PROGRAM MATERIALS
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Art of Settlement - Regulatory Compliance when Settling Catastrophic Claims

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Art of Settlement - Regulatory Compliance when Settling Catastrophic Claims

SETTLEMENT

C O M P L I A N C E f o r C e l e s q

Roadmap for Today's Presentation

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I. **Ethical Issues at Settlement**

II. **Disability-Based Government Benefits**

- Medicaid & SSI
- Medicare & SSDI
- Medicare Secondary Payer
  - Total MSP Compliance
    - MSAs

III. **Lien Resolution**

- Outsourcing Lien Resolution - Why and how to do so ethically
- Medicare Conditional Payments/Medicare Advantage
- Medicaid Lien Resolution
- ERISA Lien Resolution
- FEHBA & Military Lien Resolution
- Hospital & Provider Liens

FAILURE TO ADVISE

Ethical Issues @ Settlement

Ethics & Settlement

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An obligation to advise the client regarding public assistance preservation?
An obligation to advise client regarding financial settlement options?

Laws Impacting Public Benefits
42 U.S.C. Section 1396p (d)(4)
MSP - CFR Title 42, Part 411, Subpart B, Section 411.20 (2)

Laws Impacting Financial Issues
104(a)(2) IRC
Constructive Receipt

Grillo, French & Saunders Cases

ABA Model Rules of Professional Conduct – 1.0(e) "Informed Consent": "communicated adequate information and explanation about the material risks of and reasonably available alternatives to the proposed course of conduct."
ABA Model Rules of Professional Conduct – 2.1: "Where consultation with a professional in another field is itself something a competent lawyer would recommend; the lawyer should make such a recommendation."

"[E]nsure his client is informed about the options of structured settlements, trusts and the effect of the judgment or settlement on the client's public benefits."
ALI-ABA, Krooks, Bernard*, Special Needs Trusts: The Basics, The Benefits and The Burdens* (2009).

"[M]ake sure the client's interests are best served, for example, by considering the tax implications of [the client's] settlement."
ABA, *Ethical Guidelines for Settlement Negotiations*, (2002)

Duties at Settlement:

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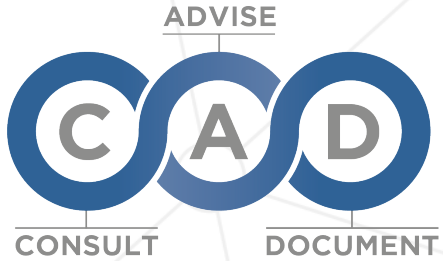
Laws that impact settlement must be explained

Silence = no informed decision & no opportunity to exercise options available under the **law & damages**

Grillo's message is to employ or consult competent experts in taxation, trusts and special needs settlement planning prior to settlement

If the law firm does not address these issues, who will given they are legal issues?



GOVERNMENT BENEFITS

Overview

Those receiving government assistance need special planning to avoid disruption of benefits. The chart immediately below describes in summary fashion the different types of benefits and generally their asset sensitivity:

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PUBLIC BENEFIT PROGRAM	CRITERIA	ASSET/INCOME SENSITIVE	PLANNING SOLUTION	LIEN
NEEDS BASED - INCOME & ASSEST SENSITIVE				
SSI (Supplemental Security Income)	Disabled, blind or over age 65 AND meet income/asset test	YES	SNT or PSNT	NO
Medicaid - Adult (Disability Based)	Disabled or over aged AND meet income/asset test	YES	SNT or PSNT	YES ***VARIES BY STATE***
Medicaid - Child (Family Related-Non Disability)	Unique financial criteria per program Settlement may not be countable	MAYBE but GENERALLY NO	N/A	YES ***CAN BE HMO***
ENTITLEMENTS - NOT INCOME OR ASSET SENSITIVE				
SSDI (Social Security Disability)	Disabled with sufficient quarters* of work history to be fully insured	NO	N/A	NO
Medicare	Disabled or Over Age 65 with sufficient quarters* of work history to be fully insured	NO	MSA should be considered	YES ***BCRC or MAO***

* Required work quarters is dependent upon when a person becomes disabled. Refer to: https://www.ssa.gov/pubs/EN-05-10029.pdf

KEY PRACTICE TIP: Disability Planning

When it comes to disability, R.E.A.D.!

- **R**eview your client's benefits at intake and throughout the case.
- **E**nlist experts early-on to educate you and your client.
- **A**ward letters—Get them!
- **D**ocument your file regarding your client's decision and what you did to educate them.
  Especially important if they don't want to keep their benefits!

MEDICAID
&
SSI

Needs Based Benefits & Planning

SSI/Medicaid

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Income and asset sensitive

SSI: Cash Assistance for 65 or Older, Blind or Disabled

$967/mo. if single (Max)

$1,450/mo. if married (Max)

No quarters requirement unlike SSDI

Asset cap (2k/3k) & income cap

Medicaid: Basic healthcare coverage for the indigent

One Dollar of SSI = Medicaid (most states)

Why special planning is needed

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Client is on Medicaid/SSI + Disabled = Consider SNT

- If assets are in the name of a person with a disability, then would eliminate eligibility for SSI and Medicaid
  - Counted as income in month of receipt
  - Counted as resource first day of next month

Loss of SSI generally acceptable, however loss of Medicaid can be devastating

KEY PRACTICE TIP: SNTs

Primary Types of SNTs for PI Settlements

- 42 USC 1396p(d)(4)(a) (*Stand alone SNT*) – Disabled under 65
- 42 USC 1396p(d)(4)(c) *(Pooled Trust*) - Disabled any age
- 3rd Party (fundraiser, insur. proceeds, testamentary, etc.)

Advantages:

- Retains SSI/Medicaid benefits
- Professional trustee
- Can avoid guardianship and annual reports
- Trust pays for everything except "food & shelter"

Disadvantages:

- No unrestricted use
- Sole Benefit
- At death Medicaid must be paid back (except 3rd party)
- Extra layer of complexity
- Trust is irrevocable

Be aware of Deeming and Exempt Assets!

MEDICARE & SSDI

Overview

SSDI & Medicare

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Not income or asset sensitive (entitlement)

Funded by FICA

Enough Quarters & Disability

Medicare Entitlement 30 months after Disability:
Parts A/B D or Part C

TOTAL MEDICARE SECONDARY PAYER COMPLIANCE

The MSP & Medicare Set Asides

Medicare Secondary Payer Act (MSP)

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Medicare Secondary Payer Act ("MSP")
42 U.S.C. §1862(b)(2)(A) of the Social Security Act
& Regulations found at 42 C.F.R. § 411

Precludes Medicare payments for services to the extent that payment has been made or *can reasonably be expected* to be made promptly due to any of the following:

- *Workers' compensation*
- *Liability insurance*
- *No-fault insurance*

Obligations Under the MSP Act

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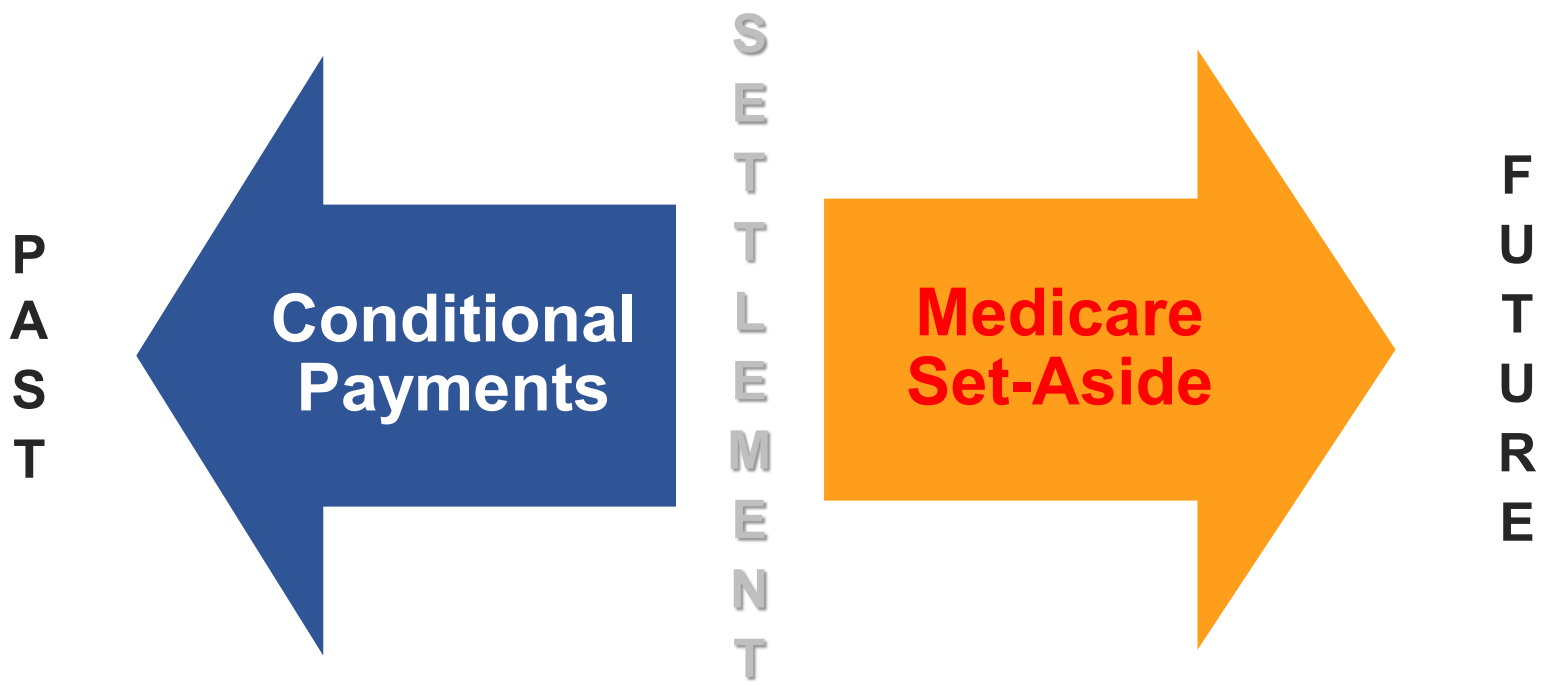

SECTION 111 REPORTING

MSP COMPLIANCE

Medicare Set Asides

Why is this so important?

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Medicare Denies Injury Related Care - What happens (Trigger – MIR)?

Must go through Medicare appeal process:

LEVEL :	ENTITY :	Request within:
1. Appeal/Dispute	MSPRC	120 days
2. Reconsideration	Maximus Federal Services	180 days
3. ALJ Hearing	Office of Medicare Hearings & Appeals	60 days
4. Medicare Appeals Council	MAC	60 days
5. Federal District Court	Federal District Court	60 days

420 days at least until you get to Federal DCA

Grey Area – Key Points

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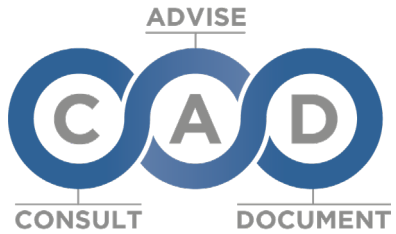
1. No reg or stat related to MSAs, yet – SNT Analogy
2. You only have to worry about this with:

   Current Medicare beni. (disabled, 65, ESRD, ALS or DAC) ***OR*** Reasonable Expectation (SSDI w/in 24)
3. There are alternatives to doing an MSA without shifting the burden (MAO, Private insur., Self pay, MMT for future medical or SS)
4. Medicare eligible, have to treat and $$$ = consider MSA or alternative
5. MSA is preferred method to protect Trust Fund

KEY PRACTICE TIP: MSP Process



Develop process to identify cases with Medicare clients and if they are eligible:

1. Determine if future medicals are funded by SX
2. If they are, educate the client on risks of failing to do anything
3. Select appropriate solution

Consult Experts, Advise client about MSP and then

Document your file

How to be TOTALLY MSP "Compliant"

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- Start early—compile public benefit data for disabled clients
- Control the MSP process from start to finish
- Never rely on the opposing side's experts as it relates to MSP compliance issues – be proactive
- When a case settles, make sure correct data gets reported

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LIEN

RESOLUTION

THE PROBLEM WITH LIEN RES

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- Law firm must track liens & can have affirmative duty to investigate/identify liens (Medicare/MAOs)
- Law firm must determine if lien claim has:
  - Merit?
  - Is legally valid?
- Resolution requires law firm to interact with variety of lien holders & recovery vendors
- At settlement, there are typically protracted negotiations
- Disbursement to client can be delayed if negotiation isn't begun soon enough

LIEN RESOLUTION

Ethical Rules Regarding Outsourcing

INTRODUCTION TO ETHICAL ISSUES

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- Litigating trial lawyers may need help with complex issues both pre/post resolution.
  - Personal injury attorneys often engage outside experts.
  - Subrogation experts can enhance net recovery and navigate pitfalls.
  - Resolving healthcare liens requires expertise.

ETHICAL RULES AND LIABILITY FOR TRIAL LAWYERS

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- **ABA Model Rule 1.15** highlights the duty to protect third-party claims. Many states bar rules mirror 1.15
  - Lawyers must safeguard disputed funds and resolve liens effectively.
- **Model Rule 1.1** requires competence in lien resolution.
  - Inadequate expertise can jeopardize client interests and create professional liability.
- Outsourcing can ensure competence and protect clients.

ABA FORMAL ETHICS OPINION **08-451** ON OUTSOURCING

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- Lawyers can outsource legal or nonlegal services while maintaining ultimate responsibility as long as:
  - Disclosure is made and informed consent given.
  - Fees are reasonable and in compliance with Rule 1.5.
  - The outsourcing lawyer avoids assisting UPL.
  - Direct supervisory authority is exercised over outsourced providers.

STATE-SPECIFIC EXAMPLES
OUTSOURCING LIEN RESOLUTION

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- Some states like New York, Ohio, and Utah provide guidance on outsourcing lien resolution.
- NY Framework Example – if passing along fees:
  - Retainer allows it/Clients must give informed consent to the arrangement.
  - Fees charged must be reasonable and without surcharge.
  - Lien resolution must result in a net benefit for the client.
  - Outsourcing complies with state specific bar rules & substantive law
  - The referring attorney must maintain ultimate responsibility for the work.

KEY PRACTICE TIP: Outsourcing Checklist

Amend Retainer/Fee Contracts: Amend your fee contracts to include specific provisions about outsourcing lien resolution services. Formalizes the arrangement and protects both parties.

Informed Consent: Provide necessary information about the outsourcing process, including the potential risks and benefits. Secure client's informed consent before initiating any outsourced services. Documentation of this consent is vital.

Reasonable Fees Without Surcharge: Ensure that the fees for the lien resolution services are reasonable. Pass on the costs directly to the client without any surcharges or overages.

Net Benefit to the Client: Your client's interests should be paramount. Make sure that outsourcing lien resolution results in a net benefit for them, whether in terms of financial savings, time, or quality of resolution.

State-Specific Compliance: Familiarize yourself with your jurisdiction's specific ethical rules and regulations related to outsourcing, if any. Make sure your practices are compliant with state-specific bar rules and any applicable substantive laws.

Vet Your Outsourcing Partner: Thoroughly research and vet the lien resolution firm you plan to outsource to. They should have proven competence, sufficient expertise, and the suitable training required for the specific lien resolution tasks you're delegating.

Maintain Supervisory Control: Even when tasks are outsourced, you still bear the ultimate responsibility for the work product. Maintain a supervisory role over the outsourced providers and ensure that their work aligns with your professional obligations as well as standards.

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LIEN RES

ISSUES BY TYPE

MEDICARE CONDITIONAL PAYMENTS

Importance of MSP Compliance

Obligations Under the MSP Act

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SECTION 111 REPORTING

Everyone has Skin in the Game

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42 CFR § 411.24(g): Recovery from parties that receive primary payments. CMS has a right of action to recover its payments from any entity, including a beneficiary, provider, supplier, physician, attorney, State agency or private insurer that has received a primary payment.

Plaintiff Attorney Liability under MSP

6/18: Under the terms of the settlement agreement, Rosenbaum agreed to pay a lump sum of **$28,000**.

"This settlement agreement should remind personal injury lawyers and others of their obligation to reimburse Medicare for conditional payments after receiving settlement or judgment proceeds for their clients."

3/19: Under the terms of the settlement agreement, **Meyers, Rodbell & Rosenbaum** agreed to pay a lump sum of over **$250,000**.

"This settlement should also remind attorneys not to disburse settlement proceeds until receipt of a final demand from Medicare to pay the outstanding debt." *****Can't rely upon a CPL!!! See later slide for further discussion***

11/19: Under the terms of the settlement agreement, **Saiontz & Kirk, P.A.** agreed to pay a lump sum of over **$90,000**. *****Can't refer a case and ignore reimbursement of Medicare (referring lawyer held responsible)***

1/20: Under the terms of the settlement agreement, Simon & Simon agreed to pay a lump sum of **$6,604.59**.

"Lawyers need to set a good example and follow the rules of the road for Medicare reimbursement. If they don't, we will move aggressively to recover the money for taxpayers." ***As part of SX, agreed to name a person within firm responsible for dealing with MSP and train them!***

8/20: Angino Law Firm, P.C. agreed to pay the United States **$53,295** to resolve liability under the Medicare Secondary Payer Statute (MSPS).

"Medicare benefits are a vital lifeline for thousands of citizens in the Middle District of Pennsylvania . . . Our Affirmative Civil Enforcement Unit is focused on making sure that such funds are appropriately billed and spent, and recovered when the situation requires. "

CONDITIONAL PAYMENTS

Step by Step Process for Personal Injury Law Firms

Process Summary

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1. Report Case to BCRC (need **Proof of Rep & Consent**)
2. BCRC Issues Rights & Responsibilities Ltr

   *** From this point on, need to use Medicare's Correspondence Cover sheet**
3. BCRC Identifies Medicare's *interim* recovery amount and issues CPL (within 65 days or R&R)
4. Audit and dispute unrelated charges
5. Settlement Notice (**FSD**) -> BCRC Issues **FINAL** Demand

https://www.cms.gov/medicare/coordination-benefits-recovery/beneficiary-services/recovery-process
(Google "Medicare Recovery Process")

KEY PRACTICE TIP: CPs

- You must pay FINAL DEMAND within 60 days, or the debt will accrue interest. Interest starts from date of FD, only assessed if not paid-60 days
- Request for Appeal or Compromise/Waiver does not toll interest.
- Interest is due and payable for each full 30-day period the debt remains unresolved.
- By law, all payments are applied to interest first, principal second.

  42 C.F.R.411.24(m)
- At 90 days, debt is referred to Treasury for collection if still unpaid.

Once payment is made, Medicare will send a letter stating the lien has been reduced to zero and the case is closed.

CONDITIONAL PAYMENTS

What you need to know about resolution

Proper Medicare CP Resolution Options

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Option 1: Pay the claimed amount (after audit/verification)

Option 2: Appeal (4 levels/lengthy) – interest 

Option 3: Post Final Demand Compromise/Waiver

- *Successful* = **REFUND**

Compromise/Waiver Request

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There are three statutory authorities under which Medicare may accept less than the full amount of its claim:

1. §1870(c) of the Social Security Act – BCRC **(Financial Hardship)**
2. §1862(b) of the Social Security Act – CMS **(Best Interest of the Program)**
3. The Federal Claims Collection Act (FCCA) – CMS **(Compromise)**

Not mutually exclusive

<u>If successful, a refund is issued by Medicare</u>

Success Rate:	**71%**
Total Refunds in 2024:	**$2,872,006**
Average 2024 Refund:	**$31,911.18**
Total Refunds 2013-2024:	**$17,874,217**

MEDICARE ADVANTAGE (MAO/PART C)

The "hidden" lien that could be very costly

Part C/MAO – Recovery Rights

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The Medicare Secondary Payer Act (MSP) provides for a private cause of action for DOUBLE DAMAGES when a primary plan fails to reimburse a secondary plan for conditional payments it has made.

42 C.F.R. §422.108(f) extends the private cause of action to Medicare Advantage Plans:

"MAOs will ***exercise the same rights*** to recover from a primary plan, entity, or individual that the Secretary exercises under the MSP regulations in subparts B through D of part 411 of this chapter."

CMS Memorandum (12/2011) Indicated MAOs have same rights to recover as Medicare itself.

In Re Avandia (3rd Cir. 2012)

Humana Medical Plan v. Western Heritage (11th Cir. 2016): Humana entitled to double their lien amount against Western Heritage, damages "SHALL" be double

But see, 9th (*Parra*) and 6th (*Engstrom*) disagree with 11th and 3rd

MAO Liens – Law Firm Liability

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42 U.S.C. § 1395y(b)(2)(B)(iii)

"In order to recover payment made under this subchapter for an item or service, the United States may bring an action against any or all entities that are or were required or responsible … to make payment with respect to the same item or service … under a primary plan. The United States may … collect double damages against any such entity. 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."

42 C.F.R. §411.24(g)

"CMS has a right of action to recover its payments from any entity, including a beneficiary, provider, supplier, physician, attorney, State agency or private insurer that has received a primary payment."

- *United States v. Weinberg*, 2002 U.S. Dist. LEXIS 12289 (E.E. Pa. July 1, 2002).
- *United States v. Harris*, 2009 U.S. Dist. LEXIS 23956 (N.D. W. Va. March 26, 2009) affirmed, 334 F. App'x 569 (4th Cir. 2009).
- Denekas v. Shalala, 943 F. Supp. 1073 (S.D. Iowa 1996).
- *Humana v. ParisBlank et al.*: Law Firm Sued Directly for $191,000 x2 – case was resolved confidentially during litigation

KEY PRACTICE TIP: MAO Lien Resolution

- Conduct thorough investigation to identify any Part C Medicare Advantage Plan (MAO) liens that may exist - Develop process and train staff to find unidentified MAO liens
- Obtain copies of all government assistance and health insurance cards to determine the types of benefits or insurance the client is receiving to help identify MAO plans who may have a lien
- Continue this inquiry throughout the representation, performing a final check before disbursing settlement proceeds
- When an MAO lien is identified, take proactive steps to negotiate its reduction, leveraging either traditional lien reduction arguments or the MSP's compromise and waiver provisions

MEDICAID LIENS

Reducing Pursuant to Ahlborn

Medicaid TPL & Limitations

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- The federal Medicaid program, Title XIX of the Social Security Act, requires every participating State to implement a "third party liability" provision which authorizes the State to seek reimbursement for Medicaid expenditures from third parties liable for injuries that require medical treatment provided to a Medicaid recipient. **42 U.S.C.§1396a(a)(25)**
- There are limitations on the State's recovery that protect the Medicaid recipient's property. Specifically, the federal anti-lien statute at 42 U.S.C. §1396p(a)(1) (exception to this is the TPL statutes) & federal anti-recovery statute at 42 U.S.C. §1396(b)(1). There is a natural tension between the requirements of Medicaid TPL mandating states recover using their automatic assignment and the anti-lien/anti-recovery provisions of the federal law.

