THE MONEY PIT:
LIENS AND SUBROGATION INTERESTS

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THE MONEY PIT:
LIENS AND SUBROGATION INTERESTS

I. INTRODUCTION:

As tort reform caps the size of potential recoveries, and plaintiffs struggle to be made whole for their injuries, it seems the appetite of lienholders and subrogees for cash has never been more voracious. The government and insurance companies are aggressively pursuing reimbursement like never before, taking greed to an unprecedented level – on the backs of the elderly, the injured, and the poor – and all with the backing of the courts. Liens and subrogation interests are the new money pit.

This paper updates the paper I presented at the 19th Annual Advanced Personal Injury Law Course in 2003. Significantly, in this paper, I emphasize the recent "clarification" of the Medicare Secondary Payer statute, which legislatively – and retroactively – overruled the Fifth Circuit's decision in *Goetzmann*. In addition, I also discuss the new Medicaid Estate Recovery law, which appears calculated to make the poorest in Texas a little poorer. Further, I have updated the sections on the made-whole and common fund doctrines.

II. 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, DADS (formerly known as 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 HIPAA compliant medical authorization** to your notice of potential lien letter to each potential lienholder, signed by your client or his/her closest immediate surviving family member.

In the notice of potential lien 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 of your 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 notice 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. 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.

D. 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."

E. 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.

F. If the Recovery is Low, Argue the "Made Whole" Doctrine:

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. If appropriate, before writing the check to a money grubber, argue strongly that the recovery received by your client in no way made him whole because his non-economic damages were limited by an arbitrary cap that does not compensate him for his true damage and loss.

G. 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 DADS, 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 DADS 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.

III. 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).

Medicare is 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 plan."[1] The MSP statute prohibits Medicare from making payments, with respect to an injury, when the payment has been made, or can reasonably be expected to be made, by a primary plan. *See* 42 U.S.C. § 1395y(b)(2)(A).

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[1] As defined by Medicare, a "primary plan" means "a group health plan or large group health plan… and a workmen's compensation law or plan, an automobile or liability insurance policy or plan (including self-insured plan) or no fault insurance."

However, the MSP statute authorizes Medicare to make *conditional* healthcare payments when a "primary plan" has not made or cannot reasonably be expected to make payment with respect to an injury promptly. *See* 42 U.S.C. § 1395y(b)(2)(B), as recently amended.

In the event that Medicare makes a conditional payment, Medicare has the right to be reimbursed out of any recovery that the beneficiary receives from a third party (e.g., a personal injury settlement or judgment). This right of subrogation entitles the government to be repaid within 60 days after providing notice of, or information related to, a primary plan's responsibility for payment. If Medicare is not timely reimbursed, the government may charge interest. *See* 42 U.S.C. § 1395y(b)(2)(B)(ii); see also 42 C.F.R. § 411.24

In order to recover a conditional payment made by Medicare, the government may bring an action against "any or all entities that are or were responsible…to make payment…under a primary plan" (i.e., the Defendant and the Defendant's insurance company). In addition, the government may bring an action against "any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity" (i.e., your client and you!). *See* 42 U.S.C. § 1395y(b)(2)(B)(iii).

Significantly, if the government is forced to sue to recover the conditional payments it made, the government may collect DOUBLE damages! *See* 42 U.S.C. § 1395y(b)(2)(B)(iii). This means that, if Medicare sues you and/or your client to recover unreimbursed conditional payments, they can collect two-times the original lien total.

2. Recent Case Law:

a. ***Thompson v. Goetzmann***

In 2003, in *Thompson v. Goetzmann*, 337 F.3d 489 (5th Cir. July 7, 2003), 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.

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 made conditional payments totaling $143,881.82 related to Loftin's 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.

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 to the trial court 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 "primary 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 trial 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[2], 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.'" *Goetzmann*, 337 F.3d at 497. 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.

b. United States v. Baxter International, Inc.

In *United States v. Baxter International, Inc.*, 345 F. 3d 866 (11th Cir. September 15, 2003), the Eleventh Circuit disagreed with the Fifth Circuit's alternative holding regarding "prompt payment" in the first *Goetzmann* opinion."[3] In addition, the Eleventh Circuit disagreed with the *Goetzmann* opinion regarding what it takes to have a "self-insured plan."

The *Baxter* case stemmed from the $4.2 billion breast implant settlement. The government intervened against the manufacturers of silicone breast implants and the escrow agent for the silicone breast implant products liability litigation settlement fund, seeking to recover the costs of medical care and treatment related to some 81,000 breast implants claimants who were or would be compensated through the revised settlement program.

The breast implant manufacturers in *Baxter* made the same prompt pay argument that the Fifth Circuit considered in *Goetzmann*. Essentially, the defendants asserted that Medicare was not entitled to reimbursement under the MSP statute because the funding of the revised settlement program was not "*made promptly.*"

The Eleventh Circuit conceded that, grammatically, it was possible to interpret the "prompt payment" language in the MSP statute the way that the Fifth Circuit had done in *Goetzmann*. However, the Eleventh Circuit concluded that the *Goetzmann* interpretation would require one "to indulge in the illogical premise that Congress intended for Medicare to pay claims that it knew for a fact had already been paid, or were about to be paid, by the primary obligor – the very claims which the statute clearly contemplates that Medicare would endeavor not to pay." *Baxter*, 345 F.3d at 888. Accordingly, in holding that Medicare was entitled to reimbursement, the Eleventh Circuit found that "Congress wanted Medicare's payments to be secondary and subject to recoupment in *all* situations where one of the statutorily enumerated sources of primary coverage could pay instead." *Id.* (emphasis in original).

