based on personal knowledge of the declarant, but while the admissibility of the former turns on contemporanaeity and corroboration, the latter is considered reliable because of the excitement which purportedly suspends the declarant's reflective powers and likelihood of fabrication. There is also an element of spontaneity but the fact that the statement is made in response to a question (e.g. from a 911 operator), will not necessarily render it inadmissible. Excited utterances are somewhat less time sensitive than present sense impressions but

the more time that passes and opportunity to interact with others increases, such statements lose their nature as excited utterances.

BUSINESS RECORDS

CPLR 4518: a. Generally, any writing or record, whether…an entry in a book or otherwise, made as a memorandum or record of any act, transaction, occurrence or event, shall be admissible (as) evidence…of that act, transaction, occurrence or event, if…it was made in the regular course of…business, and…it was the regular course of such business to make it, at the time of the act, transaction, occurrence or event, or within a reasonabler time thereafter.

Records which satisfy these foundational elements will generally be admitted even if the custodian of records (who must be familiar with the business' record-keeping practices and procedures) lacks personal knowledge of the entries, provided the information was provided by someone under a business duty to do so accurately and reasonably close in time to the events recorded therein. If the record contains hearsay from persons outside the business, such information must meet some hearsay exception in its own right, lest it be redacted as inadmissible hearsay. (See Johnson v Lutz 253 NY 124 [1930]; statements of third persons contained in police report describing automobile-motorcyle accident constituted inadmissible hearsay).

Fuentes v Acevedo 162 AD3d 613 (1st dep't 2018): In this MVA case, the lower court was deemed to have improperly considered an uncertified police accident report submitted by the plaintiff in opposition to the defendant's motion for summary judgement.

In contrast, see Colon v Val's Ocean Pacific Foods 157 AD3d 462 (1st dep't 2018) where the court, in granting summary judgment to the plaintiff on liability, properly considered a police report containing a statement by the defendant with respect to the happening of the accident because it was admissible as an admission of a party opponent.

In Ardonuy v RB Juice 164 AD3d 1296 (2d dep't 2018), another MVA case, the defendant moved for summary judgment, contending there was no triable issue with respect to proximate cause. In support thereof, the defendant offered a police report prepared by the responding officer (who was not an eyewitness), who attributed the accident to improper lane usage and passing by the plaintiff. Noting that the source of this conclusory information was unknown, the court found that there was no way to determine whether such person was under any duty to make the statement or whether some other hearsay exception applied. Hence, it constituted inadmissible hearsay.

In Nava-Juarez v Mosholu Fieldston 167 AD3d 511 (1st dep't 2018), the court held that the defendant failed to establish that the plaintiff (who spoke only Spanish) was the source of the statement, "while working, I fell down stairs" which was recorded in an accident report form (C3). In fact, the plaintiff alleged that he was injured when a ladder he was working on shifted suddenly.

The accident form in question was prepared by the plaintiff's worker's comp. attorney with the help of a translator who interpreted the plaintiff's words as stated above, but the Spanish word for stairs (escalera), is the same for ladder. Moreover, there were no stairs at the one-story building where the plaintiff was injured. Since the plaintiff was in no position to discover the error in translation (because he could not read Englsh), and the defendant failed to establish that the plaintiff actually said what was interpreted into the report, the court held that the the report was not admissible.

In 76th & Broadway Owner LLC v Con Ed 160 AD3d 447 (1st dep't 2018), an action for contribution/indemnication, the plaintiff in the underlying action, alleged that he was injured when he stepped on a nail sticking out of a piece of plywood on a traffic light platform in a fenced-in delivery area of a construction site. In the context of the defendant's motion for summary judgment, the court held that an accident report prepared by an employee of the plaintiff (stating that the plywood was dislodged from the platform by Con Ed workers and must have been moved during demolition and trench work), was inadmissible because even though the employee was under a business duty to prepare the report, his statements indicated that instead of speaking from personal knowledge, he was relying on conclusory statements made by others who were not identified. Nor was there any indication that the sources of the information were under any business obligation to report such findings. (The court also noted that the site was crowded with employess of several different subcontractors and vendors any one of whom could have struck the platform in question.

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The Use of Biomechanical Engineers in Motor Vehicle Accident Trials

By Debra Silber

In theory, a biomechanical expert in a motor vehicle accident case takes the available information about the accident and, using physics and engineering principles, his or her understanding of human anatomy and physiology, relevant scientific studies, and safety and manufacturing information about the vehicles, determines whether the forces generated in the accident were sufficient to cause the alleged injuries. With enough information, the motion of the occupants inside the vehicles can be ascertained, and it is this sudden and unexpected motion that can cause the occupants to either impact the interior of the vehicle or to move in a way that exceeds the natural physiological range of motion of human beings, either of which can cause injuries. This process is known as the expert's "theory of causation."

The analysis employed involves a type of accident reconstruction, which must determine, among other facts, the weight of the vehicles and their respective speeds. From this information, the amount of energy that is transferred to each vehicle by the impact can be calculated, which is sometimes referred to as the "first accident." Then, the expert presents a calculation of the force sustained by the occupants of the vehicles, known as the "second accident." These are only the most basic principles. There are many other factors which must be considered, such as whether the road is wet, if the person is wearing a seatbelt, the age, height and weight of the occupant, the occupant's location in the vehicle and his or her seating position, the model of the car, the height of the head rest, if there are airbags and if they deployed, how "crashworthy" the vehicles are, the points of impact on the vehicles, whether both vehicles are moving or if one is stopped, and if so, in park or neutral, if the vehicle impacts any stationary objects before coming to rest, and the interior design of the vehicles.

The "trend is to allow expert opinion testimony reconstructing motor vehicle accidents from physical evidence, provided the expert witness is sufficiently qualified in the particular field and has before him or her enough physical evidence to provide the witness with the important variables involved."[1] In order to reach any conclusions which are scientifically sound and

trustworthy, the expert must have sufficient information to base his or her opinion on. This is the issue that needs a judge's scrutiny. Whether this is described as a "*Frye* inquiry,"[2] or what has been described as the "*Parker* component," referring to *Parker v. Mobil Oil*,[3] the issue is whether the witness' methodology was "appropriately employed."[4]

Some biomechanical engineers retained to testify are unwilling to admit they cannot form a trustworthy conclusion from the information given to them. Nonetheless, they use deductive reasoning, extrapolation and inference, and report their conclusions as based on sound science. Unfortunately, with what appears to be a good deal of hocus-pocus and the use of complicated (and intimidating) mathematical formulas, they can sometimes fool a judge and jury. It is the judge's role to preclude testimony that will not be useful to the jury, which includes testimony that is misleading, inaccurate, or irrelevant.

A review of the published decisions in New York that involve the admissibility of testimony from biomechanical engineers in motor vehicle trials indicates that judges have, after holding a hearing, often concluded that the principles and procedures employed by the witness are not sufficiently established to have gained general acceptance in the scientific community (*Frye*), when it would probably be more accurate to say that the court concluded that it found too great of an analytical gap between the data and the witness' opinion (foundation).[5] The analysis for the court, described as the court's "gate-keeping function" under *Frye*, is often defined as having several "prongs." As applicable herein, the only issue or prong for the court to review is whether the expert's reasoning or methodology is relevant to the facts at issue, that is, whether the expert can demonstrate a proper foundation for his or her testimony.

The expert's testimony must be precluded when the expert does not have enough information to form a proper opinion, but attempts to offer one anyway, which testimony would not be relevant. An expert's opinion not based on accurate facts is worthless.[6] For example, if it is clear that the proffered biomechanical engineer had looked up crash test information or specifications for the wrong vehicle, or had not examined the vehicles or seen photos of the vehicles after the accident, did not know the height and weight of the allegedly injured party and where in the vehicle he or she was seated,[7] or did not have other pertinent information regarding the accident, he or she could not properly conclude that the plaintiff could not have been injured in the accident at issue.