Ahlborn – A Landmark SCOTUS Decision

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- 2006: The U.S. Supreme Court reviewed the provisions of federal Medicaid law and determined that these provisions preempt and limit a State's right to seek reimbursement of Medicaid expenditures from a Medicaid recipient's settlement with a liable third-party. See ***Ark. Dept. of Health & Human Serv. v. Ahlborn***, 547 U.S. 268 (2006).
- Federal law only allows a State to assert a lien against, and seek recovery from, the portion of the settlement representing compensation for medical expenses paid by Medicaid. The federal anti-lien and anti-recovery provisions protect a Medicaid recipient's property and prohibits a State from asserting a lien against, or recovering from, damages other than medical expenses.
- The ***Ahlborn*** Court stated that State "third-party liability provisions are unenforceable insofar as they compel a different conclusion." 547 U.S. at 292.

UNDERSTANDING PRO-RATA REDUCTION

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- According to the guidance from the Ahlborn Court, the method of making an allocation to past medical expenses based on applying the same ratio the settlement bears to the total damages to the claim for past medical expenses makes sense.
- It is a mathematical approach mimics how a jury verdict would calculate the amount of a settlement allocated to past medical expenses.
- If a jury determined the damages had a value of $3,000,000, of which the line item for past medical expenses was $200,000, but the jury determined that due to comparative negligence the Defendant was only liable for 1/6 of the overall damages, the Defendant would only be liable for paying 1/6 of each element of damages including only 1/6 of the claim for past medical expenses. With an unallocated lump-sum settlement, applying the same ratio the settlement bears to the total damages to the claim for past medical expenses mimics this result.

GALLARDO – US SCT (2022)

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Issue: Whether the federal Medicaid Act provides for a state Medicaid program to recover reimbursement for Medicaid's payment of a beneficiary's past medical expenses by taking funds from the portion of the beneficiary's tort recovery that compensates for future medical expenses.

Argued*: 1/22

Gallardo argued that the anti-lien provisions in the Medicaid Act prohibited Florida Medicaid from attempting to recover its lien from anything other than the amounts properly allocable to past medical expenses.

*Feds argued on behalf of Gallardo and against FL.

*FL and other states argued on behalf of Marstiller

6/22: 7 to 2 Decision in favor of FL

Holding – Justice Thomas:

"Under §1396k(a)(1)(A), Florida may seek reimbursement from settlement amounts representing "payment for medical care," past or future. Thus, because Florida's assignment statute "is expressly authorized by the terms of . . . [§]1396k(a)," it falls squarely within the "exception to the anti-lien provision" that this Court has recognized. Ahlborn, 547 U. S., at 284."

Important Note: Medicaid TPL statutes/law varies state to state.

ERISA LIEN TIPS

Reductions despite McCutchen

ERISA Background

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- Most, if not all, ERISA health insurance plans state that injuries caused by a liable third party are not a covered expense and require reimbursement when a plan pays for injury related medical expenses
- ERISA provides that health plans which qualify under its provisions can bring a civil action under section 502(a)(3) to obtain equitable relief to enforce the terms of the plan
- Appropriate equitable relief is really the only enforcement mechanism an ERISA plan can utilize to address its reimbursement rights contained in the plan

Who you are fighting

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- Realize who you are fighting: it isn't the plans but instead their recovery vendors like Rawlings, Conduent, Trover among many others
- Big powerful companies who employ thousands in large, beautiful office buildings with the single goal of riding the coat tails of the personal injury firm's hard work

Recovery Vendors

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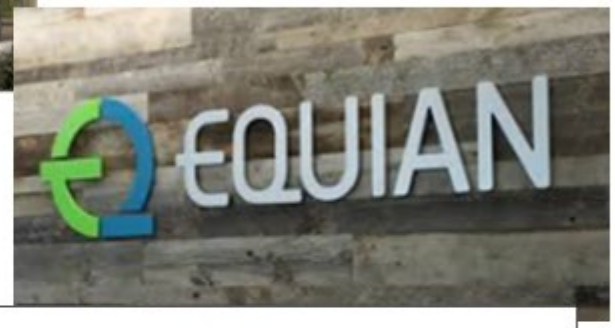
- The Big Recovery Players
  - Optum
  - Equian
  - Conduent
  - Rawlings
  - BCBS, Humana (internal)
  - Various defense firms

  - Highly trained
    - Narrow arguments
  - Form Letters
  - Limited Authority to Reduce
  - Incentivized by Bonus
  - Various Lien Types
    - ERISA, Medicare Advantage, Supplement, FEHBA, Medicaid MCO/HMO



The Rawlings Group

CONDUENT

US Supreme Court - *McCutchen*

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Us Airways v McCutchen, 133 S. Ct. 1537 (2013).

Holding that equitable theories, such as the made whole rule, common fund reduction etc., cannot override the clear language of a contractual agreement between an ERISA plan and its member.

Post McCutchen ERISA Lien Res

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- McCutchen "memo": Rawlings stated that "it is now undisputed throughout the entire nation that general principles of unjust enrichment and equitable doctrines 'reflecting those principles' cannot override an applicable ERISA plan contract."
- Still many ways to get leverage and reduce ERISA plan liens, but you must know the pressure points to use

Threshold Question: Is it really ERISA?

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ERISA governs employer-employee plans

Except:

- If the employer is the **federal** government, FEHBA applies.
- If the employer is the **state** government, state law applies.
- If the employer is a **church**, state law applies.

Next Question: Self Funded or Insured?

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Self-Funded ERISA pre-empts state law

- Funded by contributions from employer and employee

Fully insured ERISA subject to state law

- Funded by purchased insurance coverage

How do you know? Plan language (SPD), Form 5500, Ask (plan administrator or recovery agent).

Short Cuts: If the plan is a named employer group or titled as an ASO – likely self funded. If the plan is a named insurance carrier or titled HMO, PPO or POS then likely fully insured.

If YES & YES – 1024(b)(4): Required Disclosure

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29 U.S.C §1024(b)(4) provides list of what the ERISA Plan Administrator must provide upon request:

- Copy of the latest updated Summary Plan Description (SPD)
- The latest annual report
- Any terminal report
- The bargaining agreement
- The trust agreement, contract, or other instruments under which the plan is established or operated.
  - Administrative Services Agreement was subject to the ERISA disclosure requirements as it is a document "that restrict[s] or govern[s] a plan's operation."

Ask the CORRECT party:

Disclosure requirement imposed upon the **"plan administrator"**. You can't send the request to a TPA or recovery vendor (Rawlings, Conduent, Optum, etc. will NEVER be the plan administrator).

Penalties for non-compliance:

29 U.S.C. § 1132(c)(1)(b)

- Establish $100.00 per day penalty for failure to comply

29 CFR § 2575.502c-1

- Allows for this penalty to be increased to $110.00 per day

Why do you need the 1024(b)(4) docs?

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ERISA Plans – Assessment of the Plan's Right

- What do you need?
  - Plan Documents – SPD, MPD
    - Form 5500
  - Audit the Lien Claim Summary
    - Must have ICD, CPT billing codes
    - Provider name
    - Dates (ranges?)
    - Bundled charges / lump sum payments
  - Understanding of the applicable law
    - Which law applies? State or Federal.

KEY PRACTICE TIP: ERISA Liens

THE PLAN OF ATTACK:

Why is it so important to get everything requested under 1024(b)(4)?

1) Penalties - leverage

2) To check for:

A) Does the language reach to first party coverage? (i.e. UIM, UM)

- Often language is silent or vague.

B) Does the language overcome "made whole"?

- Specific Plan language is required in the 11th.

C) Does the language overcome "common fund"?

- If language is silent then a reduction of attorney fees may be appropriate.
- "If [The Plan] wishe[s] to depart from the well-established common-fund rule, it ha[s] to draft its contract to say so . *U.S. Airways v. McCutchen, 133 S. Ct. 1537, at 12 (2013) at 12*

FEHBA & MILITARY LIEN RESOLUTION

Nevils & FMCRA

FEHBA Liens

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- ***Where do FEHBA LIENS get their recovery rights?***
  - FEHBA contains an express preemption provision, 5 U.S.C.A. § 8902(m)(1). It preempts any state or local law that "relates to health insurance or plans" if the contract terms at issue "relate to the nature, provision, or extent of coverage or benefits," "including payments with respect to benefits."

Military liens

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- Military veterans and their family members may have health insurance coverage under either the Veterans' Administration, also known as the VA, Tricare, or CHAMPVA.
- When representing a client who may be eligible for Military Health coverage, it is important to understand the different types of Military Health coverage your client may be covered under. Most personal injury attorneys may be familiar with the processes for resolving Medicare, Medicaid, and private insurance liens but do not handle enough Military Liens to be familiar with differences in coverages or the different processes in resolving them efficiently and effectively.

FEHBA & Military Lien Resolution

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FEHBA - Federal Employees Health Benefits program (5 U.S.C. § 8901 et seq.)

Coventry Health Care of Missouri Inc. v. Nevils

* FEHBA preempts state law and that such preemption is constitutionally permissible
* Makes FEHBA liens similar to ERISA plan liens in that they have very powerful recovery rights

Best practices for resolving: Request plan language and review the documents for weaknesses in recovery language.

Military Liens

Three types of coverage: VA, ChampVA and Tricare

Federal Medical Care Recovery Act (FMCRA): 42 U.S.C. §§ 2651-2653 - right to recover the medical expenses incurred for medical care of an injured beneficiary when there is a liable third party

Issues: The most difficult part of resolving Military Liens is the amount of time it takes. It's important to identify the coverage EARLY and reach out to the correct party to ensure you start the process of obtaining the billing and/or lien to negotiate at the end.

Protection Agreements – no fees/costs on the "government's portion of recovery"

1st Party Benefits – question whether govt can recover under FMCRA (***Andujar***)

KEY PRACTICE TIP: FEHBA

FEHBA: These plans have strong federal preemption rights, as established in Coventry Health Care of Missouri Inc. v. Nevils:

State law limitations on subrogation and reimbursement claims are generally inapplicable.

Prioritize a thorough review of the specific FEHBA plan language, which can be accessed through the Office of Personnel Management's (OPM) website

Be prepared for a strict enforcement of reimbursement rights by FEHBA carriers, given the Supreme Court's stance on federal preemption

Develop a comprehensive strategy that includes an understanding of federal preemption and its implications on FEHBA liens

KEY PRACTICE TIP: Military

Military: When resolving military liens in personal injury cases, it's essential to understand the unique aspects of the Federal Medical Care Recovery Act (FMCRA):

The military, including the Veterans Health Administration, Champ VA, and Tricare, has both subrogation rights and independent recovery rights from responsible third parties

Promptly request and review the billing from military or VA facilities as there can be significant delays in processing these requests

Be prepared to navigate the complex tiers of review for compromise or waiver requests, understanding that each tier has different approval thresholds

Be mindful of the issues surrounding attorney fees and the military's stance on fee deductions from their portion of the recovery, as well as the specific language of any first-party insurance policies involved, especially in cases with UM policies

Policy language and state law may impact the government's right to reimbursement

HOSPITAL & PROVIDER LIENS

Resolution Tips

HOSPITAL/PROVIDER LIENS

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What is a HOSPITAL/PROVIDER LIEN?

- Hospital Lien and/or Provider liens come from statutes and ordinances that vary from state to state. A hospital lien gives hospitals a superior legal right to recovery. Many hospital liens result from charges made to accident victims. Often these individuals have no choice of where they are taken for emergency care. In some cases, hospitals and other healthcare organizations exploit liens as a way to bring in more revenue.

Best practices for resolving?

- Most state laws require a lien to be reasonable. The criteria for reasonable is often set by comparing the charges to that which a patient with Medicare, Tricare, Blue Cross, or another insurer receives. Charges sent to uninsured patients are considered as well.

- One tactic to reduce a medical lien is to approach the medical organization early in the process. Hospital lien laws vary depending on the state. In some states, hospitals must perfect the lien by filing a notice with the local court. The hospitals must follow the requirements of the Hospital lien statutes of the state to have a perfected lien. If the hospital does not comply with the statutes, then their lien is not enforceable. This does not mean that the client is now not responsible for the bill; it only means that the hospital does not have a lien against the client's settlement proceeds. The best practice is to use the actual cost of care plus a reasonable profit.

KEY PRACTICE TIP: Hospital Liens

The process of resolving hospital reimbursement claims involves several steps:

1. Identifying and verifying any hospital lien claims.
2. Assessing if the hospital has perfected the lien according to state law.
3. Confirming any insurance payments and the balance remaining.
4. Disputing balance billing if insurance payments have been made.
5. Utilizing various arguments in negotiations, such as challenging unrelated charges, employing reasonableness arguments, applying statutory limitations, and invoking equitable doctrines.
6. Finalizing the resolution with a complete lien release.

As it relates to reasonableness arguments, negotiating hospital charges down from full billed charges is a losing strategy. Starting from reasonable value, which would be cost of care plus a profit, eliminates starting off the negotiations with an extremely inflated "pie in the sky" number.

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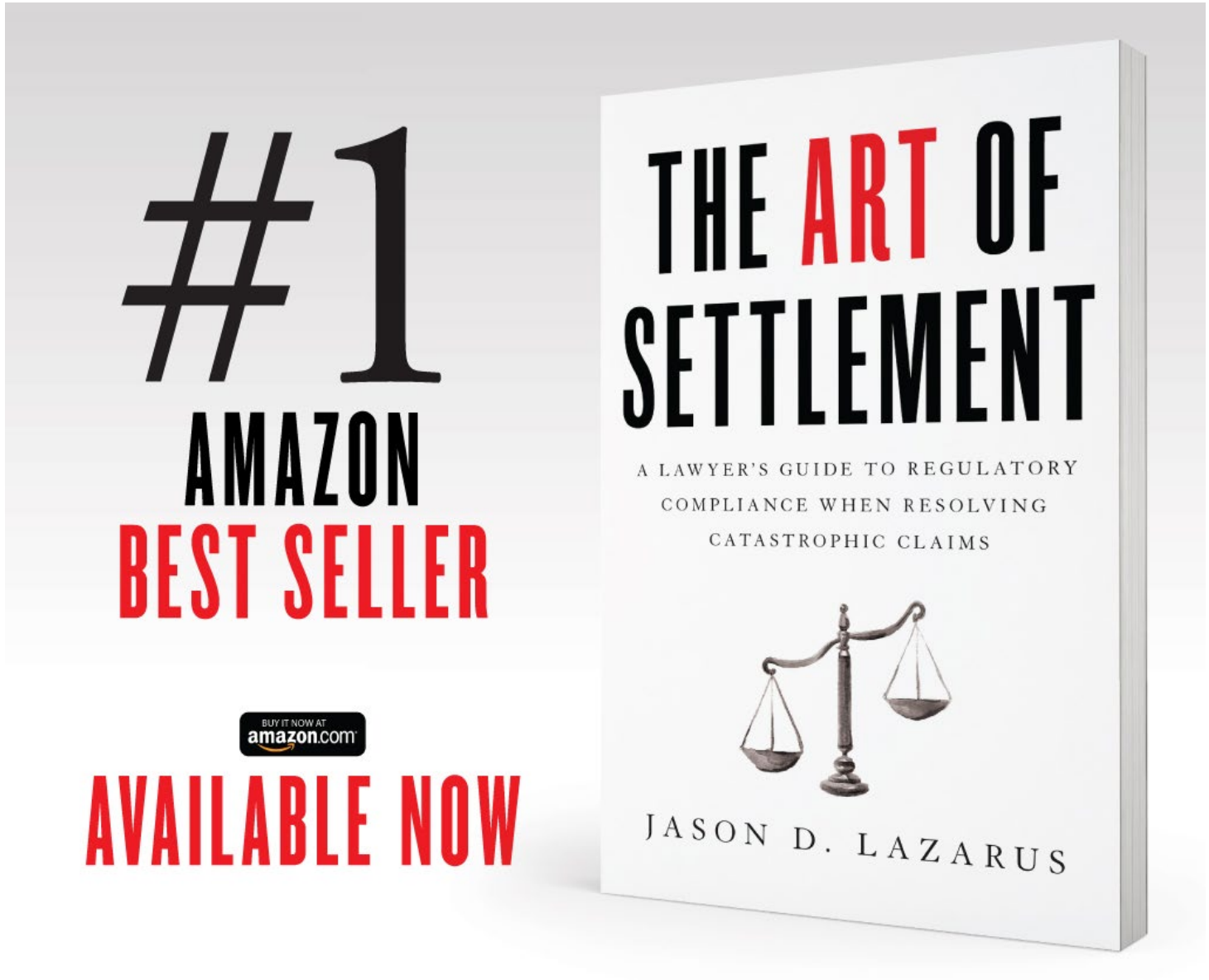

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Outsourcing & Lien Resolution Guide for Trial Lawyers

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Table of Contents

Introduction to Lien Resolution for Personal Injury Cases

In the complex landscape of personal injury practice management, lien resolution stands as a critical yet often challenging component of the firm's practice. Trial lawyers navigating these issues must balance the demands of securing favorable settlements for their clients with the intricacies of resolving various types of liens that can significantly impact the net recovery. The growing complexity of healthcare reimbursement systems, coupled with stringent regulatory requirements of government plans, necessitates a sophisticated approach to lien resolution for personal injury firms.

This guide aims to provide trial lawyers with a comprehensive resource on lien resolution, highlighting the importance of understanding and resolving liens effectively as well as efficiently. This introduction sets the stage for understanding the critical role of lien resolution in personal injury settlements.

Understanding Lien Resolution

Lien resolution involves the negotiation and resolution of claims made by healthcare providers, government agencies, and other entities against a portion of the settlement proceeds in a personal injury case. These claims, or liens, must be addressed and resolved to clear the way for the distribution of funds to the injured party. Failure to resolve liens properly can result in significant financial and legal repercussions for both clients and attorneys.

The Importance of Lien Resolution

The proper resolution of liens is crucial for several reasons:

Client Recovery: Ensuring that liens are resolved accurately and efficiently maximizes the amount of settlement funds available to the client. Bad resolution can significantly reduce the client's net recovery.

Compliance: Adhering to the legal/ethical requirements and regulations surrounding lien resolution is essential to avoid major issues. This includes understanding the specific rules governing different types of liens, such as Medicare, Medicaid, ERISA, FEHBA, Military, Hospital and private health insurance liens.

Financial Responsibility: Proper resolution of liens helps in avoiding financial liabilities for both the client and the attorney. Inappropriate handling of lien resolution can lead to claims against settlement funds even after distribution.

Professional Reputation: Successfully resolving liens enhances the attorney's reputation and leads to greater client satisfaction. This turns into more future referrals as successful resolution leaves the client with greater levels of overall satisfaction.

Structure of the Guide

This guide is structured to provide a step-by-step approach to different issues related to lien resolution, covering a wide range of topics essential for trial lawyers. There are separate sections which delve into issues like outsourcing of liens, internal resolution processes, and understanding the basics of liens along with specific types of lien resolution issues. Each section offers practical strategies and insights. From Medicare and Medicaid liens to ERISA liens and hospital/provider liens, this guide equips attorneys with the knowledge and tools needed to navigate lien resolution effectively whether you outsource it all or do some of it in-house. By gaining an understanding of the information outlined in this guide, trial lawyers can protect as

well as enhance their practice, safeguard their clients' interests, and get the best possible outcomes.

With a foundational understanding of the significance and complexity of lien resolution in personal injury cases, it's important to consider strategic approaches that can streamline this process. One effective strategy is outsourcing, which can offer significant advantages for law firms. The following section explores the benefits of this approach.

Section 1: Why Should Personal Injury Law Firms Consider Outsourcing Lien Resolution?

Introduction

You might ask yourself, why hire experts to assist with lien resolution when I can do it myself? You also might ask whether it is ethically permissible to outsource lien resolution to a lien resolution company? The first question is quite simple to answer, and the second one requires a little more examination of the rules regulating lawyers.

The problem really starts with the responsibilities a law firm has at the beginning of each new case as it pertains to liens. I use lien synonymously with subrogation, reimbursement, and debts here even though there are differences. Given the law, a law firm must track liens that are asserted against their client's personal injury claim and in some instances will have an affirmative duty to investigate and identify possible liens (Medicare & Medicare Advantage plans are good examples).

The law firm must determine whether a lien holder's claim has merit and is legally valid. To reach resolution, this requires a law firm to have significant contact and interaction with a variety of lien holders along with recovery vendors. At the conclusion of the case, it frequently requires protracted negotiations to reach an agreement to resolve the claims made by a lien holder or recovery vendor against a settlement, judgment, or verdict. The bigger issue, given the distractions it creates, is that law firms frequently wait too long to begin to negotiate a reimbursement to a lien holder which can delay disbursement to the injury victim. All the foregoing creates pressure on law firms to outsource lien resolution functions.

<u>Key Takeaway:</u> Outsourcing lien resolution is often a prudent strategy for law firms, not only for efficiency but also to meet their ethical and legal obligations to clients. Law firms face complexities from the outset of a case in identifying, tracking, and negotiating liens, which include subrogation claims and debts against their clients' personal injury settlements. These tasks require expertise and focused interaction with various stakeholders like lien holders and recovery vendors. The responsibility intensifies when law firms must assess the legal validity of lien claims and engage in often lengthy negotiations to resolve them. Additionally, delays in these negotiations can postpone receipt of settlements for injured clients. Given these challenges and obligations, the pressure for law firms to consider outsourcing lien resolution is significant.

<u>Why Outsource?</u>

As to the question of why outsource, it really comes down to efficiency and results. When resolving a lien on behalf of an injury victim, you typically are either dealing with a government benefit health plan or an aggressive recovery vendor on behalf of a plan. Dealing with Medicare, Medicaid, FEHBA on the government side can be time consuming and ineffective. Having to negotiate with and against recovery contractor groups for Medicare Advantage plans and Rawlings, Equian, Optum and Conduent can be equally difficult if not more so. Recovery contractors are massive corporations whose sole reason for existence is to take dollars from a personal injury victim's recovery. They do this by relying upon the efforts of talented trial lawyers who secure settlements and receive verdicts. These recovery contractors have very deep pockets and large staffs to pursue nothing but liens which makes for lopsided battles.

