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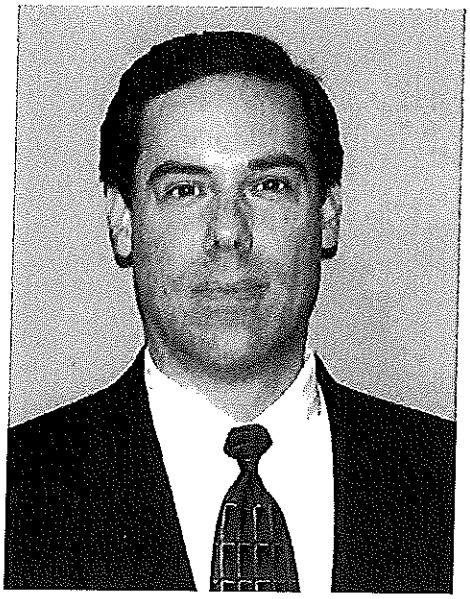
New and Old Money Grubbers: Liens, Subrogation and the Made-Whole Doctrine



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NEW AND OLD MONEY GRUBBERS: LIENS, SUBROGATION AND THE MADE WHOLE DOCTRINE

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14th Annual Medical Malpractice Conference
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NEW AND OLD MONEY GRUBBERS: LIENS, SUBROGATION AND THE MADE WHOLE DOCTRINE

I. INTRODUCTION:

You would think that giving money away to money grubbers would be easy! Surprisingly, it is a pretty difficult thing to do.

Like most lawyers, I've never enjoyed dealing with subrogation interests and liens. Obtaining final lien totals is usually an extremely trying and exasperating experience. Glaciers move quicker than most lienholders – especially Medicare! It is usually necessary to repeatedly write and telephone lienholders to nudge them into providing you with final lien information and written itemizations of claims. And, it's a thankless job. I've never had a client that wanted to give a subrogee or lienholder any of their "hard fought" money. Moreover, I've never had a lienholder or subrogee say "thank you" after I lined their pockets. Nonetheless, processing liens is a necessary evil which, if done incorrectly, can subject you and your client to liability.

In this paper, I will emphasize the relevance of the "made whole" doctrine, in light of the recent legislative caps on non-economic damages. In addition, I will provide some practical tips for efficiently handling liens that *most commonly* arise in plaintiffs' personal injury cases – especially medical malpractice and nursing home negligence cases. However, this paper is by no means a review of *all* liens and subrogated interests that you might encounter in your practice. For instance, discussion of ERISA in this paper is largely limited to its impact on the "made whole" doctrine. Finally, along the way, I will throw in some black letter law to satisfy the diehards among you.[1]

II. A FEW BASIC DEFINITIONS:

A "lien" is defined as a legal right or interest that a creditor has in another's property, lasting usually until a debt or duty that it secures is satisfied. BLACK'S LAW DICTIONARY.

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[1] I gratefully acknowledge Paul F. Waldner and his excellent paper entitled "Lienholders: The Pesky Parasites," which he presented at the Texas Trial Lawyers Association's 12th Annual Advanced Medical Malpractice Conference in 2001. With Mr. Waldner's permission, I have incorporated an entire section of his paper into mine.

For an in-depth discussion of liens and subrogation, I highly recommend an excellent treatise by Judith A. Kostura, entitled "Subrogation and Liens: Dividing the Recovery." Ms. Kostura presented this paper at the 2002 Texas Trial Lawyers Association Advanced Personal Injury Seminar. Ms. Kostura's paper contributed to my thought processes in writing this paper.

I thank Debra Davis of The Law Offices of Maloney & Maloney, P.C. for her valuable assistance in writing this paper. I have learned much about the practical aspects of handling liens from her.

Finally, I am indebted to Natalie S. Voss, a brilliant law student and member of the law review at Texas Wesleyan University School of Law, for her considerable assistance in researching and writing this paper.

"Subrogation" is defined as 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, and its rights, remedies, or securities." *Id.*

A "subrogee" is a "person who succeeds to the rights of another by subrogation," essentially, one who steps into the shoes of the party whom they have compensated. *Id.*

In this paper, however, I will generically refer to all money grubbers as lienholders.

III. SOME GENERAL PRACTICAL TIPS:

A. Identify Potential Lienholders:

There are a variety of liens the cautious attorney should consider before taking a case, entering into a settlement, receiving a verdict, and/or disbursing money to clients. For instance, a plaintiff's attorney should determine whether any governmental and/or health insuring entities have paid health care claims for curative care rendered for the physical injuries that are the basis of the lawsuit. In a medical malpractice or nursing home negligence case, this could include Medicare, Medicaid, TDHS, Veteran's Administration, and private health insurance companies. As all of these are potential lienholders, it is prudent to send all potential lienholders a letter requesting lien information on your client at the outset of the case.

B. Send a Letter to Potential Lienholders:

Immediately after filing suit, a prudent plaintiff's lawyer may wish to send each potential lienholder a letter, via certified mail, return receipt requested, which informs the lienholder of the lawsuit and which requests the submission of any lien information. In the letter, the attorney should provide all information necessary to identify your client and the defendants, to include (as applicable):

- Full name;
- Date of birth
- Social Security number
- Address
- Date of loss
- Date of death
- Description of physical injury
- HIC/Medicare ID number
- Medicaid ID number
- Private Insurance Policy number
- Private Insurance Member ID number
- Full name of each defendant
- Address of each defendant

It is wise to **attach a medical authorization** to your notice of lien letter to each potential lienholder, signed by your client or his/her closest immediate surviving family member.

In the lienholder letter, you should also **identify the dates of loss.** Importantly, lienholders are NOT entitled to recover the expense of the negligent care that the Defendant provided which resulted in an injury to your client. For example, a lienholder would not be entitled to recover the costs of a botched surgery that injured your client. Rather, the lienholder would only be entitled to recover the expense of CURATIVE care or treatment subsequently provided to your client for the injury sustained during the botched surgery.

Therefore, the "dates of loss" that you reference in your notice of potential lien letters are usually not the same as the actual date of injury by the client. Instead, the "dates of loss" are the beginning and ending dates of the CURATIVE care rendered for the physical injury made the basis of the lawsuit. It is imperative to know when the curative care for your client's injury began/ended so that, when the lienholder provides you with an itemization of claims attributed to your client's "injury," you can readily identify which charges are relevant in your lawsuit.

Also, in your notice of potential lien letters to lienholders, it is important to **provide a description of the physical injury(ies)** made the basis of your lawsuit. This will enable each potential lienholder to search through their computer databases to specifically identify the claims paid by them for care related to your case and, ultimately, to provide you with an itemized list of claims and total lien amount.

Importantly, the description of physical injury contained in the letter to potential lienholders should track the allegations in your lawsuit. Conceivably, if you were to minimize the extent or severity of the injury sustained in an effort to reduce the amount of the lien related to your lawsuit, you and your client could be subject to fraud allegations. Unfortunately, this means that if you amend your Petition to allege new injuries suffered by your client, then you must also notify all lienholders of the additional injuries, so that the lienholders can determine if they incurred expenses related to curative treatment for the care of those injuries as well. This will result in delay in an already laborious and protracted process.

If you haven't received a verbal or written response or acknowledgement of any kind to your initial notice of potential lien letter after 6-8 weeks, you should telephone the lienholder to discuss the status of obtaining a final lien. Likelihood is, your letter got misdirected, is not being worked-up, or was put on a forgotten dust pile somewhere. A telephone call, followed by a confirming letter, may rectify that situation.

C. <u>Create a Case File for Liens and Individual Folders for Each Lienholder</u>:

To stay organized, it's a good idea to maintain a case file for lien correspondence in each of your cases. You may desire to maintain separate file folders for each lienholder as

well. It is not uncommon for a good deal of correspondence to accumulate as to each lienholder.

I prefer to maintain subrogation correspondence to and from each lienholder chronologically, with the most recent correspondence on top. Typically, I file correspondence to/from the lienholder on the right side of the file folder. On the left side of the file folder, I maintain all of my attorney notes concerning liens, memos regarding discussions with clients on subrogation issues, interoffice e-mails, and interoffice memos regarding the handling of subrogation issues in each case.

D. Obtain a Written Itemization of Claims; Contest Unrelated Claims:

It is important with all lienholders to obtain a written itemization of the claims that the lienholder is asserting against your case. Study the itemization of claims to make sure that each claim is indeed related to your case. If a claim is not related to your case, you should immediately contest the claim, in writing, and provide the lienholder with your rationale.

