

**RECENT DEVELOPMENTS  
IN  
LIEN RESOLUTION LAW**

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**DISCLAIMER**

*Although every effort has been made to obtain the best information available for presentation herein, the reader must recognize that many of the issues in this area are part of a rapidly changing body of law and administrative interpretation. The author makes no warranties about the legal conclusions stated herein and this is not intended as legal advice to any individual. Application of the principals discussed in this paper to specific cases should only be taken upon the advice of knowledgeable counsel.*

## RECENT DEVELOPMENTS IN LIEN RESOLUTION LAW

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### **Introduction**

This paper is not intended to be a comprehensive analysis of this ever-changing area of the law, but a resource to point attorneys in the right direction. There have been many changes in the past months, but there is still a great deal of uncertainty regarding the creation, negotiation, and payment of liens in Georgia.

### **Why a Lien?**

Claims against the funds due a plaintiff at the conclusion of a case can come in the form of assignments, subrogation rights, or liens.

An *assignment* is a transfer or making over to another of the whole of any property, real or personal, in possession or in action, or of any estate or right therein.<sup>1</sup>

*Subrogation* is the substitution of one person in the place of another with reference to a lawful claim, demand or right, so that he who is substituted succeeds to the rights of the other in relation to the debt or claim.<sup>2</sup>

A *lien* is a right or claim against some interest in property; it may be common-law, equitable, or statutory.<sup>3</sup>

The settlement of a case is the end of one process and the beginning of another. Claims of other parties against the settlement which are created by statute, regulation, case law, or agreement may result in numerous entities vying for a portion of the plaintiff's settlement. The law under which the claims are created and the lawyer's rules of ethics

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<sup>1</sup> Black's Law Dictionary 109 (5<sup>th</sup> ed. 1979).

<sup>2</sup> Black's Law Dictionary 1279 (5<sup>th</sup> ed. 1979).

<sup>3</sup> Black's Law Dictionary 832 (5<sup>th</sup> ed. 1979).

require that the claims be properly resolved before funds are disbursed to the client.

From a public policy point of view, reimbursement inures to the benefit of all beneficiaries by reducing the total cost of the insurance. If one beneficiary is relieved of his obligation to reimburse the insurer for benefits it paid on his behalf, the cost of those benefits would be defrayed by other beneficiaries or the taxpayers in the form of higher premium payments. Both public and private health insurance plan fiduciaries must ensure that the assets of the health plans are preserved in order to satisfy present and future claims. Because maintaining the financial viability of these plans is often unfeasible in the absence of reimbursement and subrogation provisions, denying a right to reimbursement would harm other beneficiaries by reducing the funds available to pay those claims.<sup>4</sup>

Ensuring that the reimbursement claims are resolved is in the best interest of the client and part of the attorney's legal and ethical obligation.

### **The Make-Whole Doctrine**

Under the common law "make-whole" doctrine, the insured must be made whole before the insurer can exercise his right of subrogation. The Georgia make-whole doctrine as codified<sup>5</sup> applies to "benefit providers," which include "any insurer, health maintenance organization, health benefit plan, preferred provider organization, employee benefit plan, 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 contract with an individual or group." The statute provides that a benefit provider may not seek reimbursement unless the total recovery, less the amount of benefits for which the provider is seeking reimbursement, exceeds the total economic and non-economic damages. If the injured party claims that the recovery does not exceed the

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<sup>4</sup> *Zurich American Insurance Company v. O'Hara*, 604 F.3d 1232 (11<sup>th</sup> Cir. 2010).

<sup>5</sup> O.C.G.A. §33-24-56.1 (2011).

sum of his losses, the provider can seek a declaratory judgment in superior court pursuant to O.C.G.A. §9-4-2 to determine the extent to which it may share in the settlement.

Further, the claim is not enforceable unless strict notice requirements are met. The injured party must provide notice to the benefit provider no less than ten days prior to the consummation of a settlement or commencement of trial; if this notice is not provided then the claim for reimbursement is enforceable. The provider must then provide an itemized list of the benefits for which it seeks reimbursement, which must be received prior to final settlement; if the provider doesn't respond timely, then the claim is not enforceable.<sup>6</sup>

### **The Common-Fund Doctrine**

The common-fund doctrine demands that the lien holder contribute to attorney fees. The underlying theory is that the plaintiff, whose efforts create, discover, increase, or preserve a fund to which others also have a claim, is entitled to recover from the fund the costs of his litigation, including attorneys' fees.<sup>7</sup>

Georgia's make-whole statute<sup>8</sup> specifically provides for the amount of the reimbursement claim to be reduced by the pro rata amount of the attorney's fees and expenses of litigation incurred by the injured party in bringing the claim.

### **Medical Care Liens**

Georgia law provides for the creation of statutory liens against a cause of action (but not against the individual) in cases where medical care is provided by a hospital, nursing home, physician practice, or traumatic burn care medical practice, to an individual who has been injured by the acts of a third party.<sup>9</sup> The provider must follow these specific steps to perfect its statutory medical lien: (1) not less than 15 days before filing a statement with the

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<sup>6</sup> *Id.*

<sup>7</sup> Black's Law Dictionary 250 (5<sup>th</sup> ed. 1979).

<sup>8</sup> O.C.G.A. §33-24-56.1. (b)(2) (2011).

<sup>9</sup> O.C.G.A. §44-14-470 (2011).

superior court, provide written notice to the patient and, to the best of the provider's knowledge, the persons, firms, corporations, and their insurers claimed by the patient to be liable for damages, by first class and certified mail or statutory overnight delivery, return receipt requested; and (2) file a verified statement of lien with the superior court in the county where the provider is located and in the county where the patient resides. The statement must contain the name and address of the patient; the name and location of the health care provider; the dates of admission and discharge, or dates of treatment; and the amount claimed to be due for the care provided. If the statement is filed by a hospital, nursing home, or provider of traumatic burn care then it must be filed within 75 days after the person has been discharged; if filed by a physician practice then it must be filed within 90 days after the person first sought treatment from that practice for the injury.<sup>10</sup>

Given the somewhat complicated manner in which the provider is required to comply it should come as no surprise that providers do not always meet this strict standard. The 2006 amendment to this statute (effective July 1, 2006) clarified that the failure to perfect the lien by complying with the notice and filing provisions of this statute, "shall invalidate such lien, except as to any person, firm, or corporation liable for the damages, which receives prior to the date of any release, covenant not to bring an action, or settlement, actual notice of a notice and filed statement made under subsection (a) of this Code section, via hand delivery, certified mail, return receipt requested, or statutory overnight delivery with confirmation of receipt."<sup>11</sup> To date there is no case law interpreting this amendment or clarifying whether the exception applies to the prior notice of the lien, to the late filing of the statement of lien, or to both.

But beware situations where the client's health insurance contract with the health care provider controls, and may leave the provider empty handed if it doesn't bill the client's

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<sup>10</sup> O.C.G.A. §44-14-471 (2011).

<sup>11</sup> O.C.G.A. §44-14-471(b) (2011).

insurer directly. Under *Owners*,<sup>12</sup> the court held that by attempting to collect the provider's lien from the patient's settlement funds the healthcare provider was violating its contract with TRICARE, which prohibited the provider from obtaining any recourse from the TRICARE beneficiary.

When the legitimate lien has been properly perfected it is, of course, necessary to negotiate and satisfy the lien and secure a release as part of the case resolution, and prior to disbursing funds to the client. Often the providers will allow a discount for cash payment. However, in the event of a wrongful death claim where the available funds are not sufficient to cover both the wrongful death claim and the medical care lien, and when the deceased patient's estate does not make a claim for medical payments, the Georgia Court of Appeals has held that the funds may be allocated to the wrongful death claim to the detriment of the lien. The lien accrues against the patient and her estate; it does not attach to the wrongful death claim, which is not an action "accruing to the person to whom the care was furnished or to the legal representative of such person." The court determined that "someone has to determine which of the several causes of action will be satisfied out of the meager funds available, and the plaintiffs who have the right to bring those causes of action are the logical ones to make that choice."<sup>13</sup>

## **Medicare Claims**

### **Medicare Alphabet Soup**

Medicare is a national health insurance program that guarantees access to health insurance for Americans ages 65 and older and younger people with disabilities. Created in 1965 under Title XVIII of the Social Security Act, it was expanded in 1972 to include younger people who have permanent disabilities and receive Social Security Disability

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<sup>12</sup> *MCG Health, Inc. v. Owners Ins. Co.*, 288 Ga. 782, 707 S.E.2d 349 (2011).

<sup>13</sup> *Nash et al. v. Allstate Insurance Company et al.*, 256 Ga. App. 143, 567 S.E.2d 748 (2002).



Insurance (SSDI) benefits, and those who have end-stage renal disease. It was expanded again in 2001 to cover younger people with ALS, or Lou Gehrig's disease.

Medicare has four parts: A, B, C, and D. Traditional Medicare includes Part A (inpatient hospital, skilled nursing facility, home health, and hospice care) and Part B (physician, outpatient, home health, and preventive services). Part C (Medicare Advantage), was established later and allows Medicare enrollees to participate in private health plans that are required to cover all the Part A and B benefits as an alternative to traditional Medicare. Approximately 76% of Medicare enrollees have traditional Medicare while the balance have a Medicare Advantage plan.<sup>14</sup> In 2003, Congress created Part D, which covers outpatient prescription drugs, also through private plans.

Spending on Medicare Part A has exceeded income since 2008, and is projected to increase as the number of beneficiaries increases from 48 million (in 2010) to 80 million over the next twenty years. During the same time period the projected ratio of workers per beneficiary will decrease from 3.7 to 2.4. Clearly, funding will become a serious issue.

### **What is a “conditional payment”?**

A conditional payment is a payment made by Medicare for health care services provided to a Medicare beneficiary when another payer may be responsible. The payment is made so that the beneficiary doesn't have to spend his own money to pay the bill. It is considered “conditional” because it must be paid back to Medicare when a settlement, judgment, award, or other payment is received by the beneficiary.

### **MMSEA**

Under the Medicare, Medicaid and SCHIP Extension Act of 2007<sup>15</sup> (MMSEA) the

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<sup>14</sup> Medicare Advantage 2010 Data Spotlight, The Henry J. Kaiser Family Foundation, <http://www.kff.org/medicare/upload/8080.pdf>.

<sup>15</sup> Public Law No. 110-173.

Medicare Secondary Payer Act (MSPA)<sup>16</sup> was amended to require insurers to determine if their claimants are Medicare eligible, and to report information about claims of Medicare recipients to Medicare.<sup>17</sup> The stated objective is to coordinate the payment of health insurance benefits and to reveal potential claims for reimbursement, and make it clear that the federal government is serious about being the payer of last resort behind other insurers, including workers' compensation, liability, no fault, and group health insurance.<sup>18</sup> It is estimated that \$5 billion in unresolved Medicare claims will surface against which Medicare will seek recovery. Failure to comply results in a fine of \$1,000 per day per beneficiary, plus the double damages plus interest penalty that primary payers can be fined if Medicare's reimbursement claim is not honored at time of settlement. The revenue generated from payment of the fines, estimated to be \$1.1 billion, will be used to fund SCHIP (the State Children's Health Insurance Program). The reporting requirement was initially scheduled to go into effect in 2009; it was delayed several times, but went into effect on January 1, 2012 for liability settlements occurring on or after October 1, 2011. No one has been fined yet because the Centers for Medicare & Medicaid Services (CMS) hasn't determined which part of the federal government will be responsible for collecting the payments; word is that the first penalties will be imposed soon.