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[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 in December 17, 2002 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." *Goetzmann*, 337 F.3d at 492.
[3] Thompson v. *Goetzmann*, 315 F.3d 457 (5th Cir. 2002).

Noteworthy, the Eleventh Circuit's opinion in *Baxter* regarding the issue of "prompt payment" did not create a jurisdictional split with the Fifth Circuit because, at the time of the *Baxter* opinion, the Fifth Circuit had already withdrawn its first *Goetzmann* opinion, which had contained the alternative holding on "prompt payment."

However, the *Baxter* decision did create somewhat of a jurisdictional split between the Eleventh Circuit and the Fifth Circuit in *Goetzmann* on the issue of "self-insured plans," although the Eleventh Circuit carefully couched the conflict as a disagreement over "dicta." *See Baxter*, 345 F.3d at 897-898.

The Eleventh Circuit agreed with the Fifth Circuit that a single, discreet settlement by a tortfeasor with a single plaintiff, whereby the tortfeasor paid the plaintiff with its own funds, without more, does not constitute a "self-insured plan." *See Baxter*, 345 F.3d at 897. Such a circumstance, the Eleventh Circuit reasoned, "would not entail a 'plan' or *ex ante* arrangement." *Id.* However, the Eleventh Circuit disagreed with the Fifth Circuit's "dicta" in *Goetzmann*, which required a setting aside of funds and formal procedures to establish a self-insured plan. *Id.* at 898. The court in *Baxter* concluded that, in order to have a self-insured plan within the meaning of a "primary plan," as defined in the MSP statute, there must only be some *ex ante* arrangement, oral or written, by which an entity assumes legal liability for an injury or illness. *Id.* at 895.

3. Recent "Clarifying" Amendment: *Goetzmann* is Dead!

On December 8, 2003, President George W. Bush signed into law the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 ("MMA of 2003"). Deep in the bowels of the MMA of 2003, in section 301, Congress added "technical" and "clarifying" amendments to the MSP statute. The amendments legislatively overrule *Goetzmann*. *Goetzmann* is dead!

The Legislature characterized the changes to the MSP statute as "clarifications." This is ironic, given that the changes are appear to be both substantial and substantive. In order to fully appreciate the "clarifications" made to the MSP statute, I have interlineated the old and new MSP statute, as follows:

(2) Medicare secondary payer

(A) In general

Payment under this subchapter may not be made, except as provided in subparagraph (B), with respect to any item or service to the extent that--

(i) *payment has been made, or can reasonably be expected to be made, with respect to the item or service as required under paragraph (1), or*

(ii) *payment has been made or can reasonably be expected to be made ~~promptly (as determined in accordance with regulations)~~ under a workmen's compensation law or plan of the United States or a State or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance.*

In this subsection, the term "primary plan" means a group health plan or large group health plan, to the extent that clause (i) applies, and a workmen's compensation law or plan, an automobile or liability insurance policy or plan (including a self-insured plan) or no fault insurance, to the extent that clause (ii) applies. <u>An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.</u>

(B) Repayment required

<u>(i) Authority to make conditional payment</u>

The Secretary may make payment under this subchapter with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.

(~~i~~ ii) Primary plans

~~Any payment under this subchapter with respect to any item or service to which subparagraph (A) applies shall be conditioned on reimbursement to the appropriate Trust Fund established by this subchapter when notice or other information is received that payment for such item or service has been or could be made under such subparagraph.~~ A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this subchapter with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means. If reimbursement is not made to the appropriate Trust Fund before the expiration of the 60-day period that begins on the date ~~such~~ notice of, or ~~other~~ information related to, a primary plan's responsibility for such payment or other information is received, the Secretary may charge interest (beginning with the date on which the notice or other information is received) on the amount of the reimbursement until reimbursement is made (at a rate determined by the Secretary in accordance with regulations of the Secretary of the Treasury applicable to charges for late payments).

(~~ii~~ iii) Action by United States

In order to recover payment made under this subchapter for ~~such~~ an item or service, the United States may bring an action against any or all entit~~y~~ies that are or were ~~which is~~ 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 such item or service (or any portion thereof) under a primary plan. The United States ~~(and~~ may, in accordance with paragraph (3)(A) collect double damages against ~~that~~ any such entity)~~., 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.~~ In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity. The United States may not recover from a third-party administrator under this clause in cases where the third-party administrator would not be able to recover the amount at issue from the employer or group health plan and is not employed by or under contract with the employer or group health plan at the time the action for recovery is initiated by the United States or for whom it provides administrative services due to the insolvency or bankruptcy of the employer or plan.