E. Obtain a Final Lien Total Verification:

Prior to mediation and/or trial, ask all lienholders in writing for a final lien total. If you are unsure whether the lien total that you have is, indeed, a final lien total, you may wish to write a letter specifically requesting the lienholder to verify that the lien amount provided in their last letter is final. I often ask the lienholder to sign my letter under a "VERIFICATION" signature line. However, don't be surprised if the lienholder refuses to comply with this seemingly simple request. Unfortunately, many lienholders suffer from "commitment phobia."

F. Always Ask for a Reduction:

Ask and you shall receive, or so you should. Most lienholders will negotiate their liens and will reduce them by some proportion in relation to your client's recovery, attorney's fees, and expenses.

G. If the Recovery is Limited by a Legislative Damage Cap, Argue the "Made Whole" Doctrine:

Effective September 1, 2003, House Bill 4 significantly reduced the value of many medical malpractice and nursing home negligence claims by capping non-economic damages. In cases filed after September 1, 2003, an injury, which would have previously yielded a multi-million dollar recovery in non-economic damages, is now statutorily limited to $250,000. Before writing the check to a money grubbing lienholder, argue strongly that the recovery received by your client in no way made him whole because his non-economic damages were limited by arbitrary caps that do not compensate him for his true damage and loss.

H. Always Obtain a Release of Lien:

To protect you and your client from subsequent liability, always obtain a release of lien. Without question, this is easier said than done. Medicare will not enter into a formal release, but will send a letter acknowledging "payment in full" of the amount owed.

To obtain a release from Medicaid and TDHS, you will need to send a proposed release along with your remittance of the lien payment. Otherwise, you won't get one. Simply asking for a release in your payment remittance letter doesn't work, because neither TDHS nor Medicaid will expend the time to generate one.

Remember, when dealing with most lienholders, "the squeaky wheel gets the grease." If you're not squeaking, you're not likely to get the release.

IV. STATUTORY LIENS AND SUBROGATION INTERESTS:

A. MEDICARE:

1. Legal Authority -- The MSP Statute:

When Medicare was first enacted in 1965, it was essentially the primary payer for medical services supplied to a beneficiary, even when such services were also covered by private insurance. Not surprisingly, in 1980, Congress responded to the "skyrocketing Medicare costs" by enacting the Medicare Secondary Payer ("MSP") statute, 42 U.S.C. § 1395y(b)(2), which requires Medicare to serve as the secondary payer when a beneficiary has other insurance that can pay or pays for medical expenses. The MSP statute thus requires Medicare beneficiaries to exhaust all available private insurance before resorting to Medicare coverage.

The federal agency that administers the Medicare program has changed its name. The agency formerly known as the Health Care Financing Administration (HCFA) is now known as the Center for Medicare/Medicaid Services (CMS).

Congress divided Medicare into two parts. Intermediaries administer Part A benefits, and carriers administer Part B benefits. When attempting to resolve a Medicare subrogation claim with respect to a personal injury recovery, one works with the intermediary.

Medicare claims to be a "super lien," superior to all other types of subrogation interests. In essence, the MSP statute states that Medicare will serve as a back-up insurance plan to cover that which is not paid for by a primary insurance plan. The MSP statute prohibits Medicare from making payments when it has notice that payments with respect to the injury could, or should, be paid by liability insurance. Medicare will also not pay a claim if "payment has been made or can reasonably be expected to be made *promptly* ... under a workmen's compensation law ... or under an automobile or *liability insurance policy or*

plan (including a *self-insurance plan*) or under no fault insurance." 42 U.S.C. § 1395y(b)(2)(A) (emphasis added).

However, the MSP statute also *authorizes* Medicare to make *conditional* healthcare payments when a Medicare recipient already has coverage provided by a "*primary insurance plan.*" 42 U.S.C. § 1395y(b)(2)(B). "A 'primary plan' is defined as a group health insurance *plan*, or as any other type of insurance plan, such as workman's compensation law, liability insurance, or a self-insurance plan, that may reasonably be expected to pay for services promptly." *Thompson v. Goetzmann*, 337 F.3d 489, 496 (5th Cir. July 7, 2003)(underlined emphasis added).

In the event that a *conditional* payment is made, the government has a right to sue "any entity which is required or responsible (directly or as a third-party administrator or otherwise) to make payment with respect to such item or service (or any portion thereof) under a primary plan ..., or against any other entity (including any physician or provider) that has received payment from that entity with respect to the item or service, and may join or intervene in any action related to the events that gave rise to the need for the item or service...." 42 U.S.C. § 1395y(b)(2)(B).

2. Recent Case Law:

a. *Thompson v. Goetzmann*

Recently, in *Thompson v. Goetzmann*, 337 F.3d 489 (5th Cir. July 7, 2003)[2], the government tested the power of its "super lien" by trying to expand the meaning of the term "self-insurance plan," in an effort to extract reimbursement out of a products liability suit settlement. **This significant Fifth Circuit holding arguably affects Medicare's ability to assert liens against certain personal injury settlements!**

In *Goetzmann*, the government sued a personal injury plaintiff (Loftin), her lawyer (Goetzmann), and the manufacturer of an artificial hip prosthesis (Zimmer), seeking reimbursement for Medicare expenditures related to Loftin's medical treatment. Medicare paid for Loftin's hip replacement surgery. When complications arose, Medicare paid for a second surgery and other medical treatment. All totaled, Medicare expended $143,881.82 on Loftin's healthcare related to her hip. Loftin hired Goetzmann to sue Zimmer for products liability, alleging defective design of the hip prosthesis. The suit settled prior to trial for $256,000. Goetzmann took 40% of the settlement proceeds in a contingency fee, and then disbursed the balance to Loftin. No part of the settlement was paid to insurance or Medicare.

[2] On July 7, 2003, on petition for rehearing filed by the government, the Fifth Circuit amended its original opinion in *Goetzmann*, which had been published at 315 F.3d 457. In the amended opinion, the Fifth Circuit deleted portions of the original opinion that concerned the "prompt pay" requirement of the MSP statute. The Fifth Circuit explained: "As that part of the opinion was an alternative holding, our withdrawal of these portions of the opinion does not affect the central holding of our decision that the government lacked authority under the MSP statute to seek reimbursement from Zimmer."

The government filed suit under the Medicare Secondary Provider (MSP) statute, which authorizes the government to obtain reimbursement from a firm or entity that has a "self-insurance plan." The government insisted that Zimmer was "self-insured" for its liability to Loftin and, in settling the case, had ostensibly paid for Loftin's medical expenses, which had been originally paid by the Medicare.

Zimmer moved for summary judgment, asserting that its tort settlement was not tantamount to maintaining a "self-insurance plan," as defined in the MSP statute. (Zimmer argued that the term "self-insurance plan" does not automatically apply to alleged tortfeasors). In the alternative, Zimmer argued that its inability to pay for Loftin's medical treatment *"promptly,"* as required by the MSP statute, precluded it from meeting the definition of a "self-insured plan." ("*Promptly*" is defined by HCFA regulations as payment within 120 days after the *earlier* of (1) the date the claim is filed; or (2) the date the service was provided or the patient was discharged from the hospital). The district court agreed, granting summary judgment and finding as a matter of law that Zimmer could not have "promptly" paid for Loftin's medical treatment, as the statute requires. Goetzmann and Loftin subsequently moved for summary judgment, which were also granted.

On appeal, the Fifth Circuit reasoned that the term "self-insurance plan" does not exist in a vacuum within the MSP statute. Rather, it is predicated on the term "primary plan." The Fifth Circuit stated that "the term 'primary plan' is pivotal to the applicability of the MSP statute -- its reimbursement provisions are not triggered unless a Medicare recipient's source of recovery meets the definition of 'primary plan.'" Although the term "self-insurance plan" is not defined in the MSP statute, the Fifth Circuit gave the term its ordinary meaning and stated that, in order to meet the definition of self-insurance, "an entity would have to engage in the same sorts of underwriting procedures that insurance companies employ; estimating likely losses during the period, setting up a mechanism for creating sufficient reserves to meet those losses as they occur, and usually, arranging for commercial insurance for losses in excess of some stated amount." *Goetzmann*, 337 F.3d at 498. The Fifth Circuit concluded that "it is wrong for the government to contend that an entity's negotiating of a single settlement with an individual plaintiff is sufficient, *in and of itself*, for such entity to be deemed as having a "self-insurance plan." *Id.* "The failure of Congress to include in the MSP statute a right of action for reimbursement of medical expenditures against tortfeasors indicates that this statute 'plainly intends to allow recovery only from an *insurer*.'" *Id.* at 499.