### **The Medicare Subrogation Claim – Statutory Basis**

When Medicare makes conditional payments on behalf of its beneficiaries it has a subrogation interest (not a "lien"), such that if the Medicare beneficiary recovers against a third party for his injury then Medicare will be repaid.<sup>19</sup> The subrogation interest runs through the beneficiary / plaintiff, and Medicare's rights ripen only upon the settlement,

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<sup>16</sup> 42 U.S.C. §1395y (b) (2010); Section 1862 (b) of the Social Security Act.

<sup>17</sup> Section 111 of the MMSEA.

<sup>18</sup> 42 C.F.R. §411.20.

<sup>19</sup> 42 U.S.C. §1395y (b)(2)(B)(ii) (2010).

judgment, or award of the beneficiary's claim. If the beneficiary doesn't recover from a third party then Medicare has no claim or cause of action against anyone.<sup>20</sup> As a general rule Medicare allows for attorney fees and costs when calculating the reimbursement, thus following the Georgia common-fund doctrine.

If the beneficiary recovers but fails to reimburse Medicare, then the United States can bring an action against “any or all entities that are or were required or responsible to make payment under a primary plan, or any entity that has received payment from a primary plan or from the proceeds of a primary plan’s payment to any entity.”<sup>21</sup> This includes the beneficiary, a provider, supplier, physician, attorney, State agency, or private insurer.<sup>22</sup> While this topic has become “hot” in the last five years, the law is not new; it has been in effect since 1980.

### **The Medicare Subrogation Claim – Case Law**

#### **Attorney Risk – U.S. v. Harris**

The law is clear that “CMS has a right of action to recover its payments from any entity, including ..... attorney ... that has received a primary payment.”<sup>23</sup> This case didn't involve big dollars (fortunately for Mr. Harris!), but is a case of Medicare making the point that they are serious about recovering – even against attorneys.

Paul Harris was the attorney who handled the Medicare beneficiary's third party claim. When the case settled for \$25,000 he notified Medicare, as required. CMS determined that it had paid \$22,549.67 in medical expenses, and calculated that it was owed \$10,253.59, after taking into account attorney's fees and costs. CMS notified Mr. Harris of the amount due and advised him regarding the beneficiary's appeal rights.

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<sup>20</sup> See *Portman v. Goodson*, No. 3:10CV-313-S (W.D. Ky. 2011).

<sup>21</sup> 42 U.S.C. §1395y (b)(2)(B)(iii) (2010).

<sup>22</sup> 42 CFR 411.24 (g) - (i).

<sup>23</sup> 42 C.F.R. §411.24 (g).

Neither Mr. Harris nor the beneficiary sent payment or filed an appeal.

In response to the government's Motion for Summary Judgment Mr. Harris argued that he had not sent payment as he needed time to engage in discovery. The court discussed the appeal rights allowed to a Medicare beneficiary who is dissatisfied with Medicare's determination, and concluded that as neither Mr. Harris nor the beneficiary pursued the administrative remedies available, their opportunity to challenge CMS' numbers had passed and Mr. Harris was individually liable to reimburse Medicare the amount claimed plus interest.<sup>24</sup>

### **The Check – and “Did we Really Settle?”**

In a recent Florida case the parties settled and the insurance carrier tendered a check made payable to the plaintiffs, their attorney, and to Medicare. The plaintiffs attorney wrote the carrier a letter rejecting the check because Medicare was listed as a payee, and advising that the plaintiffs would resolve the Medicare lien directly with Medicare and hold the carrier harmless. The carrier rejected that offer, arguing that under the MSPA the carrier may be responsible for Medicare reimbursement regardless of the hold harmless. The court addressed the carrier's argument that it was required by law to list Medicare as a payee on the settlement check, finding that while “an insurer *may* be obligated to reimburse Medicare in certain instances .... insurers do not have an affirmative legal duty to make direct payment to Medicare.”<sup>25</sup> However, the court agreed that the carrier may still be liable to Medicare if the beneficiary does not reimburse Medicare within sixty days, as required by the statute.

So, how might this situation have been handled differently? One possibility is for the defendant to issue two checks: one check payable to the beneficiary and his attorney for the

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<sup>24</sup> *U.S. v. Harris*, No. 5:08CV102, 2009 WL 891931 (N.D.W.Va. Mar. 26, 2009).

<sup>25</sup> *Tomlinson v. Landers*, 2009 WL 1117399 (M.D. Fla. Apr. 24, 2009).

funds due him; the other payable to the beneficiary, his attorney, and Medicare for the amount of the subrogation claim.

Another option may be for the plaintiff to provide to the carrier evidence that he has made or is making payment in full to Medicare when he accepts receipt of the settlement check. This of course requires that the plaintiff have sufficient other resources to make this payment before the settlement check has cleared.

Another option is to do as the carrier in *Tomlinson* and have the check made payable to the parties and to Medicare. How Medicare will handle this is addressed in the answer to one of the frequently asked questions at [www.msprc.info](http://www.msprc.info): “When Medicare is named as a payee on a check, all other payees must endorse the check. The check is then sent to the Medicare Secondary Payer Recovery Contractor for deposit. The Medicare Secondary Payer Recovery Contractor will distribute any excess funds it has collected over and above the debt.” There is no indication how long it takes to accomplish this.

In a Kentucky case, *Wilson*, the parties settled but the value of Medicare’s lien wasn’t known. They couldn’t agree on how to ensure that the Medicare claim was paid to the satisfaction of all parties (options raised were giving the carrier permission to discuss the claim with Medicare, depositing the full settlements in an escrow account with a hold harmless agreement, or including Medicare as a payee on the check), so the carrier decided not to release the check until those issues were resolved. It did issue checks to Medicare and to the beneficiary the day after it received notice of the value of Medicare’s lien. The court held that a delay in writing the check due to lack of certainty regarding the amount of the claim was not bad faith.<sup>26</sup>

### **Beneficiary required to provide his SSN**

Garey Seger was injured and brought a lawsuit for damages for the injuries he suffered. The defendant filed a motion to compel Mr. Seger’s responses to interrogatories,

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<sup>26</sup> *Wilson v. State Farm Mutual Auto Insurance Co.* (W.D. Ky. 2011).

as Mr. Seger refused to provide information about his enrollment in Medicare. Citing the MSPA and the reporting requirements imposed on insurers, the court concluded that though it wasn't necessary that the defendant know his Medicare status and Social Security number in order to negotiate a settlement, this is information that will be necessary eventually, and ordered that he provide his Medicare Health Insurance Claim Number (HICN) or his Social Security Number.<sup>27</sup>

Harold Hackley, a minor, brought an action (through his father) seeking damages as a result of injuries he sustained in a motor vehicle accident. The case settled but the defendants' insurer refused to deliver the funds until the plaintiffs provided the insurer with their social security numbers. The insurer claimed it is statutorily obligated to determine whether a claimant is entitled to Medicare benefits before disbursing any settlement funds, and that it needs the plaintiffs' social security numbers to do so.

The plaintiffs' attorney argued that the plaintiff is just sixteen years old and obviously not eligible for Medicare benefits. The court reviewed the MSPA finding that the statute expresses a preference for a standardized procedure based on HICN or Social Security Numbers with which the insurer can make the determination itself electronically. As such, it is permissible to hold settlement funds until a Social Security Number is provided.<sup>28</sup>

The court also considered whether the settlement was ambiguous, given the issue about providing the Social Security Numbers. This is a recurring issue in Medicare resolution cases (recall *Tomlinson*<sup>29</sup> previously discussed), in large part because the landscape is changing quickly and the parties may be addressing issues they had not previously considered, or considered important.

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<sup>27</sup> *Seger v. Tank Connection*, No. 8:08CV75 (D. Neb. April 22, 2010).

<sup>28</sup> *Hackley v. Garofano*, No. CV095031940S (Conn. Super. Ct. July 1, 2010).

<sup>29</sup> *Tomlinson*, 2009 WL 1117399.

### **How Much is Owed? – Hadden v. U.S.**

Vernon Hadden was injured when he was hit by a vehicle; he received a \$125,000 settlement. He put \$62,000 in escrow for the purpose of reimbursing Medicare, but when Medicare demanded payment he paid the requested \$62,338.07 under protest, arguing that he should be required to reimburse Medicare for only ten percent of the more than \$80,000 that Medicare paid on his behalf. His logic was that he was only ten percent at fault for the accident, that an unidentified motorist (from whom he did not recover) was responsible for ninety percent of his damages, and therefore he had only been compensated for ten percent of his medical expenses. The remaining settlement dollars, he argued, compensated him for pain and suffering and so were not available to Medicare.<sup>30</sup> Hadden also argued that Medicaid statutes and *Ahlborn*<sup>31</sup> require that the government only recover its proportionate share of a discounted settlement.

The court relied on the 2003 amendment to the MSPA statute<sup>32</sup> concluding that the “scope of the plan’s ‘responsibility’ for the beneficiary’s medical expenses – and thus of his own obligation to reimburse Medicare – is ultimately defined by the scope of his own claim against the third party. That is true even if the beneficiary later ‘compromise[s]’ as to the amount owed on the claim, and even if the third party never admits liability.” Therefore, Hadden can’t tell his insurer that it is responsible for all of his medical expenses and later tell Medicare that his insurer was responsible for just ten percent of those expenses.<sup>33</sup>

### **When Must it be Paid? – Haro v. Sebelius**

In a class action the Medicare beneficiaries challenged the authority of CMS to

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<sup>30</sup> *Hadden v. United States*, No. 09-6072 (6th Cir. Nov. 21, 2011).

<sup>31</sup> *Arkansas Department of Health and Human Services v. Ahlborn*, 547 U.S. 268 (2006).

<sup>32</sup> 42 U.S.C. §1395y (b)(2)(B)(ii) (2010).

<sup>33</sup> *Hadden*, at 6.

require prepayment of a MSPA reimbursement claim before the correct amount is administratively determined, where the beneficiary appeals or seeks a waiver of the claim. The court also considered whether attorneys are financially responsible for MSPA reimbursement if they release the settlement funds to their clients.<sup>34</sup>

The challenge was to the sixty-day requirement for payment of MSPA claims and the use of scare tactics such as interest at 11.375%, threats of cessation of the beneficiary's Social Security or Railroad Retirement payments, and collection referrals to federal law enforcement agencies, when the beneficiaries were appealing the amount of their claims or requesting a waiver of the reimbursement amount.

The court analyzed the MSPA statute and its interpretation by other courts in reaching the conclusion that imposing a sixty-day requirement to collect under these facts is not authorized by the statute, is not rational, and is not consistent with the statutory scheme providing for waiver and appeal rights, "because it unnecessarily chills a beneficiary's right to seek a waiver or to dispute the reimbursement claim."<sup>35</sup>

As collection activities against beneficiaries are precluded pending the resolution of their appeals, the same is true as to recovery actions against attorneys. The question, then, in light of the requirements of 42 C.F.R. §411.24 (h) and (i)(1), is may the attorney disburse the funds to the beneficiaries while the appeal is pending? The court analyzed the MSPA, other case law, and legal ethical requirements and concluded that the attorneys are not barred from disbursing the undisputed portions of the settlement proceeds to their beneficiary clients.<sup>36</sup>

### **Statute of Limitations – U.S. v. Stricker**

In 2003 a class action case with 907 members was settled in Alabama for \$300

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<sup>34</sup> *Haro v. Sebelius*, No. 4:09-CV-00134-DCG (U.S.D.C. Ariz. May 5, 2011).