(~~iii~~ iv) Subrogation rights

The United States shall be subrogated (to the extent of payment made under this subchapter for such an item or service) to any right under this subsection of an individual or any other entity to payment with respect to such item or service under a primary plan.

(~~iv~~ v) Waiver of rights

The Secretary may waive (in whole or in part) the provisions of this subparagraph in the case of an individual claim if the Secretary determines that the waiver is in the best interests of the

program established under this subchapter.

(~~v)~~ vi Claims-filing period

Notwithstanding any other time limits that may exist for filing a claim under an employer group health plan, the United States may seek to recover conditional payments in accordance with this subparagraph where the request for payment is submitted to the entity required or responsible under this subsection to pay with respect to the item or service (or any portion thereof) under a primary plan within the 3-year period beginning on the date on which the item or service was furnished.

(C) Treatment of questionnaires

The Secretary may not fail to make payment under subparagraph (A) solely on the ground that an individual failed to complete a questionnaire concerning the existence of a primary plan.

(3) Enforcement

(A) Private cause of action

There is established a private cause of action for damages (which shall be in an amount double the amount otherwise provided) in the case of a primary plan which fails to provide for primary payment (or appropriate reimbursement) in accordance with such paragraphs (1) and (2)(A).

* * *

(d). EFFECTIVE DATES. – The amendments made by this section shall be effective--…(2) in the case of subsections (b) and (c), as if included in the enactment of section 953 of the Omnibus Reconciliation Act of 1980 (Public Law 96-499; 94 Stat. 2647).

42 U.S.C. § 1395y(b)(2)(B).

a. *Brown v. Thompson*: "Clarifications" are Retroactive!

Given that Congress characterized these changes to the MSP statute as mere "clarifications," it was not much of a stretch for Congress to deem the changes retroactive! As shown by the Effective Dates clause, directly above, the clarifications to the MSP statute, which President Bush signed into law on December 8, 2003, were made retroactive as if they had been written in 1980 – 24 years ago!

The Fourth Circuit recently held that making the clarifications retroactive is not unconstitutional and does not implicate due process concerns. In *Brown v. Thompson*, 374 F.3d 253 (4th Cir. July 7, 2004), the Fourth Circuit considered whether the MMA of 2003 constituted a substantive change of the MSP statute, or merely a clarification of previous law. The court gave great weight to the fact that "Congress formally declared in the titles of the relevant subsections of MMA that the **amendments** of MSP were 'clarifying' and 'technical.'" *Id.* at 259 (emphasis in original). Citing *United States v. Sepulveda,* 115 F.3d 882, 885 n. 5 (11th Cir. 1997), the *Brown* court opined: "Certainly, Congress may amend a statute to establish new law, but it also may enact an amendment to 'clarify existing law, to correct a misinterpretation, or to overrule wrongly decided cases.'" *Id.* Citing its own decision in *United States v. Montgomery County,* 761 F.2d 998, 1003 (4th Cir. 1985), the Fourth Circuit stated that "'a change in statutory language need not *ipso facto* constitute a change in meaning or effect. Statutes may be passed purely to make what was intended all along even more unmistakably clear.'" *Brown*, 374 F.3d at 259.

Funny, if the MSP statute was so "unmistakably clear," then how did the Fifth Circuit in *Goetzmann*, and the Eleventh Circuit in *Baxter*, interpret it so differently?

4. The Effect of the MMA of 2003? Don't Mess with Medicare!

The changes that Congress made to the MSP statute cemented Medicare's claim that it is, indeed, a super lien. By eliminating the "prompt payment" language from the statute, Congress gutted the "alternative" holding of *Goetzmann*. By defining "self-insured plan" as any entity which carries its own risk, Congress gutted both the *Goetzmann* and *Baxter* holdings. By clarifying that the government can sue to collect its lien from the insurance company, the defendant, the plaintiff, and the plaintiff's attorney, Congress ensured that someone – indeed everyone -- will be on the hook to satisfy Medicare's lien. **The bottom line? Don't Mess with Medicare!**

5. Practical Tips to Handle Medicare Liens:

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.

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. Therefore, you will likely send the notice of potential lien letter to:

TrailBlazer Health Enterprises, L.L.C.
MSP Liability
Medicare Liability Specialist
Post Office Box 9020
Denison, Texas 75021

Telephone: (903) 463-0641
Fax: (903) 463-0642

e. "Chain of Authority" Documentation:

When sending Medicare your notice of potential lien 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, documents evidencing that an individual is:

- Executor of the Estate;
- Administrator of Estate; or
- Verified in writing to be the beneficiary's designated representative.

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.

In March 2005, CMS Medicare began requiring a Medical Authorization for deceased beneficiaries. In a form letter, CMS now expressly advises that "neither CMS nor a contractor can continue to work with an individual/entity that the beneficiary authorized us to deal with prior to their death." CMS will only disclose information to "the executor of the estate, the administrator of the estate, or an individual verified in writing to be the beneficiary's designated representative."

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 (meaningfully 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. Most likely, if you speak to a representative of TrailBlazer on the telephone, you will speak to Jennifer Sharp, Johnnie Johnson, or Daylene Wright.

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.

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) and (m).