The Fifth Circuit concluded that Zimmer did not act under a "primary self-insurance plan" when it settled the products liability case with Loftin. The Fifth Circuit held that neither the products manufacturer (Zimmer), the plaintiff (Loftin), nor the plaintiff's attorney (Goetzmann) were required to reimburse the government under the MSP statute.

Although the Fifth Circuit ruled that the government was not entitled to reimbursement in this case under the MSP statute, the Fifth Circuit pointed out that "the Medical Care

Recovery Act ("MCRA")[3] explicitly provides the right of action that the government is attempting to read into the MSP statute. The MCRA expressly arms the government with a right to recover medical payments that it has made 'under circumstances creating tort liability upon some third person.' In such instances, the government may 'institute and prosecute legal proceedings against the third person who is liable for the injury or disease ... for the payment or reimbursement of medical expenses or lost pay." *Goetzmann*, 337 F.3d at 499.[4]

b. *Brown v. Thompson*

In *Brown v. Thompson*, 252 F. Supp. 312 (E.D. Va. 2003), the federal district court of the Eastern District of Virginia disagreed with the Fifth Circuit's alternative holding regarding "prompt payment" in *Goetzmann*, which was included in the first published opinion in *Goetzmann*,[5] but deleted in the opinion published following the petition for rehearing.[6] In *Brown*, the Plaintiff refused to reimburse Medicare following the settlement of a medical malpractice lawsuit. The Plaintiff alleged in the case that the Kaiser Urgent Care facility, which is owned and operated by the Kaiser Foundation Health Plan ("Kaiser"), failed to timely diagnose her condition and admit her to the hospital, which resulted in an emergent hospital admission for a perforated colon and sepsis. Medicare had made payments totaling $59,047.13 for the Plaintiff's healthcare and sought reimbursement out of the $285,000 settlement.

Kaiser did not have liability insurance, but was self-insured. The Plaintiff asserted that Medicare was not entitled to reimbursement under the MSP statute because her medical malpractice settlement was not "*made promptly*" (for the same reasons argued in *Goetzmann*). The federal district court disagreed. The court stated that "this construction misreads the statute and is at odds with the statute's obvious and sensible purpose of

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[3] The Medical Care Recovery Act ("MCRA") provides in pertinent part: "In any case in which the United States is authorized or required by law to furnish or pay for hospital, medical, surgical, or dental care and treatment ... to a person who is injured or suffers a disease, ... under circumstances creating a tort liability upon some third person ... to pay damages therefore, the United States shall have a right to recover (independent of the rights of the injured or diseased person) from said third person, or that person's insurer, the reasonable value of the care and treatment so furnished, to be furnished, paid for, or to be paid for and shall, as to this right be subrogated to any right or claim that the injured or diseased person ... has against such third person...." 42 U.S.C. § 2651(a), Pub.L. No. 87-693, § 1, 76 Stat. 593 (1962), *as amended.*

[4] *But see United States v. Phillip Morris, Inc.,* 116 F. Supp 2d 131 (D.D.C. 2000)("The congressional intent in enacting MCRA in 1962--at which time Medicare did not exist and the Federal Employees Health Benefits Act ("FEHBA") was still in its infancy--was to provide a means for the Government to recover from third- party tortfeasors medical expenses it had furnished for (primarily military) employees. Applying the principles from a recent U.S. Supreme Court decision, *FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 120 S.Ct. 1291, 146 L.Ed.2d 121 (2000), *this Court concludes that Congress did not intend that MCRA be used as a mechanism to recover Medicare or FEHBA costs.* The Court reaches this conclusion after examining the broad context in which MCRA has existed for 38 years--including its legislative history, the construction given it by those agencies charged with its interpretation, a body of longstanding state and federal case law, and its total non-enforcement by the Department of Justice for thirty-seven of those thirty-eight years (emphasis added).

[5] Thompson v. *Goetzmann*, 315 F.3d 457 (5th Cir. 2002).

[6] Thompson v. *Goetzmann*, 337 F.3d 489 (5th Cir. 2003).

ensuring that Medicare is a secondary payer only after Medicare beneficiaries have exhausted their private insurance." *Brown*, 252 F. Supp. at 318.

Essentially, the court in *Brown* focused on the phrase "payment *has been made* ... under a ... liability insurance policy or plan (including a self-insured plan)", and downplayed the importance of the phrase "payment ... can reasonably be expected to be *made promptly* ... under a ... liability insurance policy or plan (including a self-insured plan)." The federal district court in *Brown* stated that the Fifth Circuit in *Goetzmann* focused "too narrowly on the 'prompt payment' requirement." *Brown*, 252 F. Supp. at 319.

c. The Potential Effect of *Goetzmann* and *Brown*?

The potential effect of the *Goetzmann* and *Brown* decisions are significant. Although the Virginia federal district court in *Brown* disagreed with the alternative holding regarding "prompt payment", which was contained in the first Fifth Circuit opinion in *Goetzmann*, the common ground of both cases is that Medicare's right to reimbursement under the MSP statute is not automatic.

In the nursing home industry, for example, more and more facilities are going "bare" (i.e. without liability insurance coverage). The way I interpret *Goetzmann* and *Brown*, if you settle with a nursing home defendant that is "bare," and the nursing home defendant does not have a plan of self-insurance in place, and the nursing home defendant uses its general assets to fund the settlement, then Medicare has no right to reimbursement from the settlement proceeds! "Indeed, to hold otherwise would render 'every tortfeasor that used its general assets to fund a tort settlement with persons who had received federal health care benefits...potentially liable under the MSPS.'" *Brown v. Thompson*, 252 F. Supp. at 321 (quoting *In re Orthopedic Bone Screw Products Liability Litigation*, 202 F.R.D. 154, 165 (E.D. Pa. 2001)).

However, there are many attorneys in the country that read the *Goetzmann* case much more broadly. These attorneys argue that *Goetzmann* largely erodes Medicare's ability to assert a lien against personal injury settlements. This is because they read *Goetzmann* to stand for the proposition that, since virtually no case settles within 120 days of the earlier of the provision of the service or the filing of the claim with the insurer, then, in most cases, payment will not be "made promptly." They argue that, if payment is not made promptly, then Medicare has no right to reimbursement under the MSP statute.

For more information on this issue, I recommend that you access Benjamin W. Glass, III's website at http://www.vamedmal.com/mainpages/docs.cfm (after accessing the website, it is necessary for you to e-mail Mr. Glass and obtain a username and password to enter). On this website, Mr. Glass, a lawyer from Virginia, has posted most all of the on-point cases, several motions and briefs, and an excellent paper on the subject entitled, "Are Lawyers Who Reimburse Medicare Out of Tort Settlements Committing Malpractice?"

3. Practical Tips to Handle Medicare Liens:

Assuming that the "prompt payment" argument in *Goetzmann* does not relegate Medicare reimbursement to an obscure footnote in the annals of jurisprudence, the following are some practical tips for handling Medicare liens:

a. Requirement to Notify Medicare:

You must notify Medicare of your client's litigation pursuant to 42 C.F.R. §§ 411.24 and 411.26.

b. Telephone Medicare Coordination of Benefits (COB):

Prior to sending any notice of potential lien letter to Medicare, you must first telephone the Medicare Coordination of Benefits ("COB") office in New York, New York, to request that COB create a file (set up the claim) on their computer database regarding your specific case. When placing this call, you must provide COB with an HIC/MEDICARE ID number, as Medicare can not set up a claim without one. (Your client's HIC/MEDICARE ID number can usually be found on the "face sheet" of your client's medical records. If you cannot locate the number in the medical record, ask your client or his/her surviving family members for this information). COB will also ask for your client's name, the date(s) of loss, the address of the client, the physical injury made the basis of your lawsuit, AND the name of the liability carrier of the Defendant. (If you do not know the name of the Defendant's liability carrier, most COB agents will accept the name and address of the Defendant).