<sup>35</sup> *Id.* at 16.

<sup>36</sup> *Id.* at 24.



million.<sup>37</sup> A number of the plaintiffs were also Medicare beneficiaries, but no one took Medicare's interests into account or reported the settlement to Medicare. In December 2009 the government filed a claim against the plaintiff lawyers, defendant lawyers, and corporate insurers (but not the Medicare beneficiaries themselves) seeking to recover conditional payments and double damages; 69 million dollars is at stake.

Not only did the government wait over six years to file its lawsuit, but its argument was novel. The government argued that it was not barred by the statute of limitations because of the continuing accrual of its cause of action. That is, because the administration of the settlement fund required disbursements on an annual basis, a new Medicare recovery cause of action accrued every year when the annual payments were made.

The court rejected the theory, finding it "lacking in law and logic." The court explained that the government could have filed suit before the expiration of the statute of limitations seeking a total reimbursement for everything that was to be paid pursuant to the settlement agreement, including the continuing payments. The court also noted that the regulations implementing the MSPA define the government's right to initiate recovery as beginning "as soon as it learns that payment has been made or could be made under workers' compensation, any liability or no-fault insurance, or an employer group health plan."<sup>38</sup> In September 2010 the court dismissed the action based on its finding that the applicable statutes of limitations barred the government's complaint. In August 2011 the U.S. District Court for the Northern District of Alabama denied the government's motion to reconsider the court's dismissal of the case.

The government has appealed this decision to the 11<sup>th</sup> Circuit. Keep an eye on this case.

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<sup>37</sup> *U.S. v. Stricker*, No. CV-09-2423 (N.D. Ala. Aug.12, 2011).

<sup>38</sup> 42 C.F.R. § 411.24 (b) (2010).

## **Federal Law Trumps State Law – Cox v. Shalala**

The Fourth Circuit, in 1997, looked at a case where Medicare had conditionally paid \$181,187.75 for injuries Mr. Cox suffered in a motorcycle accident. An action was brought under North Carolina’s Wrongful Death Act and the case settled for \$800,000. The heirs then, recognizing that Medicare had a subrogation claim, filed a declaratory judgment action seeking an order that the government could not claim any portion of the settlement over the NC Wrongful Death Act’s \$1,500 cap on a health care provider’s right to recover damages.

The court held that federal law preempts state law when a state statute “sharply” interferes with, or is directly contrary to a federal law, to the extent that the state law is in direct conflict with Medicare’s secondary payer provisions. Therefore, “[w]hen such a conditional payment is made for medical care, the government has a direct right of recovery for the entire amount conditionally paid from any entity responsible for making primary payment.” “In the alternative, the government’s right of recovery is subrogated to the rights of an individual or entity which has received a payment from the responsible party.”<sup>39</sup>

## **State Law Trumps Federal Law – Apportionment? Bradley v. Sebelius**

The issue in *Bradley v. Sebelius*<sup>40</sup> was whether Medicare was entitled to recover in full from the wrongful death settlement when it had been settled at policy limits for less than 100% of its value. The wrongful death claim was settled for \$52,500; Medicare had paid \$38,875.08 for medical care. The probate court found that the full value of the case was \$538,875.08 and that the amount allocated to Medicare was \$787.50. Medicare refused to reduce its claim to reflect the reduced settlement the parties had taken, as determined by order of the probate court.

Medicare relied on language in one of its field manuals, citing no statutory,

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<sup>39</sup> *Cox v. Shalala*, 112 F.3d 151, 154 (4<sup>th</sup> Cir. 1997).

<sup>40</sup> *Bradley v. Sebelius*, 621 F.3d 1330 (11<sup>th</sup> Cir. 2010).

regulatory, or case law authority, in refusing to recognize the probate court's allocation. The court repeated the Supreme Court's statement that "agency interpretations contained in policy statements, manuals, and enforcement guidelines are not entitled to the force of law,"<sup>41</sup> holding that Medicare is entitled only to the amount the probate court had allocated. In so doing, it can be argued that the Eleventh Circuit essentially adopted apportionment in MSPA recovery actions regardless of the existing statutory and regulatory authority granting Medicare a right to 100% reimbursement.

With this decision the court also suggested that it believes there is merit to a state court having determined the damages, as the court went with the probate court's allocation and didn't disturb Florida law regarding ownership of wrongful death damages recovered by the deceased's survivors.

Bradley was the first MSPA action to move in the direction that the Supreme Court took in *Ahlborn*,<sup>42</sup> supporting apportionment in Medicaid recovery actions despite state law that granted the program similar rights as were granted to Medicare under the MSPA regulations. Given the Eleventh Circuit's existing subject matter knowledge, further analysis of the MSPA will likely get interesting with the *Stricker*<sup>43</sup> appeal now on its doorstep.

### **Medicare Part C Subrogation Claims – They're Different! – Humana v. Reale**

Humana, as a Medicare Advantage plan administering Medicare benefits to Medicare beneficiaries who are enrolled in the Medicare Advantage (or Medicare Part C) plan, filed suit against a beneficiary to recover funds it had paid on her behalf and for which she later recovered against a third party. The court found that a Medicare Advantage organization does not have the right to reimbursement granted under the MSPA, as "the Secretary's

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<sup>41</sup> *Id.* at 1338.

<sup>42</sup> *Ahlborn*, 547 U.S. 268.

<sup>43</sup> *Stricker*, No. CV-09-2423.

authority is limited to making payments ‘conditioned on reimbursement to the appropriate Trust Fund.’” Therefore the federal court had no subject matter jurisdiction and the case was dismissed.<sup>44</sup> It is the United States that has the claim for reimbursement, not Medicare,<sup>45</sup> and the claim is according to the insurance contract and governing state law.

Based on this decision, only the Department of Justice can bring suit in federal court to recover reimbursements due to a Medicare Advantage Plan under the MSPA. One would assume the issues will have to be litigated in state court instead – and there may be defenses available under state law. That said, the case did recognize that Medicare Advantage plans have the same recovery rights as traditional Medicare under the MSPA provisions; the ability to file suit under the MSPA is just not one of those recovery rights.

Keep in mind that Medicare beneficiaries can switch between Part A, B, and D plans, and Part C plans. Likewise, Medicare beneficiaries can switch between Part C plans, enrolling one year under a Humana plan, for example, and the next year under Aetna. As such, it is wise to quiz the client about conditional payments that may have been made under multiple Medicare plans. Also, the negotiation for reimbursements due to a Medicare Advantage Plan is done directly with the insurer, which may make these claims easier to resolve than those with Medicare directly.

### **The Process: Traditional Medicare Claim Resolution**

Under 42 U.S.C. §1395y (b), when a Medicare beneficiary retains an attorney to represent him in a liability case, it is the attorney’s duty to notify the Medicare Coordination of Benefits Contractor (COBC). The COBC can be contacted at MEDICARE - Coordination

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<sup>44</sup> *Humana Medical Plan, Inc. v. Reale*, No. 10-21493-Civ-COOKE/BANDSTRA (S.D. Fla. 2011).

<sup>45</sup> Under 42 U.S.C. §1395y (b)(2)(B)(iii), the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. See also 42 C.F.R. §422.108 (d) (2011).

of Benefits, P.O. Box 33847, Detroit, MI 48232-5847 or by phone at (800) 999-1118.<sup>46</sup> Information that needs to be provided to the COBC includes information about the beneficiary; the date and a description of the accident; the alleged injuries related to accident; the identity and contact information for the defendant and his insurer; the names and contact information for physicians, hospitals, and clinics where the client has sought treatment; and the contact information for the beneficiary's attorney. Send a Proof of Representation and signed retainer agreement to the Medicare Secondary Payer Recovery Contractor (MSPRC).

After the case is established with the COBC, the MSPRC issues a Rights and Responsibilities Letter (RAR). It is sent to all authorized individuals or entities associated with the case.

Then MSPRC identifies claims it has paid that are related to the injury, and automatically issues a Conditional Payment Letter (CPL) to the beneficiary. If the attorney has provided a Proof of Representation the attorney will also receive a copy of the CPL. Though this is supposed to happen within 65 days of the RAR letter, the word in late February 2012 is that it is presently taking 120-150 days to get a CPL due to the workload at CMS. If there is a significant delay between the initial notification to the COBC or the CPL, and the settlement, judgment, or award, the beneficiary may request an updated CPL. Of course, timeliness may be an issue for receiving that letter as well.

The beneficiary or his attorney can challenge any claims on the CPL that are not related to the injury. More current conditional payment information can be gained at [www.MyMedicare.gov](http://www.MyMedicare.gov). Attorneys must gain access through their clients.

A Conditional Payment Notice (CPN) may be issued in lieu of a CPL when a settlement, judgment, or award has already occurred. It provides conditional payment

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<sup>46</sup> The Centers for Medicare and Medicaid Services has good information and forms available for attorneys in the "toolkits" tab at [www.msprc.info](http://www.msprc.info).

information and indicates what actions must be taken due to the settlement, judgment, or award. The beneficiary has thirty days to respond, after which MSPRC will review the beneficiary's comments and issue a demand. If a response is not received in thirty days a demand will be issued based on the information MSPRC presently has. Of course, the amount of the conditional payments may increase after the CPN is issued.

As the settlement is being negotiated it often becomes important to know how much will need to be reimbursed to Medicare. The problem is that Medicare doesn't seem to make a concerted effort to provide good conditional payment information until they are told there is a pending settlement. Even then there will always be at least a 60-90 day gap between the last information that Medicare has and the settlement date (and maybe more, as providers have as much as 25 months in some cases to file a claim for payment). The subrogation claim lives from the day of first treatment to the day of settlement, so it's important to get the numbers as close as possible. One way to do this is to have the client diligently keep receipts and Explanation of Benefits (EOB) documents for that ninety-day gap and bring them to you so that you can determine what is injury related and estimate the amount of the conditional payments made. Another way is to have the client set up an account at [www.mymedicare.gov](http://www.mymedicare.gov). If Medicare has done a good job of entering data there may be good and current information on the client's account at this website.

When a settlement, judgment, or award is reached, the beneficiary or his attorney must submit information about the settlement, along with the date and attorney's fees and litigation costs, to the MSPRC (they suggest using the "final settlement detail" form at [www.msprc.info](http://www.msprc.info)). Then MSPRC will determine the final payment amount, calculate what is owed, and issue the Demand Letter.

The beneficiary can pay the amount owed within sixty days (make the check payable to "Medicare" and include the beneficiary's pertinent information), or can appeal it or ask for a waiver.

Finally, conditional payments are not generally an issue in workers compensation cases because workers comp is paying the medical bills. However, if the claimant has been eligible for Medicare benefits then he may have inadvertently shown his Medicare card as payment for injury related care. To fully protect the client it is wise to step through the requirements described above and get a Demand Letter – which usually will say that zero is owed.

### **Three Brand New Options for Resolving Medicare Claims in Smaller Cases**

For liability cases there are now three new process options for resolving the subrogation claim. Medicare came up with these processes after the congressional hearings last year where they didn't look good due to the time it takes to process a claim.