So, to sum up succinctly why you may want to hire an expert lien resolution group to help you and your client:

1) Make your law firm more efficient and profitable by reducing operating expenses;
2) Give you a deep team of experts to fight the massive recovery vendors; and
3) Most importantly, get the best possible resolution for the injury victim when it comes to what must be paid back to a lien holder.

Before moving on to ethical outsourcing discussed in the next section, let's unpack a little bit more about the reasons to partner with an experienced lien resolution provider. While the idea of subrogation and reimbursement may seem quite simple, the task of resolving these demands made against a personal injury settlement can become very time-consuming as well as very complex. "Lien law" is a dynamic and evolving area of the law with each type of lien having nuances and peculiarities along with resolution challenges.

This is so much so that the health insurance industry has for decades recognized these complexities and turned to lien resolution/recovery contractor vendors themselves to make sure they get paid back after an injury is sustained. Frequently, an attorney representing an injury victim is left to fight these vendors with one hand tied behind their back due to a lack of resources, time, and specialized knowledge. The recovery vendor's business model relies upon this to make it much more difficult than it needs to be for trial lawyers. They know it can be overwhelming and they exploit that to their own advantage. So, the first question to ask yourself is: do you want to take on large well-funded recovery vendors or partner with a lien resolution group who has the requisite expertise to fight fire with fire?

Partnering with a well-qualified lien resolution group minimizes a law firm's operating expenses. Every business seeks to decrease operating costs and increase efficiency. This can be accomplished by outsourcing all the time-consuming lien resolution functions. The large amount of time and effort a personal injury law firm devotes to post-settlement lien resolution issues typically creates a loss to the firm's bottom line. Alternatively, outsourcing lien resolution functions allows the lawyer or firm to pass on the cost to the client, in most states, similar to the cost of retaining an expert. A trial lawyer's valuable time is better spent on moving cases toward settlement or trial and not on cutting through government/private health plan red tape. Which, as stated above, are designed specifically to be difficult or frustrating to navigate.

Hiring a lien resolution group provides your law firm with a powerful partner in the lien resolution process. By partnering with lien resolution professionals, you gain a knowledgeable partner and resource for the lien resolution issues plaguing law firms. Without knowing every potential lien resolution argument and the latest rules/processes associated with health plan liens, attorneys and their staff are prone to inefficiency, or worse yet, mistakes.

A lien resolution group will have the necessary expertise to accelerate the lien resolution process as well as to get the best possible reduction. Before moving on to the last point, it is important to explore some examples. Dealing with multiple lien types in a single case can pose significant challenges for even the most experienced trial lawyers as they all will have unique rights of recovery, recovery departments and differing practices related to notice, perfecting, and compromising claims.

For example, someone covered by an employer-based ERISA plan might move to a Medicare plan after losing their job due to the injuries they suffered. These plans will have

different processes to resolve. You can have a client who is dual eligible meaning you have both Medicaid and Medicare liens. Both Medicaid and Medicare lien resolution issues are quite complex by themselves – understanding *Ahlborn/Gallardo* for Medicaid and Medicare compromise/waiver processes for Medicare. Another problematic area can be ERISA lien resolution and the impact on applicable lifetime coverage limits and future care denials.

Given the ever-shifting legal landscape of lien resolution, lawyers must keep up to date in a variety of ways from Medicare-to-Medicare Advantage and Medicaid. Add in ERISA, FEHBA, military, hospitals, provider, and private health insurance liens and you have a tremendous amount of law to keep up with and necessary analysis of the issues to get it all correct. For a lawyer handling a personal injury case, there are a multitude of questions to answer related to each lien such as:

- What are my legal obligations as plaintiff's counsel and am I personally liable?
- When looking at the client's net recovery, are they made whole and is full reimbursement to the lien holder proper?
- Is there a lien? Reimbursement obligation? Just a debt?
- What standard reductions are provided by state or federal statutes for the applicable lien?
- What other reductions of a lien or reimbursement obligation may be available to the client such as legal defenses, compromise/waivers or offsets?
- Is the reimbursement obligation owed limited to past payments or does it also include future payments?
- Are there any state-specific laws peculiar to the jurisdiction that impact lien resolution for the client?

- For non-government benefit plans, what law applies? State or federal? Is it governed by ERISA, FEHBA, FMCRA or state law? Combination of laws?
- Who is the plan administrator and recovery vendor for non-government plans?
- Can the Plan or vendor actually prove it is the type of plan it claims to be? And its recovery rights under the law?

Proper expertise and a team to issue spot these kinds of problems along with powerful negotiation strategies can make sure the end result is the best possible outcome and is in the injury victim's best interests.

Lastly, the importance of an outstanding resolution result for a lien can't be overstated. Getting outstanding results when it comes to lien resolution leaves the client with a positive, lasting impression at settlement. Clients who are not properly educated about lien resolution, don't understand these obligations, and have to pay back too much are often frustrated and discontented with the end result. A client's poor impressions post settlement can affect a lawyer or law firm's reputation in the community. Ultimately, client satisfaction with regard to the resolution of lien obligations may produce repeat business or boost new client referrals for a lawyer or law firm.

Conclusion

Outsourcing lien resolution is not just about delegating tasks; it's a strategic move for law firms handling personal injury cases. There is a compelling case for outsourcing. Improved efficiency and better outcomes are the primary reasons. Navigating lien law is a complex, time-consuming effort, especially when dealing with government benefit health plans or powerful recovery vendors. The recovery vendors are purposely organized to make lien resolution

difficult, thus impairing a law firm's effectiveness and bottom line. Outsourcing solves this by providing specialized expertise and resources to combat these well-funded entities. It also frees up valuable time for attorneys to focus on settling other cases or trials, rather than slogging through red tape. Moreover, the intricacies of lien law are ever-changing, spanning from Medicare to ERISA, making it almost impossible for a single attorney or even a law firm to keep up. By outsourcing, law firms can have a dedicated team that is up to date on current laws and skilled in negotiation, which leads to better outcomes for the clients. Client satisfaction with how liens are resolved can have a lasting impact on a law firm's reputation and future business.

While outsourcing lien resolution can provide substantial advantages, it is crucial to approach this strategy from a clear ethical framework. Ensuring ethical practices in outsourcing protects client interests and maintains professional integrity. The following section discusses how to comply with ethical rules when outsourcing.

Section 2: How to Outsource Lien Resolution Ethically

Introduction

Given the fact that litigating trial lawyers focus on personal injury law (proving causation, liability and damages), they may require outside assistance with certain areas beyond their scope of representation. Historically, personal injury law firms have sought the help of outside legal counsel along with non-attorney specialists to professionally and efficiently deal with a variety of complex issues that arise at settlement. Lien resolution is no different than when an attorney seeks the assistance of experts in other complex areas of law that he or she may be unfamiliar with.

For example, such outsourcing occurs regularly when an attorney is faced with dealing with probate, guardianship, government benefit preservation, tax, or bankruptcy situations that can and often do arise out of an underlying personal injury matter. Personal injury attorneys also frequently engage experts to help with accident reconstruction, valuation of economic damages and Medicare compliance, among many other areas. Subrogation experts are just one more type of expert that a personal injury lawyer can turn to that will enhance the bottom-line net recovery while helping to navigate the pitfalls commonly encountered during the resolution process.

The law governing health insurance subrogation claims are often litigated and are complicated as well as extensive. ERISA, the Medicare Secondary Payer Act, Medicaid, FEHBA and other types of private insurance liens are specialties unto themselves; each rest on their own statutory and regulatory authority, can be governed by different state regulations and can often exist in concert with each other on the same case. Additionally, the fact that oftentimes a personal injury victim will have multiple different types of liens asserted against their recovery,

significantly complicates the lien resolution function. A good example of this is Medicare, where Parts A/B will have a conditional payment obligation to be satisfied, a Part C Advantage Plan lien (which Medicare itself doesn't provide information about) and then a Part D prescription plan which could have a claim as well. All stemming from one accident. If a client has treated over the course of years post-injury, they could have jumped between these plans each year.

Therefore, it makes sense to ethically allow trial lawyers to outsource this function. This is especially so to get the best possible outcome for the client and because liability falls on the trial lawyer to make sure that all subrogation claims, reimbursement obligations and liens are resolved in accordance with the law.

Before moving away from the point of liability, it is important to realize that as a trial lawyer you can expose your client to litigation and possibly loss of health care coverage by failing to pay a valid lien holder. In addition, a personal injury lawyer might be guilty of legal malpractice by paying a lien holder who doesn't have a valid claim or by reimbursing a lien holder too much. And worse yet, in the case of Medicare conditional payments or Medicare Advantage liens, you could be held personally liable for double the lien amount under the Medicare Secondary Payer Act's double damages provision. To further reinforce the point, ABA Model Rule 1.15, in the comment (4) states:

"Paragraph (e) also recognizes that third parties may have lawful claims against specific funds or other property in a lawyer's custody, such as a client's creditor who has a lien on funds recovered in a personal injury action. A lawyer may have a duty under applicable law to protect such third-party claims against wrongful interference by the client. In such cases, when the third-

party claim is not frivolous under applicable law, the lawyer must refuse to surrender the property to the client until the claims are resolved. A lawyer should not unilaterally assume to arbitrate a dispute between the client and the third party, but, when there are substantial grounds for dispute as to the person entitled to the funds, the lawyer may file an action to have a court resolve the dispute."

Many states have ethical rules or opinions which mirror Model Rule 1.15 which can be read to impose a duty upon trial lawyers to safeguard disputed funds, for example, when a lien holder claims more than they are entitled to from a settlement, judgment, or award. This makes this area even more treacherous for personal injury law firms. In addition, Model Rule 1.1 requires a lawyer to have the requisite knowledge, skill, thoroughness, and preparation necessary for lien resolution if they undertake the responsibility. Under my reading of 1.1's comments, if a lawyer lacks the necessary expertise to resolve liens, then they must ensure competent representation through other means, such as by retaining other experts.

Since resolving health care liens is complex from a procedural and legal perspective, a personal injury lawyer who lacks necessary knowledge, experience, and expertise to effectively resolve health-care liens potentially jeopardizes the client's interests in their settlement and creates professional liability for himself/herself as well as the firm.

ABA Ethics Opinion on Outsourcing

That brings us to the question at hand, what are the ethical rules guiding the outsourcing of lien resolution services to experts? The ABA's Formal Ethics Opinion 08-451 is a great starting point for the analysis. While it does not address lien resolution directly, it does give the guiding framework for outsourcing. The operative provisions of the ethics opinion state:

"A lawyer may outsource legal or nonlegal support services provided the lawyer remains ultimately responsible for rendering competent legal services to the client under Model Rule 1.1. In complying with her Rule 1.1 obligations, a lawyer who engages lawyers or nonlawyers to provide outsourced legal or nonlegal services is required to comply with Rules 5.1 and 5.3. She should make reasonable efforts to ensure that the conduct of the lawyers or nonlawyers to whom tasks are outsourced is compatible with her own professional obligations as a lawyer with "direct supervisory authority" over them.

In addition, appropriate disclosures should be made to the client regarding the use of lawyers or nonlawyers outside of the lawyer's firm, and client consent should be obtained if those lawyers or nonlawyers will be receiving information protected by Rule 1.6. The fees charged must be reasonable and otherwise in compliance with Rule 1.5, and the outsourcing lawyer must avoid assisting the unauthorized practice of law under Rule 5.5."

To summarize, if you are going to outsource you must remain ultimately responsible for the work and provide "direct supervisory authority" over those to whom you outsource. You must protect confidential information and ensure that the provider who will be outsourced to is competent and suitably trained. Disclosure and informed consent of the outsourcing should be obtained from the client.

State Specific Ethical Rules on Lien Resolution Outsourcing

While that is the general framework, some states have further defined what is ethically required when outsourcing lien resolution. One great example of this is New York. In an opinion issued in July of 2008, the NYCLA Professional Ethics Committee permitted New York lawyers to retain an outside lien resolution law firm and charge its fee as an expense of litigation

paid by the client. According to the opinion, NYCLA, Ethics Op. 739 (7/7/2008), with the client's informed consent, a personal injury law firm may contract with a lien resolution firm and assess its fee as a cost in a contingency fee arrangement as long as the fee is reasonable.

The definition of the fee being reasonable was analyzed in terms of "net benefit to the client." The example was given that a "lawyer who outsources a complex lien problem to another attorney who, in turn, resolves it for a fraction of the lien amount, gains a net benefit to her client." The general parameters of outsourcing in New York were laid out as:

> "It is ethically permissible for a plaintiff's personal injury attorney to retain a specialty firm to handle the resolution of a Medicare, Medicaid, or private healthcare lien on a settled lawsuit. Under the following conditions, the fee for said outside service may be charged as a disbursement against the total proceeds of the settlement: (a) at the outset of the representation, the Retainer Agreement with the client provides that the attorney may do so, and the client has given informed consent thereto; (b) the actual charges are passed on to the client at cost (without any overage or surcharge) and must be reasonable; (c) the transaction results in a net benefit to the client on each lien negotiated; (d) the transaction complies with all principles of substantive law, including the fee limitations on contingent fees in the New York Judiciary Law and Appellate Division rules; and (e) the referring attorney remains responsible for the overall work product. If counsel cannot comply with all of the above conditions, the fee for said services should be charged against the attorney contingency fee."

> Another great example is Ohio. The Ohio Opinion 2009-9 (12/4/09) stated:

> "If a plaintiff's personal injury lawyer retains an outside law firm to provide health care lien resolution services in a settled matter, the plaintiff's lawyer may use professional judgment as to whether to charge the client for the service as part of the contingent fee or as an expense of litigation. Either way, the client's consent to the outsourcing and the fee arrangement must be obtained prior to outsourcing the service. Either way, the fees and expenses must be reasonable, not excessive. Either way, the nature and basis of the fee arrangement must be communicated to the client and pursuant to Rule l .5(c) a contingency fee agreement must be in writing. If the outsourced legal fee is included as part of a contingency fee, there is a division of fee among lawyers not in the same firm and that triggers the requirements of Rule 1.5(e). If the outsourced service is charged to the client as a litigation expense, the contingency fee rate must be appropriately set to not result in a duplicative and excessive legal fee charged to a client for a service that is billed separately as an expense."

Similarly, Utah has directly addressed the outsourcing of lien resolution by personal injury lawyers to lien resolution specialists. The Utah opinion, 14-01 (2/3/14), addressed two questions. First, can a lawyer ethically and appropriately outsource lien resolution? Second, should the fees associated with lien resolution be treated as a "cost" to the client? The opinion addressed both those questions and found that the answers to both questions were yes. The opinion stated:

> "It is ethical for a personal injury lawyer to engage the services of a lien resolution company that can provide expert advice or to associate with a law firm providing this service. If properly disclosed in the retention agreement, fee resolution services may be included as

"costs" to the client provided the resolution services are professional services equivalent to accountants or appraisers."

While most states have not directly addressed the outsourcing of lien resolution, the New York, Ohio, and Utah opinions give a general framework to use when deciding to outsource and then passing along the fee as a case "cost." These opinions all find that it is permissible to outsource and pass along the fee as a case cost if: (a) the personal injury lawyer's retainer agreement with the client provides that the attorney may do so and the client has given their informed consent; (b) the fees charged are reasonable and are passed on without any surcharge; (c) the lien resolution service results in a net benefit to the client on each lien negotiated; (d) the outsourcing transaction complies with state-specific bar rules and substantive law, including fee limitations for contingent fees; and (e) the referring attorney maintains ultimate responsibility for the work product.

Therefore, if you desire to outsource lien resolution services, the first step is amending your fee contract and providing information to the client about outsourcing these functions thereby securing informed consent. The remainder of the parameters outlined in these opinions are typically easily met.

<u>Key Takeaway:</u> The ethical landscape supports the outsourcing of lien resolution by personal injury lawyers. Given the complexity of dealing with healthcare liens—which can involve multiple layers of statutory and regulatory law—outsourcing to experts is not only advisable but may be necessary to safeguard the client's interests and to comply with professional obligations. Such outsourcing is in alignment with ABA Model Rules and various state-specific guidelines, so long as the lawyer maintains ultimate responsibility for

the work, charges reasonable fees which does not include a surcharge, and obtains informed consent from the client. This approach also protects lawyers from potential legal malpractice or other liabilities, as they are responsible for resolving all liens properly under the law. Therefore, lawyers considering this route should amend their fee contracts to clearly articulate the possibility of outsourcing lien resolution and obtain informed consent from their clients.

Conclusion

There are strong reasons for outsourcing lien resolution to a team of experts with deep subrogation experience. First, it makes your law firm more efficient by reducing operating expenses as well as removing the burden on a firm's staff in terms of time spent on liens. Second, since health insurance plans and government employ recovery vendors who are their experts, a law firm should have its own team of experts to help fight and resolve liens. Third, and probably most importantly, to make sure that the client's net proceeds are protected by negotiating the deepest reduction of the amount claimed by a lien holder.

The Utah ethics opinion mentioned above recognized that in a complicated injury case, with multiple liens, plaintiff counsel bears much responsibility to resolve these liens which can require "substantial expertise." The retention and assistance of lien resolution experts serves the "laudable goal" of fair resolution to both the client and lien holder. The lien resolution services offered, according to the Utah ethics opinion, "are often a significant value enhancement for the client" since many plaintiffs' personal injury lawyers may lack the necessary competence to evaluate medical billing. These services allow a personal injury lawyer the ability to negotiate

liens on equal terms with the lienholder's lawyer by providing expert advice coupled with specialized legal resources for the personal injury attorney.

In terms of the ethical issues surrounding outsourcing of lien resolution, the burgeoning complexities around lien resolution, potential impact to the client's net proceeds as well as law firm liability related to liens, leads to the conclusion that outsourcing may be in everyone's best interest.

The question then turns to how to make sure outsourcing is done in compliance with applicable rules. As discussed above, the ABA's model rules certainly contemplate outsourcing of certain functions by lawyers. The survey of states that have directly addressed the outsourcing of lien resolution has concluded that it is permissible but with protections put into place to address client confidentiality along with informed consent. An outsourcing attorney must make sure that the lien resolution firm it hires has the competence, expertise, and suitable training to provide those services.

Passing along lien resolution fees to the client requires that the client agree to the outsourcing as part of the retainer agreement and that the lawyer obtains informed consent for the outsourcing of lien resolution functions. The use of a lien resolution group must produce a net positive outcome for the client with the fees being reasonable and no surcharge added to the fees.

The health insurance industry has known for decades the benefits of hiring subrogation experts. A knowledgeable lien resolution partner can help even the playing field to protect your hard work and at the end of the day, your client's recovery. It makes sense to outsource for all of

the reasons enumerated herein and ethically it can be done by adhering to the principles outlined above.

Understanding why to outsource and how to do it ethically sets the stage for determining which types of liens are suitable for outsourcing. This decision requires a nuanced understanding of the different lien types and their particular characteristics which we touch upon in the next section.

SECTION 2 PRACTICE TIP:

Outsourcing lien resolution can be a strategic advantage for your law firm, but it's crucial to be aware of the ethical and legal issues. Here's a checklist to help you maintain compliance:

1. **Amend Retainer/Fee Contracts**: Before proceeding with outsourcing, amend your retainer or fee contracts to include specific provisions about outsourcing lien resolution services. This documentation serves to formalize the arrangement and protect both parties.

2. **Informed Consent**: Provide your clients with all necessary information about the outsourcing process, including the potential risks and benefits. Secure their informed consent before initiating any outsourced services. Documentation of this consent is vital.

3. **Reasonable Fees Without Surcharge**: Always ensure that the fees for the lien resolution services are reasonable. Pass on the costs directly to the client without any surcharges or overages.

4. **Net Benefit to the Client**: Your client's interests should be paramount. Make sure that outsourcing lien resolution results in a net benefit for them, whether in terms of financial savings, time, or quality of resolution.

5. **State-Specific Compliance**: Familiarize yourself with your jurisdiction’s specific ethical rules and regulations related to outsourcing, if any. Make sure your practices are compliant with state-specific bar rules and any applicable substantive laws.

6. **Vet Your Outsourcing Partner**: Thoroughly research and vet the lien resolution firm you plan to outsource to. They should have proven competence, sufficient expertise, and the suitable training required for the specific lien resolution tasks you're delegating.

7. **Maintain Supervisory Control**: Even when tasks are outsourced, you still bear the ultimate responsibility for the work product. Maintain a supervisory role over the outsourced providers and ensure that their work aligns with your professional obligations as well as standards.

Section 3: Types of Liens Appropriate for Outsourcing and Those That Aren't

Introduction

Determining which healthcare liens to outsource and which to handle internally can be a crucial decision for personal injury law firms. Outsourcing is often advantageous for healthcare liens that require specialized knowledge and extensive negotiation. However, some liens may be better resolved in-house due to their specific characteristics or the nature of the relationship with the lienholder.

Liens Suitable for Outsourcing

Medicare Conditional Payments: These repayment obligations often involve complex regulatory requirements and detailed negotiation processes. To get a significant reduction, typically a compromise or waiver must be sought which is an intricate process with specific deadlines that must be followed.

Medicare Advantage (Part C) Liens: Similar to traditional Medicare Conditional Payments, these require specialized knowledge to navigate the unique aspects of Medicare Advantage plans especially given potential double damages as well as personal liability.

Medicaid Third Party Liability: These liens involve complex regulatory requirements that vary state to state. Detailed negotiation processes are likely given the necessity of seeking an *Ahlborn* type of reduction. This applies to Medicaid HMO liens as well.

Employer-Sponsored Health Plan (ERISA) Liens: ERISA liens are governed by federal law and often involve detailed plan documents and subrogation provisions. A

deep understanding of what to look for within these documents, to get the best possible reduction, is critical. Outsourcing these liens is always advantageous due to the technical legal expertise required to resolve them.

Federal Employee Health Benefits Act (FEHBA) Liens: These liens involve federal regulations that can be intricate and challenging to interpret. Specialized firms can efficiently handle these complexities.

Military Health Plan Liens: Military health plan liens are governed by specific federal laws and benefit from specialized handling. Each branch of the military has different processes that can be difficult to navigate.

Private Health Insurance Liens: These liens are governed primarily by the terms of the insurance policy and state contract law. The intricate relationship between both requires specialized knowledge gained from decades of subrogation experience.