COB's address and phone number are:

MEDICARE Coordination of Benefits
MSP Claim Investigation Project
Post Office Box 5041
New York, New York 10274-5041
Telephone No. (800) 999-1118

After COB takes this information from you on the phone, COB will tell you to expect to receive written acknowledgement in about 15 days.

c. Consent to Release and Medicare Trauma Code Development Forms:

Usually, when COB sends a written acknowledgment of your claim, COB will also send you a "Consent to Release" (Medical Authorization) form and a "Medicare Trauma Code Development" form. Your client must sign the medical authorization form to authorize Medicare to communicate with you (the law firm) about the case and to provide you with medical/billing/lien information about your client. You must complete the "Medicare Trauma Code Development" form in as much detail as possible and return it to COB ASAP.

d. Notification of Lead Contractor:

Soon after you return to COB the signed "Consent to Release" medical authorization form and "Medicare Trauma Code Development" form, COB will send you a two-sided document that reflects which Medicare contracting entity (name and address) has been assigned by COB to act as the "lead contractor" in your specific case. **When you get this document, this is when you immediately send your written notice of potential lien letter to whichever Medicare contracting entity that COB has appointed to act as the "lead contractor."**

The "lead contractor" is the office that actually obtains and compiles all claims related to your lawsuit and calculates the final lien total to be asserted by Medicare. To do this, the "lead contractor" contacts other Medicare contracting entities that it determines may have paid claims relevant to your client's case, and asks these other contracting entities to provide claims information and a total that are attributable to your client's case.

Prior to approximately January 2001, and COB's involvement in Medicare's lien gathering process, the notice of potential lien letters were always sent directly to the Texas Medicare contracting office: TrailBlazer Health Enterprises, L.L.C., Post Office Box 9020, Denison, Texas 75021, Telephone No. (903) 463-0641, Fax No. (903) 463-0642.

Although the process has changed, it is likely that, if the health care was provided in Texas and the client was a resident of Texas, COB will appoint TrailBlazer Health Enterprises, L.L.C. to act as "lead contractor" in the bulk of your cases.

e. "Chain of Authority" Documentation:

When sending Medicare your notice of potential letter, it is prudent to also provide Medicare with "chain of authority" documentation. Providing Medicare with "chain of authority" documentation, at the outset, will avoid potential serious delay in dealing with Medicare later.

"Chain of authority" documentation are documents you must provide to Medicare when a client is unable to sign his/her own medical authorization form or is not acting directly for himself/herself in the lawsuit. In nursing home cases, because of the age, infirmity, or death of clients, this scenario occurs often.

Examples of "chain of authority" documentation include:

As to a living but incapacitated client:

- Power of Attorney, in which the client has authorized someone else (likely his next of kin) to act on his/her behalf in legal/business matters; or

- Order Appointing Guardianship (as to a client who has been declared legally incompetent).

As to a deceased client:

- Last Will and Testament (where the client sets out who has been named to act as Independent Executor of his/her Estate).
- Probate Court Order Appointing Dependent/Independent Administrator

Of course, whoever is named in any of these documents as your client's legal representative needs to sign the Medicare-proscribed Consent to Release form.

It may also be necessary for you to provide Medicare with a copy of the Contingency Fee Contract signed by your client or their surviving legal representative, evidencing your client's retention of your law firm to represent them in the litigation at issue.

f. Expect Delay!

In the last few years, TrailBlazer – Medicare has operated on its stated intent or policy of responding to subrogation-related correspondence it receives within a 60-day window. This allegedly means that, on the 60th day after the date Medicare received your subrogation-related correspondence on a case, Medicare will actually pick up the letter to work it up in some way (meaningful or not!).

Significantly, however, for the past two years, TrailBlazer – Medicare's response window has been outside 100 days, and in some cases, even longer than 150 days! Recently, Medicare reiterated its intent or policy to return to responding to subrogation-related correspondence within the 60-day window time frame. (I'm holding my breath!)

To my knowledge, TrailBlazer-Medicare is still adhering to the policy of only accepting subrogation-related telephone calls during certain hours of the work day, i.e., 10:00 a.m. to 12:00 p.m. and 1:00 p.m. to 3:00 p.m., Monday through Friday.

g. Who to Call to Complain:

If you are having difficulty dealing with any Medicare contracting entity, or are unable, after an unreasonably lengthy period, to get Medicare to provide you with a final lien total, then I suggest that you call Medicare's "troubleshooter", Ms. Sally Stalcup, of the Center for Medicare and Medicaid Services ("CMS") office in Dallas, Texas. Ms. Stalcup's telephone number is (214) 767-6415.

h. Always Request a Lien Reduction:

It is prudent to always request a reduction of sizeable lien amounts. With Medicare, any requests for reduction of the final lien amount must be in writing. Medicare will bear its pro-rata share of the "procurement costs," including legal fees and expenses, incurred by

the plaintiff in obtaining the third party recovery. It will not bear any share of the procurement fees in collecting from an automobile no-fault insurance policy or no-fault premises medical payments coverage, unless the attorney was instrumental in obtaining those no-fault benefits for the plaintiff.

Medicare utilizes a "Recovery Sheet" to calculate the portion of procurement costs to be borne by Medicare. I recommend that you complete a "Recovery Sheet" and send it to Medicare along with your letter requesting a lien reduction. Medicare will undoubtedly ignore your Recovery Sheet calculations and prepare their own. However, it will communicate your expectations to Medicare, as well as provide you with some estimation as to what Medicare is likely to do.

When requesting a lien reduction from Medicare, you must provide Medicare with the total amount of your client's gross recovery in the case (by settlement or jury verdict), the total amount of your attorney's fees (as determined by the percentage allowed under your Contingency Fee contract), and the total amount of the costs expended by your firm in handling the case.

Note: Presently, in light of the Fifth Circuit decision in *Goetzmann*, Medicare is refusing to process any requests for reduction of liens for procurement costs.

i. Payment:

Once Medicare has notified you of the total subrogation lien amount it is asserting, and if you have already settled the case, you have 60 days to remit payment to Medicare or your client will be assessed penalty and interest fees/charges. *See* 42 C.F.R. § 411.24(h).

j. Penalties for Failing to Reimburse:

An attorney should not attempt to avoid informing Medicare of a personal injury recovery in the hopes that Medicare will not discover it. Medicare has six years in which to seek reimbursement after it learns that it was not reimbursed. Medicare can recover double the amount of its claim if it takes legal action.

k. Obtain a Release:

When you mail your lien payment to Medicare, always request a Release. Upon receipt of payment, Medicare always affords itself one more careful "look-see" to make sure they have collected all that they can. When they receive the payment from you, prior to sending a Release to you, Medicare always sends a letter stating that the payment you sent may not be sufficient to fully "extinguish" the lien debt and, accordingly, Medicare is holding onto the payment pending further investigation of the claims. Upon conclusion of their final case review, Medicare will then send a letter releasing any interest that it has in your case.

B. MEDICAID:

1. Legal Authority:

Unlike Medicare, one may not recover Medicaid absent need. Medicaid provides medical assistance for families with dependent children and aged, blind, or disabled individuals who lack sufficient income and resources to meet the costs of necessary medical services. Medicaid's subrogation rights in Texas are found in section 32.003 of the Texas Human Resources Code.

The filing of an application for Medicaid benefits constitutes an assignment to Medicaid of the applicant's right of recovery from: (a) personal insurance; (b) another person for personal injury caused by such other person's negligence or wrong; and (c) other sources. TEX. HUM. RES. CODE ANN. § 32.033(a) (Vernon 2001). Section 12.036 of the Health & Safety Code confers upon the Texas Department of Health the authority to pursue and collect a subrogation interest in favor of the state.

2. Practical Tips to Handle Medicaid Liens:

a. Requirements to Notify:

i. 25 Tex. Admin. Code § 354.2313 (2002):

Pursuant to 25 Tex. Admin. Code § 354.2313(a), an applicant or recipient of Medicaid benefits has a duty to inform Medicaid of the following:

- any pending or unsettled claim for injuries for which a claim for medical services has or will be submitted to Medicaid for payment;
- the name/address of any attorney hired to represent the applicant or recipient in any claim for injuries;
- the identity of any third party health insurer or third party who is or may be responsible for paying for health coverage (e.g., name, relationship to insured, policyholder, policy number, dates of coverage, date of accident or injury).

You (as the recipient's attorney) must notify Medicaid of any of the above-listed "resources" within 60 days of learning of or discovering the existence of the "resource."

ii. 25 Tex. Admin. Code § 354.2315(a) (2002):

Pursuant to 25 Tex. Admin. Code § 354.2315(a)(2002), you (as the recipient's attorney) must notify Medicaid of your client's third party claim for personal injury damages within 45 days of the date that you are retained, or within 45 days from the date that a potential third party is identified.