Starting September 6, 2011, the **\$300 Threshold Rule** applies to Medicare beneficiaries who meet the following criteria:

- The beneficiary receives a lump sum settlement of \$300 or less; and
- The settlement is for a physical trauma-based incident; and
- This is the only settlement the beneficiary will receive for this incident; and
- Medicare has not issued a recovery demand letter.

If the beneficiary meets each of these criteria then Medicare will not exert a claim against the settlement. This does not apply to cases where an insurer has paid or is paying medical bills.

Effective November 7, 2011, the **Fixed Percentage Option** is available to Medicare beneficiaries who meet the following criteria:

- The beneficiary receives a lump sum settlement of \$5,000 or less; and
- The settlement is for a physical trauma-based incident; and
- This is the only settlement the beneficiary will receive for this incident; and
- Medicare has not issued a recovery demand letter.

In these cases the beneficiary can quickly resolve Medicare's recovery claim by

paying Medicare 25% of the total gross liability settlement (instead of using the traditional recovery process). Note that this is based on the gross settlement, so is not reduced for attorney fees and costs. This can be a benefit to the beneficiary and his attorney as it saves time and effort otherwise required to navigate the MSPA recovery process.

To request the Fixed Percentage Option, make a written request (using the form in the Attorney Toolkit at [www.MSPRC.info](http://www.MSPRC.info)) and mail it to the address provided at that website. They indicate that a response will be generated within thirty days of receipt of the request. According to the instructions, if the request is approved the beneficiary will receive a bill for the amount due, and must pay the bill within the time frame indicated on the bill. However, on the model language form there is an option to enclose a check for 25% of the total settlement. If the request is denied the beneficiary will receive an explanation and the case will be handled under the traditional recovery process.

The other option which became available on February 21, 2012, is to **Self-Calculate the Final Conditional Payment Amount** prior to settlement. A Medicare beneficiary can qualify for this if:

- The settlement is expected to be \$25,000 or less; and
- The settlement is for a for a physical trauma-based incident; and
- The incident occurred at least six months before the information is submitted to Medicare; and
- The beneficiary demonstrates with a written attestation from his physician or his own written certification that he has not received medical treatment related to the case for at least 90 days and that he expects that no further care will be necessary (BUT, will plaintiff lawyers advise their clients to have the doctor sign off on no need for further medical care?); and
- The beneficiary gives up his right to appeal the amount or existence of the debt.

To apply, the beneficiary must have reported to the COBC and received a Conditional



Payment Letter. He follows the instructions on the letter to calculate the value of the injury-related care that has been provided by Medicare. MSPRC will respond within sixty days agreeing and demanding payment within sixty days, or disagreeing and recalculating the amount due. According to the instructions, after Medicare receives a copy of the settlement agreement showing the attorney's fees and costs they will reduce the amount for attorney fees and costs, "as appropriate."

Is this a good idea for your client? The biggest benefit is that the beneficiary will now know the amount of the subrogation claim when he settles, rather than settling with just a Conditional Payment Summary. But it still takes time, as it requires a Conditional Payment Letter, which takes 90 days starting with the reporting to the COBC; then the beneficiary goes through the self-calculation process and then waits for the MSPRC response; then he can request a Final Demand. And in exchange for this the beneficiary waives his appeal rights.

**Keep an Eye On:**

H.R. 1063: Strengthening Medicare And Repaying Taxpayers Act of 2011, sponsored by Rep. Tim Murphy (R-PA) and Ronald Kind (D-WI) and known as the SMART Act was introduced on March 14, 2011. As of February 2012 it is in four House committees for review. It purports to provide a more streamlined approach to reimbursing Medicare under the MSPA and less onerous requirements for entities to report under MMSEA. If passed by Congress and signed into law, the SMART Act would provide for notice to Medicare one time 120 days before settlement, judgment, or award, asking for a statement of conditional payment. Medicare would have sixty-five days to respond, and if they failed to do so the claimant would provide another notice after which Medicare would have thirty days to respond. If Medicare failed to respond then the lien presumably would be waived. A three year statute of limitations would be established after which the Federal government could not bring any action associated with compliance under the MSPA. The bill also provides

that Social Security Numbers and Health Insurance Claim Numbers (i.e. Medicare numbers) would not be required, which would make Garey Seger and Harold Hackley happy.

### **So, What's a Lawyer to Do?**

1. At the beginning of the case ask to see all of the client's health insurance cards; make copies for the file.
2. Start early. Determine if the client is eligible for Medicare benefits, or likely will be during the course of the case. If he is, notify the COBC and send a Proof of Representation and signed retainer agreement to MSPRC to get the process started.
3. Talk early with the client about the existence of a Medicare claim, the fact that the claim will need to be resolved, and the effect the resolution of this claim will have on him and on his case. Surprises are not good. Determine if the client participates or participated in a Part C Medicare Advantage Plan. Statistically, 24% of your Medicare eligible clients will presently be covered by a Part C Plan.
4. Recognize that if conditional payments have been made and the client recovers more than \$300 for his damages there will likely be a claim to resolve.

### **ERISA Liens**

The Employee Retirement Income Security Act of 1974,<sup>47</sup> "ERISA," is an "enormously complex and detailed" statute<sup>48</sup> that mandates that federal law preempts state law with respect to most employer-provided health benefits plans. This usually means that the plan provider has a strong claim to recover benefits paid out to a beneficiary when that beneficiary recovers from a third-party. ERISA subrogation has become a minefield for

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<sup>47</sup> ERISA is codified at 29 U.S.C. §§1001-1461 (2010). It governs many employee health and welfare plans and retirement plans.

<sup>48</sup> *Hughes Aircraft Co. v. Jacobson*, 525 U.S. 432, 447 (1999).

attorneys.

### **Self-Funded or Insured?**

There are two types of ERISA plans; self-funded and insured. Which is it? A self-funded plan is one in which the employer both funds the plan with its own assets and pays for employee health care costs with its own funds. An insured plan is one where the employer has purchased a group insurance policy for its employees from a health insurance carrier.

Self-funded ERISA plans are not subject to state law because they are not considered (“deemed”) an insurance company under the ERISA law.<sup>49</sup> Because they are exempt from state law regulation they benefit from ERISA preemption. “State laws that directly regulate insurance 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.”<sup>50</sup> The Department of Labor has taken the position that a plan that is self-funded but has also purchased excess insurance to cover large unexpected claims is still a self-funded plan.<sup>51</sup>

Insured ERISA plans are subject to state law. This narrows the scope of ERISA preemption where health insurance carriers are concerned. When an insured plan asserts a lien against a settlement it is the insurer (not the plan) that is attempting to subrogate.

How do you know which it is? The Summary Plan Description (SPD) is required to disclose the funding arrangement of the plan.<sup>52</sup> The SPD is the summary of the plan that

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<sup>49</sup> 29 U.S.C. §1144 (b)(2)(B) (2010).

<sup>50</sup> *FMC Corp. v. Holliday*, 498 U.S. 52 (1990).

<sup>51</sup> Dept. of Labor Op. Ltr., No. 91-05A (Jan. 14, 1991).

<sup>52</sup> 29 U.S.C. §1022 (b) (2010).

the plan administrator is required to provide to each participant. Obtaining a copy of the SPD early and reviewing it before getting too far into the case is important.

However the SPD should not be relied on as the final authority on an issue as important as this. Because it is a summary it doesn't contain as much detail as the entire health benefit plan itself. If the SPD doesn't contain specific subrogation language it is important to know which document controls; in the 11<sup>th</sup> Circuit the plan controls unless the employee can show that he relied on the SPD.<sup>53</sup> Another way to tell is to check the plan's Form 5500.

The plan itself, the SPD, and the annual Form 5500 report must be filed with the Secretary of Labor. These documents are online at [www.freeerisa.com](http://www.freeerisa.com); search the Form 5500 filings by employer name. Or a plan beneficiary can make a written request to the plan administrator for a copy of the following documents,<sup>54</sup> which must be provided within thirty days or subject the plan to a penalty of \$100.00 per day and other costs, including attorney fees:<sup>55</sup>

- The plan's employer identification and three digit plan number;
- A copy of the policy which states the right to reimbursement of a portion of any settlement in this claim;
- A copy of the updated summary plan description in effect for the last three years;
- A copy of the summary annual reports for the last three years;

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<sup>53</sup> *Branch v. G. Bernd Co.*, 955 F.2d 1574 (11<sup>th</sup> Cir. 1992).

<sup>54</sup> 29 U.S.C. §1024 (b)(4) (2010).

<sup>55</sup> 29 U.S.C. §1132 (c)(1) (2010).

– A copy of the bargaining agreement, trust agreement, contract or other instrument under which the plan was established and all amendments since the established date until the present;

– If the plan is insured, partly insured, or provides stop-loss coverage, a copy of the documents which engage the insurance carrier and all policies of insurance;

– A copy of the Series 5500 returns and the company’s schedules for the last three years; and,

– A copy of all written policies, memoranda, minutes of meetings and any other written documentation addressing reimbursement or subrogation, enforcement of the same, or waiver of the same from the date of establishment of the plan until the present.

### **“Equitable Relief”**

Marlene Sereboff’s employer sponsored a health insurance plan that was covered by ERISA. She and her husband were beneficiaries under the plan, which contained an “Acts of Third Parties” provision requiring a beneficiary of the plan to reimburse the plan when that beneficiary recovered against third parties for injuries, the care for which had been paid by the plan.

The Sereboffs suffered injuries in an automobile accident; the plan paid \$75,000 for their medical care. Thereafter they filed suit against third parties seeking compensation for their injuries. The litigation settled for \$750,000. The plan sought reimbursement of the \$75,000 and, when it was not reimbursed, it filed suit against the Sereboffs.

The U.S. Supreme Court, in *Sereboff*,<sup>56</sup> held that while ERISA itself is silent on the reimbursement issue, language in a benefit plan providing for the plan to be reimbursed is binding. The reimbursement provision in the Sereboff’s plan created a lien by agreement

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<sup>56</sup> *Sereboff v. Midland Atlantic Medical Services, Inc.*, 547 U.S. 356 (2006).

in that it “specifically identified a particular fund, distinct from the plan beneficiaries’ general assets and a particular share of that fund to which the plan was entitled.”<sup>57</sup>

By characterizing the plan’s reimbursement claim as an “equitable lien based on an agreement,” rather than as a claim for subrogation, the court sidestepped the equitable principles of the common fund doctrine and the make whole doctrine. The court says this “parcel of equitable defenses” to a subrogation claim “are beside the point” when the plan’s claim is characterized as an equitable lien based on an agreement.<sup>58</sup>

In footnote two the court notes that the Sereboffs’ appear to have raised a new argument – that even if the plan’s claimed remedy is “equitable,” the remedy is not “appropriate.” What isn’t clear is the criteria the court will use to determine “appropriate” equitable relief. Will it be fairness as to the parties, or will the court consider ERISA’s policy objectives, such as a chilling effect on plan providers if a subrogation claim is not enforced? This language is foreshadowing of the decision in *US Airways*,<sup>59</sup> decided in November 2011 by the Third Circuit and discussed in more detail below.