If, for example, the expert is unaware that the plaintiff's truck hit a stationary object, such as a lamppost, after contacting the other vehicle, all of his calculations would be not merely unreliable, but useless. Where the expert was unaware of a plaintiff's prior injuries, which could make him or her more susceptible to a new injury, the expert's conclusions were found to be unreliable.[8] This was also the case where the expert testified that damage to a seatbelt was caused by a prior accident without providing any basis for this conclusion.[9] Thus, when an expert has insufficient information upon which to base an opinion, his or her testimony is properly precluded.[10]

It is the judge's role to preclude testimony that will not be useful to the jury.

It must be noted that the Court of Appeals has opined that this analysis is not really a *Frye* inquiry, but an "admissibility question applied to all evidence – whether there is a proper foundation – to determine whether the accepted methods were appropriately employed in a particular case."[11] In *Cornell v. 360 W. 51st St. Realty*,[12] the court explained that "a court may exclude the expert's opinion if 'there is simply too great an analytical gap between the data and the opinion proffered.'" In addition, the Court in *Cornell* described *Parker* as having "clarified rules for the foundation necessary to admit expert evidence."

In New Jersey, a *Daubert*[13] state which uses the Federal Rules of Evidence in its state courts, biomechanical engineers may testify if they lay a proper foundation. This analysis is also applicable in New York despite New York being a *Frye* state. In *Hisenaj v. Kuehner*,[14] the Supreme Court of New Jersey concluded that the proposed expert, who based his opinion on the findings in 17 different biomechanical engineering studies of persons involved in similar low-impact collisions, which involved humans and not cadavers or crash test dummies,[15] should have been permitted to testify, and therefore reversed the intermediate appellate court, finding that the trial court's decision to allow the testimony was not an abuse of discretion. The court explained that "the biomechanical engineer applies concepts of mechanics to explain the physiological effects of [outside] force acting upon a living being, and specifically how that force likely would affect the normal functions of [that being] or [its] organs." The hearing, the court states, is "to determine admissibility, not credibility."[16]

The Appellate Division, Second Department has instructed "where the tendered scientific deduction has been deemed generally accepted as reliable, there remains a separate inquiry applied to all evidence. This inquiry is 'whether there is a proper foundation – to determine whether the accepted methods were appropriately employed in a particular case.'"[17] There is no longer any question that a biomechanical engineer with sufficient information may apply the procedures of

the witness' profession to generate an opinion as to the forces which impacted the plaintiff. The judge, however, must ascertain that the expert has obtained sufficient and reliable information, the foundation, upon which to base his or her conclusion.

When a biomechanical engineer is called to testify, *Frye* is satisfied in a motor vehicle case, as the science is not "novel" and has been held to be relevant, but the witness must establish "that the processes and methods employed in arriving at his or her opinions are methods or processes deemed reliable in the biomechanical engineering community. This is usually accomplished by establishing that the methods or processes used by the engineer in formulating his or her opinion have been extensively tested under proper testing conditions and that the tests and the results have been published and peer reviewed."[18]

Unfortunately, in New York, counsel proffering an expert can be seriously hamstrung by the state of the law concerning the admissibility of scientific studies, peer reviewed or otherwise. In the federal courts and in the 41 states that have adopted the Federal Rules of Evidence, such as New Jersey, learned treatises and scientific studies are inadmissible. But in New York, they are considered hearsay on the direct examination of an expert witness, but may be used on cross-examination for the purpose of impeachment.[19] However, even on cross-examination, the substance of the treatise or study may only be put before the jury if the expert witness first agrees that the material is "authoritative" on the subject. Even if admitted into evidence during the cross-examination of a witness, the jury must be told that the study is not offered as proof of the information therein.[20] Thus, in New York, a party may not introduce treatises or articles or studies into evidence or read from them during the direct examination of an expert. Nor may an expert testify about his or her research of the scientific literature on direct examination. As a result of this evidentiary rule in New York, a biomechanical engineer is unable to testify about the studies which support his conclusion on the "theory of causation." This is precisely why the *Frye* hearing (or foundation hearing) is so important. It is only at the hearing, held outside the jury's presence, that the expert may present the studies he or she has relied on and which support the conclusions he or she intends to present to the jury. Without this information, which enables the judge to determine whether the witness has a proper basis for his or her conclusions on the "theory of causation" concerning the plaintiff's claimed injuries, only the expert's analysis of the "first accident," that is, the contact between the vehicles, can be admitted, as that testimony is based on the witness' own calculations, while the "theory of causation" testimony concerning the "second accident," the contact between the vehicle and the plaintiff, must be precluded if not based on reliable, peer-reviewed studies.[21]

It should be noted that only one New York appellate decision regarding biomechanical engineers has, to date, upheld a trial court decision which precluded a biomechanical engineer from testifying without first holding a hearing outside of the jury's presence.[22] All four Appellate Departments have affirmed trial court judges who have permitted biomechanical engineers to testify, provided the testimony had a proper foundation.[23]

In New York, a party may not introduce treatises or articles or studies into evidence or read from them during the direct examination of an expert.

The published New York trial court decisions which concern motions *in limine* seeking to preclude a biomechanical engineer witness from testifying at trial are almost equally divided between those that after a hearing find the witness' testimony on the issue of causation admissible and those that find it not admissible.[24] One jurist opined that there was no basis to preclude on the grounds that it is "junk science," as biomechanical engineers are generally accepted, without making the appropriate inquiry as to the foundation for the testimony.[25] To be clear, while in a motor vehicle accident case there is no doubt that the testimony of a biomechanical engineer is based on scientific principles or procedures which have been sufficiently established to have gained general acceptance in the particular field, one of the prongs of a *Frye* inquiry, the court still must make a determination that the processes and methods employed by the expert in formulating his or her opinion adhered to accepted standards of reliability within the field, a different "prong" of a *Frye* inquiry.

On the point of whether a scientific theory is generally accepted, the findings of New York trial courts should be consistent. Indeed, "a party proffering expert testimony may demonstrate reliability by pointing to existing judicial decisions that announce that particular evidence or testimony is generally accepted in the scientific community."[26] As all four Appellate Departments in New York have found biomechanical engineers to be proper witnesses in motor vehicle accident cases, this issue should be deemed decided in New York.

Some courts have precluded the testimony of a biomechanical engineer regarding the cause of a party's injuries while permitting testimony about the forces involved in the collision and allowing the expert to speak in general about the types of injuries those forces could cause.[27] The courts that follow this reasoning do not permit

the expert witness to opine as to whether the accident caused or did not cause the plaintiff's specific injuries.[28] On the other hand, where the biomechanical engineer was also a medical doctor, the witness was permitted to testify whether "there was an injury mechanism present in the rear impact in a sufficient magnitude of force as well as an appropriate direction of force so as to cause the plaintiff's injuries as alleged."[29]

In Phillip Good's article, *Refuting the Testimony of Biomechanical Experts: A Guide for Personal Injury Attorneys*,[30] he lists the information that, in his opinion, must be provided by a biomechanical engineer at a hearing, and indicates that if it is not, the witness' conclusions should be considered unreliable and suspect. This includes:

1. Was the population in the study relied upon by the expert relevant to the case? Mr. Good points out that the participants in the studies must not only be live humans, and not cadavers or crash test dummies, but they must be of similar age, sex and pre-accident physical condition as the plaintiff. He cites studies that show that women are more likely to suffer whiplash and are more severely affected by rear-end collisions than men, and have post-accident symptoms for a longer period of time than male motor vehicle accident victims. Therefore, for example, a study which only includes healthy young men is not applicable to an accident involving two older women.
2. How large is the sample in the study? A study of only a handful of people is not reliable, but sometimes the studies cited only include a small sample. According to Mr. Good, the failure to state how many participants were in the study makes the study unreliable.
3. The forces involved in the accident must be calculated and the information relied on and calculations used must be disclosed at the hearing.
4. Other factors. Additional factors to consider are: the make and model of the vehicles, how and where the plaintiff was sitting in the vehicle, whether there was a lap belt, a lap and shoulder belt, or no seatbelt, the direction of the impact, and the velocity of the impact.
5. Mr. Good concludes that, in addition to the above, the guidelines of the Society of Automotive Engineers (SAE) must be followed, or the "testimony is suspect." He points out that these guidelines are updated regularly. In particular, he cites SAE J885 ("Human Tolerance to Impact Conditions as Related to Motor Vehicle Design") and SAE J1460/2 ("Human Mechanical Impact Response Characteristics"). All of the society's papers can be purchased online at SAE.org. Mr. Good's article also cites a number of scientific studies concerning humans in motor vehicle accidents.