The notice should include:

- the name/address and identifying information of the recipient (date of birth and/or Social Security or Medicaid identification number;
- the name/address of the third party from whom a claim for injuries is being asserted; and
- the name/address of health care providers who have asserted a claim for payment for medical services for which a third party may be liable.

This information should be supplemented as necessary. The applicant's intentional failure to give notice as required by statute is a Class C misdemeanor.

b. Authorization:

You should attach an authorization, signed by the recipient (or the recipient's power of attorney) to your notice to Medicaid. *See* 25 Tex. Admin Code § 354.2315(b)(2002).

c. Who to Contact:

Medicaid utilizes a contracting collection agent for the collection of benefits reimbursement. All of your correspondence and communication should be directed to:

National Heritage Insurance Company
ATTN: Tort/Subrogation Department
12545 Riata Vista Circle
Austin, Texas 78727
Telephone No. (800) 846-7307
Fax No. (512) 514-4225

You should always reference your client's Medicaid I.D. number on your notice of potential lien letter, as well as on all of your subsequent correspondence to Medicaid.

d. Always Request a Lien Reduction:

Again, ask and you shall receive. To obtain a reduction of Medicaid's asserted lien, reference 25 Tex. Admin. Code Ann. § 354.2332(b) and (c), which authorizes a reduction of lien for costs and attorney's fees. Specifically, this statute authorizes Medicaid to reduce its lien by paying attorney's fees in the amount of 15% of the entire amount recovered for Medicaid. Further, the statute authorizes Medicaid to reduce its lien by paying prorata expenses not to exceed 10% of the entire amount recovered for Medicaid.

When requesting a lien reduction from Medicaid, you are required to provide the total amount of your client's monetary recovery in the case (by settlement or jury verdict), and to provide a summary (maximum one page total in length) of your law firm's costs expended in handling the case. The summary of expenses should itemize expenses by type and include a total expense amount, and the expense summary must be signed by the attorney of record. Medicaid will not authorize a reduction for costs expended unless you provide them with the expense summary with your letter requesting the lien reduction.

They frown upon receiving lengthy expense itemizations, in lieu of an expense summary. In fact, they have been known to totally refuse to accept a lengthy expense itemization in lieu of an expense summary.

e. Notify Social Security of Change in Client's Unearned Income:

If your client is alive at the time of the final distribution of funds, and your client is a recipient of Supplemental Security Income, via Medicaid, you must notify the Social Security Administration office that processes your client's SSI payments of the change in your client's financial resources or unearned income as a result of the personal injury recovery. *See* 20 CFR § 416.710, et seq. This may impact your client's ability to continue to receive SSI benefits. You should notify your client of this as well, preferably at the outset of the case. Implementing a Special Needs Trust to safeguard your client's SSI benefits does not excuse you from having to notify the Social Security Administration office of your client's net monetary recovery from the lawsuit.

C. TEXAS DEPARTMENT OF HUMAN SERVICES ("TDHS"):

1. Legal Authority:

The Texas Department of Human Services ("TDHS") pays for some care-related expenses that a nursing home resident receives via the Medicaid program. (Note: This is separate from Medicaid claims paid to other health care providers, like doctors and hospitals). TDHS has the right to assert a lien for care that it has paid for. Title XIX of the Federal Social Security Act requires reimbursement by liable third parties when Medicaid funds have been paid. The Texas Human Services Code, section 32.033, establishes automatic assignment of the Medicaid recipient's right of recovery from personal insurance and other sources to TDHS as a condition of eligibility.

2. Practical Tips to Handle TDHS Liens:

a. Requirement to Notify:

As with Medicaid, you must notify TDHS of your client's lawsuit. The following is the contact information for TDHS:

Texas Department of Human Services
ATTN: Ms. Gayle Sandoval, Supervisor, PBS Recovery Unit [Y948]
Post Office Box 149081
Austin, Texas 78714-9081
Telephone No. (512) 490-4680
Fax No. (512) 490-4667

If one is available, you should always reference your client's Medicaid ID number on your notice of potential lien letter, as well as on all of your subsequent correspondence to TDHS.

b. Always Request a Lien Reduction:

To obtain a lien reduction from TDHS-Medicaid (for costs expended and attorney's fees), you must do so through Barry Browning, TDHS's Assistant General Counsel. His address/phone numbers are as follows:

Barry Browning, Esq.
Assistant General Counsel
Texas Department of Human Services
Post Office Box 149030
Austin, Texas 78714-9030
Telephone No. (512) 438-3126
Fax No. (512) 438-3747

It will help you to note that TDHS only has a lien right to recover the **difference** in Medicaid-related monies expended by TDHS for your client's care/treatment at a nursing home, due to a change in your client's TILE rating, as a direct result of the injury your client sustained, which is the basis of your lawsuit. Therefore, you should look for a **difference** amount on the itemization of claims TDHS provides to you reflecting their final lien total, as being the amount of the lien you must repay.

To obtain a reduction of TDHS' asserted lien, you only have to request one in writing in general terms.

c. Obtain a Release of Lien:

Release of lien documents are obtained through Barry Browning, at the above address, as well. Remember, to obtain a release from Medicaid and TDHS, you will need to send a proposed release along with your remittance of the lien payment.

D. VETERAN'S ADMINISTRATION ("V.A."):

1. Legal Authority:

The Veterans Administration has a statutory subrogation interest pursuant to the Federal Medical Care Recovery Act, 42 U.S.C. § 2651. The V.A. may obtain reimbursement out of the recovery from the plaintiff's personal injury lawsuit, the plaintiff's Personal Injury Protection (PIP), the plaintiff's workman's compensation benefits, or any health plan contract.

2. Practical Tips Regarding Handling V.A. Liens:

a. How to Contact the V.A.

To reach the regional office, contact:

Department of Veterans Affairs
Office of Regional Counsel (02)
4800 Memorial Drive, Building 12
Waco, Texas 76711
Main Telephone No. (254) 754-9300
Fax No. (254) 754-9310
Additional Fax No. (254) 754-9344

b. Amend Your Petition:

After you send a notice of potential lien letter to the V.A., the V.A. will likely want to strike a deal with you (the plaintiff's attorney). The V.A. will offer to present your client's V.A. doctors and nurses for informal meetings, depositions, and trial, and provide certified copies of medical records, if you will protect the V.A.'s interest by amending Plaintiff's petition to assert the following:

> "As a result of the Plaintiff's injuries, he has received and will continue to receive medical care furnished by the United States of America. The Plaintiff, for the sole use and benefit of the United States of America under the provisions of 42 U.S.C. 2561, et seq, and with its express consent, asserts a claim for the reasonable value of said past and future care."

Since the V.A. has a solid right to reimbursement, the plaintiff's attorney loses nothing and gains much by striking this "bargain" with the V.A.

c. Always Request a Lien Reduction:

The V.A. is usually willing to reduce its lien in order to enable the veteran to be fairly compensated for his injuries. In doing so, the V.A. does not enter into any formal calculations and does not formally consider procurement costs. However, the V.A. does tend to employ equitable principles in an effort to make the veteran whole.

E. HOSPITAL LIENS:

1. Legal Authority:

The Texas Hospital Lien Statute, TEX. PROP. CODE ANN. § 55.001 et seq. (Vernon 1996), provides hospitals an additional method of securing payment for medical services. The legislature's intent was to provide hospitals with a separate cause of action to satisfy their liens. The lien to which a hospital is entitled attaches to the patient's right of action against a third party for negligently causing the personal injuries for which he or she was treated. The lien also attaches to money paid as a result of a claim or lawsuit for personal injuries sustained by a patient in an accident.