Hospital and Provider Liens: When dealing with hospital or provider liens, outsourcing can help manage the extensive documentation and negotiation required to reduce these substantial claims. Without knowing the trust cost of care, these liens often aren't negotiated on equal footing.

Multi-Jurisdictional Liens: Cases Involving Multiple States: When a personal injury case involves medical treatment in multiple states, it can be beneficial to outsource lien resolution to firms with multi-jurisdictional expertise, particularly for law firms not in the state of originating lien.

Liens Typically Not Appropriate for Outsourcing

“Small” Liens: Small liens of $2,000 or less may not make sense in certain situations to outsource. Law firms can often handle these liens more efficiently in-house. However, Synergy does accept liens of any size for resolution, so it becomes a decision for the firm to make in terms of whether or not a “smaller” lien is appropriate to outsource (for a small administrative fee).

Local Providers with Ongoing Relationships: For liens involving local providers with whom the law firm has established relationships, it is often better to handle these liens in-house. This approach can help maintain goodwill and may result in more favorable negotiations based on the existing relationship between the provider and the firm.

Workers' Compensation Liens: Workers' compensation liens involve state-specific laws and can often be resolved more effectively by attorneys familiar with local workers' compensation practices and regulations. In many states, these liens are not negotiable.

Medicaid Estate Recovery Liens: Medicaid estate recovery liens are asserted against the entire estate once a Medicaid beneficiary has passed regardless of any third-party liability case. These liens are typically managed by state agencies with unique procedures and requirements. Given the local differences, law firms who understand the state-specific nuances can handle these liens more effectively in-house.

Child Support Liens: Child support liens on personal injury settlements are primarily governed by state law, with each state having specific statutes and regulations addressing how these liens are enforced.

Pre-Settlement Funding Liens: Pre-settlement funding liens are primarily governed by state contract law, as they involve agreements between the plaintiff and the funding

company. Some states have specific regulations or consumer protection laws that address pre-settlement funding practices, but the legal framework is largely shaped by the terms of the contract between the parties involved.

Conclusion

Deciding whether to outsource lien resolution depends on the type and complexity of the lien, as well as the law firm's existing relationships and expertise. By understanding and evaluating lien types, personal injury law firms can make informed decisions that balance cost-efficiency, expertise, and client satisfaction when deciding whether to outsource. This strategic approach ensures that the right lien types are outsourced to specialized professionals, while certain liens are handled in-house (if desired).

Recognizing which liens to outsource and which to handle in-house highlights the inherent challenges personal injury law firms face in managing liens. These challenges underscore the complexity and demanding nature of lien resolution. The following section discusses in more detail the daunting task of lien resolution for personal injury law firms.

Section 4: The Daunting Task of Resolving Liens for Personal Injury Law Firms

Introduction

If you are going to handle certain liens in-house, it is important to understand the intricacies involved in identifying, negotiating, and resolving liens. This demands a strong understanding of legal obligations, regulatory frameworks, and the practical aspects of lien resolution. This section explores why working on liens is so daunting for personal injury law firms by discussing key common questions which highlight areas of concern for the personal injury lawyer.

Questions - Areas of Concern

Legal Obligations and Personal Liability

What are my legal obligations as plaintiff's counsel and am I personally liable?

Plaintiff's counsel has a duty to ensure that all liens are properly identified, negotiated, and resolved. Failure to do so can result in significant legal consequences, including personal liability for unpaid liens in certain situations. Attorneys must adhere to ethical rules, comply with federal and state statutes, and protect their client's interests while managing these obligations.

Identifying Liens and Obligations

Is there a lien? Reimbursement obligation? Just a debt?

Determining whether there is a lien, reimbursement obligation, or just a debt requires meticulous investigation and analysis. Attorneys must review medical records, insurance

policies, and correspondence from potential lien holders. This process is time-consuming and requires attention to detail to ensure all obligations are accurately identified.

Scope of Reimbursement Obligations

Is the reimbursement obligation owed limited to past payments or does it also include future payments?

Understanding whether reimbursement extends to future payments by a plan adds another layer of complexity. Attorneys must carefully review the terms of the plan and the relevant legal issues to determine the scope of the reimbursement rights. This often involves interpreting policy language and potentially calculating future medical costs.

Jurisdiction-Specific Laws

Are there any state-specific laws peculiar to the jurisdiction that impact lien resolution for the client?

State-specific laws can significantly impact lien resolution. Attorneys must be familiar with the peculiarities of the jurisdiction related to enforceability of liens where the case is filed. This requires staying updated on state laws and regulations that may affect lien resolution processes, which can vary greatly from one state to another.

Applicable Laws for Non-Government Benefit Plans

For non-government benefit plans, what law applies? State or federal? Is it governed by ERISA, FEHBA, FMCRA, or state law? Combination of laws?

Determining the applicable law for non-government benefit plans involves analyzing whether the plan is governed by state or federal law, such as ERISA, FEHBA, or FMCRA. This requires an understanding of complex legal frameworks and how they interact, which can be particularly challenging in multi-jurisdictional cases.

Identifying Plan Administrators and Recovery Vendors

Who is the plan administrator and recovery vendor for non-government plans?

Identifying the correct plan administrator and recovery vendor is essential for effective lien resolution. Attorneys must establish communication with these entities, understand their lien recovery processes, and negotiate accordingly. This often involves dealing with large, bureaucratic organizations, which can be time-consuming and frustrating.

Verification of Plan Type and Recovery Rights

Can the plan or vendor actually prove it is the type of plan it claims to be? And its recovery rights under the law?

Verifying the legitimacy of the plan and its recovery rights is a critical step. Attorneys must scrutinize the documentation provided by the plan or vendor to ensure that they are entitled to the claimed recovery. This involves legal research and, at times, challenging the assertions made by lien holders.

Made Whole and Reimbursement

When looking at the client's net recovery, are they made whole and is reimbursement to the lien holder proper?

Ensuring that clients are made whole while balancing the required reimbursement to lien holders is a delicate task. Attorneys must navigate the complexities of lien negotiations to maximize the client's net recovery. This involves challenging the lien amount, negotiating reductions, and understanding the impact of reimbursement on the client's net.

Standard Reductions and Legal Defenses

What standard reductions are provided by state or federal statutes for the applicable lien?

Different states and federal statutes provide various standard reductions for liens. Attorneys must be well-versed in these statutes to apply the appropriate reductions. Identifying these standard reductions and applying them correctly requires thorough legal knowledge and careful scrutiny of the lien details.

What other reductions of a lien or reimbursement obligation may be available to the client such as legal defenses, compromise/waivers, or offsets?

In addition to standard reductions, other avenues for reducing lien obligations include legal defenses, reductions based on equitable arguments, compromise or waiver requests. Attorneys must explore all possible options to minimize the lien amount, which involves complex legal arguments, negotiations, and sometimes litigation.

Conclusion

The multifaceted nature of lien resolution in personal injury cases makes it a daunting task for law firms to undertake alone. Attorneys must navigate a labyrinth of legal obligations, complex negotiations, and meticulous documentation to protect their clients' interests.

Understanding the intricacies of lien types, applicable laws, and negotiation strategies is essential for successful lien resolution, underscoring the need for specialized knowledge and diligent effort in this challenging area of personal injury practice. This is why outsourcing makes sense for most types of healthcare liens.

Given all of the foregoing, it is essential for law firms that decide to handle the resolution in-house to some degree utilize a structured approach to identifying and negotiating liens. Establishing clear processes can help law firms navigate these complexities more effectively if they handle certain lien types in-house. The next section addresses these critical processes.

Section 5: Processes for Lien Identification, Verification, and Audit

Introduction

Effective lien resolution begins with accurately identifying, verifying, and auditing all potential liens that may be asserted against a client's personal injury settlement. This foundational step ensures that all possible claims are identified and addressed, preventing future disputes and protecting the client's net recovery. This section outlines the critical processes for lien identification, verification, and audit.

Lien Identification Process

Initial Case Assessment

- **Client Intake**: During the initial client intake, gather comprehensive information about all healthcare providers, insurers, and any other potential lienholders. This includes government programs (Medicare, Medicaid), private health insurance, workers' compensation, and any other relevant health plans.
- **Medical Records and Bills**: Collect and review all medical records and bills related to the client's injury. This helps in identifying the entities that have provided medical services and may assert a lien.

Gathering Critical Information Post Intake

- **Insurance Policies**: Obtain copies of the client's health insurance policies and any correspondence from insurance companies. This documentation is crucial for understanding the scope of coverage and potential subrogation claims.

- **Provider Correspondence**: Request itemized statements and correspondence from healthcare providers to identify charges that might lead to liens.
- **Medicare and Medicaid:** Conduct a thorough search for any Medicare and Medicaid liens. Use the Medicare Secondary Payer Recovery Portal (MSPRP) for Medicare liens and the respective state Medicaid office for Medicaid liens.
- **Private Health Insurance:** Contact all private health insurers who you identify to check for any liens. Verify the details with Explanation of Benefits (EOB) statements and correspondence from insurers.
- **Other Liens:** Identify potential liens from ERISA plans, FEHBA plans, military healthcare providers, workers' compensation carriers, and any other relevant entities.

Lien Verification Process

Confirming Lien Claims

- **Direct Communication**: After identifying, contact all potential lienholders directly to confirm the existence and amount of any liens. This includes reaching out to Medicare, Medicaid, private health insurers, and any other identified entities.
- **Requesting Documentation**: Request formal lien documentation from each lienholder. This should include detailed billing statements, explanation of benefits (EOB) forms, and any legal notices of lien.

Cross-Referencing Information

- **Medical Records Review**: Cross-reference the lienholder's claims with the client's medical records and bills to verify the accuracy of the lien amounts. Ensure that the claimed amounts correspond to the actual medical services provided.
- **Policy Provisions**: Review the relevant insurance policy provisions or plan documents to confirm the lienholder's right to recovery. This includes verifying subrogation clauses and reimbursement rights.

Lien Audit

Audit Preparation

- **Compiling Data**: Compile all information gathered during the identification and verification stages for all potential and actual liens. Organize this data in a comprehensive lien spreadsheet or database, detailing each potential lien, the amount claimed, and the status of verification.
- **Setting Audit Criteria**: Establish criteria for the audit, such as accuracy of claimed amounts, compliance with legal requirements, relatedness, and consistency with the client's medical records/injuries.

Conducting the Audit

- **Reviewing Lien Claims**: Conduct a thorough review of each lien claim against the established criteria. Identify any discrepancies, overcharges, or unsupported and unrelated claims.

- **Legal Compliance Check**: Ensure that all lien claims comply with relevant state and federal laws. This includes verifying that lienholders have adhered to notification and filing requirements.

Resolving Discrepancies

- **Dispute**: Contact lienholders to dispute any discrepancies or inaccuracies identified during the audit. Provide evidence to support your dispute, such as medical records or billing statements.

Documentation and Record-Keeping

Maintaining Records

- **Lien Log**: Maintain a detailed lien spreadsheet that records all identified and verified liens, including the outcomes of the audit process. This log should be updated regularly to reflect any changes or resolutions.
- **Correspondence Archive**: Keep copies of all correspondence with lienholders, including dispute letters, negotiation communications, and final agreements. This ensures a clear audit trail and supports future reference.

Client Communication

- **Informing Clients**: Keep the client informed throughout the lien identification, verification, and audit process. Provide updates on the status of each lien and any negotiations or disputes. Transparency with the client builds trust and ensures they understand the impact on their net recovery.

Conclusion

Accurate lien identification, verification, and auditing are essential steps in the lien resolution process. By implementing structured processes for these tasks, personal injury law firms can ensure that all potential liens are properly identified, reducing the risk of future unanticipated claims arising. This thorough approach not only enhances client satisfaction but also protects the firm from violations of professional standards and legal obligations.

For a complete in-house process related to liens, it is important to have a comprehensive understanding of the steps to resolve healthcare liens. This foundational knowledge helps to shape the overall strategies the firm uses as part of its resolution program. The following section tackles the basics of the steps to resolve healthcare liens.

Section 6: Steps for Negotiating & Resolving Healthcare Liens

Introduction

Resolving healthcare liens is a critical aspect of the resolution of personal injury cases. These liens, if not addressed properly, can significantly impact the net recovery for clients. This section outlines a general approach that personal injury law firms can use to negotiate healthcare liens effectively, ensuring compliance with legal requirements and maximizing the client's net recovery.

Step-by-Step Process for Negotiating the Resolution of Healthcare liens

Pre-Negotiation Preparation

- **Case Analysis:** Assess the total settlement amount and the client's overall recovery to determine the impact of liens. Evaluate liens based on their legal enforceability and potential for negotiation.
- **Client Communication:** Keep the client informed about the identified liens and their potential impact on the settlement. Discuss negotiation strategies and obtain consent for proposed lien reductions.

Engagement with Lienholders

- **Direct Negotiations:** Engage directly with lienholders through phone calls, letters, and meetings. Clearly articulate the rationale for lien reductions and provide supporting documentation.

Negotiation Strategies

- **Arguments for Reduction:** Use legal arguments to negotiate lien reductions. This may include challenging the validity of the lien, arguing for equitable distribution, or invoking state-specific lien reduction statutes.

    1. **Financial Hardship:** Present evidence of the client's financial hardship to negotiate reduced lien amounts. This is particularly effective with government liens such as Medicare and Medicaid where favorable law exists for such reductions.

    2. **Equitable Distribution/Proportional Reductions:** Advocate for equitable distribution/proportional (or pro-rata) reductions based on the client's net recovery. Lienholders may agree to reduce their claims to ensure the client receives a fair portion of the settlement.

Documentation and Compliance at Resolution

- **Lien Resolution Confirmation:** Document all negotiated agreements in writing, clearly outlining the reduced lien amounts and any payment terms. Ensure that lienholders release their claims upon payment with a lien satisfaction (see below).

- **Compliance:** Verify compliance with all legal and regulatory requirements during the negotiation process. This includes timely reporting and proper documentation of lien resolution activities.

Payment and Finalization

- **Lien Payment:** Arrange for the payment of the negotiated lien amounts from the settlement proceeds.

- **Lien Satisfaction**: Obtain lien waivers or release of lien from the health insurance providers upon agreement to the reduced amounts, confirming that no further claims will be made against the settlement funds and that the lien has been fully satisfied as well as released.

File Closure - Compliance and Documentation

- **Legal Compliance:** Ensure compliance with all legal and ethical requirements at the final resolution stage.
- **Document Retention:** Retain all relevant documentation for future reference and in case of any disputes or audits.
- **Case Closure:** Update the lien spreadsheet and client records to reflect the resolution of all liens. Ensure that the client's final distribution is accurately reflected in the closing statement after lien payments.
- **Client Notification:** Inform the client of the successful resolution of their healthcare liens and provide them with a final closing statement showing the distribution of funds.

Conclusion

By following these generalized steps, personal injury law firms can effectively manage and resolve healthcare liens, ensuring that their clients receive the maximum possible net recovery from their settlements.

Despite the many benefits of ethically outsourcing lien resolution, personal injury law firms still will face inherent challenges dealing with liens themselves, highlighting the need for

proper resolution processes within the firm that have been discussed in the foregoing sections. The following sections delve into some of the nuanced issues around resolution of different types of liens. As you will see, it can get very complicated quite quickly. This is where experts in lien resolution really can make a difference in terms of the best possible outcome for the injured party.

Section 7: Understanding Liens and Overview of Various Lien Types

Introduction

Understanding what a lien is and the various types of liens that can arise is essential for effectively managing and resolving them. This section provides an overview of liens, explaining their nature and detailing the different types of liens that personal injury lawyers may encounter.

What is a Lien?

In the context of personal injury cases, liens are claims made by healthcare providers, insurance companies, or government agencies against the settlement proceeds or judgment awarded to the injured party. These entities seek reimbursement for the medical expenses or benefits they have provided to the plaintiff during the course of treatment for their injuries.

Overview of Various Lien Types

1. Medicare Liens

    - **Medicare Conditional Payments**: When Medicare pays for medical expenses related to an injury before the settlement, known as a Medicare conditional payment, it has a right to be reimbursed from the settlement proceeds under the Medicare Secondary Payer Act.
    - **Resolution Process**: The Medicare Secondary Payer Recovery Contractor (MSPRC) manages the lien resolution process. Attorneys must report the settlement to Medicare and resolve the reimbursement obligation, often through the Medicare Secondary Payer Recovery Portal.

2. Medicare Advantage (Part C) Liens

    - **Private Insurers**: Medicare Advantage plans, provided by private insurers, can also assert liens for medical expenses covered under these plans under the Medicare Secondary Payer Act.

    - **Resolution Process**: Negotiation with the private insurer administering the Medicare Advantage plan, or their recovery contractor, is necessary to resolve these liens. The resolution rules are similar to dealing with traditional Medicare conditional payments but involves the private insurer directly.

3. Medicaid Liens

    - **State-Specific Liens**: Medicaid liens are asserted by state Medicaid programs for medical expenses paid on behalf of the injured party. Each state has its own Medicaid agency and specific laws governing third party liability recovery.

    - **Resolution Process**: Attorneys must contact the state Medicaid agency to determine the lien amount, negotiate reductions, and ensure compliance with state-specific procedures.

4. Private Health Insurance Liens

    - **Subrogation Claims**: Private health insurance companies may assert subrogation claims to recover the costs of medical treatment provided to the injured party. These liens are based on the insurance policy's subrogation provisions.

- **Resolution Process**: Attorneys must review the insurance policy's subrogation clause, communicate with the insurance company or their recovery contractor, and negotiate the lien amount, often based on equitable distribution arguments.

5. ERISA Liens

   - **Employee Health Plans**: ERISA (Employee Retirement Income Security Act) liens arise from employer-sponsored health plans that have paid for the injured party's medical treatment. These plans often have strong subrogation rights if it is a self-funded plan.

   - **Resolution Process**: Attorneys must understand the specific terms of the ERISA plan, engage with the plan administrator, and negotiate lien reductions. Federal law governs these liens, which can be more challenging to reduce.

6. FEHBA/Military Liens

   - **Federal Employee Health Benefits Act (FEHBA)**: FEHBA plans, covering federal employees, and military health plans, such as TRICARE, may assert liens for medical expenses.

   - **Resolution Process**: Resolving these liens involves contacting the relevant federal agency or military health plan administrator, understanding the specific lien rights, and negotiating reductions where possible.

7. Hospital and Provider Liens

- **Direct Provider Claims**: Hospitals and other healthcare providers may assert liens directly against the settlement for unpaid medical bills.
- **Resolution Process**: Resolving these liens involves direct negotiation with the healthcare providers, often leveraging the financial hardship or the equitable distribution of the settlement. It is also very important to understand the reasonable cost of care when attempting to resolve these liens.

Conclusion

Understanding the various types of liens and their specific resolution processes is critical for personal injury lawyers. Each type of lien has unique characteristics and legal requirements that must be addressed to protect the client's interests and ensure the greatest possible net recovery.

With a basic understanding of different lien types, we can now delve into the specific processes required for handling some of the most common and complex liens. We first take on resolution of Medicare conditional payments then finish with dealing with hospital as well as provider liens. In the middle, the guide addresses MAO liens, Medicaid liens, ERISA liens, Military, and FEHBA liens.

Section 8: Resolution of Medicare Conditional Payments

Introduction to Conditional Payment Resolution under the MSP

Congress has given the Centers for Medicare and Medicaid Services (hereinafter CMS) both subrogation rights and the right to bring an independent cause of action to recover its conditional payment from "any or all entities that are or were required or responsible . . . to make payment with respect to the same item or service (or any portion thereof) under a primary plan."[1] Furthermore, CMS is authorized under federal law to bring actions against "any other entity that has received payment from a primary plan."[2] Personal injury lawyers have been sued under this provision for failing to repay a Medicare lien. Most ominously, CMS may seek to recover double damages if it brings an independent cause of action.[3] Given all of the foregoing, Medicare subrogation law is a problematic area for personal injury practitioners. The MSPA[4] presents liability concerns for personal injury practitioners because of its complexity, and the difficulty in dealing with Medicare's subrogation bureaucracy.[5]

The government is very serious about its reimbursement rights when it comes to Medicare conditional payments. As an example, in *U.S. v. Harris*, a November 2008 opinion, a personal injury plaintiff lawyer lost his motion to dismiss against the U.S. Government in a suit involving the failure to satisfy a Medicare subrogation claim.[6] The plaintiff, the United States of America, filed for declaratory judgment and money damages against the personal injury attorney

[1] 42 U.S.C. § 1395y(b)(2)(B)(iii) (2007).
[2] *Id.*
[3] 42 U.S.C. § 1395y(b)(2)(B)(iii) (2007).
[4] 42 U.S.C. § 1395y(b)(2)(B)
[5] For a good discussion of the issues relating to conditional payments *see* Jonathan Allan Klein & Annmarie M. Liermann, *Medicare Lien Interests in Liability Settlements – Easy Solutions to Help Resolve Medicare Reimbursement Issues for Beneficiaries and Insurers*, Medicare Secondary Payer Act Reform Task Force (2007).
[6] *U.S. v. Harris*, No. 5:08CV102, 2009 WL 891931 (N.D. W.Va. Mar. 26, 2009), *aff'd* 334 Fed. Appx 569 (4th Cir. 2009).

owed to the Centers for Medicare and Medicaid Services by virtue of 3rd party payments made to a Medicare beneficiary.[7] The personal injury attorney had settled a claim for a Medicare beneficiary (James Ritchea) for $25,000.[8] Medicare had made conditional payments in the amount of $22,549.67. After settlement, plaintiff counsel sent Medicare the details of the settlement and Medicare calculated they were owed approximately $10,253.59 out of the $25,000.[9] Plaintiff counsel failed to pay this amount, and the Government filed suit.

A motion to dismiss filed by plaintiff counsel was denied by the United States District Court for the Northern District of West Virginia despite plaintiff counsel's arguments that he had no personal liability. Plaintiff counsel argued that he could not be held liable individually under 42 U.S.C. 1395y(b)(2) because he forwarded the details of the settlement to the government and thus the settlement funds were distributed to his clients with the government's knowledge and consent. The court disagreed. The court pointed out that the government may under 42 U.S.C. 1395y(b)(2)(B)(iii) "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." Further, the court pointed to the federal regulations implementing the MSPA which state that CMS has a right of action to recover its payments from any entity including an attorney.[10] Subsequently, the U.S. Government filed a motion for summary judgment against plaintiff counsel. The United States District Court, in March of 2009, granted the motion for summary judgment against plaintiff counsel and held that the Government was entitled to a judgment in the amount of $11,367.78 plus interest.[11]

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[7] *Id.* at *1.
[8] *Id.*
[9] *Id.*
[10] *See* 42 C.F.R. 411.24 (g).
[11] *U.S. v. Harris,* No. 5:08CV102, 2009 WL 891931 at *5.