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. *See* 42 C.F.R. § 411.24(c)(2).

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 32.033 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) other sources; and (c) another person for personal injury caused by such other person's negligence or wrong. TEX. HUM. RES. CODE ANN. § 32.033(a) (Vernon 2003). Section 12.036 of the Health & Safety Code confers upon the Texas Department of State Health Services (formerly the Texas Department of Health) the authority to pursue and collect a subrogation interest in favor of the state.

2. Medicaid Estate Recovery:

Significantly, on June 10, 2003, Governor Perry signed HB 2292, which allowed the State of Texas to recover payments made on behalf of a person who received Medicaid benefits. The law effecting estate recovery was brief:

> "SECTION 2.17. Subchapter B, Chapter 531, Government Code, is amended by adding Section 531.077 to read as follows: Sec. 531.077. RECOVERY OF MEDICAL ASSISTANCE. (a). The commissioner shall ensure that the state Medicaid program implements 42 U.S.C. § 1396p(b)(1). (b). The Medicaid account is an account in the general revenue fund. Any funds recovered by implementing 42 U.S.C. § 1396p(b)(1) shall be deposited in the Medicaid account. Money in the account may be appropriated only to fund long-term care, including community-based and facility-based care."

The federal law in the noted section 42 U.S.C. § 1396p(b)(1) is a creditor statute, requiring a state to recover expenditures from the estate of a deceased person who received Medicaid benefits – thus the name "estate recovery." The federal statute does not set out the rules for estate recovery, but left the rule

making to the Commissioner of the Texas Department of Health and Human Services, which heads the State Medicaid program. The Commissioner's rules are found in the December 3, 2004 and February 18, 2005 *Texas Registers*, and became effective on March 1, 2005.

Estate recovery in Texas will only those persons who are **age 55 or over**, are in a **nursing home**, **intermediate care facility for the mentally retarded** (referred to as "ICF – MR"), or are receiving **Community Attendant Services**, and who **apply for Medicaid on or after the effective date (i.e., March 1, 2005) of the rules**. *See* 1 T.A.C. 373.103. According to the rules, there will be no estate recovery from the estate of a person who initially applied for Medicaid benefits prior to March 1, 2005.

Medicaid will not have a "lien," *per se*. Rather, as proposed, Medicaid will be a Class 7 creditor (which is just above an unsecured creditor) of the Medicaid recipient's probate estate. But, as a Class 7 creditor, Medicaid can force the sale of the homestead (if the heirs do not timely request an "undue hardship" waiver), family heirlooms (e.g., grandmother's wedding ring, antiques), or any other asset of the Estate.

I have attached, as **Appendix A**, Patricia F. Sitchler's excellent paper on Medicaid estate recovery in Texas entitled, "ESTATE RECOVERY: The Death Tax on the Poor." This is a "must read" for any trial attorney that comes in contact with Medicaid.

3. 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:

All of your correspondence and communication should be directed to:

Texas Medicaid & Health Care Partnership
ATTN: Tort Department MC-AO7
P.O. Box 202298
Austin, Texas 78720-2948

Telephone: (512) 506-7546
Fax: (512) 506-7804

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. Who to Call to Complain:

If you are having difficulty dealing with Medicaid, or are unable to get Medicaid to provide you with a final lien total, then I suggest that you call Alex Manrique (Tort Analyst) at (512) 506-3757.

e. 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. § 354.233(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.

f. Recent Significant Case: *Heide Ahlborn v. Arkansas Department of Human Services*, 397 F.3d 620 (8th Cir. Feb. 9, 2005).

In February 2005, the 8th Circuit handed-down an extremely significant decision, *Heide Ahlborn v. Arkansas Department of Human Services*, 397 F.3d 620 (8th Cir. Feb. 9, 2005). The plaintiff, Heidi Ahlborn, was seriously injured in a car accident in 1996. She suffered severe personal injuries, especially to her head, which required extensive medical care and rendered her permanently disabled. While under medical treatment, Ahlborn applied for, and received, medical benefits under the Arkansas Medicaid Program. In applying for benefits, Arkansas law required Ahlborn to assign to Arkansas Department of Human Services her "right to any settlement, judgment, or award" she might receive from third parties, "to the full extent of any amount which may be paid by Medicaid for the benefit of the applicant." *Id.* at

622. Thus, *like Texas*, the Arkansas Medicaid law placed "a lien on the entirety of third-party payments – not just that portion of third-party payments made for medical care." *Id.* at 623.

Ahlborn received $215,645.30 in Medicaid benefits, which fully relieved her debt to health care providers. She settled her lawsuit in the underlying car wreck case for a lump sum of $550,000, which did not allocate Ahlborn's recovery amongst her various claims for past medical expenses, lost earnings, lost earning capacity, and pain and suffering. Medicaid asserted a lien against the entire settlement for the amount of benefits Medicaid provided. Ahlborn then sought a declaratory judgment, arguing that Medicaid can only recover that portion of her settlement that represents payment of past medical expenses. Both Medicaid and Ahlborn characterized the sole issue as one of statutory construction: "whether federal Medicaid statutes, which provide for the assignment of rights to third-party payments, but prohibit placing a lien on a Medicaid recipient's property, limit the State's recovery to only those portions of the payments made for medical expenses." *Id.* at 622.