2. Important Facts:

Here are some important facts to know regarding the statute:

a. Look for a hospital lien in the deed records of the county where the medical services were rendered—the hospital must file its lien there. For the lien to attach, the hospital must file the lien with the county clerk before money is paid to an entitled person because of the injury. TEX. PROP. CODE ANN. § 55.005(a) (Vernon 1996).

b. Hospital liens attach to causes of action, judgments, and proceeds of settlements. §§ 55.003(a)(1)(2)(3).

c. For the lien to attach, the individual must be admitted to a hospital not later than 72 hours after the accident. A hospital cannot perfect a lien against the judgment or settlement of any claims if the injured person initially comes in for treatment 72 hours or more after the accident. § 55.002(a).

d. The lien extends to both the admitting hospital and any hospital to which the individual is transferred for treatment of the same injury. § 55.002(b).

e. Hospital liens do not attach to certain claims brought under Texas workers' compensation laws. § 55.003(b)(1). One must look at the parties involved and claims made to determine whether a hospital lien attaches to that action. If an injured person brings a claim against his or her employer or workers' compensation carrier for workers' compensation benefits and is found to have suffered a compensable injury under the Workers' Compensation Act, the hospital's right to recover for treatment of the employee is wholly governed by the provisions of the Workers' Compensation Act, not on its hospital lien. If the patient did not suffer a compensable injury under the workers' compensation laws, the hospital retains its rights under the Hospital Lien Statute. Further, if the injured employee sues a third party for causing the non-compensable injury, the hospital may maintain a lien on that third- party lawsuit. *McCollum v. Baylor Univ. Med. Ctr.*, 697 S.W.2d 22, 25–26 (Tex. App.—Dallas 1985, no writ).

f. While survival proceeds are subject to a hospital lien, wrongful death damages are not. *Tarrant County Hosp. Dist. v. Jones*, 664 S.W.2d 191, 194–95 (Tex. App.—Fort Worth 1984, writ ref'd n.r.e.).

g. The lien does not cover charges for other services that exceed a "reasonable and regular rate" for the services. § 55.004(d)(1). The lien covers the first 100 days of the injured individual's hospitalization. § 55.004(b).

h. The limitations period for the hospital's cause of action is four years from the date of the settlement or judgment. *Baylor Univ. Med. Ctr. v. Borders*, 581 S.W.2d 731, 732–34 (Tex. Civ. App.—Dallas 1979, writ ref'd n.r.e.).

i. A hospital is not required to shoulder any part of the plaintiff

lawyer's charges for services rendered resulting in collection on a hospital lien through a third-party lawsuit. The rationale is that plaintiffs' attorneys are performing services they are obligated to their clients to perform and the benefit to the hospital is incidental. *Bashara v. Baptist Mem'l Hosp. Sys.*, 685 S.W.2d 307–310 (Tex. 1985).

j. All persons involved in a settlement may be liable if a lien is not satisfied. Though a hospital can bring a claim against the injured patient seeking satisfaction of a lien, cases have held that insurance companies and defendants who pay the injured party also remain responsible to the hospital for unpaid bills. *Borders*, 581 S.W.2d at 733–34; *Baylor Univ. Med. Ctr. v. Travelers Ins. Co.*, 587 S.W.2d 501, 501 (Tex. Civ. App.—Dallas 1979, writ ref'd n.r.e.); *Republic Ins. Co. v. Shotwell*, 407 S.W.2d 864, 867 (Tex. Civ. App.—Amarillo 1966, writ ref'd n.r.e.).

k. In the 2001 session of the legislature, Sec. 55.004 of the Property Code was amended to include the bills of certain physicians within the lien. Within that amendment, sec. 55.004(a) added a definition of "emergency hospital care" to include care that the average prudent layperson would believe was necessary to treat "a serious medical problem of recent onset or severity." Section 55.004(b) grants the lien for the first 100 days of hospitalization but, under sec. 55.004(d)(1), the lien does not extend to charges that "exceed a reasonable and regular rate for the services. Section 55.004 now allows the physician to claim a lien (which the hospital may file on the physician's behalf) for the reasonable and necessary charges within the first seven days of hospitalization. However, if the physician "has accepted benefits or payment under a private medical indemnity plan or program, regardless of whether the benefits or payment equals the full amount of the physician's charges for those services," or if the injured person "has coverage under a private medical indemnity plan or program from which the physician is entitled to recover payment for the physician's services under an assignment of benefits or similar right," or if the physician is a member of the state legislature, then the physician's fees are not covered by the lien.

F. NEW LIENS: EMERGENCY MEDICAL SERVICES PROVIDER

1. Legal Authority:

The Texas Hospital Lien Statute, TEX. PROP. CODE ANN. § 55.001 et. Seq. (Vernon 1996), was recently amended to include a cause of action for an emergency medical services provider to recover payments in limited circumstances. Act of June 18, 2003, 78th Leg., R.S., S.B. 504, § 1 (to be codified as an amendment to TEX. PROP. CODE ANN. § 55). An emergency medical services provider (hereafter EMSP) is defined in TEX. HEALTH & SAFETY CODE ANN. § 773.003 (Vernon 2002) as a person who uses or maintains emergency medical services vehicles, medical equipment, and emergency medical services personnel to provide emergency medical services. This will most commonly include ambulance and life-flight helicopter services who provide emergency medical care after September 1, 2003. The new provisions are similar to the criteria for a hospital lien. The lien attaches to the injured party's cause of action against a third party for negligently causing the personal injuries for which the injured party received services

from an emergency medical services provider. TEX. PROP. CODE ANN. § 55.002(c). However, the new lien includes several important distinctions and limitations.

2. Important Facts: Key Similarities to Hospital Liens:

a. EMSPs are required to file liens with the deed records of the county where the services were rendered. The lien must be filed before the entitled party receives payment as a result of his injuries. § 55.005(a)

b. EMSP liens also attach to the causes of action, judgments, and proceeds of settlements. § 55.003(a)(1)(2)(3).

c. The services provided by an EMSP must also be rendered within 72 hours of the accident causing the individual's injuries. § 55.002(c).

3. Important Facts: Distinctions and Limitations:

a. The lien only applies to providers located in a county with a population of less than 575,000 people (i.e. every county in Texas, other than Bexar, Dallas, El Paso, Harris, Hildago, Tarrant, and Travis). § 55.002(c).

b. The amount of lien is limited to the amount charged by the EMSP and may not exceed $1,000. § 55.004(f).

c. The lien does not cover EMSP charges

- for services that "exceed a reasonable and regular rate" (§ 55.004(g)(1));
- for services that the EMSP has accepted insurance benefits or payment under a private medical indemnity plan, even if the benefits or payments do not equal the full amount of the charges (§ 55.004(g)(2));
- for services if the injured individual is covered under a medical indemnity plan or program from which the EMSP is entitled to recover payment under an assignment of benefits or similar right (§ 55.004(g)(3)).

G. PRIVATE HEALTH INSURANCE COMPANIES:

1. Legal Authority:

A private health insurance entity, which provided health care coverage benefits to your client following the injury made the basis of your lawsuit, may have a contractual right of subrogation pursuant to a provision that may be contained in their health insurance policy.

2. Practical Tips To Handle Insurance Subrogation:

a. Requirement to Notify:

If your client has received private insurance benefits for medial care related to an injury, there may be a provision in the insurance contract that mandates that you notify the carrier of any third party action that you are bringing to recover damages for injuries sustained by the insured. If you do not initially have access to the insurance policy, the safe practice is to send private insurance carriers a notice of potential lien letter.

b. Request Copy of Applicable Insurance Policy/Plan:

In your notice of potential lien letter to a private health insurance entity, you should always ask for a copy of your client's health insurance policy/plan that was in effect during the date(s) of loss referenced in your letter. Upon receipt, study this policy! This is the only way you can determine whether the private health insuring entity actually has a contractual right of subrogation recovery in connection with your particular case. Insurance companies do not have a right of subrogation absent a contract or agreement that allows for one. *See TAC v. Matagorda County*, 52 S.W.3d 128 (Tex. 2001).

c. Beware of Reimbursement Agreements:

Often, after receiving your notice of potential lien letter, a private health insurance company will respond by demanding that your client sign an onerous Reimbursement Agreement. It is rarely in your client's best interest to sign.

These reimbursement agreements are usually worded in such a way as to essentially ignore your client's right to be "made whole" and/or to be reimbursed for procurement costs in accordance with *Esparza v. Scott & White Health Plan*, 909 S.W.2d 548 (Tex. App.—Austin 1995, writ denied). Typically, the reimbursement agreements foreclose any opportunity that your client may have to negotiate a reduction of the lien amount. The reimbursement agreements also tend to abrogate jury findings, by mandating reimbursement to the private health insuring entity based upon the total sum recovered, regardless of how damages are allocated by the jury. In some instances, the reimbursement agreements specifically subordinate the insured's other family members, who are covered under the same policy, from recovering on their individual claims, such as for loss of consortium, until after the insurance company is reimbursed in full. Some of these reimbursement agreements also interfere with the settlement of the case, by requiring the tortfeasor to make payment directly to the private health insuring entity, bypassing the insured and the insured's attorney! Finally, most reimbursement agreements are objectionable in that they provide that, if litigation is necessary to enforce the agreement, then your client will be responsible for the insurance company's costs and attorney's fees.