Additionally, it is very helpful if the expert witness is able to inspect the vehicle, instead of just looking at pictures. This information is useful in determining the speed involved in the collision. Of course, it is important that the vehicle be unaltered between the time of the accident and the expert's inspection, which requires the chain of custody to be proven. If there is too much time between the accident and the inspection, the validity of the inspection suffers. If the vehicle was damaged in the tow, if the "jaws of life" were used to remove the injured people, if the car was repaired before the inspection, or was in another accident, this information must be provided to the expert. It is also important that the expert know the condition of the road surface at the time of the accident.[31] If the road was resurfaced before the site inspection, it affects the reliability of the expert's conclusions.[32]

It is not merely that the absence of sufficient information upon which to form an opinion renders the expert's opinion suspect, and therefore useless in assisting the trier of the facts, but that the absence of sufficient information upon which to form an opinion should result in the preclusion of that opinion from being put before the jury at all. In this author's opinion, a hearing is necessary in every instance when a party in a motor vehicle accident case wants to call a biomechanical engineer to testify and the adverse party requests a hearing. This is because the basis for his or her opinion cannot be properly vetted before a jury under New York's rules of evidence. Of course, if the adverse party does not make a motion to preclude *in limine*, it is waived.[33]

Conclusion

When a party proffers the testimony of a biomechanical engineer in a motor vehicle trial on the issue of damages, if the adverse party moves *in limine* to preclude the testimony, a hearing must be held. Following the hearing, the court may permit the testimony as to the first accident, that is, between the vehicles, or may permit the testimony as to both the first accident and the second accident, that is, between the vehicle and the plaintiff's body. Even if the court permits testimony as to the "second accident," the judge may preclude the witness from testifying as to whether the accident could have caused the claimed injuries on the grounds that the witness is not a doctor, and may only allow the witness to testify as to the forces involved in the collision and allow the expert to speak in general about the types of injuries those forces could cause.[34] Whether a biomechanical engineer who is not a medical doctor may testify that the plaintiff's alleged injuries were not caused by the accident is still an unresolved issue in New York courts. The Court of Appeals has not issued any guidelines on this issue. ■

1. Matthew Bender & Co., Scientific Evidence § 27.10(a), The Admissibility of Accident Reconstruction Testimony.
2. *Frye v. United States*, 293 F. 1013 (D.C. Cir. 1923).
3. 7 N.Y.3d 434 (2006).

4. *Id*. at 447. *See* Michael J. Hutter, *Toxic Mold Case: Experts, Gate Keeping, Admissibility*, N.Y.L.J., June 6, 2014.

5. *See Cornell v. 360 W. 51st St. Realty LLC*, 22 N.Y.3d 762 (2014), *citing General Electric Co. v. Joiner*, 522 U.S. 136 (1997).

6. *Caton v. Doug Urban Constr. Co.*, 65 N.Y.2d 909 (1985).

7. *Withrow v. Spears*, 967 F. Supp. 2d 982 (U.S.D.C. N.D. Del. 2013).

8. *Wellman v. Norfolk & Western Ry.*, 98 F. Supp. 2d 919 (U.S.D.C. S.D. Ohio 2000).

9. *Id*.

10. *See, e.g.*, *White v. Grocery Haulers, Inc.*, 2014 N.Y. Misc. LEXIS 738 (Sup. Ct., N.Y. Co. 2014).

11. *Parker v. Mobil Oil Corp.*, 7 N.Y.3d 434 (2006), *citing People v. Wesley*, 83 N.Y.2d 417 (1994).

12. 22 N.Y.3d 762 (2014).

13. *Daubert v. Merrill Dow Pharmaceuticals, Inc.*, 509 U.S. 579, 590 (1993). This holding has been codified in Federal Rule 702.

14. 194 N.J. 6 (2008).

15. In *Suanez v. Egeland*, 353 N.J. Super. 191 (App. Div. 2002), a witness who based his opinion on studies involving cadavers was precluded from testifying.

16. *Hisenaj*, 194 N.J. at 24.

17. *Ratner v. McNeil-PPC, Inc.*, 91 A.D.3d 63 (2d Dep't 2011).

18. Robert Glick and Sean O'Loughlin, *The Rise of Biomechanical Experts at Trial*, N.Y. St. B.J., Nov/Dec 2010 at p. 49.

19. CPLR 4515 allows experts to testify as to opinions without specifying the data/studies upon which it is based, leaving that inquiry for cross-examination. Of course, the data/studies must be reliable.

20. *See* PJI 1:90.2 and the cases cited in the commentary thereto, and *see* Eric Dinnocenzo, *I Don't Need Your Authority – The Use of Learned Treatises in New York State Courts*, N.Y. St. B.J., June 2010, at p. 9. In his article, Mr. Dinnocenzo notes that New York law "has slowly inched toward the federal rule, though its roots still remain firmly in the 19th Century."

21. *See, e.g.*, *White v. Grocery Haulers, supra* note 10.

22. *See, e.g.*, *Abramson v. Pick Quick Foods*, 56 A.D.3d 702 (2d Dep't 2008). The one published decision, *Vargas v. Sabri*, 115 A.D.3d 505 (1st Dep't 2014), upheld a trial court's denial of a *Frye* hearing. However, the plaintiff opposed the expert on the grounds he did not have a medical license. It thus seems the party who moved to preclude didn't raise a sufficient issue for the court to direct a hearing.

23. *Shifrel v. Singh*, 61 A.D.3d 401 (1st Dep't 2009) (biomechanical engineer permitted to testify that it was unlikely that plaintiff's left shoulder impacted the steering wheel); *Valentine v. Grossman*, 283 A.D.2d 571 (2d Dep't 2001) (biomechanical engineer should have been allowed to testify that the force in the accident was insufficient to cause a herniated disc); *Cocca v. Conway*, 283 A.D.2d 787 (3d Dep't 2001), *lv. denied*, 96 N.Y.2d 721 (2001) (witness allowed to testify that the impact between the vehicles did not have enough force to cause the injuries claimed by the plaintiff); *Martell v. Chrysler Corp.*, 186 A.D.2d 1059 (4th Dep't 1992) (plaintiff properly permitted to call biomechanical engineer to testify in products liability action). *See also* Richard M. Sands, *Using Biomechanical Science in Labor Law and Premises Cases*, N.Y.L.J. Nov. 3, 2010.

24. *Shifrel*, 61 A.D.3d 401; *Gaona-Garcia v. Gould*, 31 Misc. 3d 1237A (Sup. Ct., Bronx Co. 2011). *See also Santos v. Nicolos*, 24 Misc. 3d 999 (Sup. Ct., Bronx Co. 2009); *Clemente v. Blumenberg*, 183 Misc. 2d 923 (Sup. Ct., Richmond Co. 1999).