During the pendency of the declaratory judgment suit, Medicaid and Ahlborn entered into a stipulation, whereby Medicaid would recover $215,645.30 if it prevailed on the statutory construction issue, but only $35,581.47 if Ahlborn prevailed. *Id.* at 622.

In its analysis, the 8th Circuit stated the following:

> "The sole issue presented by the parties in this case is whether the Arkansas statutory scheme for recovering Medicaid payments comports with the federal statutes governing how state Medicaid recovery programs must operate. The essential disagreement is whether the State may recover from Ahlborn's settlement any amount beyond that stipulated to be expenses for medical care…*Id.* at 623.
>
> Ahlborn argues that the Arkansas scheme conflicts with federal law. She relies on 42 U.S.C. § 1396p(a)(1), which prohibits (with certain exceptions not applicable here) the imposition of a lien 'against the property of an individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan[.]' This provision, sometimes referred to as the 'anti-lien statute,' generally prevents a State from attaching property of a recipient to reimburse the State for benefits paid under a Medicaid plan. Under the statute's implementing regulation, 'property' is defined as 'the homestead and all other personal and real property in which the recipient has a legal interest.' 42 C.F.R. § 433.36(b). *Id.*
>
> The State argues that the Arkansas statutory lien 'on any settlement, judgment, or award received by the recipient from a third party' does not conflict with the anti-lien statute, because the settlement that Ahlborn received from the tortfeasor is not Ahlborn's property. The State contends that because Ahlborn assigned to the State her right to any settlement as a condition of receiving Medicaid benefits, the settlement remains property of the tortfeasor until the State is fully reimbursed for all funds expended on Ahlborn's medical care…. *Id.*
>
> We believe that Ahlborn's right to a settlement that may be received from a third party, which the Arkansas statute required her to assign to the State, was Ahlborn's 'property." Her unliquidated tort claim, in other words, is a form of 'personal…property in which the recipient has a legal interest.' 42 C.F.R. §433.36(b).... *Id.* at 624.
>
> **We do not believe, moreover, that the State may circumvent the restrictions of the federal anti-lien statute simply by requiring an applicant for Medicaid benefits to assign property rights to the State before the applicant liquidates the property to a sum certain….** *Id.*
>
> **We believe a straightforward interpretation of the text of these [anti-lien] statutes demonstrates that the federal statutory scheme requires only that the State recover payments from third parties to the extent of their legal liability to compensate the beneficiary *for medical care and services* incurred by the beneficiary.** *Id.* at 625 (italicized emphasis in original).

I believe the holding in *Ahlborn* can be applied, by analogy, to personal injury actions in Texas in which Medicaid is asserting a subrogation interest. Given that most personal injury settlements encompass all damages (i.e., pain and suffering, mental anguish, impairment, disfigurement, lost wages, lost wage earning capacity) and not just medical expenses, the Medicaid plaintiff can now argue that Medicaid is only entitled to recover that portion of the settlement allocated to medical care and services.

Note, however, that it may be prudent to obtain a court order that apportions the settlement proceeds amongst the various elements of damages. If the allocation is merely made by the settling parties, the 8th Circuit in *Ahlborn* left the door open for Medicaid to challenge the allocation and obtain reimbursement on a greater portion of the settlement proceeds.[4]

g. Where to Mail Final Payment to Medicaid:

Once you have successfully negotiated a reduction of the Medicaid lien, you should mail the final lien payment to:

TMHP/Medicaid
Tort Receivables
12357 – B Riata Trace Parkway
Austin, Texas 78727

h. 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 AGING AND DISABILITY SERVICES ("DADS") [formerly known as Texas Department of Human Services ("TDHS")]:

Effective September 1, 2004, twelve state agencies were merged into four departments under the umbrella of the newly formed Texas Health and Human Services Commission ("HHSC"). As a result of these mergers, the Texas Department of Human Services ("TDHS") ceased to exist and became the Texas Department of Aging and Disability Services (DADS").

1. Legal Authority:

The Texas Department of Aging and Disability Services ("DADS") 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). DADS 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 Resources Code, section 32.033,

[4] In this regard, the 8th Circuit stated the following: "And we do not foreclose the possibility that manipulation of settlement amounts might, in an appropriate case, provide the basis for a State to recover funds received by a Medicaid beneficiary from a third-party tortfeasor, even though they are not technically denominated payments for medical care and services. In such a circumstance, however, the recovery might be permissible because the third-party payment is properly recharacterized *as a payment for medical expenses*, despite a different label applied by the parties...." *Ahlborn v. Arkansas Dep't of Human Services*, 397 F.3d 620, 627 (8th Cir. 2005).

establishes automatic assignment of the Medicaid recipient's right of recovery from personal insurance and other sources to DADS as a condition of eligibility.