Resolution of the government's interests concerning conditional payment obligations is simple in application but time consuming. The process of reporting the settlement starts with contacting the BCRC (Benefits Coordination Recovery Contractor).[12] This starts prior to settlement so that you can obtain and review a conditional payment letter (CPL).[13] These letters are preliminary and can't be relied upon to as a final demand to pay Medicare from. However, they are necessary to review and audit for removal of unrelated care. Once settlement is achieved, Medicare must be given the details regarding settlement so that they issue a final demand. Once the final demand is issued, Medicare must be paid its final demand amount regardless of whether an appeal, compromise or waiver is sought.[14] Paying the final demand amount within sixty days of issuance is required or interest begins to accrue at over ten percent (10%) and ultimately it is referred to the U.S. Treasury for an enforcement action to recover the unpaid amount if not addressed.[15]

<u>KEY TAKEAWAY:</u> Under the Medicare Secondary Payer Act (MSPA), the Centers for Medicare and Medicaid Services (CMS) has robust powers to recover its payments, including the ability to sue personal injury lawyers directly and seek double damages. The U.S. government is diligent in enforcing its rights to be reimbursed for these payments, and a failure to properly navigate the system can lead to severe financial and legal consequences. Lawyers must initiate the resolution process by contacting the Benefits Coordination Recovery Contractor (BCRC) and carefully auditing any conditional payment letters, which are not final and should not be relied upon. The final demand

[12] *See* https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Attorney-Services/Attorney-Services.html.
[13] *See* https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Attorney-Services/Conditional-Payment-Information/Conditional-Payment-Information.html.
[14] *Id.*
[15] 42 C.F.R. 411.24(m).

amount issued by Medicare must be paid within 60 days to avoid accruing interest and potential legal action. Therefore, caution, thoroughness, and an understanding of the law are crucial for personal injury practitioners handling Medicare subrogation issues.

Resolution of Conditional Payments – Appeal, Compromise or Waiver

The repayment formula for Medicare is set by the Code of Federal Regulations. Sections 411.37(c) & (d) prescribes a reduction for procurement costs.[16] The formula doesn't take into account liability-related issues in the case, caps on damages or policy limits. The end result can be that the entire settlement must be used to reimburse Medicare. The only alternative is to appeal, which requires you to go through four levels of internal Medicare appeals before you ever get to step foot before a federal judge or compromise/waiver. There is plenty of case law requiring exhaustion of the internal Medicare appeals processes which means that Medicare appeals are a lengthy and unattractive resolution method.[17] What makes them even more unattractive is the fact that interest continues to accrue during the appeal so long as the final demand amount remains unpaid.

An alternative resolution method is to request a compromise or waiver post payment of the final demand. By paying Medicare their final demand and requesting compromise/waiver, the interest meter stops running. If Medicare grants a compromise or waiver, they actually issue a refund back to the Medicare beneficiary (typically payable to their legal counsel who made payment to satisfy the final demand). There are three viable ways to request a

[16] 42 C.F.R. 411.37(c) &(d).
[17] A perfect example of this is *Alcorn v. Pepples* out of the Western District of Kentucky. In *Alcorn*, the court held that "Alcorn's claim with respect to the Secretary arises under the Medicare Act because it rests on the repayment obligations set forth under 42 U.S.C. § 1395y. She therefore must exhaust the administrative remedies established under the Medicare Act before this court may exercise subject matter jurisdiction over her claim." Alcorn v. Pepples, 2011 U.S. Dist. LEXIS 19627 (W.D. Ky. Feb. 25, 2011).

compromise/waiver. The first is via Section 1870(c) of the Social Security Act which is the financial hardship waiver and is evaluated by the BCRC.[18] The second is via section 1862(b) of the Social Security Act which is the "best interest of the program" waiver and is evaluated by CMS itself.[19] The third way is under the Federal Claims Collection Act and the compromise request is evaluated by CMS.[20] If any of these are successfully granted, Medicare will refund the amount that was paid via the final demand or a portion thereof depending on whether it is a full waiver or just a compromise.

KEY TAKEAWAY: There is a rigid and often problematic Medicare repayment formula dictated by the Code of Federal Regulations. The formula is particularly unforgiving as it does not consider liability issues, damage caps, or policy limits, potentially consuming an entire settlement amount. Appeals are a lengthy and burdensome process, comprised of four levels of internal Medicare appeals before one can appear before a federal judge, all while interest accumulates on the unpaid final demand amount. An alternative to this protracted process is paying the final Medicare demand upfront to halt the accrual of interest, then requesting a compromise or waiver. Three specific methods are available: 1) financial hardship waivers (evaluated by the Benefits Coordination Recovery Contractor (BCRC) under Section 1870(c)), 2) "best interest of the program" waivers (evaluated by CMS under Section 1862(b)), and 3) "compromise" under the Federal Claims Collection Act, (evaluated by CMS). If successful, these could result in a refund of some or all of the final demand amount paid to Medicare, making it a potentially quicker and more appealing option for resolving repayment issues.

[18] 42 U.S.C. § 1395gg
[19] 42 U.S.C § 1395y
[20] 31 U.S.C. § 3711

Mistakes & Pitfalls to Avoid in Resolving Conditional Payments

The Department of Justice has pursued law firms for failure to properly reimburse Medicare when it has made a conditional payment. There are certainly some clear mistakes to avoid when it comes to resolution of Medicare conditional payments. The first mistake to avoid is relying upon a conditional payment letter's dollar figure when settling a case. The second mistake to avoid is using the wrong resolution mechanism when it comes to Medicare. The following two examples of mistakes made in both of these situations are relevant to help avoid falling into these same traps.

You Can't Rely Upon a Conditional Payment Letter

In 2019, a Maryland personal injury law firm settled a claim brought by the United States Department of Justice for claims related to failing to reimburse Medicare for payments made on behalf of one of the firm's clients. The facts of this Medicare resolution issue are important to demonstrate why you can never rely upon the amount you get from Medicare before submitting your final settlement details and receiving a final demand. The law firm in question represented a Medicare beneficiary in a medical malpractice action. Apparently, according to the settlement agreement, in and prior to 2012, Medicare made conditional payments to healthcare providers to satisfy medical bills for a client of the firm. Accordingly, they properly notified Medicare of the case by reporting it to the BCRC. Medicare's interim recovery amount according to a conditional payment letter the firm received was $14,990. The firm indicated that the amount was confirmed via mail, the phone and the portal. The case eventually settled for $1,150,000 with the law firm relying upon the $14,990 figure in resolving the case. Medicare was properly notified of the settlement by the law firm and was presented with written information about the

settlement. Sixty days later, Medicare issued a final demand indicating the amount owed was $330,000.00 instead of $14,990 as previously detailed in the conditional payment letter.

The problem here is settling the case and relying upon a conditional payment letter which didn't bind Medicare. In response to the final demand, the law firm filed an administrative appeal with Medicare challenging the amount owed that unsurprisingly was denied. After losing their appeal, the U.S. Attorney's office sent a letter to the firm claiming that over $330,000 was due and indicating that interest would be tacked on as well. The law firm ultimately turned the matter over to their malpractice insurance carrier. The government and the law firm's malpractice insurance carrier settled the matter for $250,00.00. In the press release related to the resolution, the government stated that the settlement should "remind attorneys not to disburse settlement proceeds until receipt of a final demand from Medicare to pay the outstanding debt." So, the moral of the story is that you can't rely upon a conditional payment letter, only a final demand letter will bind Medicare to an amount due to satisfy a conditional payment claim.

You Must Use the Proper Resolution Process

In yet another example of Medicare conditional payment resolution issues, a Houston law firm and its managing partner were sued by the government for failing to pay back a Medicare conditional payment. This is a unique situation though as plaintiff counsel did properly report the settlement to Medicare and attempted to resolve it, albeit through improper channels. In March of 2020, the United States Attorney in Texas filed suit on behalf of the Centers for Medicare and Medicaid Services (CMS) against the firm and the managing partner to recover the unpaid conditional payments plus interest, fees and costs. While it has become commonplace for the Department of Justice to pursue lawyers and law firms for failing to reimburse Medicare conditional payments in the recent past, those were situations where Medicare's right to

reimbursement was completely ignored. Here that was not the case; instead, the law firm notified CMS' Benefits Coordination & Recovery Center (BCRC) of the lawsuit and communicated with them about settlement but ultimately the firm disagreed with the final demand amount. Instead of requesting an appeal, compromise or waiver, the matter was addressed in Texas state court. It is a cautionary tale in terms of following proper procedures if one does decide to challenge the amount owed to Medicare under the Medicare Secondary Payer Act (MSP).

Attorney Stephen P. Carrigan and his firm represented Tomas Tijerina in a personal injury lawsuit related to a car accident in April of 2014. In April of 2016, Mr. Carrigan's firm notified the BCRC about Tijerina's accident, his resulting injuries and lawsuit to recover damages. In March of 2017, Carrigan properly notified BCRC that the personal injury case had been settled for $70,000.00. The next month, in April, BCRC sent out an Initial Determination with a payment summary detailing the $46,244.74 that Medicare was claiming as required reimbursement. That same month, Carrigan filed a motion in Texas state court challenging the amount asserted by Medicare and notified Medicare of the pending action in state court. In July of 2017, Medicare issued its Final Demand letter for $47,343.05 which included the related medical expenses plus statutory accrued interest. In August of 2017, Carrigan sent to Medicare an order issued by the state court that reduced Medicare's Conditional Payments by 90% down to $4,700 along with a check for the $4,700.

That brings us to March of 2020 where the U.S. Attorney, Ryan Patrick, filed suit against Carrigan and his firm in the United States District Court for the Southern District of Texas. Central to the lawsuit is the issue of the Texas state court lacking jurisdiction to adjudicate Medicare's recovery of conditional payments under federal law. In the complaint, Mr. Patrick

pointed to sovereign immunity and the fact that the Texas state court lacked subject matter jurisdiction related to conditional payments made under the MSP. He outlined that proper challenges, disputes or attempts to reduce/avoid reimbursement due to Medicare for conditional payments must go through the administrative appeal process set out in the Medicare Act and regulations. According to the complaint, only after exhaustion of those administrative remedies can a claim be made to a United States District Court, which has exclusive subject matter jurisdiction to hear claims under the MSP. There is plenty of case law on that point and it is a winning argument. The complaint also laid out the liability for an attorney who fails to reimburse Medicare under 42 U.S.C. § 1395y(b)(2)(B)(ii); 42 C.F.R. § 411.24(g).

While the matter was ultimately settled, it is very likely that the suit by the government would have been successful, and the attorney would be liable for the full lien amount plus interest, fees and costs. The fact that the state court had no jurisdiction and based its order on applying Ahlborn, a Medicaid lien decision, to a Medicare conditional payment means there is little likelihood that the federal district court would have respected the state court's ruling. Sovereign immunity and preemption by federal law alone prevents the state court ruling from being given any consideration at all by the federal court.

This all could have easily been avoided by paying the final demand and then seeking a compromise/waiver. By doing so, you prevent the interest meter from continuing to run and eliminate the need to engage in lengthy appeals involving exhaustion of administrative remedies within Medicare. If Medicare grants a compromise or waiver, they issue a refund back to the Medicare beneficiary. As discussed in the previous section, there are three viable ways to request a compromise/waiver. The first is via Section 1870(c) of the Social Security Act which

is the financial hardship waiver and is evaluated by the BCRC.[21] The second is via section 1862(b) of the Social Security Act which is the "best interest of the program" waiver and is evaluated by CMS itself.[22] The third way is under the Federal Claims Collection Act and the compromise request is evaluated by CMS.[23] If any of these are successfully granted, Medicare will refund the amount that was paid via the final demand or a portion thereof depending on whether it is a full waiver or just a compromise.

The critical takeaway is that an attorney must use the proper channels for challenging conditional payments owed to Medicare. There are multiple considerations before deciding to appeal or seek a compromise/waiver of conditional payments. Certain steps are necessary to resolve a conditional payment which includes audit/verification of the amount after receiving the conditional payment letter and securing a final demand by providing final settlement details to Medicare. Failure to resolve a conditional payment exposes a trial lawyer to personal liability for the amount of the conditional payment and the government does pursue lawyers individually if they fail to reimburse Medicare, so be very careful when it comes to dealing with Medicare as you do not want to become a cautionary tale. You and your firm never want to be in this position or have the possibility of a double damages claim by the government. The key here is to work with competent experts when it comes to Medicare compliance. Lien resolution companies specialize in protecting law firms against this sort of precise scenario by being a law firm's Medicare compliance expert partner.

<u>KEY TAKEAWAY:</u> Attorneys must exercise extreme caution and due diligence when dealing with Medicare conditional payments in settlements. Firstly, reliance on

[21] 42 U.S.C. § 1395gg
[22] 42 U.S.C. § 1395y
[23] 31 U.S.C. § 3711

conditional payment letters as final figures is a serious mistake; only a final demand from Medicare confirms the amount due. Secondly, it is crucial to use proper legal channels and mechanisms to challenge or appeal these payments. Failing to do so can result in significant legal repercussions, including personal liability and legal action from the government. The section highlights two cautionary tales that demonstrate the risks of mishandling Medicare issues. To mitigate such risks, lawyers should consider working with specialized lien resolution companies that can guide them through the complex landscape of Medicare compliance, from the audit and verification of conditional payment amounts to the strategic utilization of appeal or compromise/waiver options. Ignoring these guidelines may not only jeopardize the financial viability of a settlement but could also expose attorneys to punitive damages and professional embarrassment.

Conclusion

To summarize, resolution of a Medicare conditional payment is either by following the reduction formulas found in the Code of Federal Regulations or by appeal, waiver and/or compromise. There are multiple considerations before deciding to appeal or seek a compromise/waiver of conditional payments. Certain steps are necessary to resolve a conditional payment which includes audit/verification of the amount after receiving the conditional payment letter and securing a final demand by providing final settlement details to Medicare. Failure to resolve a conditional payment exposes a trial lawyer to personal liability for the amount of the conditional payment and the government does pursue lawyers individually if they fail to reimburse Medicare.

The following section details the concerns raised when a client has opted into a Part C Medicare Advantage Plan and they then have a lien against the settlement. Medicare Advantage

(Part C) plans also present distinct challenges that require unique resolution strategies. Understanding these nuances is crucial for effective lien resolution. The following section will address resolution of Medicare Advantage liens.

Medicare Conditional Payment Resolution Practice Tip:

You must pay the FINAL DEMAND within 60 days, or the debt will accrue interest. Interest starts from the date of Final Demand, yet it is only assessed if not paid within 60 days. A request for Appeal or Compromise/Waiver does not toll interest. Interest is due and payable for each full 30-day period the debt remains unresolved. By law, all payments are applied to interest first, principal second.[24] At 90 days, debt is referred to the Department of Treasury for collection if still unpaid.

[24] 42 C.F.R. § 411.24(m).

Bonus CP Resolution Process Summary:

Pre-Settlement

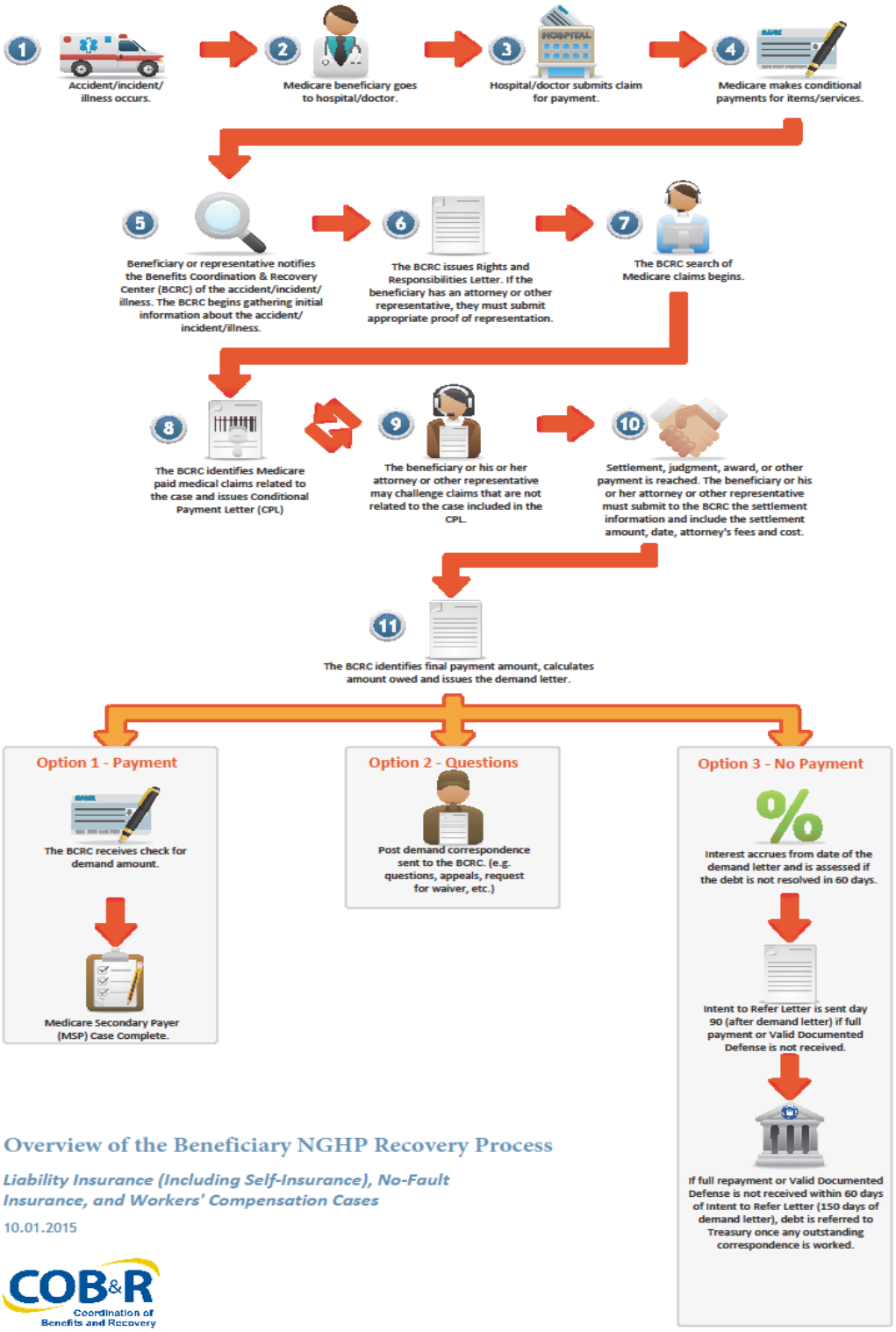
1. Report Case to BCRC (Provide Proof of Representation & Consent)
2. BCRC Issues Rights & Responsibilities Letter (R&R)

   * From this point on, need to use Medicare's Correspondence Cover sheet.
3. BCRC Identifies Medicare's interim recovery amount and issues a Conditional Payment Letter (within 65 days of R&R). This DOES NOT bind Medicare. Only the final demand binds Medicare in terms of what is owed.
4. Dispute Period: Audit and dispute unrelated charges on the CPL

Post-Settlement

5. After the case is settled, provide Settlement Notice (Final Settlement Detail).
6. BCRC issues the Final Demand letter.
7. If the Final Demand isn't paid within 60 days, interest begins to accrue from the date of the Final Demand. After 90 days, if the debt is still unpaid, then an Intent to Refer to Treasury for Collection letter is sent. It is referred to the Department of Treasury for collection after 150 days from the date of the Final Demand.

Overview of the NGHP Recovery Process:



Section 9: Resolution of Part C Medicare Advantage (MAO) Liens

Introduction to Medicare Advantage

In the previous section, Medicare conditional payment resolution was explored. Some clients, post-accident, may have switched over to a Part C Medicare Advantage Plan. Therefore, even if you have gone through the resolution process for your client and gotten the Medicare conditional payment related issues dealt with, you might not be finished. What lurks out there is that a Part C Advantage Plan (hereinafter MAO) may have paid for some or all of your client's care. You may wonder how that is possible when you were told that the client was a Medicare beneficiary and Part A/B was paid back for conditional payments. The reason is that MAOs aren't Medicare and injury victim clients can elect to enroll in an MAO during relevant enrollment periods. Therefore, a MAO may have made payments after election of which you are completely unaware.

Neither Medicare, BCRC nor CMS will alert you to this fact and it can be difficult to get this information. Medicare beneficiaries themselves often do not understand the distinction between original Medicare, Medicare Advantage, Part D plans, supplements, etc, so asking your client may not yield a clear or complete answer. One way for the client to verify is to log into their account on MyMedicare.gov, which will show what type of coverage they have and how long they've had it. In 2020, Congress passed the Provide Accurate Information Directly Act (hereinafter PAID Act). As a result of this law, CMS now provides reporting that shows which Medicare Advantage plans (if any) an individual has been enrolled in for the past three years. Unfortunately, as of the writing of this guide, this information is only available via query from a Non-Group Health Plan Responsible Reporting Entity (RRE). The RREs are the primary payers with reporting responsibilities under Section 111. While plaintiff's attorneys do not have direct

access to this information, it may be obtainable from the defense if they are willing to share the information. Lastly, a review of the medical bills should indicate what coverage was available, but this can be tedious and time consuming. Therefore, attorneys handling matters that involve a Medicare beneficiary must be vigilant and do their own due diligence to track down possible MAO liens or face the possibility of having to personally pay the lien times two. Although shocking, it is an area of the law that is rapidly developing in favor of MAO plans.

The MSP & MAOs

MAO plans use the Medicare Secondary Payer statute as the basis for their claims to reimbursement.[25] Accordingly, their repayment formulas are the same as Medicare under 411.37 (c) and (d) which only requires a procurement cost reduction. That being said, these plans are typically willing to negotiate and arguably must provide a mechanism for a compromise or waiver if they avail themselves of the MSP in terms of their recovery rights. All of that is well and good but what happens when you don't know that an MAO plan has a lien? The answer is fairly ominous for all the parties to a personal injury settlement. A private cause of action can be brought as an enforcement action for double the amount of the lien. This right is provided for in the Medicare Secondary Payer Act itself. While parties have long been afraid of the government using this provision, it is on behalf of the MAOs that these actions are now being brought effectively to enforce their reimbursement rights times two.