25. *Martell v. K & K Auto and Towing Corp.*, 2013 N.Y. Slip Op. 31950(U) (Sup. Ct., Queens Co.).

26. *Hisenaj v. Kuehner*, 194 N.J. 6, 17 (2008).

27. *Smelser v. Norfolk S. Ry Co.*, 105 F.3d 299 (6th Cir. 1997); *Bowers v. Norfolk S. Corp.*, 537 F. Supp. 2d 1343 (U.S.D.C. M.D. Ga. 2007); *Berner v. Carnival Corp.*, 632 F. Supp. 2d 1208 (U.S.D.C. S.D. Fla. 2009).

28. *Kelham v. CSX Transp. Inc.*, 2015 U.S. Dist. LEXIS 93669 (U.S.D.C. N.D. Ind.).

29. *Harden v. Haven*, 2014 Fla. Cir. LEXIS 815 (Circuit Ct. of 18th Jud. Dist., Brevard Co.).

30. statcourse.com (2009) (available as an e-book on Amazon.com).

31. *Rose v. Truck Ctrs., Inc.*, 611 F. Supp. 2d 745, 751 (N.D. Ohio 2009).

32. *Knox v. Simmons*, 838 S.W.2d 21 (Mo. Ct. App. 1992).

33. *Cocca v. Conway*, 283 A.D.2d 787 (3d Dep't 2001), *lv. denied*, 96 N.Y.2d 721 (2001).

34. *Neat v. Pfeffer*, 2013 N.Y. Misc. LEXIS 4185 (Sup. Ct., N.Y. Co.).

LINKS TO ARTICLES REFERENCED

https://www.schwebel.com/press/low-speed-impacts/

https://www.bermansimmons.com/law-articles/defense-biomechanical-expert/

Understanding the Labor Law - Construction Site Accidents

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NEW YORK STATE BAR ASSOCIATION

TRIAL LAWYERS SECTION

Understanding the Labor Law – Construction Site Accidents

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Mr. Adams is a Member in the firm's Litigation department and has extensive experience litigating in construction negligence, labor law, product liability, transportation negligence, employment litigation and other complex and catastrophic injury litigation. Mr. Adams heads the firm's New York Labor Law team and is the editor of the firm's monthly electronic newsletter Labor Law Pointers, which provides a review and analysis of the most current and significant New York State Labor Law cases. He leads the firm's 24-Hour Emergency Response Team for construction site accidents.

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Understanding the Labor Law – Construction Site Accidents

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The New York Labor Law imposes liability on Owners and Contractors for failure to provide a safe place to work. New York State is the only state which has such a law imposing absolute liability on owners, contractors and their agents without the culpable conduct of the plaintiff being considered for any elevation related injury. These cases are always among the highest verdicts recorded in the state every year. Understanding the law is essential not only for handling these cases but also for counseling clients on their safety practices, contract language and accident investigation.

We will address the different section of the Labor Law, their similarities and differences, and the essential elements necessary to analyze and handle these cases.

NEW YORK STATE LABOR LAW

THREE MAIN SECTIONS:

Labor Law § 240 (1)

- Elevation related risk
- Absolute Liability if there is a violation that is the proximate cause of the injury
- **DEFENSES**:
    - Sole proximate cause
    - Recalcitrant worker

Labor Law § 241 (6)

- Violation of specific rule (Code Rule 23)
- Liability is established if the violation was the proximate cause of the injury
- DEFENSE: Culpable conduct of the plaintiff

Labor Law § 200

- NEGLIGENCE
- DEFENSE: Culpable Conduct of the plaintiff

Each section asks the same four questions

Each section answers these questions differently.

- Is this a statutory defendant?
- Is the project “covered” by the statute?

- Is the injured party “protected” by the statute?
- Is the accident an “event” within the contemplation of the statute.

  Thus it becomes a basic equation;

  (Statutory defendant) x (covered project) x (protected worker) x (covered event) = liability

If any element is missing, there is no liability under the statute.

LABOR LAW § 240 (1)

- Absolute liability
- Culpable conduct of plaintiff not an available defense
- Defenses:
  - Sole proximate cause
  - Recalcitrant worker

§ 240. Scaffolding and other devices for use of employees

1. All contractors and owners and their agents, except owners of one and two-family dwellings who contract for but do not direct or control the work, in the erection, demolition, repairing, altering, painting, cleaning or pointing of a building or structure shall furnish or erect, or cause to be furnished or erected for the performance of such

labor, scaffolding, hoists, stays, ladders, slings, hangers, blocks, pulleys, braces, irons, ropes, and other devices which shall be so constructed, placed and operated as to give proper protection to a person so employed.

STATUTORY DEFENDANTS

- Contractors
  - Party with authority to enforce safety standards and choose responsible subcontractors. Mergenhagen v. Dish Network Service L.L.C., 64 A.D.3d 1170 (4th Dept. 2009) (status is dependent on their right to exercise control, not whether they in fact did so).
- Owners
  - Actual titleholder. Nephew v. Barcomb, 260 A.D.2d 821 (3rd Dept. 1999)
  - Leaseholder of the property. Walp v. ACTS Testing Labs Inc., 28 A.D.3d 1104 (4th Dept. 2006).
  - One who contracts to have the work performed for his benefit. Scaparo v. Village of Illion, 13 N.Y.3d 864 (2009). Example is owner of easement. Fisher v. Coghlan, 8 A.D.3d 974 (4th Dept. 2004).
- Agents –

- A third party with authority to supervise and control job. Weber v. Baccarat, Inc., 70 A.D.3d 487 (1st Dept. 2010).

- Subcontractors who control the work that caused the plaintiff's injury. Zervos v. City of New York, 8 A.D.3d 477 (2nd Dept. 2004); Russin v. Picciano & Son, 54 N.Y.2d 311 (1982).

- Construction Manager with authority to direct and control the work. Rodriquez v. JMB Architecture, LLC, 82 A.D.3d 949 (2nd Dept. 2011); Lodato v. Greyhawk North America, LLC, 39 A.D.3d 491 (2nd Dept. 2007).

Scheduling authority is not enough

- Owners of one and two family homes

  - Who direct or control the work. Byrd v. Roneker, 90 A.D.3d 1648 (4th Dept. 2011) (direction and control exists if owner specifies how work should be performed).

  - Where the work was residential (not commercial) in nature. Landon v. Austin, 88 A.D.3d 1127 (owners of one and two-family dwellings exemption does not apply to owners who use their residences purely for commercial purposes).

    - Renovation for *resale or rental* qualifies as work being performed for a commercial purpose. Id.

COVERED PROJECTS

1. Altering/Renovating –

Liability requires a *significant* physical change to the configuration or composition of the building or structure. Sanatass v. Consolidated Investing Co., Inc., 10 N.Y.3d 333 (2008).

-Installation of draperies. Wormuth v. Freeman Interiors, Ltd., 34 A.D.3d 1329 (4th Dept. 2006).

-Installation of new phone system. Schick v. 200 Blydenburgh, LLC, 88 A.D.3d 684 (2nd Dept. 2011).

-Boarding up windows. Santiago v. Rusciano & Son, Inc., 92 A.D.3d 585 (1st Dept. 2012).

-Not applying advertisements to billboard. Hatfield v. Bridgedale, LLC, 28 A.D.3d 608 (2nd Dept. 2006).

2. Repairing –

Troubleshooting and investigating malfunctions are protected activities. Pieri v. B & B Welch Associates, 74 A.D.3d 1727 (4th Dept. 2010).