2. Practical Tips to Handle DADS Liens:

a. Requirement to Notify:

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

Texas Department of Aging and Disability 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 DADS.

b. Always Request a Lien Reduction:

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

Barry Browning, Esq.
Assistant General Counsel
Texas Department of Aging and Disability Services
Post Office Box 149081
Austin, Texas 78714-9030

Telephone No. (512) 438-3126
Fax No. (512) 438-3747

It will help you to note that DADS only has a subrogation interest in the **difference** in Medicaid-related monies expended by DADS 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 DADS provides to you reflecting their final lien total, as being the amount of the lien you must repay.

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

c. Who to Contact if Dissatisfied with Lien Reduction:

Occasionally, Barry Browning is unwilling to meaningfully compromise a DADS lien. Conveniently, DADS may insist that, if a TILE rating increased as a result of the negligence in question, then DADS is entitled to recover the difference between the pre-injury TILE and post-injury TILE *for all time*. The problem with DADS's position is that, in some cases, there are other reasons that justify a sustained increase in TILE level (e.g., increased age, immobility, decubitus ulcer, fracture), which may be unrelated to the injury sustained as a result of the negligence in question.

If you feel that DADS is unreasonably wanting to bilk your personal injury recovery for all of the increased costs which DADS has spent on your client from the date of injury to the present date, then I

suggest that you provide DADS with a detailed medical chronology, supported by specific medical records, to demonstrate that the TILE level remained high for reasons other than your client's injury.

For instance, if the TILE level increased after your client fractured her hip in a nursing home fall, but now your client's hip has healed, then submit the specific pages of the medical record which substantiate that the injury that formed the basis of your lawsuit has "healed." Then argue that, since "healed is healed," any sustained increase in TILE level is unrelated to the injury and should not be part of DADS's lien.

If Barry Browning still refuses to see the light, I suggest you proactively contact the Attorney General's office, which must actually litigate to enforce the decisions made by Barry Browning.

In this regard, I have found that George Jennings, Assistant Attorney General, is often willing to take a more reasonable approach to lien reduction than Barry Browning. The following is the contact information for Mr. Jennings:

George Jennings
Assistant Attorney General
Bankruptcy & Collections Division
P.O. Box 12548
Austin, Texas 78711-2548

Telephone: (512) 475-4094

d. 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 DADS, 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 Medicare 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 workman's compensation benefits, or any "health plan contract," which is defined in 38 U.S.C. 1729. It is unclear whether the V.A.'s statutory subrogation interest encompasses a plaintiff's Personal Injury Protection (PIP) coverage. Arguably, the unambiguous language of the statute does not provide a subrogation interest in a plaintiff's first party insurance coverage.

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, the Plaintiff 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. In this regard, you may wish to play up the emotional aspects of the sacrifice that your veteran made for his country and emphasize that it is now time for his country to give something back.

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 extend to a UM/UIM recovery because UM/UIM is not a "public liability insurance." § 55.003(b)(3); *Members Mut. Ins. Co. v. Hermann Hosp.*, 664 S.W.2d 325 (Tex. 1984).

h. 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).

i. 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.).

j. 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).

k. 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.).

l. A physician may claim a lien (which the hospital may file on the physician's behalf) for the reasonable and necessary charges for emergency hospital care provided within the first seven days of hospitalization. § 55.004(c). 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. § 55.004(d).

F. EMERGENCY MEDICAL SERVICES PROVIDER LIEN:

1. Legal Authority:

The Texas Hospital Lien Statute was amended in 2003 to include a cause of action for an emergency medical services provider ("EMSPs") to recover payments in limited circumstances. *See* TEX. PROP. CODE ANN. § 55.002(c). An EMSP is defined in TEX. HEALTH & SAFETY CODE ANN. § 773.003 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 that 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. § 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, Hidalgo, 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 medical 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 may 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 may 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 is 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.

i. But, Beware of 4th Circuit's Holding in *Kress*![5]

In *Kress v. Food Employers Labor Relations Assoc. and United Food and Commercial Workers Health and Welfare Fund and Giant Food Stores*, No. 03-2269 (4th Cir. Dec. 10, 2004), the failure of the client's attorney to sign a subrogation reimbursement form caused the client and the client's family to lose all health benefits under their ERISA plan. The ERISA plan had ominous language warning the plan

[5] I freely credit Judith A. Kostura for this subsection of my paper. In this subsection, I have borrowed verbatim from her excellent paper "Lien, Subrogation and the Made-Whole Doctrine," which she presented to the Texas Trial Lawyer's Association on April 28-29, 2005. Ms. Kostura is a recognized authority on liens and subrogation interests. She has recently authored a book on the topic, which is being published by the Texas Law Institute.

member that the plan did not cover third party injuries, but would "assist its participants" by advancing money when the member was injured if, and only if, the member and his attorney signed a reimbursement agreement, agreeing to put the plan's right of reimbursement first "before all others" when the third party recovery was received. The plan stated further that the failure of the plan member to hire an attorney who would support the plan's right of recovery above the client's rights would lead to termination of coverage. The member's attorney, who must have thought such an onerous plan would never be approved by the courts, refused to sign. The benefits of the injured worker, and his innocent family, were terminated when the attorney refused to sign.