According to the MSP, a private cause of action exists when a primary plan fails to reimburse a secondary plan for the conditional payments it has made. "There is established a private cause of action for damages (which shall be in an amount double the amount otherwise

[25] An MAO "will exercise the same rights to recover from a primary plan, entity, or individual that the Secretary exercises under the MSP regulations in subparts B through D of part 411 of this chapter." 42 C.F.R. § 422.108(f).

provided) in the case of a primary plan which fails to provide for primary payment (or appropriate reimbursement) in accordance with paragraphs (1) and (2)(A)."[26] 42 C.F.R. §422.108(f) extends the private cause of action to Medicare Advantage Plans. "MAOs will exercise the same rights to recover from a primary plan, entity, or individual that the Secretary exercises under the MSP regulations in subparts B through D of part 411 of this chapter." According to 42 C.F.R. §411.24(g), "CMS has a right of action to recover its payments from any entity, including a beneficiary, provider, supplier, physician, attorney, State agency or private insurer that has received a primary payment." Case in point: a plaintiff personal injury law firm was sued by Humana for a $191,000 lien that wasn't repaid because the firm was unaware of the lien. The damages claimed were $382,000, which is precisely double the lien that wasn't paid. That case was resolved confidentially out of court.

Western Heritage – Damages Shall be Double

The seminal case on this issue is, for now, *Humana v. Western Heritage Ins. Co.*,[27] from late 2016. This was a slip and fall case wherein just before settlement the existence of a Humana Medicare Advantage plan was discovered.[28] Western Heritage, the defendant insurer, initially put Humana on the settlement check but a state court judge ordered it removed.[29] The plaintiff failed to repay Humana, so Humana initiated litigation directly against the defendant insurer.[30] Western Heritage placed the amount of Humana's demand in trust during the litigation and disclosed the existence and location to Humana.[31] The 11th Circuit Court of Appeals granted

[26] 42 U.S.C. § 1395y(b)(3)(A).
[27] *Humana Medical Plan, Inc. v. Western Heritage Insurance Company*, 832 F. 3d 1229 (11th Cir. 2016).
[28] *Id.* at 1232
[29] *Id.*
[30] *Id.*
[31] *Id.*

Humana's Motion for Summary Judgment and held that Humana's right to reimbursement for the conditional payments it made on behalf of the plan beneficiary under a Medicare Advantage Plan was enforceable.[32] Western Heritage had an obligation to independently reimburse Humana. When they failed to do so, the Court ruled that as a matter of law, Humana was entitled to maintain a private cause of action for double damages pursuant to 42 U.S.C. § 1395y(b)(3)(A) and was therefore entitled to $38,310.82 in damages.[33] The Eleventh Circuit said that placing the $19,155.41 in trust was not the same as paying the MAO and that the damages "SHALL" be double.[34]

Conclusion

In summary, when it comes to MAO liens there is a good chance you may be unaware that a lien exists without your own research. A good practice is to obtain copies of all government assistance program cards and any health insurance cards to see just what the injury victim is receiving in terms of benefits/insurance coverage. Make sure a thorough investigation is done if the client is a Medicare beneficiary for the existence of Part C/MAO liens. The investigation and inquiry should start upon intake and continue throughout representation with the final check occurring before disbursement of settlement proceeds. Failing to do so may expose you and your firm to personal liability for double damages to a Part C Plan or Medicare itself. Once a Part C/MAO lien is identified, you must aggressively pursue reduction methods either using traditional lien reduction arguments if the MAO doesn't insist upon adherence to the MSP or using the MSP's compromise or waiver provisions.

[32] *Id.* at 1239
[33] *Id.* at 1240
[34] *Id.*

Beyond Medicare-related liens, Medicaid liens necessitate a deep understanding of state-specific regulations and procedures. The next section explores the fundamentals of Medicaid lien resolution to equip law firms with the necessary knowledge.

KEY TAKEAWAY: When dealing with Medicare beneficiaries in personal injury cases, attorneys must be diligent in identifying potential liens with Medicare Advantage Plans (Part C or MAOs) in addition to traditional Medicare (Part A/B). Failure to recognize and resolve MAO liens could result in having to pay double the lien amount. This is because MAOs operate under the Medicare Secondary Payer (MSP) statute, allowing them to bring a private cause of action for double damages for unpaid liens. Accordingly, it is critical to do a thorough search for potential MAO lien claims from the case intake stage, through conclusion of representation, and before disbursement of any settlement proceeds to safeguard against personal and firm liability.

Medicare Advantage Lien Resolution Practice Tip:

To avoid potentially expensive mistakes in closing files for Medicare Advantage clients, attorneys should conduct thorough investigation to identify any Part C Medicare Advantage Plan (MAO) liens that may exist. As part of the case intake process, obtain copies of all government assistance and health insurance cards to determine the types of benefits or insurance the client is receiving to help identify MAO plans who may have a lien. Remember that your client can obtain information about their coverage online by logging into MyMedicare.gov. Continue this inquiry throughout the representation, performing a final check before disbursing settlement proceeds. When an MAO lien is identified, take proactive steps to negotiate its reduction,

leveraging either traditional lien reduction arguments or the MSP's compromise and waiver provisions.

Section 10: Medicaid Lien Resolution Fundamentals

Introduction to Medicaid Third Party Laws & Anti-Lien Provisions

For clients who are on Medicaid, they will most likely have a Medicaid lien when their case is settled. When Medicaid has made payments for medical expenses related to an injury, it may assert a lien against the beneficiary's recovery under state Medicaid third party recovery laws. Every state must comply with federal Medicaid statutes and regulations to participate in the joint federal-state Medicaid program. Pursuant to Title XIX of the Social Security Act, the federal Medicaid program requires every participating State to enact a "third party liability" provision which empowers a State to seek reimbursement from liable third parties for injury-related medical expenditures paid on behalf of a Medicaid recipient.[35] In order to comply with this requirement, a State Medicaid program must have statutory provisions under which the Medicaid recipient is considered to have assigned to the State his or her right to recover from liable third parties medical expenses paid by Medicaid. Federal law codifies this stating[36]:

> (H) that to the extent that payment has been made under the State Plan for medical assistance in any case where a third party has a legal liability to make payment for such assistance, the State has in effect laws under which, to the extent that payment has been made under the State Plan for medical assistance for health care items or services furnished to an individual, the State is considered to have acquired the rights of such individual to payment by any other party for such health care items or services.

Despite the mandate in federal law for state Medicaid agencies to seek reimbursement from liable third parties by "acquiring the rights of such individual to payment by any other party for such health care items or services," there are important limitations on a state's recovery rights which protect the Medicaid recipient's property. The limitation comes from the federal anti-lien statute which proclaims "[n]o lien may be imposed against the property of any individual prior to

[35] *See* 42 U.S.C. §1396a(a)(25).
[36] 42 U.S.C. §1396a(a)(25)(H).

his death on account of medical assistance paid," and the federal anti-recovery statute at §1396p(b)(1) states "[n]o adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan may be made."[37]

KEY TAKEAWAY: While states participating in the joint federal-state Medicaid program are mandated under Title XIX of the Social Security Act to have "third party liability" provisions that enable them to seek reimbursement from third parties for injury-related medical costs covered by Medicaid, there are significant restrictions to ensure the protection of Medicaid recipients. Federal law dictates that once the State provides medical assistance, it assumes the rights of the individual to receive payment from any liable third party for such health care items or services. However, the federal anti-lien statute prevents a lien from being placed against an individual's property due to medical assistance provided before their death. Additionally, the federal anti-recovery statute ensures that no adjustments or recoveries can be made on medical assistance correctly paid on behalf of an individual. These protections ensure that while the state can recoup costs, the rights and property of Medicaid recipients remain safeguarded.

The Ahlborn SCOTUS Decision

The tension between these provisions in federal law and state law recovery statutes has become the source of litigation in federal as well as State courts. When these cases reached the top court in the land, the Supreme Court held that federal provisions preempt and limit a state's right to seek reimbursement from a Medicaid recipient's settlement to the extent that it reaches elements of damages beyond medical expenses. The United States Supreme Court first weighed in on the rights of a State Medicaid agency to recover from personal injury settlements via State

[37] 42 U.S.C. §1396p(a)(1).

third party liability recovery statutes in 2006. The Supreme Court's decision in *Arkansas Department of Health and Human Services v. Heidi Ahlborn*[38] limited a State Medicaid program's ability to assert a lien against the entire recovery from a third-party tortfeasor. The United States Supreme Court interpreted federal law authorizing States to recover Medicaid payments in a tort action to be limited to medical payments.[39] Stated a different way, the *Ahlborn* decision forbids recovery by Medicaid state agencies against the non-medical portion of the settlement or judgment.[40] Non-medical portions of a settlement or judgment are damages such as pain and suffering or lost wages. According to the Court in *Ahlborn*:

> . . . [t]here is no question that the State can require an assignment of the right, or chose in action, to receive payments for medical care. So much is expressly provided for by §§1396a(a)(25) and 1396k(a). And we assume, as do the parties, that the State can also demand as a condition of Medicaid eligibility that the recipient "assign" in advance any payments that may constitute reimbursement for medical costs. To the extent that the forced assignment is expressly authorized by the terms of §§1396a(a)(25) and 1396k(a), it is an exception to the anti-lien provision. See Washington State Dept. of Social and Health Servs. v. Guardianship Estate of Keffeler, 537 U. S. 371, 383–385, and n. 7 (2003). But that does not mean that the State can force an assignment of, or place a lien on, any other portion of Ahlborn's property. As explained above, the exception carved out by §§1396a(a)(25) and 1396k(a) is limited to payments for medical care. Beyond that, the anti-lien provision applies.[41]

The holding of *Ahlborn* was a surprising result and has had a significant impact on personal injury litigation. In some instances, it has resulted in a much larger net amount being available to the injury victim at the "expense of the States' ability to recover Medicaid expenditures."[42]

When the *Ahlborn* decision was published, it was hailed by the Center for Constitutional Litigation (hereinafter "CCL"), associated with the American Trial Lawyers Association (now

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[38] 547 U.S. 268 (2006).
[39] *See Ahlborn* 547 U.S. at 290.
[40] *Id.*
[41] *Id.* at 284.
[42] Joseph D. Juenger, *In Light of Ahlborn – Designing State Legislation to Protect the Recovery of Medicaid Expenses from Personal Injury Settlements*, 35 N. KY. L. REV. 103 (2008).

"American Association for Justice"), as a "significant victory" for injury victims.[43] Other commentators have agreed with the CCL that it represents a major victory for injury victims.[44] State courts have limited its application in some instances or found it wholly inapplicable.

Ahlborn by the Facts

Heidi Ahlborn was injured in a very serious car accident in January of 1996.[45] At the time, she was a nineteen year old college student pursuing a degree in teaching.[46] She suffered a catastrophic brain injury that left her incapable of finishing college and unable to care for or support herself in the future.[47] Due to her injuries and lack of assets, Ahlborn qualified for Medicaid coverage in Arkansas.[48] Medicaid paid Arkansas healthcare providers $215,645.30 for injury-related care on her behalf.[49]

After the accident, a personal injury action was filed on behalf of Heidi in April of 1997.[50] The damages sought included not only past medical costs but also for her "permanent physical injury; future medical expenses, past and future pain, suffering and mental anguish; past loss of earnings and working time; and permanent impairment of the ability to earn in the future."[51] During the pendency of the litigation, the Arkansas Department of Health Services (hereinafter "ADHS") sent Ahlborn's personal injury attorneys periodic notices regarding the

[43] Lou Bograd, Center for Constitutional Litigation, P.C., Memorandum to Interested Parties, *Possible Extension of Ahlborn Ruling to Medicare and Guidance to Plaintiff's Counsel Regarding the Decision* (May 16, 2006).
[44] Juenger, *supra* note 6 at 103.
[45] *Ahlborn*, 547 U.S. at 273.
[46] *Id.*
[47] *Id.*
[48] *Id.*
[49] *Id.*
[50] *Id.*
[51] *Id.*

outlays by Medicaid on behalf of Ms. Ahlborn.[52] The letters indicated that Arkansas law provided ADHS with a claim for reimbursement from "any settlement, judgment or award" that was obtained from "a third party who may be liable" for Heidi Ahlborn's injuries and no settlement "shall be satisfied without first giving [ADHS] notice and a reasonable opportunity to establish its interest."[53]

When suit was filed, ADHS wasn't notified of the suit, as requested. Plaintiff's counsel did inform ADHS of the available insurance coverage in the suit. [54] ADHS intervened in the personal injury action in February of 1998 to assert a lien against any proceeds from a settlement or judgment.[55] The case was ultimately settled in 2002 without, per customary practice, any allocation of the settlement proceeds between categories of damages.[56] ADHS asserted a lien against the settlement for the total amount of the payments made by ADHS for Ahlborn's care which totaled $215,645.30.[57]

In September of 2002, Ahlborn filed suit in the United States District Court for the Eastern District of Arkansas seeking a declaratory judgment that "the lien violated the federal Medicaid laws insofar as its satisfaction would require depletion of compensation for injuries other than past medical expenses."[58] Certain stipulations were entered into by the parties in the litigation in the US District Court. Firstly, ADHS and Ahlborn stipulated that Heidi Ahlborn's total claim "was reasonably valued at $3,040,708.18."[59] Secondly, the parties agreed that the out

[52] *Id.* at 274.
[53] *Id.*
[54] *Id.*
[55] *Id.*
[56] *Id.*
[57] *Id.*
[58] *Id.*
[59] *Id.*

of court settlement reached represented "one-sixth of that sum."[60] Thirdly, the parties stipulated that if the plaintiff's "construction of federal law was correct, ADHS would be entitled to only the portion of the settlement ($35,581.47) that constituted reimbursement for medical payments made."[61]

On cross motions for summary judgment, the Federal District Court found that Ahlborn, under Arkansas law, assigned to ADHS her right to any tort recovery from third parties to the "full extent of Medicaid's payments for her benefit."[62] The Court held accordingly that ADHS was entitled to its full lien amount of $215,645.30.[63] The ruling was appealed to the Eighth Circuit and the judgment of the District Court was reversed.[64] The Eighth Circuit held that ADHS was only entitled to the portion of the settlement attributable to payments for medical care.[65] ADHS appealed to the United States Supreme Court which affirmed the Eighth Circuit's decision.[66]

Ahlborn Legal Analysis

The heart of the controversy before the Supreme Court was the interpretation of federal law requiring state Medicaid programs to recover from third party tortfeasors amounts paid on behalf of an injury victim.[67] State Medicaid agencies must "take all reasonable measures to ascertain the legal liability of third parties . . . . to pay for care and services available under the plan."[68] Federal law also requires state Medicaid agencies to seek recovery from third parties

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[60] *Id.*
[61] *Id.*
[62] *Id.*
[63] *Id.*
[64] *Id.* at 275.
[65] *Id.*
[66] *Id.*
[67] *Id.*
[68] *Id.* (quoting 42 U.S.C. §1396a(a)(25)(A)).

where the reimbursement the State will receive exceeds the costs of recovery.[69] States are required to enact State statutes to facilitate recovery of such claims by providing an assignment from the injury victim to the State Medicaid agency for recovery of third party medical care payments.[70] Finally, the amount collected by the State Medicaid agency "shall be retained by the State as is necessary to reimburse it for medical assistance payments made on behalf of" the Medicaid recipient.[71]

Arkansas had complied with federal law and enacted statutes providing ADHS with the right to recover "the cost of benefits" from third parties.[72] Arkansas law provided that as a "condition of eligibility", Medicaid applicants "shall automatically assign his or her right to any settlement, judgment or award which may be obtained against any third party to [ADHS] to the full extent of any amount which may be paid by Medicaid for the benefit of the applicant."[73] Further, the Arkansas statute provided that ADHS "shall have a right to recover" when medical assistance is provided to the Medicaid recipient due to "injury, disease, or disability for which another person is liable."[74] It was pursuant to this statute that the ADHS claimed an entitlement to recover all of the costs expended on Ahlborn's behalf even though it would be recovered from portions of a settlement that didn't represent medical expenses.[75]

The question squarely before the United States Supreme Court was whether the ADHS could "lay claim to more than the portion of Ahlborn's settlement that represents medical expenses."[76] Justice Stevens said in the opinion that the "text of the federal third-party liability

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[69] 42 U.S.C. §1396a(a)(25)(B).
[70] 42 U.S.C. §1396a(a)(25)(H); *see also* 42 U.S.C. §1396k(a).
[71] 42 U.S.C. §1396k(a).
[72] *Ahlborn*, 547 U.S. at 277 (citing Ark. Code Ann. §§20-77-301 through 20-77-309 (2001)).
[73] *Id.* at 277.
[74] *Id.*
[75] *Id.* at 278.
[76] *Id.* at 280.

provisions suggests not; it focuses on recovery of payments for medical care."[77] While the State of Arkansas made many legal arguments to the Supreme Court as to why ADHS's lien attached to Ahlborn's entire settlement, each was rejected by the Court. Arkansas' primary legal argument was that the federal statute mandated every State to pass laws that require the assignment of a Medicaid beneficiary's rights to the State and assertion of liens to collect from the entire third-party recovery.[78] Justice Stevens addressed this argument by pointing to federal law which says the "State must be assigned 'the rights of [the recipient] to payment by any other part for such health care items or services.'"[79] According to the Court, federal law didn't sanction "an assignment of rights to payment for anything other than medical expenses –not lost wages, not pain and suffering, not an inheritance."[80] This was not the basis of the Court's decision in favor of Ahlborn though.

Instead, the Court's decision rested on its interpretation of the "anti-lien"[81] statute in the United States Code.[82] The anti-lien statute prohibits States from exerting liens against a Medicaid recipient's property prior to death for medical assistance paid on their behalf except in specifically enumerated situations.[83] While the Court found one of the anti-lien statute's enumerated exceptions was relevant to Ahlborn's situation, it was the assignment of a Medicaid beneficiary's rights to the State and assertion of liens to collect from a third-party recovery which it found was limited only to medical care.[84] Accordingly, because the exception that was

[77] *Id.*
[78] *Id.* at 281.
[79] *Id.*
[80] *Id.*
[81] 42 U.S.C. §1396p.
[82] *Ahlborn*, 547 U.S. at 284.
[83] *Id.*
[84] *Id.*

carved out was limited to payments for medical care, the anti-lien provision bars recovery by ADHS against the portion of Ahlborn's settlement that was non-medical.[85]

Arkansas made several public policy arguments as to why a rule of full reimbursement was needed. The most "colorable" argument was that there was an "inherent danger of manipulation in cases where the parties to a tort case settle without judicial oversight or input from the State."[86] The Court found that this issue was not before them because the ADHS had stipulated that only $35,581.47 of Ahlborn's settlement proceeds were attributable to payment for medical costs.[87] Nevertheless, Justice Stevens pointed out that "[e]ven in the absence of such a post-settlement agreement, though, the risk that parties to a tort suit will allocate away the State's interest can be avoided either by obtaining the State's advance agreement to an allocation or, if necessary by submitting the matter to a court for decision."[88] He went on to say "just as there are risks in underestimating the value of readily calculable damages in settlement negotiations, so also is there a countervailing concern that a rule of absolute priority might preclude settlement in a large number of cases, and be unfair to the recipient in others."[89]

<u>KEY TAKEAWAY:</u> The U.S. Supreme Court's ruling in *Arkansas Department of Health and Human Services v. Heidi Ahlborn* set a pivotal precedent regarding Medicaid liens in personal injury settlements. While states are obligated to seek reimbursement for Medicaid expenditures under the "third party liability" provisions, the Supreme Court in the Ahlborn case emphasized that federal law limits a state's claim to only the portion of a settlement or judgment that corresponds to past medical expenses. This distinction ensures

[85] *Id.*
[86] *Id.* at 288.
[87] *Id.*
[88] *Id.*
[89] *Id.*

that Medicaid cannot recover from elements of a settlement like pain and suffering or lost wages, which are deemed non-medical. The ruling highlights the interplay between federal statutes and state law and emphasizes the balance between a state's reimbursement rights and a Medicaid recipient's property rights. The decision is significant for personal injury litigation, ensuring that Medicaid recipients retain larger portions of their settlements by limiting the reach of state recovery.

A Word About Pro-Rata

The United States Supreme Court noted in *Ahlborn*, while discussing the stipulation that led to the ratio formula, that its effect "is the same as if a trial judge had found that Ahlborn's damages amounted to $3,040,708.12 (of which $215,645.30 were for medical expenses), but because of her contributory negligence, she should recover only one-sixth of those damages."[90] The pro-rata methodology of reducing Medicaid liens, as it has been termed since *Ahlborn*, is in essence a way of reducing a lien based upon equitable principles of the plaintiff not recovering his or her full measure of damages.

A 2008 decision by the California Supreme Court explained the pro-rata methodology succinctly.[91] In *Bolanos*, the court said "we come now to the aspect of *Ahlborn* that addresses how to allocate medical and nonmedical damages in an otherwise unallocated settlement. We have already set forth how the parties went about this task in *Ahlborn*; the ratio of the settlement to the total claim, when applied to the benefits provided by ADHS, yielded $35,581.[9] (See p. 752, *ante*.) One very direct indication of the court's approval of the approach followed by the parties in *Ahlborn* is the court's unequivocal conclusion that ADHS was entitled to no more than $35,581. (*Ahlborn*, *supra*, 547 U.S. at p. 292.)" And further said, "[w]hile it is perfectly correct

[90] *Ahlborn*, 547 U.S. at n 9.
[91] *Bolanos v. Superior Court of the State of California*, 87 Cal. Rptr. 3d 744 (2008).

to speak of the ratio of the settlement to the total claim, it may be both easier and more accurate to determine what percentage the settlement is of the total claim, and then to apply that percentage to the sum paid by the director to the beneficiary. Thus, taking the facts of *Ahlborn*, $550,000 is 18.08 percent of $3,040,708; 18.08 percent of $215,645 is $38,988. (The difference between the latter sum and the stipulated amount of $35,581 is, in all likelihood, the proportionate share of litigation costs to be borne by ADHS.)" Lastly, the court pointed out "one cannot take lightly the fact that the Supreme Court, expounding federal law governing a federal program, concluded that the formula devised by the parties in *Ahlborn* produced a reliable result."