*Sereboff*, described by Chief Justice Roberts as a decision that “simplified” ERISA law,<sup>60</sup> has caused ERISA plan administrators to bravely go where they have not gone before, and has led to striking decisions by federal courts. Courts have held that ERISA liens can

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<sup>57</sup> *Id.* at 364. Contrast *Sereboff* with *Great-West Life & Annuity Insurance Co. v. Knudson*, 534 U.S. 204 (2002), which described the conditions under which a fiduciary might recover when it was seeking equitable restitution under an “Acts of Third Parties” provision like that at issue in *Sereboff*. In *Knudson* the court concluded that equitable restitution was unavailable because the funds sought were in a Special Needs Trust and so were not in the possession of the employee. The *Knudson* decision will likely be limited to its unique facts and so will be of limited import going forward.

<sup>58</sup> *Sereboff*, at 368.

<sup>59</sup> *US Airways, Inc. v. McCutchen*, Case No. 10-3836 (3<sup>rd</sup> Cir. 2011).

<sup>60</sup> Workplace Prof Blog, [http://lawprofessors.typepad.com/laborprof\\_blog/2006/05/sereboff\\_and\\_th.html](http://lawprofessors.typepad.com/laborprof_blog/2006/05/sereboff_and_th.html) (May 20, 2006, 11:06:47 PM).

trump a catastrophically injured plaintiff's need for lifetime care,<sup>61</sup> and can consume a special needs trust.<sup>62</sup> An Arkansas District Court applied a three part test (does the plan seek to recover funds (1) that are specifically identifiable, (2) that belong in good conscience to the plan, and (3) that are within the possession and control of the beneficiary) to hold that the entire settlement – including attorney fees – was subject to the subrogation claim.<sup>63</sup> The court's logic was that the plaintiff had a pre-existing contractual obligation to the plan to reimburse it for the full amount of any benefits paid on behalf of the beneficiary without a reduction for attorney's fees (the plan specifically stated that it is not responsible for the beneficiary's attorney fees, expenses or costs), and as such that obligation precluded the plaintiff from entering into an agreement with her lawyer to pay him from a fund the plaintiff was not entitled to. This leaves the practitioner wondering where the equity is in denying compensation to the attorney who secured the settlement, without whose efforts there would have been no funds.

In the Eleventh Circuit the court combined two cases with similar facts, and reached opposite decisions in each based on the plan language in each.<sup>64</sup> Deborah Parrott and Josue Carillo were employees of different employers with different plans. Both were injured by the acts of third parties, their medical care was paid for by their respective employer's health insurance plans, they each recovered against third parties for their injuries, and they each failed to reimburse their respective plans from their recoveries.

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<sup>61</sup> *Administrative Committee for the Wal-Mart Stores, Inc. v. Salazar*, 525 F. Supp.2d 1103 (D. Ariz. 2007).

<sup>62</sup> *Administrative Committee of the Wal-Mart Stores, Inc. v. Shank*, 500 F.3d 834 (8<sup>th</sup> Cir. 2007).

<sup>63</sup> *Brown v. Associates Health and Welfare Plan*, No. 07-2006 (W.D. Ark. Aug. 16, 2007).

<sup>64</sup> *Popowski v. Parrott*, 461 F3d 1367 (11<sup>th</sup> Cir. 2006).

Deborah Parrott’s employer’s plan subrogation and reimbursement provision provided that “the Plan has a lien on any amount recovered by the Covered Person whether or not designated as payment for medical expenses.” “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.”<sup>65</sup>

The court found that this language, which is nearly identical to the plan language in *Sereboff*, “specifies both the fund (recovery from the third party or insurer) out of which reimbursement is due to the plan and the portion due the plan (benefits paid by the plan on behalf of the defendant).” Therefore the plan administrator had stated a claim for “appropriate equitable relief” under 29 U.S.C. §1132(a)(3).<sup>66</sup>

The language in the plan that provided care for Josue Carillo read, “If, however, the Covered Person receives a settlement, judgment, or other payment relating 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.”<sup>67</sup>

The court found that this language, requiring reimbursement “in full, and in first priority,” does not specify that the reimbursement be made out of any particular fund, as distinct from the beneficiary’s general assets. “Further, in requiring reimbursement ‘in full,’ it fails to limit recovery to a specific portion of a particular fund.” The court concluded that because the plan “fails to specify that recovery come from any identifiable fund or to limit that recovery to any portion thereof, it fails to meet the requirements outlined in *Sereboff*

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<sup>65</sup> *Id.* at 1370.

<sup>66</sup> *Id.* at 1373.

<sup>67</sup> *Id.* at 1371.



for the assertion of an equitable lien for the purposes of 29 U.S.C. §1132(a)(3).<sup>68</sup> The plan made the “recovery from a third party only a trigger for reimbursement and sets no limit upon the reimbursement” initiated, failing the *Sereboff* requirements to state a claim for appropriate equitable relief.<sup>69</sup>

### **“Other Appropriate Equitable Relief”**

More recently in *US Airways*,<sup>70</sup> decided November 16, 2011, the Third Circuit found that Congress intended to limit the “other appropriate equitable relief” to which the ERISA plan is entitled through the application of equitable defenses and principles. While the written plan remains the key factor, adequate consideration should be given to the facts of the case and whether the ERISA plan is being unjustly enriched.

The facts in *US Airways* are striking, in that the District Court ordered the employee to reimburse the self-funded ERISA plan for 100% of its costs although (after attorney fees and expenses) the employee had not recovered sufficient funds to do so. The result was that the employee would have been required to pay from his own pocket to reimburse the ERISA plan in full, putting him in a worse situation financially than he would have been in had he not pursued the case at all!

The Supreme Court in *Sereboff* defined whether a claim was equitable in nature in terms of imposing an equitable lien and identifying a specific fund, but expressly reserved the question of the qualifying term “appropriate” and whether this term would allow for the application of equitable defenses to such a claim – such as a claim of unjust enrichment. The unjust enrichment issue in *US Airways* centered on a “common fund” type of argument and whether or not the plan must make an allowance for procurement costs (the court

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<sup>68</sup> *Id.* at 1374.

<sup>69</sup> *Id.* at 1375.

<sup>70</sup> *US Airways, Inc.*, No. 10-3836.

didn't address the made whole doctrine as it was not raised on appeal). The court analyzed "relief typically available in equity" and its interplay with unjust enrichment and concluded that unjust enrichment is a principle which covers more than a common fund consideration and is applicable when considering any ERISA claim.

The court also determined that while the express terms of the plan language are important and create the equitable claim, such express terms cannot limit or foreclose the discussion regarding that claim's appropriateness. This is a departure from other ERISA cases whereby equity is found by applying the express terms of the plan even if in opposition to federal common law (most notably in *Zurick*<sup>71</sup>). The court does not disagree with enforcing the express terms of plan language but rather holds that such enforcement must be subject to a court's discretion in applying an appropriateness standard. Nevertheless, the Third Circuit did not define "appropriate equitable relief" as it remanded to the District Court to determine whether US Airways' claim would constitute appropriate equitable relief based on factual findings.

The bottom line is that it is critical to examine the third-party recovery provision of an ERISA plan closely. If the language does not identify a specific fund to which it is entitled — namely, the settlement proceeds — or does not limit the plan's recovery to the amount it has paid for injury-related care and is thus rightfully entitled to, then under *Sereboff* and *Popowski* the lien is unenforceable. And if the facts are compelling enough, then under *US Airways* "other appropriate equitable relief" may be available.

## **Wrongful Death**

Contrast the medical care lien in a wrongful death claim, discussed above (where the available funds are not sufficient to cover both the wrongful death claim and the medical care lien, and when the deceased patient's estate does not make a claim for medical

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<sup>71</sup> *Zurich*, 604 F.3d 1232 (11<sup>th</sup> Cir. 2010).

payments, the funds may be allocated to the wrongful death claim to the detriment of the lien), to the ERISA rule in a wrongful death claim as stated by the U.S. District Court, Northern District of Georgia: “Here, the Estate’s attorney structured the settlement with the third party tortfeasor in a manner that prejudiced the rights of the Plan by arranging for Tamara Hayes to recover the vast majority of the settlement funds” by allocating \$837,000 of a \$900,000 settlement to the wrongful death claim. “The Estate’s actions in structuring the settlement to minimize its reimbursement to the Plan for the medical expenses of Deborah Hayes violates the terms” of the Plan.<sup>72</sup>

### **The Make-Whole Doctrine**

Consider the effect of the make-whole doctrine and how the plan language addresses it, or not. As described above, under the common law “make-whole” doctrine, the insured must be made whole before the insurer can exercise his right of subrogation. Under the Georgia statute,<sup>73</sup> this applies to “benefit providers,” which include “any insurer, health maintenance organization, health benefit plan, preferred provider organization, employee benefit plan, 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 contract with an individual or group.” The claim is not enforceable unless strict notice requirements are met. The injured party must provide notice to the benefit provider no less than ten days prior to the consummation of a settlement or commencement of trial; if this notice is not provided then the claim for reimbursement is enforceable. The provider must then provide an itemized list of the benefits for which it seeks reimbursement, which must be received prior to final settlement; if the provider doesn’t respond timely, then the claim is not enforceable.

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<sup>72</sup> *Diamond Crystal Brands, Inc. v. Wallace*, 563 F. Supp.2d 1349 (N.D. Ga. 2008).

<sup>73</sup> O.C.G.A. §33-24-56.1.

The 11<sup>th</sup> Circuit, in *Cagle v. Bruner*,<sup>74</sup> held that the make whole doctrine operates as a default rule, to limit an ERISA plan's subrogation rights where an insured has not received compensation for his total loss, and the plan is ambiguous or does not explicitly preclude operation of the doctrine. Because the make whole doctrine is a default rule the parties can contract out of the doctrine. Further, if the parties contract out of the doctrine then sending the ten-day letter as provided under O.C.G.A. §33-24-56.1(g) does not protect the injured party from a reimbursement claim.

In 2006 the *Smith* court held that "Under the make whole doctrine, 'an insured who has settled with a third-party tortfeasor is liable to the insurer-subrogee only for the excess received over the total amount of his loss.'"<sup>75</sup>

Just last month the U.S. District Court for the Southern District of Georgia applied the default make whole doctrine to deny an ERISA lien assertion in the amount of \$17,632 made against a tort recovery of \$25,000.<sup>76</sup> The plan language was detailed but did not specifically negate the make whole doctrine. The court cited *Diamond*,<sup>77</sup> a Northern District of Georgia case, as an example of plan language that is sufficient to contract out of the make whole doctrine: "No consent or agreement of the plan to reduce its recovery for any reason shall be implied either in fact or in law by any doctrine or rule of law to the contrary . . . Except as otherwise agreed by the Plan in writing, the proceeds shall be applied first to the Plan's recovery, whether or not any Covered Individual, dependent or other Recipient is or would be fully compensated, notwithstanding any 'Made-Whole Doctrine,' . . . or any other

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<sup>74</sup> *Cagle v. Bruner*, 112 F.3d 1510 (11<sup>th</sup> Cir. 1997).

<sup>75</sup> *Smith v. Life Ins. Co. of North America*, 466 F. Supp.2d 1275, 1285 (N.D. Ga. 2006).

<sup>76</sup> *Cody v. Management International Longshoreman's Association*, No. CV409-104 (S.D. Ga. Feb 2, 2011).