The 4th Circuit upheld the plan. The 4th Circuit noted: Paul Kress chose to work for Giant....He signed the agreement, but his attorney refused, writing to the fund that 'attorneys fees and related costs must be paid first.'" Page 4, 5. When the plan refused to accept the attorney's efforts to graft the common fund doctrine onto the plan, the member's "last connection to the Fund was severed, and his dependents' benefits were terminated." Page 5.

When the member's attorney argued that no attorney will take an injured worker's case if the attorney's fees and expenses are subordinate to the plan's recovery, the court said, "so what:" "[T]his purported unfairness is nothing more than commonplace calculus....A given plan's subrogation rules obviously make the payment of fees more or less likely, and prudent attorneys would factor those rules into their calculus as well. If the participant and his attorney conclude that private litigation will not produce a sufficient recovery to make litigation worthwhile, they need not bring the case." Page 9.

d. Humana and Secure Horizons/Pacificare:

If an individual qualifies for Medicare, that individual can enroll in a Medical replacement plan. Two of the most common Medicare replacement plans are Humana Gold Plus and 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.

Importantly, although Medicare replacement plans, such as Humana Gold Plus and Secure Horizons/Pacificare, stand in the shoes of Medicare for the provision of services to Medicare-eligible plan members, Medicare replacement plans do not have the right to assert Medicare's "super lien," which arises by virtue of the MSP statute.

However, the Medicare Act allows a Medicare replacement plan to include in its insurance contract a right of subrogation against an insured's recovery from a third party for money previously paid for the insured's medical care. 42 U.S.C. §§ 1395w-22(a)4), 1395mm(e)(4). Accordingly, Medicare replacement plans merely have a contractual right of subrogation – the same as any private health insurance company.

Importantly, Medicare replacement plans may not assert their subrogation interests in federal court – as the Medicare Act (§1395mm(e)(4)) does not completely preempt the plaintiff's state causes of action. *See Nott v. Aetna U.S. Healthcare, Inc.*, 303 F. Supp 2d 565 (E.D. Pa. 2004). And, the Medicare Act (§1395mm(e)(4)) "does not confer any affirmative rights to reimbursement to Medicare replacement plans, much less contain an implied private right of action in federal court." *See Care Choices HMO v. Engstrom*, 330 F.3d 786, 789 (6th Cir. 2003).

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:

As always, it is advisable to 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. Chapter 74: Can Anyone Be "Made Whole"?

Effective September 1, 2003, Chapter 74 of the Texas Civil Practice & Remedies Code significantly reduced the value of many medical malpractice and nursing home negligence claims by capping non-economic damages. Regardless of the severity of the non-economic injury, in most cases, non-economic damages are now statutorily limited to $250,000.

Before writing the check to a private health insurance company (including a Medicare replacement plan), 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 Ortiz's 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. It is not sufficient for the plan to claim ERISA status without proving the proper steps were undertaken in its creation. *See Gahn v. Allstate Life Ins. Co.*, 926 F. 2d 1449 (5th Cir. 1991). In order for a plan to be entitled to the protections of ERISA, the plan must prove that it was, indeed, established by the employer to be an employer benefit plan. *See Hansen v. Continental Ins. Co.*, 940 F.2d 971, 977 (5th Cir. 1991).

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. *See* 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.[6] 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 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 benefits 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.

If these four criteria are present, the plan is disqualified as an ERISA plan 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, when an ERISA plan agreement is unambiguous and clearly sets out the extent of the subrogation right and/or states that the participant's right to be made whole is superseded by the plan's subrogation right, federal courts have failed to recognize a federal common law "made whole" doctrine.[7]

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[6] According to *Hamilton v. United Health Care of Louisiana, Inc.*, No. 01-31179 (5th Cir.), it may be a violation of the Federal Fair Debt Collection Practices Act for a subrogation collection agency to falsely claim ERISA status.

[7] *See Bill Gray Enterprises, Inc. Employee Health and Welfare Plan v. Gourley*, 248 F.3d 206, 220 (**3rd Cir.** 2001)("Because we find the terms at issue in this case unambiguously require Mr. Gourley to reimburse the Plan with the proceeds of his uninsured motorist benefits, we decline to extend the make whole remedy to his claim"); *Paris v. Iron Worker's Trust Fund*, 211 F.3d 1265, 2000 WL 384036 at *2 (**4th Cir.** 2000) (unpublished opinion) ("As a federal matter, our decision … prevents us from resorting to federal common law in this case, let alone adopting the make-whole doctrine as a new federal common-law principle for ERISA cases… the subrogation provision in the Fund's Plan is plain and clear.); *Marshall v. Employers Health Insurance Co.*, 1997 WL 809997 at *4 (**6th Cir.** 1997)(unpublished opinion)("We adopt the make-whole rule as a default rule in this circuit. Such a rule is consistent with the equitable principle that insurer does not have a right of subrogation until the insured has been fully compensated, unless the agreement itself provides to the contrary… If a plan sets out the extent of the subrogation right or states that the participant's right to be made whole is superseded by the plan's subrogation right, no silence or ambiguity exists.); ***Sunbeam-Oster Co. v. Whitehurst*, 102 F.3d 1368, 1375-78 (5th Cir. 1996)(In dicta, the Fifth Circuit stated: "Regardless of whether the Make Whole rule might be applicable in situations involving private insurance policies or Workers' Compensation, and irrespective of what we might be *Erie*-bound to hold were this a diversity case and not a federal question ERISA case, we have serious doubts whether we would ever approve or adopt the Make Whole rule as this circuit's default rule for the priority of recovery in reimbursement or subrogation between an ERISA plan and its participant or beneficiary)**; *Waller v. Hormel Foods Corp*., 120 F.3d 138 (**8th Cir.** 1997)(finding that the made whole doctrine

When faced with preemption, however, you may still wish to consider the reasoning of *UNUM v. Ward* and argue that ERISA should not preempt application of the state common law “made whole” doctrine.

ii. Does ERISA Preempt the “Made Whole” Doctrine?