Repair of nonfunctioning door – Lofaso v. J.P. Murhpy Assocates, 37 A.D.3d 769 (2nd Dept. 2007)

Replacing transformer on building roof's HVAC unit - Bruce v Fashion Square Associates, 8 A.D.3d 1053, 1054, 778 N.Y.S.2d 823 (2004).

3 Erecting – not specifically been defined by the New York Court of Appeals.

-Attachment of power screen not erecting because the power screen came already assembled. Hodges v. Boland's Excavating and Topsoil, Inc., 24 A.D.3d 1089 (3rd Dept. 2005).

4 Demolition –

-Removal of a large air conditioning duct attached to the ceiling considered demolition. Salinas v. Barney Skanska Constr. Co., 2 A.D.3d 619 (2nd Dept. 2003).

-Cutting and removing horizontal pipe 9-10 feet above ground considered demolition. Durmiaki v. International Business Machines Corp., 85 A.D.3d 960 (2nd Dept. 2011).

5 Painting – painting is protected activity and need not be incidental to other listed activities. Artoglou v. Gene Scappy Realty Corp., 57 A.D.3d 460 (2nd Dept. 2008)

Where work is being done on or to a;

1. Building or

2. Structure –

Pipeline. Convey v. Iroquois Gas Transmission System, L.P., 218 A.D.2d 197 (3rd Dept. 1996).

Telephone pole. Sarigul v. New York Telephone Co., 4 A.D.3d 168 (1st Dept. 2004).

Airplane. Wong v. City of New York, 65 A.D.3d 1000 (2nd Dept. 2009).

NON-COVERED PROJECTS

1. Cleaning

-Cleaning a product in the course of a manufacturing process Dahar v. Holland Ladder & Mfg. Co., 18 N.Y.3d 521 (2012);

-Cleaning leaves from gutter Berardi v. Coney Island Ave. Realty, LLC, 31 A.D.3d 590 (2nd Dept. 2006);

-Routine household window washing Broggy v. Rockefeller Group, Inc., 8 N.Y.3d 675 (2007).

-Commercial cleaning not covered where the cleaning is routine and regular, does not require specialized equipment or expertise, does not generally require significant elevation risk and it is unrelated to construction. Soto v J. Crew Inc., 2013 NY Slip Op 06603

2. Maintenance –

-Removing garage door motor from its box was routine maintenance Ventura v. Ozone Park Holding Corp., 84 A.D.3d 516 (1st Dept. 2011);

-Debris that is removed from movable dam parts each time dam sections are lifted or lowered constitutes routine maintenance Len v. State of New York, 74 A.D.3d 1597 (3rd Dept. 2010).

3. Wallpapering. Schroeder v. Kalenak Painting & Paperhanging, Inc., 27 A.D.3d 1097 (4th Dept. 2006)

4. Excavating

5. Inspecting, Measuring, Estimating

COVERED PERSON

A "person so employed"

1. Covered

    - Plaintiff must demonstrate he was hired by an owner, contractor or their agent – not a volunteer; and

    - Was permitted or required to work at the worksite at issue.

Stringer v. Musacchia, 11 N.Y.3d 212 (2008).

2. Not covered if not engaged in a protected activity

    - Plaintiff is not covered if not performing work integral or necessary to completion of construction project, nor a member of a team that undertook an enumerated activity under contract. Coombs v. Izzo General Contracting, Inc., 49 A.D.3d 468 (1st Dept. 2008).

    - Investigatory work prior to the commencement of an enumerated activity is not protected. Vasquez v. Minadis, 86 A.D.3d 604 (2nd Dept. 2011).

Failure to "to give proper protection" resulting in a:

1. **Falling Worker**

    a. Must be subjected to an elevated related risk, such as worker's 12-15 feet fall into an excavated trench. Bell v. Bengomo Realty, Inc., 36 A.D.3d 479 (1st Dept. 2007).

    b. Worker's fall just under 2 1/2 feet when a handrail detached was not deemed a covered event because worker was not subjected to any "exceptionally dangerous conditions posed by elevation differentials," nor was the handrail one of the types of safety devices enumerated in the statute. Mattingly v. AES Corp., 291 A.D.2d 862 (4th Dept. 2002).

2. **Falling Object**

    a. A worker is *not* categorically barred from recovery where an injury is caused by a falling object whose base stands at the same level as the worker. Wilinski v. 334 East 92nd Housing Development Fund Corp., 18 N.Y.3d 1 (2011).

    b. Liability "is not limited to cases in which the falling object is in the process of being hoisted or secured." Quattrocchi v. F.J. Sciame Constr. Corp., 11 N.Y.3d 757 (2008).

c. "Related to a significant risk inherent in … the relative elevation … at which materials or loads must be positioned or secured." Perillo v. Lehigh Constr. Group, Inc., 17 A.D.3d 1136 (4th Dept. 2005)

d. "The object fell, while being hoisted or secured, because *of* the absence or inadequacy of a safety device of the kind enumerated in the statute." Narducci v. Manhasset Bay Assocs., 96 N.Y.2d 259 (2001).

However, "[t]he inquiry does not depend on whether the injury resulted from a fall, either of the worker or of an object upon the worker. Rather, the single decisive question is whether plaintiff's injuries were the direct consequence of a failure to provide adequate protection against a risk arising from a physically significant elevation differential." Runner v. New York Stock Exchange, Inc., 13 N.Y.3d 599 (2009).

DEFENSES

1. Recalcitrant worker

Liability "does not attach when the safety devices that plaintiff alleges were absent were readily available at the work site, albeit not in the immediate vicinity of the accident, and plaintiff knew he was expected to use them but for no good reason chose not to do so, causing an accident." Gallagher v. New York Post, 14 N.Y.3d 83 (2010).

2. Sole Proximate Cause

-Misuse of a safety device. Blake v. Neighborhood Housing Services of N.Y., 1 N.Y.3d 280 (2003).

-When worker decided to climb onto main roof, without instruction, worker's decision was sole proximate cause of injuries. Serrano v. Poppovic, 91 A.D.3d 626 (2nd Dept. 2012)

-Failing to use an available and proper safety device. Robinson v. East Medical Center, LP, 6 N.Y.3d 550 (2006).

-Five basic requirements, there needs to be 1) an available and 2) appropriate safety device which 3) the plaintiff was instructed to use or knew he was required to use and 4) the plaintiff did not use or improperly used 5) for no good reason.

LABOR LAW § 241 (6)

Liability: based on violation of the New York State Industrial Code

Defenses: Culpable conduct of the plaintiff

Negligence

Assumption of Risk

§ 241. Construction, excavation and demolition work

6. All areas in which construction, excavation or demolition work is being performed shall be so constructed, shored, equipped, guarded, arranged, operated and conducted as to provide reasonable and adequate protection and safety to the persons employed therein or lawfully frequenting such places. The commissioner may make rules to carry into effect the provisions of this subdivision, and the owners and contractors and their

agents for such work, except owners of one and two-family dwellings who contract for but do not direct or control the work, shall comply therewith.;

Statutory defendant – same as 240(1)

1. Owners
2. Contractors
3. Agents
4. Owners of one or two family homes who direct or control the work

COVERED PROJECTS

1. Construction (Alteration and Painting not specifically mentioned)
2. Excavation
3. Demolition

NON-COVERED PROJECTS

1. Repair. Mata v. The Park Here Garage Corp., 71 A.D.3d 423 (1st Dept. 2010).

2. Interior decorating. Rajkumar v. Budd Contracting Corp., 77 A.D.3d 595 (1st Dept. 2010).

3. Tree Removal. Crosset v. Wing Farm, Inc., 79 A.D.3d 1334 (3rd Dept. 2010).

PROTECTED WORKER

Persons employed thereon

-Volunteers are not protected. Stringer v. Musacchia, 11 N.Y.3d 212 (2008).