<sup>77</sup> *Diamond Crystal Brands, Inc. v. Wallace*, 2010 U.S. Dist. LEXIS 48684 (N.D. Ga. Feb. 11, 2010).

law which would otherwise require a Covered Individual, dependent or other Recipient to be compensated before reimbursement of a subrogee.”<sup>78</sup> Contrast this with plan language that the Eleventh Circuit determined allowed for the make whole doctrine to be applied eight years before *Cagle* was decided, based on a “general principle of subrogation law that an insured who has settled with a third-party tortfeasor is liable to the insurer-subrogee only for the excess received over the total amount of his loss.”<sup>79</sup>

So again, a careful review of the plan language is required. If the make whole doctrine does not apply or has been negated by the language of the plan, the plan could be entitled to most or even all of the client’s settlement proceeds if the settlement amount isn’t large enough to satisfy the lien. In a situation like this the attorney must rely on his or her best negotiating skills to try to resolve the case favorably for the client. Of course, it is important to also advise the client of the facts, as this result may affect the client’s interest in proceeding with the case.

### **The Common-Fund Doctrine**

Under the common-fund doctrine the plaintiff is entitled to recover from the fund the costs of his litigation, including attorneys’ fees.<sup>80</sup> Georgia’s make-whole statute, O.C.G.A. §33-24-56.1.(b)(2), specifically provides for the amount of the reimbursement claim to be reduced by the pro rata amount of the attorney’s fees and expenses of litigation incurred by the injured party in bringing the claim.

Because reductions for attorney fees are routine and expected with respect to other liens, attorneys have come to expect the same of ERISA liens. However, the majority of

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<sup>78</sup> *Id.* at 24.

<sup>79</sup> *Guy v. Southeastern Iron Workers’ Welfare Fund*, 877 F.2d 37, 39 (11<sup>th</sup> Cir. 1989).

<sup>80</sup> Black’s Law Dictionary 250 (5<sup>th</sup> ed. 1979).

federal circuits have held that an ERISA plan need not contribute to attorney fees where its own plain language gives it an unqualified right to reimbursement. The law is also unsettled on the question of whether the plan must contribute to the fees if the plan is ambiguous or silent on that issue.

In 2001 the U.S. District Court for the Middle District of Georgia held against a claimant asking for the ERISA plan to participate in the legal fees. “The use of the ‘common fund’ theory most often occurs in actions seeking equitable relief where specific statutory guidelines underlying the award of attorneys fees are not available.” “We believe that ERISA §502(g), 29 U.S.C. §1132(g), as a specific statutory authorization of attorneys fees, will, in most cases, eliminate the necessity which gave rise to the common fund exception to the American rule. By enacting a statutory authorization for award of attorneys fees, we believe Congress intended that the offending party bear the costs of the award, rather than non-culpable, non-party plan participants.”<sup>81</sup> But five years later the U.S. District Court for the Northern District of Georgia held that ERISA provides that a court may, in its discretion, award attorney’s fees and costs to either party, citing 29 U.S.C. §1132(g)(1).<sup>82</sup>

Just two years ago the court in footnote four of *Zurich*<sup>83</sup> expounded on the common fund doctrine and its application in ERISA cases, citing cases from the third, sixth, and eighth Circuits. The plan in *Zurich* clearly disclaimed the common fund doctrine, such that it was correct that the employee owed the plan the entire amount the plan paid on his behalf without a deduction for legal fees. Other cases cited held that the employee was required to reimburse the plan in full where the plan expressly required full reimbursement and the employee failed to show that applying “the common fund doctrine would advance any

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<sup>81</sup> *HCA v. Clemmons*, 162 F. Supp.2d 1374, 1380 (M.D. Ga. 2001).

<sup>82</sup> *Smith*, 466 F. Supp.2d 1275.

<sup>83</sup> *Zurich*, 604 F.3d at 1239.

explicit statutory purpose of ERISA;” employee’s theory that the common fund doctrine should apply failed because the parties “expressly and unambiguously agreed” that the employer would reimburse the plan in full; and the employee’s “unjust enrichment” argument failed where enrichment was allowed by the terms of the plan. The bottom line: “applying federal common law doctrines to alter ERISA plans is inappropriate where the terms of an ERISA plan are clear and unambiguous.”<sup>84</sup> In other words, look to the document.

### **So, What’s a Lawyer to Do?**

1. At the beginning of the case ask to see all of the client’s health insurance cards; make copies for the file. Determine if the client’s health insurance plan is governed by ERISA. While ERISA governs most private employee health plans, it does not control many government and church employee plans.<sup>85</sup> Prepare the client for the possibility that there may be an ERISA claim.

2. Obtain a copy of the summary plan description (SPD) early and review it before getting too far into the case. Determine if the plan is self-funded or insured.

3. Determine if a lien is enforceable under the specific fund doctrine. When reviewing the language of an ERISA plan it is critical to examine the third-party recovery provision closely. If the language does not identify a specific fund to which it is entitled—namely, the settlement proceeds—or does not limit the plan’s recovery to the amount it has paid for injury-related care and is thus rightfully entitled to, then under *Sereboff* and *Popowski* the lien is unenforceable.

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<sup>84</sup> *Id.*

<sup>85</sup> 29 U.S.C. §1003 (b) (1) and (2) (2010); see also 29 U.S.C. §1002 (32) and (33) (2010).

4. Determine if the plan language negates the make-whole doctrine. Under *Cagle, Smith, and Cody*, the make-whole doctrine is the default rule unless the plan language specifically negates it.

5. Are there defenses? With *Sereboff* we know that the issue was whether the relief the plan requested was “equitable” under §502 (a)(3)(B). So in that light, are there traditional equitable defenses that can be raised? Consider, given appropriate facts, the defense of laches, equity will not aid in the enforcement of a forfeiture, or unclean hands.<sup>86</sup>

6. Make an “appropriate equitable relief” argument ala *Sereboff, Popowski, US Airways*, and *Ahlborn*. Exactly what the court considers to be “appropriate equitable relief” has not yet been fully addressed, as it is decided by the courts on a case by case basis. Under *US Airways* an argument can be made that in applying equitable principles of recovery, the concept of unjust enrichment may be applied and procurement costs should be taken into account in an ERISA claim (perhaps in the same manner that Medicare and Medicaid do), regardless of plan language.

*Ahlborn*<sup>87</sup> is a Medicaid case that was decided unanimously by the Supreme Court in a decision handed down on May 1, 2006 – just two weeks before the *Sereboff* decision was handed down on May 15, 2006. In *Ahlborn*, the court held that reimbursement to Medicaid was limited to 1/6 of the state’s payment for medical bills where the insured collected only 1/6 of her total damages. The court was critical of the lower court for not rendering an equitable interpretation of the statutes which brought this result. While *Ahlborn* is not binding in an ERISA reimbursement case, it is interesting to

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<sup>86</sup> *National Railroad Passenger Corporation v. Morgan*, 536 U.S. 101, 121-22 (2002); *Oregon & California Railroad Company v. United States*, 238 U.S. 393, 420 (1915); *Hobbs v. Head & Dowst Company*, 231 U.S. 692, 701 (1914); and *Precision Instrument Mfg. Co. v. Automotive Maintenance Machinery Co.*, 324 U.S. 806, 814 (1945).

<sup>87</sup> *Ahlborn*, 547 U.S. 268.



note that the court was deciding what was “equitable” in the *Ahlborn* case at the same time it was hearing oral argument in *Sereboff*, and that it was the “equitable” resolution of a claim that was decided in *Ahlborn* and that was addressed in the oral argument in *Sereboff*.

7. Consider if you have an obligation to an ERISA lien holder. Under *Sereboff* and emerging ethical rules the plaintiff’s attorney may have a duty to hold disputed funds (i.e. the amount of the lien) in the attorney’s trust account until the matter is resolved.<sup>88</sup> Failure to do so potentially subjects the lawyer to an ethics complaint as well as a complaint seeking the civil remedies prescribed by 29 U.S.C. §1132 (a)(3).

8. It should go without saying that if the plan is exerting a valid lien then refusing to negotiate is not a good strategy. With the *Sereboff* decision it is clear that failing or refusing to satisfy a valid lien can endanger the client’s future benefits and risk litigation by the lien holder. This approach not only damages the client’s interests, but also raises issues of professional liability against the attorney.

9. A good understanding of the law and an attitude of cooperation with the lien holder can go a long way. If it has been verified that the plan has a right to recovery the attorney should acknowledge that right, but discuss other considerations as well. The plan administrator might consider the facts of the case, the client’s injury and loss, whether the client has dependents, and other factors.

10. Above all, it is important to keep the client informed of the possible outcomes in order to encourage realistic expectations. If an ERISA lien is substantial enough to cause much or all of the settlement to be subject to the lien, the client should be informed immediately so that he can make an informed decision about the wisdom of pursuing the case. Of course this fact can also be used as leverage with the ERISA plan, as if the client

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<sup>88</sup> Va. Legal Ethics Op. 1747 (2000). This opinion interprets Virginia’s Rules of Professional Conduct as ethically prohibiting an attorney from disbursing funds to the client when the client is under a legal obligation to deliver those funds to another.

elects not to proceed then the lien holder doesn't get reimbursed either. Ultimately, failing to give these liens the attention they deserve may expose the attorney to liability and could have serious ramifications for the client.

### **Medicaid Claims**

Medicaid is a means-test program that is funded by federal and state dollars, and administered by the Georgia Department of Community Health (DCH). Individuals who are eligible for Medicaid benefits are, by definition, aged (65 or older) or blind or disabled, and have very limited income and resources. There are a number of different Medicaid programs in Georgia, covering pregnant women, infants, children, families, adults with disabilities, and individuals in need of nursing home care.

#### **The Medicaid Claim (Assignment, Lien, Subrogation) – Statutory Basis**

When Medicaid pays for medical care for an injury that was caused by a third party, the recipient of the care is deemed to have assigned to DCH any rights the recipient has to payments for such medical care from a third party,<sup>89</sup> so that the state is in compliance with the requirement that it “take all reasonable measures to ascertain the legal liability of third parties ... to pay for care and services available” under Medicaid.<sup>90</sup> The Medicaid agency is required to take steps to identify third parties who are liable to pay for services that were provided by Medicaid.<sup>91</sup> DCH has a lien for the cost of care provided for the injury that is the fault of a third party, and can enforce the lien by following the procedures set for medical care liens in O.C.G.A. §§44-14-470 through 44-14-473 with one very notable exception: DCH has “one year from the date the last item of medical care was furnished to

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<sup>89</sup> O.C.G.A. §49-4-149 (d) (2011); 42 U.S.C. §1396k (a)(1)(A) (2011).

<sup>90</sup> 42 U.S.C. §1396a (a)(25)(A) (2011).

<sup>91</sup> 42 C.F.R. §433.138 (2011).

file its verified lien statement.”<sup>92</sup> Further, DHC may seek reimbursement for medical assistance paid on account of an injury for which another person is legally liable, and is subrogated to the extent of the reasonable value of the medical assistance that it paid for that injury. The commissioner of DCH has authority to compromise, settle, and execute a release of any such claim or to waive any claim in whole or in part.<sup>93</sup> The statute of limitations for DCH to file suit against the person liable for the damages or his insurer is one year after the settlement or judgment.<sup>94</sup> Failure to cooperate in resolving a Medicaid lien may result in the denial of future benefits for the Medicaid recipient.