Because the state common law “made whole” doctrine arguably 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 “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*.

Arguably, the “made whole” doctrine impacts insurance – at least 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.

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did not apply because the ERISA plan unambiguously provided that the plan would be first to recover any money which the insured received from a third party tortfeasor); *Cagle v. Bruner*, 112 F.3d 1510, 1522 (**11th Cir.** 1997)(“…if the Fund wants to escape the make whole doctrine, it need only include language in the plan explicitly providing the Fund with the right to first recovery, even when a participant or beneficiary is not made whole. The Fund did not include such language in its plan. Therefore, the make whole doctrine applies to this case.”); *Barnes v. Independent Auto. Dealers Assoc. of Calif.,* 64 F.3d 1389, 1395 (**9th Cir.** 1995) (“We would not apply the interpretive "make-whole rule" as a "gap-filler" if the subrogation clause in the Plan document specifically allowed the Plan the right of first reimbursement out of any recovery Barnes was able to obtain even if Barnes were not made whole. The clause, however, contains no such language.”); *Cutting v. Jerome Foods Inc*., 993 F.2d 1293, 1297 (**7th Cir.** 1993)("Because ... the make whole rule is just a principle of interpretation, it can be overridden by clear language in the [ERISA] plan.").

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.[10]

4. The "Common Fund" Doctrine vs. ERISA

The "Common Fund" doctrine provides that a litigant or lawyer who recovers a common fund for the benefit of persons other than himself or his client is entitled to a reasonable attorney's fee from the fund as a whole. This doctrine rests on the perception that persons who obtain the benefit of a lawsuit without contributing to its costs are unjustly enriched at the successful litigant's expense.

Using the analysis of *UNUM v. Ward*, 526 U.S. 358 (1999), the state common law "common fund" doctrine arguably affects state insurance law. Accordingly, the "common fund" doctrine should arguably fall within the protection of ERISA's savings clause, and is not preempted.

But, beware of three 5th Circuit cases that stripped the plaintiffs of their personal injury recovery and denied the plaintiffs' attorney from recovering any attorney's fees or expenses. In *Sunbeam-Oster, Inc. v. Whitehurst*, 103 F.3d 1368 (5th Cir. 1996) and *Walker v. Walmart Stores, Inc.*, 159 F.3d 938 (5th Cir. 1998), the 5th Circuit held that, since the ERISA plan document stated that the plan would receive first-money reimbursement from "any and all" third-party recovery that the plaintiffs' received, the plan controlled – irrespective of the fact that the plaintiffs and the plaintiffs' attorney would receive nothing from the settlement.

In *Bombardier Aerospace Employee Welfare Benefit Plan v. Ferrer, Poirot & Wansbrough*, 354 F.3d 348 (5th Cir. 2003), the Fifth Circuit again found the "common fund" doctrine inapplicable because the language of the ERISA plan provided that attorney's fees and expenses were the responsibility of the plan member, not the plan. In fact, in *Bombardier*, the Fifth Circuit even imposed a constructive trust on the proceeds of the settlement in the attorney's trust account because the funds were identifiable, belonged to the plan, and were under the possession and control of the plan member.

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[8] *Walker v. Southern Co. Services Inc.*, 279 F.3d 1289 (11th Cir. 2002); *Alloco v. Metropolitan 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).

[10] Note, however, that if the plan is a self-funded employee welfare plan, then ERISA trumps common law, state law, and equitable principles, including the made-whole doctrine, common fund doctrine, quantum meriut, etc. *See FMC Corp. v. Holliday*, 498 U.S. 52 (1990)(Congress showed a "clear intent" for ERISA to preempt state laws in favor of self-funded employee welfare plans).

As incredible as it may sound, a plaintiff's rights in the 5th Circuit are no longer governed by long-standing common law principles like the "common fund" doctrine, but are determined by the whim of greedy plan authors.[11]

IV. CONCLUSION:

Timely and proper handling of subrogation interests and liens in personal injury 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 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" and "common fund" doctrines.

[11] *But see Bishop v. Burgood*, 764 N.E.2d 24 (Ill. 2002)(In this case, the Supreme Court of Illinois found that "a claim for attorneys fees based on the [common fund] doctrine is, 'in substance if not form,' a 'separate and distinct action,' resting 'upon equitable considerations of quantum meruit and the prevention of unjust enrichment;' an action 'wholly independent of and unrelated to the underlying benefit plan;' a cause of action premised on the rights of the attorney who rendered services").