-Seeking employment is covered. DeFreece v. Penny Bag, 137 A.D.2d 744 (2nd Dept. 1988).

2. Lawfully frequenting the premises

-Need to be engaged in construction activity or in the class of persons to be protected. Vasquez v. Minadis, 86 A.D.3d 604 (2nd Dept. 2011); Davis v. Wind Sun Constr., Inc., 70 A.D.3d 1383 (4th Dept. 2010).

-Plaintiff injured while delivering materials to the work site for use at construction site was covered. Whit v. Village of Port Chester, 92 A.D.3d 872 (2nd Dept. 2012).

WORKERS NOT PROTECTED

- Plaintiff inspecting work is not covered. Mordkofsky v. V.C.V. Development , 76 N.Y. 2d 573 (1990)
- Pedestrians not employed are not covered. Morales v. 569 Myrtle Ave., LLC, 17 A.D.3d 418 (2nd Dept. 2005).
- Plaintiff delivering to vendor is not covered. Haines v. Dick's Concrete Co., Inc., 84 A.D.3d 732 (2nd Dept. 2011) ("plaintiff was **not** delivering the masonry materials to a

construction site; rather, he was delivering them from a supplier to a vendor. Therefore, the plaintiff's work is not a covered activity . . . .").

COVERED EVENT

Statutory requirement

- "so constructed, shored, equipped, guarded, arranged, operated and conducted as to provide reasonable and adequate protection and safety"
- And "The commissioner may make rules to carry into effect the provisions of this subdivision"
    - Rules are: Code Rule 23, New York State Industrial Code and 12 NYCRR – Part 23. All the same these rules are the same, just maintained n different locations.

OSHA violations do not trigger liability

Regulation must establish a specific safety requirement.

A. General duty is not sufficient

e.g. "All load carrying equipment shall…safely support the loads intended to be imposed thereon (12 NYCRR §23-1.5(c))

Regulation must establish a specific safety requirement.

B. Specific duty triggers §241 (6)

e.g. “All passageways shall be kept free from….obstructions or conditions that could cause tripping.” (12 NYCRR §23-1.7(e)(1))

LABOR LAW §200

§ 200. General duty to protect health and safety of employees; enforcement

All places to which this chapter applies shall be so constructed, equipped, arranged, operated and conducted as to provide reasonable and adequate protection to the lives, health and safety of all persons employed therein or lawfully frequenting such places. All machinery, equipment, and devices in such places shall be so placed, operated, guarded, and lighted as to provide reasonable and adequate protection to all such persons. The board may make rules to carry into effect the provisions of this section.

1. Liability is based on common law negligence

2. Defense – Culpable conduct.

DEFENDANT:

Not defined in statute, but, courts apply this section to:

1. Owners and

2. Contractors

Who direct and control the work where the injury is caused by the means and method by which the work is being done. Where the claim is for a dangerous condition on the work site it is a general negligence standard the same as a premises liability case.

COVERED PROJECT

"All places to which this chapter applies…"

General construction site

General construction activity

PROTECTED WORKER

"…all persons employed therein or lawfully frequenting such places…"

Same as Labor Law §241(6)

COVERED EVENT

Occurs because of the failure to:

"..provide reasonable and adequate protection to the lives, health and safety…"

Standard: General negligence

RISK TRANSFER IN LABOR LAW CASES

Two legal theories:

1. Common Law Indemnity

    a. Against non-employer - no limitations

    b. Against employer - limited by Workers' Compensation Reform Act of 1996 to cases where the plaintiff has sustained a "*grave injury*":

GRAVE INJURIES

Workers Compensation Law §11:

1. Death
2. Permanent & total loss of use of an arm, leg, hand or foot
3. Amputation of an arm, leg, hand or foot
4. Loss of multiple fingers or toes
5. Paraplegia or quadriplegia
6. Total and permanent blindness or deafness
7. Loss of nose or ear
8. Loss of index finger
9. Brain injury resulting in total disability

2. Contractual indemnity

   a. Enforceable against employer and non-employer

   b. Cannot be indemnified for your own negligence

Focus Groups – How to Deal with Case Issues

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What is a legal focus group?

A legal focus group is a collection of individuals brought together to hear facts, evidence, and arguments regarding a pending or potential lawsuit. The group of people should match the demographics of the community where a lawsuit and/or trial is located. Feedback is solicited from the group by a moderator or presenter. This feedback assists with discovery, depositions, and trial. A more formal definition from Merriam Webster's online dictionary states that a "focus group" is a noun describing "a small group of people whose response to something (such as a new product or a politician's image) is studied to determine the response that can be expected from a larger population." The Small Business Encyclopedia defines a focus group as follows:

> "A focus group is a marketing research tool in which a small group of people (typically eight to ten individuals) engages in a roundtable discussion of selected topics of interest in an informal setting. The focus group discussion is typically directed by a moderator who guides the discussion in order to obtain the group's opinions about or reactions to specific products or marketing-oriented issues, known as test concepts. While focus groups can provide marketing managers, product managers, and market researchers with a great deal of helpful information, their use as a research tool is limited in that it is difficult to measure the results objectively. In addition, the cost and logistical complexity of focus group research is frequently cited as a deterrent, especially for companies of smaller size. Nonetheless, many small businesses find focus groups to be useful means of staying close to consumers and their ever-changing attitudes and

feelings. By providing qualitative information from well-defined target audiences, focus groups can aid businesses in decision making and in the development of marketing strategies and promotional campaigns."

Focus groups can provide vital information and a glimpse into the minds of a potential jury pool. Done correctly, a focus group can provide well-reasoned honest opinions about the issues in your case. This information is important for all stages of litigation. Focus groups help develop an insight into juror beliefs, opinions, and their overall rationale for making decisions.

Why do focus groups?

Focus groups provide useful insight into community values, opinions, and viewpoints. While you can't expect the exact same reactions from an actual jury, what you can count on is gaining an understanding into what will resonate with a jury.

Many lawyers assume they know what persuades a jury, in reality they simply guess. Focus groups help take the guess work out of a trial and can provide a clearer roadmap to success. Focus groups not only gives insight into what it will take to persuade a juror but also what it will take to change their minds on issues. .

The following is a short list of just a few areas ripe for focus group testing:

Should the case be sued? Defended? How? Why?

What evidence will persuade?

What information is missing?

What more information does the jury need to see?

Is your witness credible?

Is your witness's story believable?

Is there something about your witness that bothers the jury?

What is your witnesses' body language saying?

What other witnesses do they want to hear from?

Does your client's body language say anything positive/negative?

Are your demonstratives really all that demonstrative?

Is the story of your case really as compelling as you think it is?

Is my opening really conveying what I think it is?

Where do I get focus groups participants?

- Facebook
- Craigslist
- Employment Agencies
- College campus job placement office
- YouTube ads
- Senior Centers
- Church bulletins

Who do I get for my focus groups?

You want the focus to match the demographics of a common jury as much as possible. The goal is to get a focus group with varying ages, races, genders, employment and economic backgrounds. You want to avoid focus group professionals and repeat focus group participants as much as possible.

How much do I pay focus groups participants?

Pay well and feed them. You want to attract people to take time out of their busy schedules. If you're looking to match the demographics of a wealthier area, your focus group pay should match the pay in that area. It's not uncommon for focus group pay to range from $100-300 per-person per day. Also, including a small meal and/or snacks is a must.

What types of focus groups are there?

Concept: a brainstorming session to gain an understanding of the underlying concepts in your case.

Narrative: Read short narrative with facts and circumstances. Ask who, where, why, when, how type questions.

Timeline: Read narrative in the form of timeline. Ask what happened, when and why type questions.