### **Required Notice to DCH**

Georgia law provides that “If the person whose legal right has been affected has received medical assistance benefits pursuant to Chapter 4 of Title 49, prior to initiating recovery action, the representative or attorney who has actual knowledge of the receipt of said benefits shall notify the Department of Community Health of the claim. Mailing and deposit in a United States post office or public mail box of said notice addressed to the Department of Community Health with adequate postage affixed is adequate legal notice of the claim. Notice as provided in this subsection shall not be a condition precedent to the filing of any action for tort. Initiating recovery action shall include any communication with a party who may be liable or someone financially responsible for that liability with regard to recovery of a claim including but not limited to the filing of an action in court.”<sup>95</sup> Notice can be provided to The Subrogation Unit; Health Management Systems, Inc.; 5660 New

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<sup>92</sup> O.C.G.A. §49-4-149 (a) and (b) (2011).

<sup>93</sup> O.C.G.A. §49-4-148 (a) (2011).

<sup>94</sup> O.C.G.A. §44-14-473 (a) (2011); *Department of Medical Assistance v. Hallman*, 203 Ga. App. 615, 417 S.E.2d 218 (1992).

<sup>95</sup> O.C.G.A. §9-2-21 (c) (2011).

Northside Drive, Suite 750; Atlanta, GA 30328. Phone: (770) 980-9777; Fax: (770) 937-0180.

## **The Medicaid Claim (Assignment, Lien, Subrogation) – Case Law**

### **Cases involving Claims of Minors**

Georgia has codified the parent's duty to provide for the maintenance and protection of his child until he reaches the age of majority.<sup>96</sup> In 1987 the court held that only a parent can bring a cause of action for medical expenses for a minor child. This is because the parent is bound by law to provide necessary medical care to his minor child. The child has no right to bring that cause, even upon reaching majority.<sup>97</sup>

Five years later the court found that because the right to recover damages for medical expenses for a minor vests in her parents, and because the settlement for her damages was held by her father in a fiduciary capacity and not individually, the insurer could not recover against the minor for medical care they had paid on her behalf.<sup>98</sup>

Further, the court found that the defendant's reliance on representations contained in a petition to compromise filed with the probate court that the funds would be applied to medical bills was not well founded, as any use of the funds received by the parent in a fiduciary capacity can only be viewed as a loan from the minor to her parents, since it is the parents who are responsible for the medical bills.<sup>99</sup>

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<sup>96</sup> O.C.G.A. §19-7-2 (2011).

<sup>97</sup> *Rose v. Hamilton Medical Center, Inc.*, 184 Ga. App. 182, 361 S.E.2d 1 (1987).

<sup>98</sup> *Jarrell v. State Merit System*, 205 Ga. App. 527, 423 S.E.2d 1 (1992).

<sup>99</sup> *Jarrell*, at 529.

And five years later the court held that because parents are responsible for the medical expenses incurred to treat their minor children, the right to recover damages for medical expenses is vested exclusively in the parents.<sup>100</sup>

Then in 2009 Judge Lamar W. Sizemore, Jr. of the Superior Court of Bibb County addressed the issue whether DCH can assert a lien for recovery of Medicaid benefits where the minor child is not seeking to recover, and has no legal claim for, medical benefits from the tortfeasor or its insurer.<sup>101</sup> Basing his decision on *Ahlborn*, Judge Sizemore held that it doesn't matter that the lien is also referred to as an "assignment" in the statute. It is clear from *Ahlborn* that the statutory provisions relating to Medicaid liens "require an assignment of no more than the right to recover that portion of a settlement that represents payments for medical care."<sup>102</sup> As a minor cannot bring a claim for recovery of medical expenses there can be no recovery against general damages recovered on behalf of a minor.

### **Allocating Damages and Pro-Rating Claims; Attorney Fees**

In a medical care lien (not Medicaid) case the Georgia Court of Appeals held that the medical care lien statute gives no right of action against the patient, but only against those liable to pay the patient's damages.<sup>103</sup>

In 1993 in *Ramsey* the Georgia Court of Appeals found that lien laws, including the attorney's lien statute, must be strictly construed, concluding that the attorney lien had

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<sup>100</sup> *Southern Guaranty Insurance Company v. Sinclair*, 228 Ga. App. 386, 491 S.E.2d 843 (1997).

<sup>101</sup> *Everest Security Insurance Company v. Frankie Lewis*, No. 08-CV-48746 (Superior Court of Bibb County June 22, 2009).

<sup>102</sup> *Ahlborn*, at 282.

<sup>103</sup> *Hospital Authority of the City of Augusta v. Boyd*, 96 Ga. App. 705, 101 S.E.2d 207 (1957).

priority over all medical claims.<sup>104</sup> But ten years later in *Padgett*<sup>105</sup> the court distinguished the federal Medicaid anti-lien provision at 42 U.S.C. 1396p (a)(1) providing that “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,” from O.C.G.A. 49-4-149 (a) which expressly authorizes a lien against “moneys or other property accruing to the recipient” from third parties on account of the third parties’ liability to the recipient that “necessitated the medical care” for which DCH provided payment. The court concludes that the two statutes are not in conflict because the lien that DCH imposes is against the settlement proceeds received from a third party, not against the property of the Medicaid recipient. The lien is imposed against so much of the settlement proceeds as is necessary for DCH to recover the amount DCH paid for her care. Contrast this with the *Ahlborn* decision three years later, discussed below.

The court also addressed the issue of attorneys fees and concluded that a proportional reduction of the Medicaid lien for legal fees was not required as it “is well established that each litigant is generally obliged to bear his or her own attorney fees.” The complete compensation rule applies only to the subrogation rights of an insurance carrier and does not apply to Medicaid liens.<sup>106</sup>

Then one short year later the Georgia Supreme Court, in *Richards*,<sup>107</sup> found DCH’s practice to assert a lien on all of the proceeds of a recovery to be consistent with federal law.<sup>108</sup> Further, the lien created by statute is on “any moneys or other property” recovered

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<sup>104</sup> *Ramsey v. Sumner*, 211 Ga. App. 202, 438 S.E.2d 676 (1993).

<sup>105</sup> *Padgett v. Toal*, 261 Ga. App. 154, 581 S.E.2d 744 (2003).

<sup>106</sup> *Padgett*, at 157; *Holland v. State Farm Mutual Auto Insurance Co.*, 236 Ga. App. 832, 513 S.E.2d 48, 50 (1999).

<sup>107</sup> *Richards v. Georgia Department of Community Health*, 278 Ga. 757, 604 S.E.2d 815 (2004).

<sup>108</sup> 42 U.S.C. §1396k (a)(1)(A); 42 U.S.C. §1396a (a)(25)(H) (2010).

in a tort action.<sup>109</sup> The court concluded that to read it otherwise would give the parties room to structure a settlement so as to avoid having to pay back the state. Further, the court found no requirement that the state pay a part of the cost of pursuing the claim.

The U.S. Supreme Court considered the issue whether the statutory Arkansas state lien violated the federal Medicaid laws if to satisfy the lien would consume all of the compensation that Heidi Ahlborn received for injuries other than past medicals.<sup>110</sup> The court held that while the State can demand as a condition of Medicaid eligibility that the recipient “assign” any payments that may constitute reimbursement for medical costs, that does not mean that the State can force an assignment of, or place a lien on, any other portion of the recipient’s property.

Heidi Ahlborn’s case settled for \$550,000, which the parties agreed amounted to approximately one-sixth of the value of her claim; the settlement had not been allocated among the various damages alleged in her complaint. Medicaid had paid \$215,645.30 for her care; therefore, Medicaid’s pro-rata one-sixth of that amount is \$35,581.47.

The court treated the other five-sixth’s of Ahlborn’s recovery (for pain and suffering and wage loss) as her property, and determined that under the federal anti-lien provision the State can’t impose a lien against that property prior to the death of the recipient.<sup>111</sup>

With this decision attorneys have greater leverage to negotiate for a reduced Medicaid lien, which should help facilitate negotiated settlements. This logic can also be used in asking a court (including the probate court if the case involves a minor or an incapacitated adult) to enter an order allocating the settlement proceeds and determining the amount that Medicaid will be reimbursed.

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<sup>109</sup> O.C.G.A. §49-4-149(a) (2011).

<sup>110</sup> *Ahlborn*, 547 U.S. 268.

<sup>111</sup> 42 U.S.C. §1396p (a)(1) (2010).

## **DCH's Position on *Ahlborn***

In spring 2010, a request to the Subrogation Unit for a statement of DCH's position on *Ahlborn*, resulted in this reply: "There is no policy at the moment, each case is reviewed on its own merits with the facts provided. We are able to negotiate most files without having to force an *Ahlborn* hearing." In January 2012 the answer to the same question was that DCH Legal would review and respond to the request. As of this writing there has been no response.

## **So, What's a Lawyer to Do?**

1. At the beginning of the case ask to see all of the client's health insurance cards; make copies for the file.
2. If the client is receiving or has received Medicaid benefits, notify DCH "prior to initiating recovery action." Initiating recovery action doesn't only mean filing an action in court. It includes any communication with a party who may be liable or someone financially responsible for that liability.<sup>112</sup>
3. Talk early with the client about the existence of a Medicaid claim, the fact that the claim will need to be resolved, and the effect the resolution of this claim will have on him and on his case.
4. Search for liens in the county where the plaintiff resides or has resided, in any county where he received medical treatment, and in Fulton County if he is a Medicaid recipient. This search can easily be accomplished online at [www.GSCCCA.org](http://www.GSCCCA.org) (which is a subscription service).
5. Check for regular Medicaid as well as Managed Care claims. It isn't unusual for an individual who is in Managed Care to have some services billed to regular Medicaid. Call Darcy Brown at the Georgia Casualty Unit, at 678-564-1163 x 2140, to check for claims in all Medicaid systems.

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<sup>112</sup> O.C.G.A. §9-2-21 (c) (2011).



6. A Georgia Medicaid lien can often be resolved in a matter of days. Make the *Ahlborn* argument, and have your facts at hand. The people negotiating these claims are charged with collecting on behalf of the State, but they do have hearts and can be swayed by compelling facts.

7. Consider asking the trial court (or, if the client is a minor or an incapacitated adult, the probate court) to allocate damages. Provide notice to Medicaid. The knowledge that the court will make the determination may force a more reasoned compromise.

8. If the client is a minor ask the trial court or probate court to allocate the recovery for medical expenses to the parents under *Rose v. Hamilton*, *Jarrell v. State*, *Southern Guaranty v. Sinclair*, and *Everest v. Lewis*, all discussed above. This will often be a small percentage of the total recovery, leaving more dollars to compensate your client for his general damages.

### **Who to Call**

For Medicaid and PeachCare for Kids contact:  
Marisol Rodriguez, Operations Supervisor  
Health Management Systems, Inc.  
5660 New Northside Drive, Suite 750  
Atlanta, GA 30328  
(678) 564-1163 x 2150  
mrodriguez@hms.com

For WellCare contact:  
First Recovery Group  
26899 Northwestern Highway  
Suite 250  
Southfield, MI 48033  
(866) 449-4800

For Peach State Health Plan contact:  
Centene Corporation (their phone message says Health Management Systems)  
Caseworker: Alice Hicks  
5615 High Point Drive  
Suite 100  
Irving, TX 75038  
(877) 835-7068  
Fax (866) 389-2706.