KEY TAKEAWAY: The U.S. Supreme Court's decision in *Ahlborn* set a precedent by using a clear methodology, known as the pro-rata method, for reducing Medicaid liens when a plaintiff does not recover their full damages in a settlement. This approach is anchored in equitable principles, suggesting that if a plaintiff recovers only a fraction of their total damages in a settlement, then Medicaid should be reimbursed equivalently — only a fraction of its claim. The California Supreme Court's 2008 decision in *Bolanos v. Superior Court* further elucidated this methodology, emphasizing that the pro-rata approach produces a reliable result and aligns with the intentions of federal law governing Medicaid. The decisions from both courts underscore the importance of ensuring that Medicaid liens are equitable and proportionate to the actual recovery in a settlement.

Post Ahlborn - The Wos SCOTUS Decision

Since the primary holding in *Ahlborn* is that federal laws that authorize States to assert recoveries against third parties who have provided payments for medical care for Medicaid beneficiaries only applies to the portions of a settlement that represent compensation for medical

expenses, it appeared to invalidate state statutes that require full reimbursement of Medicaid expenditures from a third-party recovery. After the *Ahlborn* decision, States began to revise their third-party liability statutes with inconsistent results in the courts. In 2012, a challenge of the North Carolina Medicaid's third-party liability recovery statute would lead the United States Supreme Court to again weigh in on state Medicaid agencies' rights to recover.

In *E.M.A. v. Cansler*[92], the Fourth Circuit Court of Appeal agreed with the Third Circuit that in determining what portion of a Medicaid beneficiary's third-party recovery a State Medicaid agency may claim as reimbursement for Medicaid expenses, the state must have in place procedures that allow a dissatisfied beneficiary to challenge a statutory default allocation. In reaching its conclusion, the Fourth Circuit also held that the North Carolina Supreme Court wrongly interpreted *Ahlborn* in upholding the validity of North Carolina's statutory default allocation in a previous decision.

According to the *E.M.A.* decision, the United States Supreme Court's unanimous decision in *Ahlborn* makes clear, "federal Medicaid law limits a state's recovery to settlement proceeds that are shown to be properly allocable to past medical expenses. In the event of an unallocated lump-sum settlement exceeding the amount of the state's Medicaid expenditures, as in this case, the sum certain allocable to medical expenses must be determined by way of a fair and impartial adversarial procedure that affords the Medicaid beneficiary an opportunity to rebut the statutory presumption in favor of the state that allocation of one-third of a lump sum settlement is consistent with the anti-lien provision in federal law."[93]

[92] 674 F.3d 290 (4th Cir. 2012), *cert. granted sub nom. Delia v. E.M.A.*, 567 U.S. ___ (Sept. 25, 2012)
[93] *Id.* at 312 (emphasis added).

The Fourth Circuit went on to say "The Supreme Court has characterized the third-party liability provisions in federal Medicaid law as an exception to the anti-lien provisions, stating that "[t]o the extent that the forced assignment [of payments that constitute reimbursement for medical expenses] is expressly authorized in §§ 1396a(a)(25) and 1396k(a), it is an exception to the anti-lien provision."[94] At the same time, the Supreme Court has emphasized that this exception is strictly limited—a State cannot force assignment of, or place a lien on, any property that does not constitute reimbursement for medical expenses.[95]

The Fourth Circuit did not agree with North Carolina's argument that its statute set a "reasonable cap" on the State's recovery and therefore satisfied the federal anti-lien law.[96] Instead, the court concluded that North Carolina's one-third cap on a Medicaid recipient's settlement proceeds does not satisfy *Ahlborn* insofar as it permits North Carolina to assert a lien against settlement proceeds intended to compensate the Medicaid recipient for other claims, such as pain and suffering or lost wages.[97] The court declined to express a view as to whether allocation disputes must be adjudicated by a court, or may instead be resolved through other "special rules and procedures" alluded to in *Ahlborn.* However, the court held that in determining what portion of a Medicaid beneficiary's third-party recovery the State may claim in reimbursement for Medicaid expenses, it must have in place procedures that allow a dissatisfied beneficiary to challenge the default allocation.[98] As the North Carolina statute had no such provision, the court remanded the case back to the district court to make the allocation.

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[94] *Id*. citing *Ahlborn*, 547 U.S. at 284, 126 S.Ct. 1752 (citing *Wash. State Dep't of Soc. & Health Servs. v. Guardianship Estate of Keffeler*, 537 U.S. 371, 383-85, & n. 7, 123 S.Ct. 1017, 154 L.Ed.2d 972 (2003)).
[95] *Ahlborn*, at 284-85, 126 S.Ct. 1752 ("[T]he exception carved out by §§ 1396a(a)(25) and 1396k(a) is limited to payments for medical care. Beyond that, the anti-lien provision applies.")."
[96] *Id.* at 308.
[97] *Id.* at 307.
[98] *Id.* at 311.

The United States Supreme Court granted certiorari on September 25, 2012. Oral arguments occurred on January 8, 2013. The Court rendered its opinion on March 20, 2013, upholding the Fourth Circuit's judgment in a 6-3 decision.[99] In *Wos v. EMA*, the Supreme Court was asked to review North Carolina's Medicaid Third-Party Liability Recovery statute. North Carolina's statute required that up to one-third of any damages recovered by a beneficiary for their injuries must be paid to Medicaid to reimburse it for payments it made on account of the injury. The Supreme Court found that this statute was not compatible with the federal anti-lien provision and violated the holding of *Ahlborn* which "precludes attachment or encumbrance" of any portion of a settlement not "designated as payments for medical care".[100]

The *Wos* decision discussed the tension between the mandate under federal law requiring an assignment to the State of "the right to recover that portion of a settlement that represents payments for medical care," and the preclusion of "attachment or encumbrance of the remainder of the settlement." The *Ahlborn* opinion held that the federal Medicaid statute sets both a floor and a ceiling on a State's potential share of a beneficiary's tort recovery. The *Wos* court pointed out that an injury victim has a property right in the proceeds of a settlement "bringing it within the ambit of the anti-lien provision."[101] "That property right is subject to the specific statutory exception requiring a State to seek reimbursement for medical expenses paid on the beneficiary's behalf, but the anti-lien provision protects the beneficiary's interest in the remainder of the settlement."[102]

North Carolina's statute as applied ran afoul of the holding in *Ahlborn* because it set "forth no process for determining what portion of a beneficiary's tort recovery is attributable to

[99] *Wos v. E.M.A.*, 133 S. Ct. 1391, 185 L. Ed. 2d 471(2013).
[100] *Id.*
[101] *Id.*
[102] *Id.*

medical expenses." Instead, the statute applies an arbitrary figure (one-third) and mandates that amount be the payment for medical care out of the tort recovery. As applied, this violates the federal anti-lien law and is therefore pre-empted. The *Wos* Court pointed out that if "a State arbitrarily may designate one-third of any recovery as payment for medical expenses, there is no logical reason why it could not designate half, three-quarters, or all of a tort recovery in the same way."[103] Since North Carolina could provide no evidence to substantiate the claim it made that the one-third allocation was reasonable and provided no mechanism for determining whether it was a reasonable approximation in any particular case, the Court rejected its application.

In a very important part of the decision, the *Wos* Court discusses when the state may not demand recovery from a portion of the settlement allocated to non-medical damages. The court stated that when "there has been a judicial finding or approval of an allocation between medical and nonmedical damages—in the form of either a jury verdict, court decree, or stipulation binding on all parties—that is the end of the matter."[104] "With a stipulation or judgment under this procedure, the anti-lien provision protects from state demand the portion of a beneficiary's tort recovery that the stipulation or judgment does not attribute to medical expenses."[105]

In applying all of the foregoing to the facts of the case, the *Wos* Court pointed out the flaws of the North Carolina statute which didn't allow for an allocation. The Court found that a substantial share of the damages in the settlement must be allocated to skilled home care in the future. This would not be reachable by the state Medicaid agency to satisfy their lien. In addition, the *Wos* Court noted that it may also be necessary to consider how much E.M.A. and her parents could have expected to receive in terms of compensation for the other tort claims made in the suit

[103] *Id.*
[104] *Id.*
[105] *Id.*

had it gone to trial. "An irrebuttable, one-size-fits-all statutory presumption is incompatible with the Medicaid Act's clear mandate that a State may not demand any portion of a beneficiary's tort recovery except the share that is attributable to medical expenses."[106]

KEY TAKEAWAY: The U.S. Supreme Court, through the *Ahlborn* and *Wos* decisions, emphasized that state recovery from Medicaid beneficiaries' settlements should be strictly limited to the portion representing medical expenses. The Court rejected state provisions that attempted to set fixed percentages or arbitrary allocations, insisting that any such claim by the state should be supported by evidence or a proper adjudicative procedure. State statutes allowing blanket claims on a set percentage of settlements, without provisions for individual case evaluations or challenges, were deemed incompatible with federal Medicaid law. Furthermore, if a settlement or judgment specifies allocations for damages, these allocations should guide states in determining recoverable amounts. This ensures that portions of settlements meant for non-medical damages, such as pain and suffering or lost wages, remain protected and outside the reach of state Medicaid recovery efforts.

The Gallardo SCOTUS Decision

After *Wos*, the Supreme Court did not address Medicaid liens again until June of 2022. The United States Supreme Court decided in *Gallardo v. Marstiller*,[107] a 7-2 decision, to allow Florida Medicaid to recover its lien from all medical damages past and future, pursuant to Section 409.910 of the Florida Statutes. This decision has nothing to do with future eligibility for Medicaid post settlement, which is still protected by special needs trusts, instead it allows a state Medicaid agency to pursue its lien against all medical damages in the case. This is a departure from the

[106] *Id.*
[107] *Gallardo v. Marstiller*, 596 U.S. ____ (2022).

dictates of *Ahlborn* which protected a Medicaid recipient's property right in their settlement as prescribed by the federal anti-lien provisions.

Gallardo argued that the anti-lien provisions in the Medicaid Act prohibited Florida Medicaid from attempting to recover its lien from anything other than the amounts properly allocable to past medical expenses. The Supreme Court held otherwise finding that it falls within an exception to the anti-lien provisions that served as the pillars of the *Ahlborn* decision. Further, the court held that the assignment provisions in the Medicaid Act require a Medicaid beneficiary, as a condition of eligibility, to assign all rights to payments for medical care from a third party back to the state Medicaid agency. States must also enact recovery provisions that allow for the state to recover from liability third parties when a Medicaid beneficiary is injured, and Medicaid pays for that care. While the court upheld the property right and anti-lien prohibitions against recovery from non-medical damages, it held it didn't protect damages that were for medical care.

The bottom line of the holding is as follows:

> "Under §1396k(a)(1)(A), Florida may seek reimbursement from settlement amounts representing "payment for medical care," past or future. Thus, because Florida's assignment statute "is expressly authorized by the terms of . . . [§]1396k(a)," it falls squarely within the "exception to the anti-lien provision" that this Court has recognized. Ahlborn, 547 U. S., at 284."

Justice Sotomayor's dissent in *Gallardo* is right on point about the inequity of the majority's opinion related to Medicaid liens and from what elements of damages a state agency can recover from: "It holds that States may reimburse themselves for medical care furnished on behalf of a beneficiary not only from the portions of the beneficiary's settlement representing compensation for Medicaid-furnished care, but also from settlement funds that compensate the Medicaid beneficiary for future medical care for which Medicaid has not paid and might never pay. The Court does so by reading one statutory provision in isolation while giving short shrift to

the statutory context, the relationships between the provisions at issue, and the framework set forth in precedent. The Court's holding is inconsistent with the structure of the Medicaid program and will cause needless unfairness and disruption." Justice Sotomayor also recognized that due to the majority's ruling, many injury victims would have fewer dollars from their settlement to place into federally authorized special needs trusts that protect their ability to pay for important expenses Medicaid will not cover. This is exactly what had been done for the benefit of Gallardo when her case was settled but now, she will have less going into that trust since more money will have to go to reimburse Florida Medicaid.

So, what does *Gallardo* mean for injury victims? A state Medicaid agency or its recovery contractor can now take the position that the recovery right applies to past and future medicals so when you do an *Ahlborn* analysis, it would be the appropriate reduction percentage (using a pro-rata formula) applied to the entire value of medical damages to see if there is a reduction in the lien. Pre-*Gallardo*, some states were already taking that position as well as some recovery contractors. From a practical perspective, in cases with a large life care plan or a lot of future medicals, there may not be a reduction at all in the lien. It is going to be important that the non-economic damages get properly valued with some multiplier times specials to make strong arguments for a reduction.

<u>KEY TAKEAWAY:</u> The Supreme Court's decision in *Gallardo v. Marstiller* marked a significant shift in the landscape of Medicaid lien recovery. In contrast to the prior precedent set by *Ahlborn*, the *Gallardo* decision permits state Medicaid agencies to recover liens from both past and future medical damages contained in a settlement, not just those related to past medical expenses. The Court anchored its reasoning on the Medicaid Act's assignment provisions, emphasizing that beneficiaries, as part of their Medicaid eligibility

conditions, assign all rights to third-party payments for medical care back to the state. This expansive interpretation means that amounts designated in settlements for future medical expenses are now accessible to state Medicaid agencies for reimbursement. Justice Sotomayor's dissent underscores the potential consequences of the majority's decision, highlighting that it could inadvertently burden injured individuals by diminishing funds allocated to special needs trusts, thus compromising their ability to afford necessary services not covered by Medicaid. For practitioners, the ruling emphasizes the importance of meticulous damage valuation, especially concerning non-economic damages, to advocate for reduced Medicaid claims.

Conclusion

As a trial lawyer, it is important to understand the underpinnings of the *Ahlborn* and *Wos* and *Gallardo* decisions so you can apply them to your State's third-party liability recovery provisions. The important thing to remember is that these cases limit a State Medicaid agency's recovery rights related to a third-party liability settlement. In order to reduce a Medicaid lien, State-specific statutes must be followed, but arguments to reduce should be based on the principles espoused in *Ahlborn*, *Wos* and *Gallardo* so that the lien is reduced in proportion to the full value of damages versus what was received.

Another critical area of focus is ERISA liens, which involve employer-sponsored health plans governed by federal law. These liens present their own set of complexities and require specific resolution strategies. The next section focuses on how to effectively resolve ERISA liens.

Medicaid Lien Resolution Practice Tip:

Given the importance of *Gallardo* and its impact on Medicaid lien resolution, the following are some strategies to deal with some of the issues created by the decision (depending on your state law):

Strategize Around Medical Expenses: Consider disclaiming medical expenses as part of the settlement. Before finalizing a settlement, consider amending the complaint to dismiss claims related to these expenses. Remember, you may need to provide notice to the Medicaid agency when making such changes.

Maximize Pro-Rata (Ratio) Strategies:

- **Value Non-Economic Damages Robustly:** Be assertive and ensure non-economic damages are not undervalued. Leverage high-end jury verdicts to advocate for higher pain and suffering awards.
- **Substantiate Damages:** Consider using a mock jury post-resolution. This strategy can help in affirming the value of damages claimed and can add weight to your negotiations.

Optimize Future Medical Expense Calculations:

- **Categorize Non-Medical Expenses Carefully:** Remove items that aren't strictly "medical" from the Life Care Plan (LCP). This can include vehicles, durable medical equipment, home renovations, etc.
- **Dual Eligible Beneficiaries:** If a person is eligible for both Medicare and Medicaid, note that Medicare Set-Asides (MSAs) are arguably off-limits for Medicaid claims.
- **Use Medicaid Rates for Future Medical Valuation:** If the injured party will require Medicaid in the future and will utilize a Special Needs Trust (SNT), then value future

medical expenses at Medicaid rates. Since Medicaid rates are often lower than private or out-of-pocket rates, this can decrease the potential lien amount.

Section 11: ERISA Lien Resolution

Introduction to ERISA

Although a deep dive into ERISA law and liens is beyond the scope of this guide, this section will give you an overview and a starting point. The Employee Retirement Income Security Act (ERISA) was passed by Congress and signed into law by President Ford in 1974.[108] According to the U.S. Department of Labor, ERISA "protects the interests of employee benefit plan participants and their beneficiaries. It requires plan sponsors to provide plan information to participants. It establishes standards of conduct for plan managers and other fiduciaries. It establishes enforcement provisions to ensure that plan funds are protected and that qualifying participants receive their benefits, even if a company goes bankrupt." Many would not agree with that statement when it comes to actually protecting plan participants as it relates to resolution of ERISA liens, but that is the stated purpose.

ERISA governs nearly all employer health plans. The primary exceptions are government employer plans governed by the Federal Employees Health Benefits Act (FEHBA) and state government or church plans which are governed by state law. Most, if not all, ERISA health insurance plans state that injuries caused by a liable third party are not a covered expense and require reimbursement when a plan pays for injury-related medical expenses (often referred to as subrogation clauses). ERISA provides that health plans which qualify under its provisions can bring a civil action under section 502(a)(3) to obtain equitable relief to enforce the terms of the plan. Appropriate equitable relief is really the only enforcement mechanism an ERISA plan can utilize to address its reimbursement rights contained in the plan. While that all may sound

[108] 29 U.S.C. 1001, et seq.

simple, ERISA is a "compressive and reticulated statute" which means that the law on this subject is quite complicated.[109] The Supreme Court has clarified exactly what is appropriate equitable relief under ERISA over the last twenty years.

ERISA Law per SCOTUS

Starting in 2006, the United States Supreme Court began to clarify and articulate just how powerful a "self-funded" ERISA plan's recovery rights are under federal law. In 2006, the Supreme Court issued its opinion *Sereboff*.[110] In that decision, the Supreme Court found generally that reimbursement provisions asserted by ERISA group medical plans were enforceable under the ERISA statute and qualified as equitable relief under the ERISA provisions.[111] Prior to *Sereboff*, there was disagreement amongst federal courts about whether an ERISA plan could even enforce its repayment provisions. Post *Sereboff*, an ERISA qualifying plan's contractual provisions for repayment can be enforced via equitable principles under section 502(a)(3) by filing an action for an equitable lien or for constructive trust.[112]

In 2013, the *McCutchen* case was decided by the Supreme Court.[113] After the *Sereboff* decision was issued, most lawyers understood that defeating reimbursement actions under ERISA depended on the strength of equitable defenses/arguments like "made whole" and "common fund." *McCutchen* took on the issue of whether those doctrines could prevent an ERISA plan from enforcing its recovery rights. The exact question as framed by the Supreme Court was "[w]hether the Third Circuit correctly held--in conflict with the Fifth, Seventh, Eighth, Eleventh, and D.C. Circuits--that ERISA Section 502(a)(3) authorizes courts to use equitable

[109] *Great-West v. Knudson*, 534 U.S. 204, 209 (2002)
[110] *Sereboff v. Mid Atlantic Medical Servs., Inc*. 547 U.S. 356 (2006).
[111] *Id*.
[112] *Id*.
[113] *U.S. Airways, Inc. v. McCutchen*, 133 S.Ct. 1537 (2013).

principles to rewrite contractual language and refuse to order participants to reimburse their plan for benefits paid, even where the plan's terms give it an absolute right to full reimbursement." At the time, there was a split of the federal circuits on the question of whether notions of fairness (equitable defenses) could override an ERISA medical plan's reimbursement provision. The *McCutchen* Court reversed the Third Circuit and held that in a section 502(a)(3) action based on an equitable lien by agreement, the ERISA plan's terms govern. "Neither general unjust enrichment principles nor specific doctrines reflecting those principles--such as the double-recovery or common-fund rules invoked by McCutchen--can override the applicable contract."

Post-McCutchen Strategies for ERISA Lien Resolution

Post *McCutchen*, the lesson to savvy plans is to word your master plan in such a way as to prevent any and all equitable defenses by disavowing "made whole" and "common fund". This is so since the root of the holding in *McCutchen* was that the written terms of the ERISA plan win the day over any possible equitable defenses. In its now infamous "McCutchen memo," Rawlings stated that "it is now undisputed throughout the entire nation that general principles of unjust enrichment and equitable doctrines 'reflecting those principles' cannot override an applicable ERISA plan contract." Obviously the *McCutchen* decision is important and a tough pill to swallow for the plaintiff who makes a recovery and then must reimburse an ERISA plan. While it is important, there are still many ways to get leverage and reduce ERISA plan liens, but you must know the pressure points to use. You also must realize who you are fighting. In most instances, it isn't the plans but instead their recovery vendors like Rawlings, Conduent, and Trover, among many others. These are big powerful companies who employ thousands in large, beautiful office buildings with the single goal of riding the coat tails of the

trial lawyer's hard work to get reimbursement for the plan. They are paid based on what they recover so there is plenty of incentive for the industry players to work hard against the plaintiff.

In fighting plans, the first and most important question is whether the plan is self-funded or not. A self-funded plan is funded by contributions from the employer and employee. If it is self-funded, then ERISA preempts state law, and you are left with fighting an uphill battle under *McCutchen*. If it is fully insured, then the ERISA plan is subject to state law subrogation statutes or general equitable principles under common law. These are plans which are funded by purchased insurance coverage. How do you determine the funding status? The safest way is by reviewing the Summary Plan Description (SPD) and the Master Plan. How do you get those documents? Simply put, you make a written request to the ERISA plan administrator under 29 U.S.C. §1024(b)(4). Under 1024(b)(4), an ERISA plan administrator must provide, upon request by a participant or beneficiary, a copy of the summary plan description, annual report, "bargaining agreement, trust agreement, contract, or other instruments under which the plan is established or operated." The request must go to the plan itself, not the plan administrator (TPA) or its recovery contractor (i.e., Rawlings, Optum, Conduent, etc.). If the plan administrator does not comply within thirty days, 29 U.S.C. §1132(c)(1)(b) establishes a $100.00 per day penalty for failure to comply. Further, 29 U.S.C. §2575.502c-1 allows for this penalty to be increased to $110.00 per day. There are plenty of cases out there where federal courts have imposed penalties upon a plan administrator for failing to comply.[114]

[114] *See generally* in the Second Circuit, the cases are *McDonald v. Pension Plan of the Nysa-Ila Pension Trust Fund*, 320 F.3d 151, 163 (2d Cir. 2002) ($15/day for 71 days; $1065 total); in the Third Circuit, *Gorini v. AMP*, Inc., 94 Fed. Appx. 913, 916 (3d Cir. April 16, 2004) (award of $160,780 for an unnamed amount of time); in the Fourth Circuit, *Faircloth v. Lundy Packing Co*., 91 F.3d 648, 659 (4th Cir. 1996)($2500 for each of three plaintiffs for a delay of about 90 days); in the Seventh Circuit, *Blazejewski v. Gibson*, 1999 U.S. Dist. LEXIS 18028 at 14 (N.D. Ill. 1999)($10/day for about 400 days); in the Eighth Circuit, *Keogan v. Towers*, 2003 U.S. Dist. LEXIS 7999 at 34 (D. Minn. 2003)($100/day for 649 days; $64,900 total); in the Ninth Circuit, *Advisory Comm. for Stock Ownership &*

The following are key things to do/review and remember for a 1024(b)(4) request:

The Plan Documents should be requested directly from the Plan Administrator and **not the TPA or the subrogation vendor**

1. **Written Request**:
    - Plan participants or beneficiaries can request copies of certain plan documents in writing from the plan administrator.
2. **Types of Documents**:
    - **Summary Plan Description (SPD)**: Provides a comprehensive overview of the plan, including benefits, rights, and obligations of participants.
    - **Summary of Material Modifications (SMM)**: Describes changes to the plan or the SPD.
    - **Annual Report (Form 5500)**: Contains financial information, plan operations, and compliance information.
    - **Plan Document**: The formal written document that establishes the plan and its terms.
    - **Trust Agreement**: If applicable, the document that sets up the trust to hold plan assets.