Opening Statement: Present opening. Ask follow-ups to determine the level of understanding and/or confusion.

Trial: Run condensed trial. Ask follow-ups to determine the level of understanding and/or confusion.

Demonstrative: Test your demonstratives until they need no explanation.

How do I prepare for a focus group?

Preparation is key. Know what you want to achieve and what your goals are before starting any focus group. Know what facts you want to disclose and when. Unlike a Survey in which you can come up with questions in advance and have potential jurors fill out the survey, a focus group is interactive and only preparation will help you take full advantage of what the group has to offer.

Should I have focus group rules?

Yes, the following rules should be stated at the beginning of the focus group, these rules can help with effective facilitation of the group.

1. Cell phones off-not just silenced. If simply silenced, most focus groups participants can still check e-mail, send texts, etc. Let them know that you will be taking breaks and they can access their phone during any and all breaks.

2. One at a time. Tell the group that you need to hear everyone's comments clearly and that becomes difficult if more than one person speaks at a time.

3. No interrupting. Let the group know that in order to hear everyone's comments please wait until one person has completed their comments before beginning yours.

4. No bad opinions. Tell the group that all opinions and comments are welcome and that there is no such thing as bad or dumb opinions in this focus group. Follow this up by saying that if they are thinking it, then someone on the jury will be, too.

5. Confidentiality. Explain that everything they hear must be kept confidential and that by participating they are promising to keep the information they learn to themselves.

6. Breaks. Make sure you explain when and how long breaks will be taken.

7. Bathrooms. The most asked question from focus participants: "Where's the bathroom?" Make sure you explain where the bathroom is at the beginning of the session.

8. Length. Explain how long the focus group will go and how many cases will be discussed.

How long should the focus group last?

The length will depend heavily on the type of focus group you are running and how many cases or issues you are planning on presenting. However, the typical focus group lasts 4-6 hours and a 10-15-minute break should be taken a few times during each focus group.

If you are planning a 4-6 hour group, your introductory remarks should be limited to 15-30 minutes, the presentations should last no longer than one to two hours, and the remaining time should be reserved for focus group discussion.

Where should focus groups be conducted?

Focus groups are best conducted at a site that is not associated with you or your firm. Hotels and conference centers are the ideal location. However, this is not always practical or affordable and therefore focus groups can be effectively carried out in your office under the correct circumstances.

When should focus groups be conducted?

When considering a time to start your focus group it is best to consider what hour suits your demographics. If you're looking to include people with jobs a start time between 9:00-5:00 will exclude most of those people. Therefore, it is best to start most focus groups after 5:00 p.m. preferably at 6:00 p.m.

Presenting: The importance of a seating chart.

Use of a seating chart will help the presenter interact with the focus group participants on more direct level. For example, the chart allows the presenter to refer to the participants by their first name. The chart should also include demographic information for each participant.

Presenting: Staying Unbiased.

The presenter must remain unbiased throughout the proceeding. Even a little bias can impact the opinions of the focus group. Presenters should not inject their opinions, feelings, or notions into the process. Treat everyone's opinions or statements equally and avoid giving weight to an opinion. For example, avoid statements like, "good point" or "I agree with you" or "I like what you're saying". Also, be cognizant of body language. Avoid things like frowning or shaking your head in agreement/disagreement.

Presenting: Getting Everyone Involved.

Some focus groups members will have strong opinions and great feedback but simply don't like to talk. The presenter must make sure to get these quieter participants involved and attempt, sometimes repeatedly, to get them talking and express themselves.

Presenting: Controlling the Group

One of the most common problems in a focus group is the one or two people who attempt to dominate the conversation and in effect control the discussion. The presenter cannot let this occur and must work hard to control the group so that everyone feels free to get involved in the group discussion.

Presenting: Guide the Discussion

The presenter's main job is to guide the conversation while at the same time staying out of the conversation. The presenter directs the topics to be discussed and moves the group through each topic once the conversation on the previous topic is exhausted.

Post Focus Group: Case Weaknesses

A focus group can help determine case weaknesses. Lawyers sometimes lean heavily on facts and arguments they find persuasive without ever knowing if that same fact or argument is truly persuasive to the average person. What some lawyers miss is that certain facts/arguments are simply rejected by people even if those facts/arguments are logical and reasonable. For example, many lawyers love catching someone in a lie and then proceed to hang their hat on the lie, they build arguments around the lie and depend on that lie to make their case. Focus grouping that lie often leads to the realization that the lie will not carry the day and will not be anywhere near as persuasive

as the lawyer hoped. The focus group reveals the rationale for negative responses to issues in a case and helps build alternatives or highlight other facts that are helpful to building a successful argument.

Post Focus Group: Case Strengths

Focus groups can also help point out the true strengths of a case. Once the focus group revels the facts they find persuasive, arguments can then be built on those facts. Unnecessary facts and arguments can be removed from your case and the emphasis can be on the important facts and issues that actually persuade.

Post Focus Group: Memo

Immediately after every focus group a memo should be done summarizing the focus group's opinions and laying a game plan for the next focus group.

Sources include:

Focus Groups: Hitting the Bull's-Eye by Phillip Miller and Paul Scoptur

The "Why" and "How" of Focus Group Research by Douglas L. Keene

How to Do Your Own Focus Groups: A Guide for Trial Attorneys by David Ball

Focus Group Strategies: Winning and Successfully Settling Jury Trials by Ami Gordon & Robert Gordon

LINK TO POWERPOINT PRESENTATION:

https://prezi.com/view/2FnsDjgFC3EEuQhyYuLc/

Speaker Biographies

DAVID R. ADAMS, ESQ.

Biography

David R. Adams is a member of Hurwitz & Fine, P.C. Mr. Adams has extensive experience defending clients in construction accidents/New York Labor Law, construction defect, environmental toxic exposure, product liability, transportation negligence and other complex and catastrophic injury litigation. Mr. Adams heads the firm's New York Labor Law practice group and is the editor of the firm's monthly electronic newsletter *Labor Law Pointers*, which provides a review and analysis of the most current and significant New York State Labor Law cases. He also has significant experience handling environmental litigation and toxic exposure lawsuits, having handled matters including the initial and current Love Canal litigation.

Mr. Adams heads the firm's 24-Hour Emergency Response Team for construction site accidents and is a member of the firm's 24-Hour Emergency Response Team for trucking accidents.

Mr. Adams is a member and past President of the Western New York Defense Trial Lawyers Association, a member of the New York State Bar Association, (Trial Lawyers, Torts, Insurance and Compensation and the Labor and Employment Law sections), a member of the Bar Association of Erie County and a member of the Western New York Trial Lawyers Association.

He earned his Juris Doctor from the State University of New York at Buffalo School of Law where he was awarded the Connelly Award for outstanding performance in trial technique and was selected to the UB Law School National Mock Trial Team. Mr. Adams is a cum laude graduate of Canisius College.

Noted for his excellent reputation in Construction Litigation by New York Super Lawyers Magazine, Mr. Adams is a frequent speaker and lecturer on New York State Labor Law and risk transfer issues.

HON. THOMAS P. (TIM) FRANCZYK
BIOGRAPHY

Thomas P. (Tim) Franczyk is a recently retired (December, 2017) Erie County Court Judge who serves as Co-Director of the Trial Advocacy Program at the University at Buffalo School of Law. He also coaches National Trial Teams and has taught Evidence, Professional Responsibility and Trial Technique. He has been an Adjunct Instructor of Law at the Law School since 1994. Judge Franczyk has overseen and coordinated the Buffalo Niagara Trial Competition (one of the largest competitions in the country) since 2004. He is also a member of the Judicial Advisory Committee on the Guide to New York Evidence.