For Amerigroup contact:  
ACS  
(800) 454-3730  
mpswb@amerigroupcorp.com

## **Other Claims that may Arise**

### **State Worker's Compensation**

Where there is a State Worker's Compensation claim and also a third party liability case and the third party liability case settles, there is a worker's comp lien against the third party liability proceeds. Frequently the worker's comp lien is negotiable because the worker's comp carrier is anxious to get the plaintiff off its books.

### **Federal Employees Compensation Act**

Federal Employees Compensation Act (FECA) is the federal equivalent of State Worker's Compensation. It covers benefits under the Longshore and Harbor Workers' Compensation Act and the Federal Employees Compensation Act. The federal government has a lien under either of these two acts.<sup>113</sup> The beneficiary is entitled to retain a minimum of one-fifth of the net money he receives, and a reasonable attorney's fee.<sup>114</sup>

### **Veterans Administration Claims**

The "VA claim statute"<sup>115</sup> grants the United States the right to recover reasonable charges in repayment for health care benefits provided to a veteran or his family through the U.S. Department of Veterans Affairs (VA) from certain third parties who would otherwise be liable for the veteran's medical care. Thus, the VA has authority, similar to that provided to CMS under the MSPA statute, to recover from third parties for payments it has made for injury-related medical care for non-service-connected disabilities. This means that the claimant's disease, injury or other physical or mental defect cannot have

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<sup>113</sup> 5 U.S.C. §8131 (2010).

<sup>114</sup> 5 U.S.C. §8132 (2010).

<sup>115</sup> 38 U.S.C. §1729 (2010).

been “incurred or aggravated . . . in the line of duty in the active military, naval or air service.”<sup>116</sup>

The United States has a right to recover or collect reasonable charges for such care or services from a third party to the extent that the Veteran (or the provider of the care or services) would be eligible to receive payment for such care or services from such third party, if the care or services had not been furnished by a department or agency of the United States.<sup>117</sup> However, that authority is limited to recovery from the employer or carrier in a WC claim; from a health plan contract; or from an automobile liability policy.<sup>118</sup>

A “disability” is defined under federal law governing VA benefits as “a disease, injury, or other physical or mental defect.”<sup>119</sup> This definition is much broader than the Social Security Act’s definition of “disabled,” which is “the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.”<sup>120</sup> So consider that a VA claim may exist, even if the claimant is not able to qualify for Social Security Disability Insurance or for Medicare.

### **Federal Employee Health Benefits Act**

Federal Employee Health Benefit Act (FEHBA) provides group health insurance benefits to federal employees.<sup>121</sup> The federal government enters into private contracts with insurance carriers. The federal statute does not contain lien language but most plans contain subrogation or reimbursement provisions.

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<sup>116</sup> 38 U.S.C. §101 (17) (2010).

<sup>117</sup> 38 U.S.C. §1729 (a)(1) (2010).

<sup>118</sup> 38 C.F.R. §17.101.

<sup>119</sup> 38 U.S.C. §1701 (1) (2010).

<sup>120</sup> 20 C.F.R. §404.1505.

<sup>121</sup> 5 U.S.C. §8901 (2010).

## **Federal Medical Care Recovery Act**

The Federal Medical Care Recovery Act (FMCRA)<sup>122</sup> applies in all cases in which the United States provides or pays for medical care for a military person or dependent injured in a third party liability case. Under FMCRA the government has a right to recover, from a tort-feasor the value of medical care it has furnished an injured person and provides that the government shall be subrogated to any claim of the injured person against the tort-feasor to the extent of the value of the care and treatment it has already provided and will provide in the future. The federal government may require an injured person to assign his claim to the government if the injured person does not pursue the claim.

## **TRICARE Claims**

TRICARE claims are covered under the Federal Medical Care Recovery Act (FMCRA).<sup>123</sup> The right of recovery includes care that may be received by the beneficiary at the Uniformed Services facility or under TRICARE, or both. Each branch of the service has a slightly different model agreement that must be signed when private counsel is asserting a separate cause of action to recover for injury-related care paid by TRICARE/CHAMPUS on a contingent basis.

## **Qualified Settlement Funds**

The case has settled and things are moving quickly. Many decisions need to be made by the client and his family. Allocations need to be made. A Special Needs Trust needs to be established. Decisions need to be made about lump sum versus structure. Liens need to be negotiated.

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<sup>122</sup> 42 U.S.C. §§2651-2653 (2010).

<sup>123</sup> *Id.*

A Qualified Settlement Fund (QSF)<sup>124</sup> may be the answer. It allows the plaintiff and his attorneys to “stop the clock,” take a deep breath, carefully evaluate the options, and make good decisions.

Establishing a QSF allows for payment of the settlement into a trust. The defendant is released upon payment to the Trustee, and the Trustee can immediately pay the plaintiff's attorney's fees and the litigation costs. When all of the outstanding issues are resolved the Trustee can still use structured settlement annuities and establish the special needs trust without adverse tax consequences.

### **Advantages of the QSF**

1. Funding the QSF removes the defendant and their counsel from the litigation. They can pay and walk. Once a petition is filed by either party in a court and a Trustee for the fund is appointed, the settlement payment to the Trustee satisfies the economic performance test. The defendant is out of the case.

2. The QSF removes the defendant from the allocation of the settlement amounts between the various plaintiffs. The plaintiffs' attorney does not have to negotiate with the defense counsel about either the allocation of the settlement between the injured parties or the derivative claim for loss of consortium.

3. The plaintiffs' attorney's fees and other expenses can be paid immediately from the QSF.

4. The plaintiffs receive the income from the settlement inside the QSF. The plaintiffs can take their time, carefully selecting among the options of a lump sum payment, structured settlement annuity and a special needs trust pursuant to 42 U.S.C. §1396p (d)(4)(A).

5. Time is no longer a pressing factor for the lien negotiations, allocations, and probate proceedings. The settlement can be placed in the settlement trust while you handle

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<sup>124</sup> Internal Revenue Code §486 (b) (2010).

other matters, such as waiting for the final figures for the Medicare claim and Medicaid lien, determining allocations between plaintiffs, and deciding on a method of payment. You now have additional time to apply for and obtain a Conservator or a Guardian in the probate court, and to establish a special needs trust if appropriate.

### **Requirements for the QSF**

A Qualified Settlement Fund must meet the following requirements:<sup>125</sup>

1. It must be a trust, account or fund, which is established or approved by order of a court of law and is subject to continuing jurisdiction of that authority;
2. It is established to resolve contested or uncontested claims asserting liability for a tort, breach of contract or a violation of law;
3. It must be a Trust under applicable state law, or the assets must be kept separate from the assets of the tortfeasor, insurance carrier or other related parties.
4. It cannot be created for liabilities under a Worker's Compensation Act claim or self-insured health plan.
5. A fund is not considered a Qualified Settlement Fund until the court has approved the Trust fund and the assets have been paid into it by the tortfeasor (referred to in the statute as the "Transferor"). This payment meets the economic performance test.
6. The QSF must be approved by a court or a governmental agency. This approval occurs when the governmental authority issues its preliminary order to establish the fund even if the order is subject to review or revision. An arbitration award granted by an arbitration panel will suffice as long as the award is judicially enforceable, the award is issued pursuant to a bona fide arbitration proceeding and the fund is subject to the arbitration panel's continuing jurisdiction.
7. The QSF must be established to satisfy a claim. This requirement has been strictly interpreted.

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<sup>125</sup> Treasury Regulation §1.468B-1(c).

8. QSFs have the “relation-back rule,” which says that if the fund meets all the statutory requirements with the exception of obtaining governmental approval, then the transferor and fund administrator may treat the fund as being created either when the last two (of the three) statutory requirements are met, or on January 1<sup>st</sup> of the year in which all three statutory requirements are met, whichever occurs later. If a relation-back election is made, the funds are treated as being transferred to the fund on this date.

### **No Constructive Receipt**

The economic performance test allows the defendant to pay a settlement into a QSF and deduct the claim even though the payout to or for the benefit of the plaintiff occurs later. However, the QSF does not constitute constructive receipt to the plaintiff because of the restrictions placed upon the QSF. The plaintiff’s attorney does not have custody of the fund. An independent Trustee owns the funds. This arrangement preserves the opportunity to use the structured settlement annuity option.

### **Ethical Issues**

The lawyer’s duty in negotiating liens is, as always, first to the client. Toward that end, “A lawyer shall provide competent representation to a client.”<sup>126</sup> So as claim resolution has become an ever moving target many attorneys have concluded that they should focus their efforts in their areas of expertise and delegate the claim resolution to other attorneys or companies that regularly handle this work. Is that ethical?

### **Ethics of Outsourcing**

The ABA has considered the issue, and concluded that an attorney can outsource work to other lawyers or non-lawyers, but the attorney remains responsible for rendering competent legal services to the client under Model Rule 1.1.<sup>127</sup> There is nothing unethical about a lawyer outsourcing legal and nonlegal services, provided the outsourcing lawyer

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<sup>126</sup> Georgia Rules of Professional Conduct Rule 1.1 (2001).

<sup>127</sup> ABA Standing Comm. on Ethics and Professional Responsibility, Formal Op. 08-451 (2008).

renders legal services to the client with the “legal knowledge, skill, thoroughness and preparation reasonably necessary for the representation,” as required by Rule 1.1.

Appropriate disclosures should be made to the client, and client consent should be obtained if the individuals doing the work will be receiving confidential information protected by Rule 1.6. The lawyer should make “reasonable efforts” to ensure that the conduct of the outsourced individuals is compatible with the lawyer’s professional obligations as a lawyer, per Rules 5.1 and 5.3.

### **Ethics regarding Billing for Outsourced Work**

In Ohio the specific issue of how a client should be billed for the costs of outsourcing the lien resolution was considered. The conclusion was that the lawyer should exercise professional judgment in determining whether to bill as part of the contingent fee or as an expense. In either case, if it will cost the client additional funds it must be reasonable and must be communicated to the client before outsourcing the service.<sup>128</sup>

### **Ethics of Holding Lien Funds in IOLTA**

Courts and State ethics opinions have imposed a duty to hold disputed funds (i.e. the lien amount) in the attorney’s trust account until the lien is resolved.<sup>129</sup> In Virginia a lawyer violated Rule 1.15 when he refused to honor a vendor’s consensual lien with the client. The court found that the lawyer owed a duty to either pay the full amount owed or hold the amount in dispute in trust until the dispute could be resolved.<sup>130</sup>

A Comment to the Georgia Rules says that “Third parties, such as a client's creditors, may have just claims against funds or other property in a lawyer's custody. A lawyer may have a duty under applicable law to protect such third-party claims against wrongful interference by the client, and accordingly may refuse to surrender the property to the

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<sup>128</sup> Ohio Board of Comm. on Grievances and Discipline, Op. 2009-9 (2009).

<sup>129</sup> Va. Legal Ethics Op. 1747 (2000).

<sup>130</sup> *Virginia State Bar v. Timothy O'Connor Johnson*, No. CL09-2034 (Richmond Cir. Ct. August 11, 2009).



client. However, a lawyer should not unilaterally assume to arbitrate a dispute between the client and the third party.”<sup>131</sup>

### **Conclusion**

Claim resolution is an ever changing area of the law. It's a big world out there but it needn't be scary. A working understanding of the types of claims that may be lurking and the questions to ask, and the negotiating skills you have honed, will serve your client well!

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<sup>131</sup> Georgia Rules of Professional Conduct Rule 1.15(I), Comment [3].