Private health insuring entities will also use duress in an effort to force your client to sign their reimbursement agreement. Oftentimes, the insurance company threatens to stop payment for treatment of the injuries made the basis of the suit unless your client signs the reimbursement agreement. They will also threaten not to provide you with any subrogation lien information or amounts unless and until your client signs the reimbursement agreement.

You should notify, in writing, the private health insuring entity of the unethical and inappropriate nature of their demands. Using the "savings clause" of ERISA, 29 U.S.C. 1144(b)(2)(A), argue that the "made whole" doctrine and the "common fund" doctrine are not preempted by ERISA and that your client is entitled to a lien reduction, regardless of whether your client signs the reimbursement agreement. In addition, argue that the reimbursement agreement is contrary to equitable common law regulation of insurance plans in the state of Texas, which is also not preempted by ERISA. If possible, try to work with the private health insurer's legal department to draft a reimbursement agreement that is consistent with your client's rights.

d. Humana and Secure Horizons/Pacificare:

If an individual qualifies for Medicare, that individual can enroll in a Medical replacement plan, like Humana Gold Plus or Secure Horizons/Pacificare. These health care plans stand in Medicare's shoes and provide to plan members the benefits that Medicare would have provided. In addition, the plans provide additional benefits that Medicare would not have provided, under the theory that a for-profit company is more efficient than the federal government. In nursing home cases, it is not uncommon for your client to be a member of a Medicare replacement plan, like Humana or Secure Horizons/Pacificare.

Humana's contracting collection agent is Healthcare Recoveries, Inc., and may be reached at the following address:

Healthcare Recoveries, Inc.
Post Office Box 37440
Louisville, Kentucky 40233
Telephone No. (800) 685-0419 (Lorie Sebastian)
Telephone No. (800) 405-09556 (Tracy Wilson)
Fax No. (502) 454-1291

Secure Horizons/Pacificare's contracting collection agent is Primax Recoveries, Inc., and may be reached at the following address:

Primax Recoveries, Inc.
ATTN: Third Party Liability/Subrogation Dept.
Post Office Box 4003
Schaumburg, IL 60168-4003
Telephone No. 1-800-442-2911

When corresponding to either of these contractors, you should always reference your client's Policy number, Group ID number, and Member ID number.

e. Always Request a Lien Reduction:

If the lien asserted by any private health insuring entity is sizeable, it is advisable to always request a reduction of the final lien amount asserted (for costs expended and attorney's fees), pursuant to *Lancer Corp. v. Murillo*, 909 S.W.2d 122 (Tex. App.—San Antonio 1995, no writ).

3. Argue the "Made Whole" Doctrine

a. Recent Legislation: Can Any Party Ever Be "Made Whole"?

Effective September 1, 2003, House Bill 4 significantly reduced the value of many medical malpractice and nursing home negligence claims by capping non-economic damages. Act of June 11, 2003, 78th Leg., R.S., H.B. 4, § 10.01 (to be codified as an amendment to TEX. CIV. PRAC. & REM. CODE ANN. §§ 74.001-74.507). Regardless of the severity of the non-economic injury, all non-economic damages are statutorily limited to $250,000 after September 1, 2003.

Before writing the check to a money grubbing lienholder, argue strongly that the recovery received by your client in no way made him whole because his non-economic damages were limited by arbitrary caps that do not compensate him for his true damage and loss.

The "made whole" doctrine, an equitable common law rule, states that if the loss suffered by the insured is greater then the combined amount recovered from the insurer and the tortfeasor, then the insurer is not entitled to subrogation. *Ortiz v. Great S. Fire & Casualty Ins. Co.*, 597 S.W.2d 342, 343 (Tex. 1980). "In other words, the insurer's right of subrogation may not be exercised until the insured has been made whole." *Esparza v. Scott & White Health Plan*, 909 S.W.2d 548, 552 (Tex. App. -- Austin 1995, no writ)(citing *Ortiz*). Arguably, when defending against an equitable subrogation interest, where the injured party's non-economic damages far exceed the amount he is legally able to claim in court, the injured party will never be "made whole." In this instance, the injured party should not be forced to pay subrogation interests that would further erode his damages.

b. Legal Authority

The Texas Supreme Court affirmed the "made whole" doctrine in *Ortiz v. Great S. Fire & Casualty Ins. Co.*, reasoning that "an insurer should not be required to account for more than the surplus which remained in his hands after satisfying his own excess of loss in full and his reasonable expenses in recovery." *Id.* at 343 (quoting *Camden Fire Ins. Ass'n. v. Missouri K. & T. Ry.*, 175 S.W. 816, 821 (Tex. Civ. App. – Dallas 1915, no writ). In *Ortiz*, a fire insurance company paid $4,000 to the Ortiz family who suffered

more than $15,000 in personal and real property damage when a carpet company negligently started a fire. The Ortiz family settled for $10,000 from the carpet company. The court denied the fire insurance company's subrogation claim, stating that there was no evidence of double recovery because the Ortizes' combined collection from the tortfeasor and the insurance company did not exceed their total damages. *Id.* Since the purpose behind a subrogation interest is to prevent double recovery, the court found that the trial court was within its discretion not to enforce payment of the fire insurance company's subrogation claim. *Id.* at 343-344.

Ortiz addressed common law equitable subrogation interests. *Id.* at 343. In *Esparza v. Scott & White Health Plan*, the Austin Court of Appeals applied the reasoning in *Ortiz* to contractual subrogation interests in a medical malpractice suit. *Esparza*, 909 S.W.2d at 550. The court found that contractual subrogation interests "confirm, but do not expand" the equitable right to subrogation. *Id.* at 552. Citing *Ortiz*, the court said "the principal purpose of an insurance contract is to protect the insured from loss, thereby placing the loss on the insurer." *Id.* at 551. If either party must go unpaid, the loss should be borne by the insurer-- the insured has paid the insurer to assume this risk. *Id.* at 552. The court of appeals rejected Scott & White's argument that the subrogation provision in their insurance contract entitled them to full indemnification, and found that these "basic principle(s) cannot be summarily overcome by a boiler-plate provision in an insurance contract that purports to entitle the insurer." *Id.* at 551-552. Ultimately, the court found fault in the actions of both parties and affirmed the trial court's award to Scott & White of half of its subrogation interest. *Id.* at 553.

c. The Potential Effect of *Esparza?*

The *Esparza* ruling demonstrates that, in response to contractual subrogation claims, Texas courts may determine an equitable solution by examining the facts of the case. **A contract provision creating a subrogation interest in a private health insurance policy does not automatically determine when or how much the insurance company should receive.** *Id.* at 551. When evaluating the facts of a given case, a court could potentially give weight to the injured party's loss resulting from severely limited non-economic damages. It is worth arguing that the "made whole" doctrine is applicable in defense to a contractual subrogation claim because a court, in its discretion, can completely deny recovery to the subrogee or simply reduce the amount paid, as it did in *Esparza.*

d. Ask the Subrogee to "Chip In" For Expenses!

Always ask for an offset of attorney's fees and expenses from the insurer's subrogation interest. Texas law requires a subrogee to contribute to the injured party's costs and expenses in collecting damages. *Ortiz,* 597 S.W.2d at 344. Moreover, the court of appeals in *Esparza* recognized that the trial judge considered the offset of attorney's fees and costs to the injured party when determining how much to award Scott & White Health Plan. *Esparza*, 909 S.W.2d at 553. Argue that your client cannot be "made whole" if forced to pay the health insurer's share of attorney's fees and expenses.

e. The "Made Whole" Doctrine vs. ERISA

Many health insurance plans will not fall under ERISA. In these cases you may immediately apply Texas equitable subrogation rules like the "made whole" doctrine. However, many plaintiffs will receive health insurance through their employment. Undoubtedly, these insurance companies will argue that their plan falls under ERISA, and that ERISA preempts Texas equitable subrogation laws. 29 U.S.C. § 1144(a). Do not be discouraged by this distraction. Instead, ask the insurer to prove that the plan is subject to ERISA and, perhaps, consider the argument utilized in *UNUM v. Ward, infra,* that the "made whole" doctrine is protected by ERISA's savings clause, and is not subject to preemption.

i. Is it *Really* an ERISA Plan?