Judge Franczyk also serves as the Director of CLE Training for the Assigned Council Program of Erie County. He has also presented on matters of substantive law, procedure and evidence to judges on behalf of the Office of Court Administration, to lawyers, (New York State Bar Association, New York State Trial Lawyers Association, Erie County Assigned Counsel Program, National Business Institute), to recent law graduates (Video Presentation on Evidence for the New York State Law Exam) and to law students.

Judge Franczyk was an Erie County Court Judge for ten years and a Buffalo City Court Judge for the preceding decade (1996-2006). In addition to presiding over criminal cases and some civil trials (as an Acting State Supreme Court Judge), he also served as Domestic Violence Judge in both courts. Before that, he was a prosecutor with the Erie County District Attorney's Office for 14 years.

In 1982, Franczyk graduated from Syracuse University College of Law where he was a member of the National Trial Team which was a national finalist in the National Trial Competition. He also received the Syracuse Defense Group Award for Excellence in Trial Advocacy.

Other recognitions include: Special Services Award (Erie County Bar Association 2019); Outstanding Jurist Award (Erie County Bar Association 2010); Award for Judicial Excellence (Western New York Trial Lawyers Association, 2017), Ken Joyce Award for Excellence in Teaching (UB Law School, 2014), Distinguished Non-Alumnus Award (UB Law School, 2010), Prosecutor of the Year Award (BPD Detective Sergeant's Association, 1992).

Franczyk resides in Buffalo with his wife, Michele, a retired school teacher. They have twin daughters, Clare and Natalie, age 31, who live in Richmond Virginia, and one granddaughter, Bella, age one, who is as her name describes in all relevant respects.

Franczyk is also a member of the Kensingtons Rock-and-Roll band which plays all over Western New York.

SHARON STERN GERSTMAN
Biography

Sharon Stern Gerstman is counsel to the Buffalo, New York law Firm of Magavern Magavern Grimm LLP. She concentrates in the areas of mediation and arbitration, litigation and appellate practice.

Practice Areas
Appellate Practice (/practice-areas/appellate-practice/), Litigation (/practice-areas/litigation/),
Mediation and Arbitration

Experience
She has taught in the law schools of University of Toledo, University of Missouri-Kansas City, and University at Buffalo, where she taught New York Practice for 30 years. She is the author of numerous law review articles, is a co-author of *New York Civil Practice* (James Publishing), and is on the editorial board of Weinstein Korn and Miller, *New York Civil Practice: CPLR*.

In addition to law school teaching, Ms. Gerstman's professional experience includes 29 years of service as Court Attorney/Referee and Principal Law Clerk in New York State Supreme Court, where her primary responsibility was mediating civil cases to settlement.

Court Admissions
She is admitted to practice in all of the state courts in New York and Pennsylvania and before the
United States Supreme Court.

Professional & Community Associations
Ms. Gerstman has served on the Board of Governors of the American Bar Association and continues to serve in its House of Delegates. She is Immediate Past President of the New York State Bar Association and serves in its Executive Committee and its House of Delegates.

She is a past director of the Bar Association of Erie County and a past president of the Erie County Bar Foundation and of the Women Lawyers of Western New York. She has received numerous awards from various bar associations and is a life fellow of the American Bar Foundation and of the New York State Bar Foundation. She is also an elected member of the American Law Institute.

Education
Ms. Gerstman received her bachelor's degree from Brown University, her juris doctorate from the University of Pittsburgh, and her master's in law from Yale Law School.

RICHARD A. HALL, IV, ESQ.

Biography

I grew up in North Buffalo and currently live in Amherst with my wife and three children. My mother was a teacher in the city of Buffalo, and my father was a salesman with Proctor & Gamble. I graduated from Canisius High School where I was a standout on the football team. I obtained my undergraduate degree and law degree from SUNY Buffalo.

Early in my career, I did work for numerous insurance companies and big corporations, this experience changed my life for the better. I quickly learned that insurance companies and big corporations have only one goal: to put profits over people. I knew first hand that the insurance companies and big corporations were hurting far more people and families than they were ever helping. I became a plaintiff's lawyer because helping people should be a priority. Now I use my experience with the insurance companies and big corporations to help others, instead, of harming them.

Helping people and families that suffer when big companies break important safety rules has become my passion. As a community, we must hold companies accountable for breaking the safety rules that keep us all safe. Holding these companies accountable for the harm they have caused helps keep all of us and our families safe. As a community, we must deter these companies from breaking our safety rules because behavior rewarded is behavior repeated.

Since becoming a Plaintiff's lawyer I have obtained numerous verdicts in excess of a million dollars, some of the largest verdicts of their type in New York State. The juries that awarded those verdicts told me afterward that they understood the importance of their role on the jury as community leaders. Those leaders simply could not stand by while members of our community were harmed by safety rule violators. Those jury members knew that their verdict would help stop the safety rule violation from ever happening again. I focus my practice on the areas of construction accidents, Workers' Compensation, falls, and motor vehicle accidents.

PAUL K. ISAAC, ESQ.
Biography

Paul K. Isaac, Esq. is a former trial attorney and the Founder and Chief Counsel of Precision Resolution, LLC and Paramount Settlement Planning, LLC.

A strategic life planner, holding his life and health insurance license, as well as securities licenses in Series 6, 63, 65 and 7, Mr. Isaac's years of experience allow him to anticipate plaintiffs' long-term financial needs. During Mr. Isaac's time as a practicing attorney, he helped several clients obtain large settlements and favorable verdicts. In addition to assisting plaintiffs with the strategies for handling settlements from all types of personal injury lawsuits, Mr. Isaac is experienced in navigating the intricacies of complicated life care cases in which Medicaid and Medicare benefits must be preserved. He is also experienced in negotiating all types of liens associated with personal injury cases and their settlements.

Mr. Isaac earned both his undergraduate and law degrees from Duquesne University in Pittsburgh, Pennsylvania.

HONORABLE SHIRLEY TROUTMAN, ESQ.

Biography

Justice Troutman was designated to the Appellate Division, Fourth Department by Governor Andrew M. Cuomo on February 19, 2016. She previously served as a trial judge in New York State Supreme Court, assigned to the 8th Judicial District, where she handled matrimonials and general civil litigations matters. Prior to her election to Supreme Court, Justice Troutman was a County Court Judge, where she handled felony criminal cases, appeals and civil matters. Additionally, she served as a City Court Judge, where she presided over criminal and civil cases within that court's jurisdiction. She has served as an Adjunct Professor at the State University of New York at Buffalo Law School. She has served as a Lecturer of the New York State Judicial Institute, as well as CLE programs and seminars including serving as a Faculty Member for the National Judicial Institute on Domestic Violence. Prior to joining the bench, Justice Troutman was an Assistant United States Attorney for the Western District of New York, Assistant State Attorney General and an Assistant District Attorney. Justice Troutman received a B.S. from the State University of New York at Buffalo and a J.D. from Albany Law School of Union University. She is also designated as an Advanced Science Technology and Resource (ASTAR) fellow, which is a program sponsored by the United States Department of Justice. As an ASTAR fellow she serves as a resource judge for members of the judiciary of New York State handling complex cases involving scientific evidence.

Justice Troutman also served as a member of the editorial board that published "New York State Public Health Legal Manual" in 2011 and authored a report on minority representation on juries in the 8th Judicial District which included recommendations on how to improve diversity in jury pools. Additionally, Justice Troutman serves as a Member of the Advisory Committee on Judicial Ethics.

She has received the following honors: M. Dolores Denman Award - WNY Chapter of WBASNY, Legal Service Award - Minority Bar Association of WNY, Achievement Award - Committee on Women in the Courts and Local Specialty Bar Associations, and numerous other recognitions.