An insurance company may claim a plan is subject to ERISA simply because the plan is purchased in the context of employment. In reality, a health plan must meet certain statutory criteria outlined under the "employee welfare benefit plan" section of ERISA. ERISA covers any plan, fund, or program established or maintained by an employer for the purpose of providing its participants and their beneficiaries with medical benefits in the event of sickness, accident, disability, death or unemployment. 29 U.S.C. § 1002(1) (West 2002). *Kidder v. H & B Marine, Inc.*, 932 F.2d 347, 351 (5th Cir. 1991). Do not take it for granted that an insurance plan meets this description. Although it is fairly easy to create a plan that is subject to ERISA, the determination is fact dependent, and exceptions exist. Make sure the employer intended to create a benefit plan for his employees, that there was a method for application and receipt of benefits, and a that the employer helped fund or finance the plan. The court looks at the circumstances as a whole. For example, in *Kidder v. H.B. Marine, Inc.*, the Fifth Circuit noted that an employer's purchase of a health plan may not, in itself, establish an "employee welfare benefit plan" under ERISA. *Id.* at 352-353.

In *Kidder*, the Fifth Circuit also acknowledged the widely recognized "safe harbor" rule. Under 29 C.F.R. § 2510.3-1, the Department of Labor provided that certain "employment welfare benefit plans" were excluded from ERISA if they met the following criteria:

> (1) No contributions are made by an employer or employee organization:
> (2) Participation [in] the program is completely voluntary for employees or members;
> (3) The sole functions of the employer or employee organization with respect to the program are, without endorsing the program, to permit the insurer to publicize the program to employees or members, to collect premiums through payroll deductions or dues check offs and to remit them to the insurer; and
> (4) The employer or employee organization receives no consideration in the form of cash or otherwise in connection with the program, other than reasonable compensation, excluding any profit, for administrative services actually rendered in connection with payroll deductions or dues check offs.

Kidder, 932 F.2d at 352.

Plans that fall under the "safe harbor" provision will not be subject to ERISA, and will be subject to the "made whole" doctrine.

Insurers, whose plans do fall under ERISA, will seek to enforce contractual subrogation interests based on the explicit terms of the contract and without regard to the "made whole" doctrine. They will claim that 29 U.S.C. Sec. 1132 (a)(3) authorizes the insurer to enforce the terms of the plan. Traditionally, the "made whole" doctrine has been preempted by ERISA in federal courts.[7] When faced with preemption, you might consider the reasoning of *UNUM v. Ward* and argue that ERISA does not preempt application of the "made whole" doctrine.

ii. Does ERISA Preempt the "Made Whole" Doctrine?

Because the "made whole" doctrine affects state insurance law, it is arguable that it falls within the protection of ERISA's savings clause, and is not preempted. ERISA health insurance plans must follow state insurance regulations that are protected by the savings clause.

The Supreme Court affirmed the state's power to regulate insurance when it denied one insurance company's attempt to enforce the terms of an insurance contract without regard to state common law insurance regulation in *UNUM v. Ward*, 526 U.S. 358 (1999). The Court held that a state common law "notice-prejudice" rule regulated insurance and therefore fell under the savings clause of ERISA and was not preempted. *Id.* at 359.

In *Ward*, beneficiary John Ward sued his employer's insurance carrier for disability benefits when he was denied the benefits because he submitted his proof of claim after the deadline in the insurance contract. *Id.* at 363. Ward claimed that the California "notice-prejudice" rule prevented the insurer from denying his claim unless the insurer could demonstrate that it was prejudiced by the late claim. *Id.* at 364. UNUM claimed that the "notice-prejudice" rule was preempted by ERISA and further argued that, even if it fell under the savings clause, it was still preempted because 28 U.S.C. §1104 (a)(1)(D) "preempts any state law contrary to a written plan term." In dictum, the Court responded by arguing that UNUM's "'contra plan term' argument" would make state regulation of insurance law futile. An insurer would only have to add contract terms contrary to any state insurance regulation it disliked. The court emphasized that it had "repeatedly held that state laws mandating insurance contract terms are saved from preemption" under ERISA's savings clause, 29 U.S.C. § 1144(b)(2)(A). *Id.* at 375.

ERISA's "savings clause" exempts most state laws that regulate insurance from preemption. 29 U.S.C. § 1144(b)(2)(A). *Ward* affirmed the power of states to regulate insurance, even through common law. The Court set up a two part test to determine if a law is protected by the savings clause. First, the Court looked at the law from a

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[7] *See Paris v. Iron Worker's Trust Fund*, 211 F.3d 1256, 2000 U.S. App. LEXIS 6883 at *2 (4th Cir. 2000) (unpublished opinion) (rejecting common law "made whole" doctrine); *Sunbeam-Oster Co. v. Whitehurst*, 102 F.3d 1368, 1375 (5th Cir. 1996); *Waller v. Hormel Foods Corp.*, 120 F.3d 138 (8th Cir. 1997); *Cutting v. Jerome Foods Inc.*, 993 F.2d 1293 (7th Cir. 1993).

"common sense" view to determine whether the law regulates insurance. *Id.* at 386. Next, the court utilized three factors outlined in the McCarran Ferguson Act, 15 U.S.C. § 1011, to confirm whether the law truly involved in the business of insurance. The three factors were (1) "whether the practice has the effect of transferring or spreading a policy holder's risk", (2) "whether the practice is an integral part of the policy relationship" and (3) "whether the practice is limited to entities within the insurance business". *Id.*

The "made whole" doctrine certainly impacts insurance from a common sense perspective. As outlined in *Ortiz* and *Esparza*, it prevents insurers from asserting common law or contractual subrogation interests against beneficiaries who have not fully recovered their losses. It also satisfies the three factors of the McCarran Ferguson Act, 15 U.S.C. § 1011. The "made whole" doctrine is used to determine whether or not a beneficiary will be forced to reimburse an insurer for medical payments, a risk the beneficiary has paid the insurer to assume. It explicitly affects the contractual relationship between a beneficiary and an insurance company.

The Supreme Court's reasoning in *Ward* is indicative of its desire to provide the states with substantial influence on insurance law, and could potentially prevent preemption of the "made whole" doctrine. The "made whole" doctrine has not been actively litigated in conjunction with this creative *UNUM v. Ward* argument. *Ward* has been used with mixed results in attempts to expand the number of state insurance laws protected from preemption by ERISA's savings clause. Federal courts have frequently declined to extend Ward as support for a state common law "bad faith" cause of action.[8] A federal district court in Illinois has repeatedly stated that "UNUM did not dramatically alter the landscape when it comes to the preemptive effect of ERISA on state law enforcement actions."[9] Of course, there is hope in a decision by the Wisconsin Court of Appeals, which found that the state's "made whole" doctrine is protected by ERISA's savings clause because it regulates insurance as described in *UNUM v. Ward*. *See Kavelaris v. MSI Ins. Co.*, 631 N.W.2d 665 (Wis. Ct. App. 2001).

If an insurance company claims it is entitled to reimbursement because ERISA authorizes the insurer to enforce the terms of the plan under 29 U.S.C. § 1132 (a)(3), you may argue, using the reasoning in *Ward,* that ERISA health plans are still subject to regulation by most Texas insurance laws via the savings clause, including the "made whole" doctrine, and your client should not be forced to hand over more of his diminished damages.

V. CONCLUSION:

Timely and proper handling of subrogation interests and liens in medical malpractice and nursing home negligence cases entails a lot of perseverance, patience, and paperwork. Delay in timely notifying lienholders of a case and uncertainty about the dates of loss and/or the injuries in question will negatively impact your ability to timely obtain final lien totals. Without final lien totals, a final distribution of proceeds can not occur. This

[8] *Walker v. Southern Co. Services Inc.*, 279 F.3d 1289 (11th Cir. 2002); *Alloco v. Meteropolitan Life Ins. Co.*, 256 F.Supp.2d (D. Ariz. 2003); *Morris v. Highmark Life Ins. Co.*, 255 F.Supp.2d 16 (D.R.I. 2003).
[9] *Cencula v. John Alden Life Ins. Co.*, 174 F.Supp.2d 794, 801 (N.D. Ill. 2001).

invariably results in dissatisfied clients and a case that perpetually drags-on. Although much about the timing of processing liens is out of a plaintiff's lawyer's control, it is possible for a plaintiff's lawyer to ensure that any delay is not attributable to him. It may also be possible for a plaintiff's lawyer to minimize the erosion of your client's recovery by aggressively arguing the "made whole" doctrine.