Trust for Employees of Montana Bancsystem, Inc. v. Kuhn, 1996 U.S. App. LEXIS 2273 at 22-23 (9th Cir. 1996) ($33/day for 586 days; total of 19,338); in the Tenth Circuit, *Dehner v. Kansas City S. Indus., Inc.*, 713 F. Supp. 1397, 1402 (D. Kan. 1989)($20/day for 84 days; $1680 total); in the Eleventh Circuit, *Curry v. Contract Fabricators, Inc. Profit Sharing Plan*, 891 F.2d 842, 848 (11th Cir. 1990) ($3/day for 240 days; $800 total).

- **Collective Bargaining Agreement**: If the plan is subject to one, this document outlines the agreement between the employer and the union.
- **Insurance Contract**: For plans funded through insurance, the contract between the plan and the insurer.

3. **Response Time**:
   - Plan administrators are required to provide the requested documents within 30 days of receiving the written request.
4. **Civil Penalties**:
   - If the plan administrator fails to comply with a request for documents within 30 days, they may be liable for a penalty of up to $110 per day (adjusted periodically for inflation) from the date of the failure to provide the documents.

In order to combat ERISA plan recovery attempts, the information received from the 1024(b)(4) request is critical. You want to evaluate the strength of the plan's claim based on the language in the plan. The 1024(b)(4) request arms you with the proper information to do so. This allows you to make the appropriate arguments for reduction. What you are looking for is abrogation of "common fund" and "made whole" primarily. If those equitable principles have not been abrogated, there are strong arguments for reduction. In addition, when the plan administrator fails to comply with the request, and they often do, penalties will begin to accrue. Once penalties have accrued, you have more leverage to negotiate with the ERISA recovery contractor for a reduced lien amount.

Contract Law Principles and Strategies for Reduction of ERISA Liens

Obtaining documents through a 1024(b)(4) request allows you to evaluate potential contract law principles and strategies to reduce an ERISA lien. It allows you to:

Examine the Plan Language

- **Ambiguities in the Plan Document**: Carefully review the ERISA plan documents to identify any ambiguities in the reimbursement or subrogation clauses. Under the doctrine of contra proferentem, ambiguities in the contract are construed against the drafter. If the language is unclear, you may argue that it should be interpreted in favor of your client.
- **Scope and Limits of Reimbursement**: Ensure the plan's reimbursement claim strictly adheres to the terms outlined in the plan document. Some plans may have specific provisions or limitations regarding the scope of their recovery rights.

Evaluate Whether to Assert the Make Whole Doctrine

- **Plan Language Examination**: Assess whether the plan explicitly disclaims the "make whole" doctrine. If it does not, you can argue that the plan should only be reimbursed if your client has been fully compensated (made whole) for all their losses, including pain and suffering, lost wages, and future medical expenses.
- **Equitable Arguments**: Use the make whole doctrine to negotiate a reduction in the lien amount, arguing that the plaintiff has not been fully compensated for their total losses.

Determine Whether to Insist Upon Application of the Common Fund Doctrine

- **Attorney's Fees and Costs**: The common fund doctrine may require the ERISA plan to share in the attorney's fees and costs incurred in obtaining the settlement. Argue that the plan's recovery should be reduced proportionally to account for the legal expenses incurred in creating the settlement fund.
- **Explicit Plan Language**: Verify if the plan explicitly addresses the common fund doctrine. If the plan does not waive this doctrine, you can argue that it applies.

Analyze the Plan's Equitable Lien by Agreement

- **Equitable Lien Requirements**: For an equitable lien by agreement to be enforceable, the plan must identify a specific fund (the settlement) and assert a right to a portion of that fund. Ensure the lien is tied to the settlement and not your client's general assets.
- **Constructive Trust**: ERISA plans often seek a constructive trust on settlement funds. Argue that the plan's right to recovery should be limited to specific funds clearly identified in the settlement agreement.

Potentially Demand a Proportional Allocation of Damages

- **Detailed Settlement Allocation**: Structure the settlement to allocate specific amounts to various categories of damages, such as medical expenses, pain and suffering, and lost wages. Argue that the ERISA lien should only apply to the portion allocated to medical expenses.

- **Court Approval**: Seek court approval of the settlement allocation to strengthen the argument against the ERISA lien's applicability to non-medical portions of the settlement.

Evaluate Forms of Equitable Relief

- **Equitable Defenses**: Use equitable defenses such as unjust enrichment, undue hardship, or the unclean hands doctrine to argue that full reimbursement would be inequitable under the circumstances, if applicable.

Negotiate and Settle the Lien Optimally

- **Negotiation Tactics**: Engage in negotiations with the ERISA plan administrator, insurance carrier, subrogation vendor, etc., presenting all legal and equitable arguments to seek a reduction in the lien amount.

Conclusion

To sum up, when evaluating an ERISA plan's right of recovery, it is important to first determine if it is, in fact, a plan covered by ERISA and then secondly is it a self-funded plan. The *McCutchen* decision has given ERISA self-funded plans strong recovery rights under federal law. Since under that decision plan language is vitally important, using a 1024(b)(4) request to get plan documents is an important tool to properly evaluate the strength of a reimbursement claim. In addition, failure to comply with this information request provides for penalties which can be leveraged to get the lien resolved.

Similar to ERISA, resolving FEHBA and military health plan liens involves understanding specific federal regulations and negotiation tactics. Mastery of these processes is

essential for effective lien resolution in these contexts. The following section provides an overview of these lien types and the resolution challenges trial lawyers will face.

ERISA Lien Resolution Practice Tip:

When dealing with ERISA liens, it is crucial to first determine if the plan in question is indeed covered by ERISA, and if so, whether it is a self-funded plan. This distinction is significant as ERISA self-funded plans have strong recovery rights under federal law, per the McCutchen decision. An essential tool in evaluating the strength of a reimbursement claim is obtaining the plan documents through a 1024(b)(4) request, which mandates the plan administrator to provide necessary documents such as the Summary Plan Description and Master Plan. Non-compliance with this request can result in penalties, which can then be used as leverage in negotiations with ERISA recovery contractors for a reduced lien amount. Always carefully analyze the plan's language, specifically looking for any abrogation of “common fund” and “made whole” principles, as these can provide strong arguments for lien reduction.

Section 12: FEHBA/Military Lien Resolution

Introduction

In this section, you will get an overview of common issues that arise when representing clients who have healthcare coverage by virtue of their employment with the federal government or military service. For federal workers, they get their coverage through specialized plans provided under federal law. Military service members and their dependents are covered through different programs based upon their service. When settling cases for these classes of clients, it is important to understand the recovery rights of government health plans which are summarized below. Since this area is not succinct, below is a summary of salient points so that you can issue spot.

FEHBA

The Federal Employees Health Benefits program provides health insurance coverage to federal employees, retirees, and their survivors. Federal law, found at 5 U.S.C. § 8901 et seq. (Federal Employees Health Benefits Act or FEHBA), governs these programs which provide benefits to millions of federal workers and their dependents. FEHBA authorizes the Office of Personnel Management (OPM) to enter into contracts with private insurance carriers to administer these plans. OPM's contracts have traditionally required the private insurance carriers to pursue subrogation and reimbursement. According to the Supreme Court, "FEHBA expressly 'preempt[s] any State or local law' that would prevent enforcement of 'the terms of any contract' between OPM and a carrier which "relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits)." Id. § 8902(m)(l)."[115] "In a

[115] *Coventry Health Care of Missouri, Inc. V. Nevils*, 137 S. Ct. 1190, 197 L. Ed. 2d 572, 581 US _ (2017).

2015 regulation, OPM codified its longstanding position that FEHBA-contract provisions requiring carriers to seek subrogation or reimbursement 'relate to ... benefits' and 'payments with respect to benefits,' and therefore FEHBA preempts state laws that purport to prevent FEHBA insurance carriers from pursuing subrogation and reimbursement recoveries. 5 C.F.R. § 890.106(h)."[116]

A 2017 United States Supreme Court decision is the seminal case on FEHBA plans and their recovery rights from personal injury settlements. In *Coventry Health Care of Missouri Inc. v. Nevils*[117], the Court was asked to decide whether FEHBA preempts state laws that prevent these plans from seeking subrogation or reimbursement pursuant to FEHBA contracts and whether FEHBA's express-preemption clause (5 U.S.C. § 8902(m)(l)) violates the Supremacy Clause. The case came to the Supreme Court from the Missouri Supreme Court which interpreted FEHBA not to preempt state law and finding that Section 8902 violated the Supremacy Clause of the U.S. Constitution. The United States Supreme Court unanimously reversed the holding of the Missouri Supreme Court because "contractual subrogation and reimbursement prescriptions plainly 'relate to . . . payments with respect to benefits,' §8902(m)(1), they override state laws barring subrogation and reimbursement" and "[t]he regime Congress enacted is compatible with the Supremacy Clause."[118]

Nevils has empowered FEHBA plans to demand full reimbursement when a settlement occurs. With the holding that FEHBA preempts state law and that such preemption is constitutionally permissible, *Nevils* has ended future disputes between private litigants and

[116] *Petition for Writ of Certiorari, Coventry Health Care of Missouri, Inc. v. Nevils*, No. 16-149 (2016), https://www.supremecourt.gov/qp/16-00149qp.pdf.
[117] *Coventry Health Care of Missouri, Inc. v. Nevils*, 137 S. Ct. 1190, 197 L. Ed. 2d 572, 581 US _ (2017).
[118] *Id.*

FEHBA carriers over whether state subrogation laws limit their recovery rights. Now, it is very clear that federal preemption applies, and state law provisions have no impact on the arguments to reduce a FEHBA lien. Unfortunately, this makes FEHBA liens similar to ERISA plan liens in that they have very powerful recovery rights under federal law that completely preempt state law. The good news is that most FEHBA plans do not have as draconian recovery provisions as ERISA plans which does mean there is the possibility of a reasonable reduction, but it is far more difficult post *Nevils*. As with most insurance plans, the first step in attempting to reduce the lien is reviewing the FEHBA plan's language that governs the client's healthcare coverage with the government. This information is available on the OPM's website. [119]

Military Liens

While much more attention is paid to Medicare, ERISA and other lien types, federal reimbursement rights of military programs should be on a trial lawyer's radar. With a rise in those serving in the US military abroad leaving their families at home, claims involving these plans are rising. There are three different types of coverages available to those in the military and their dependents/survivors. First, the Veterans Health Administration delivers healthcare insurance to eligible and enrolled veterans encompassing both inpatient and outpatient services at their facilities. Second, Champ VA is health insurance provided through the Civilian Health and Medical Program of the Department of Veteran Affairs for the spouse or child of a Veteran with disabilities or a Veteran who has died. Third, Tricare is the Department of Defense's health care program for active-duty and retired service members and their families. The legal starting point for reimbursement claims when it comes to the military is the Federal Medical Care Recovery

[119] See https://www.opm.gov/healthcare-insurance/healthcare/plan-information/plans/

Act (FMCRA). It is found at 42 U.S.C. §§ 2651-2653 and provides the federal government with the right to recover the medical expenses incurred for medical care of an injured beneficiary when there is a liable third party. Under this act, the United States has a right to recover the reasonable value of the care and treatment from the person(s) responsible for the injury. It is noteworthy that there really is no "military lien" and instead a direct cause of action against the third party under FMCRA. In addition, 10 U.S.C. §1095 is the basis upon which the government relies to recover from liable third parties and requires the beneficiary to protect its interests. The government, through these military healthcare programs, demands that plaintiff attorneys sign protection agreements to acknowledge the claim and protect the interests of the federal government. Signing these types of agreements is generally not advisable for the reasons I outline below. Accordingly, health insurance coverage under the Veterans' Administration (VA), Champ VA and Tricare all have recovery rights under FMCRA and other provisions of the federal law.

The VA's recovery rights come from 38 U.S.C. § 1729 and FMCRA (42 U.S.C. §§ 2651 - 2653) and allows them to, after rendering treatment, pursue recovery provided that is connected to a compensable third-party claim. Under federal law, the VA has both an independent right of recovery from responsible third parties and a right of subrogation, assignment, and ability to intervene or join a beneficiary's claim. According to § 1729 of the United States Code, "the United States has the right to recover or collect reasonable charges for such care or services (as determined by the Secretary) from a third party to the extent that the veteran (or the provider of the care or services) would be eligible to receive payment for such care or services from such third party if the care or services had not been furnished by a department or agency of the United States." When care is received at a military or VA facility, there can be significant delays in

resolving their claim because you must request that a bill be generated. These requests can take 60 days or more to process. There are forms for this kind of request included on the VA's website.[120] If you want to request a compromise or waiver of a VA subrogation claim, you must provide the amount of settlement, attorney's fees and costs, other medical claims and reductions and overall policy limits available. There are three tiers of review for compromise/waiver requests. Tier one is the Revenue Law Group who must approve requests for a compromise or waiver on claims between $1 and $300,000. Tier two is the DOJ who must approve requests for compromise or waiver on claims between $300,000 and one million dollars.[121] Tier three is The Office of the Attorney General who must approve all requests for compromise or waiver on claims greater than one million dollars.[122]

Tricare is similar to the VA as its recovery rights are governed by the same federal law provisions as the VA (38 U.S.C. §1729 and 42 U.S.C. §§2651 – 2653) along with 32 C.F.R. §199.12. And like the VA, Tricare also has both a right of subrogation and an independent right of recovery from responsible third parties. While Tricare doesn't require set-asides, Section 199.12 states "[n]o TriCare-related claim will be settled, compromised or waived without full consideration being given to the possible future medical payment aspects of the individual case." So, these regulations do allow Tricare to include future medical related to the personal injury claim as part of their recovery claim. Tricare claims are generally resolved through the U.S. Army Judge Advocate General's Corps (JAG) office where the military serviceman is posted. While "made whole" and "common fund" don't apply to subrogation claims under FMCRA, reductions may be granted when there is an undue burden placed upon the injured party.

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[120] https://www.va.gov/OGC/Collections.asp
[121] *Id.*
[122] *Id.*

Two problematic issues come up with military reimbursement claims. The first issue relates to attorney fees and Tricare. The military's official position is stated in their form protection agreement which states in pertinent part that "Title 5, United States Code, Section 3106, prohibits the payment of a fee for representing the Government." It goes on to state, '[f]urther, as the claim of the Government is an independent cause of action rather than a lien on any settlement or judgment obtained by the injured party, any contingent fee arrangement with the injured party applies solely to the client's claim and not to the Government's portion of the recovery." In resolving a reimbursement claim with the military, one will have to navigate the issue of fees and costs as applied to the whole settlement versus the amount less the "Government's portion of the recovery." Arguably, you can take your whole fee if you refuse to sign the protection agreement, but you will get pushback from the JAG officer you will be dealing with to resolve the military's claim when requesting a compromise or waiver of the military's claim.

The second issue is whether the military has a claim against first-party auto insurance policies. The question of whether the military has a right to recover its claim for medical expenses against UM is determined by the UM policy's language. FMCRA does not directly provide the government with the right to recover its claim against first-party insurance proceeds. This issue was addressed in *Government Employees Ins. Co. v. Andujar*[123] which arguably, properly, held that the U.S. military didn't have a reimbursement claim directly against UM proceeds under FMCRA. Under FMCRA, as discussed above, the government's claim is only against the tortfeasor. In *Andujar*, neither the injured party nor their UM insurer were considered the tortfeasor and accordingly there was no right to recover from the UM auto policy proceeds.

[123] 773 F. Supp 282 (D. Kan. 1991)

It is also important to note that in *Andujar*, there was specific policy language in the automobile insurance contract that stated the government was not covered by the policy. Accordingly, the result can be different where the automobile policy provisions protect the government or where applicable state law provides that protection. An important part of the analysis when dealing with a reimbursement claim by the military is the express language of the automobile policy. If the government can be considered a third-party beneficiary or insured under the automobile policy, then they may have a right to reimbursement. This is precisely what the *Andujar* decision turned on.

Conclusion

In the end, FEHBA plans have very strong recovery rights under the *Nevils* case. FEHBA completely preempts state subrogation laws so arguments for reduction must be made based on the policy language. Fortunately, most FEHBA plans aren't as punitive as ERISA plans so often there are reductions available. Military liens are governed by the Federal Medical Care Recovery Act, which provides the federal government with the right to recover the medical expenses incurred for medical care of an injured beneficiary when there is a liable third party. There are different issues that arise when it comes to Tricare and for example attorney fees reduction and whether the military has reimbursement rights from first-party recoveries.

Finally, hospital and provider liens often present a maze of legal and financial issues that demand a strategic approach. Successfully navigating these liens ensures timely and effective resolution, enhancing overall case outcomes. In the next and last substantive section of this guide, we will review the challenges of resolving these liens.

Lien Resolution Practice Tips:

FEHBA - When handling FEHBA liens in personal injury settlements, it's critical to recognize that these plans have strong federal preemption rights, as established in *Coventry Health Care of Missouri Inc. v. Nevils*. Consequently, state law limitations on subrogation and reimbursement claims are generally inapplicable. Attorneys should prioritize a thorough review of the specific FEHBA plan language, which can be accessed through the Office of Personnel Management's (OPM) website. Understanding the precise terms of the FEHBA plan is crucial since these terms will govern the recovery rights and potential negotiation leverage. It's also advisable to be prepared for a strict enforcement of reimbursement rights by FEHBA carriers, given the Supreme Court's stance on federal preemption. Therefore, developing a comprehensive strategy that includes an understanding of federal preemption and its implications on FEHBA liens is essential for effective resolution of these claims.

Military - When resolving military liens in personal injury cases, it's essential to understand the unique aspects of the Federal Medical Care Recovery Act (FMCRA) and related statutes governing these claims. Firstly, be aware that the military, including the Veterans Health Administration, Champ VA, and Tricare, has both subrogation rights and independent recovery rights from responsible third parties. For efficient resolution, promptly request and review the billing from military or VA facilities as there can be significant delays in processing these requests. Be prepared to navigate the complex tiers of review for compromise or waiver requests, understanding that each tier has different approval thresholds. Additionally, be mindful of the issues surrounding attorney fees and the military's stance on fee deductions from their portion of the recovery, as well as the specific language of any first-party insurance policies involved, especially in cases with UM policies. The policy language and state law may impact the

government's right to reimbursement. Keeping these factors in mind will help effectively negotiate and resolve military liens in accordance with federal law.

Section 13: Navigating the Maze of Hospital and Provider Lien Resolution

Introduction

Navigating the complexities of hospital and provider liens presents a significant challenge for personal injury attorneys. These liens trigger ethical obligations, require the resolution of unreasonable charges, and require the knowledge of the intricacies of local lien laws. Unreasonable medical charges, particularly hospital bills, have become a significant issue in the resolution of personal injury cases. These charges often bear no relation to the hospital's internal costs. Injured plaintiffs in third-party liability cases unfairly bear the brunt of these inflated charges. Thankfully, the law in most states supports injury victims in challenging excessive charges. The key thing to realize is that if you negotiate from full billed charges down then you have already lost the fight against hospital and provider lien holders. Full billed charges are "pie in the sky numbers" which aren't grounded in reality so using them as a starting point for negotiations instead of a "reasonable value" is a mistake.

In general, hospital reimbursement claims can be highly problematic for several key reasons:

1. As discussed above, charges can be incredibly inflated and greatly in excess of what insurer contractual rates are or even legitimate cost of care.
2. Hospitals may only have a debt or can only claim a lien if statutorily authorized.
3. If they have a statutory lien right, they may refuse to reduce their claims like other liens holders.
4. Hospitals can and will refuse to bill insurance and instead try to claim a lien against the settlement, which means you are forced to deal with them directly.

5. Balance billing can be a problem where an insurer does pay but then the hospital tries to collect the difference between what was paid and their usual & customary rate.

The following explores in an overview fashion the issues at play in resolution of these liens.

Understanding the Hospital/Provider Claims

Is the claim a lien or debt? As a starting point, it is important to distinguish a lien versus a debt when it comes to strategies around hospital/provider lien resolution. A lien is a legal claim on settlement proceeds, created by statute, ordinance, or contractual agreement. In contrast, a debt arises when a patient receives care that remains unpaid. When you are dealing with a debt, the question for the personal injury victim as a starting point is whether they want to resolve the debt from their settlement proceeds. In most instances it does make sense to encourage resolution so as to avoid having debt collection pursued in the future. Assuming the client does want to resolve the debt, employing reasonableness of charges arguments together with equitable distribution/pro-rata arguments are appropriate resolution strategies.

By contrast, when dealing with a lien, it is a legal claim against the personal injury recovery, borne out of statutes and ordinances. These liens are subject to state-specific statutes, with variations in treatment, rights, obligations, and penalties under state law. It is crucial for attorneys to be familiar with their state's lien statutes and related case law to effectively negotiate and resolve these liens. If there is a lien, just like in other sections of this guide, the starting point is reviewing the statute or contract creating the lien. Thereafter, deploying strategies around reasonable value (as discussed below) coupled with a pro-rata/equitable

distribution argument similar to Medicaid liens discussed infra. The techniques will vary though from state to state based upon applicable law.

Given the foregoing, it is important to understand the basics of the wide variation from state to state when it comes to treatment of hospital liens and to review your own state law to use the appropriate resolution strategies. There are forty states that have codified hospital liens across the country. The majority use reasonable charges as a starting point for the lien but they are all different. For instance, California's consumer-friendly laws codify limitations on recovery rights whereas Ohio and Pennsylvania have no statewide lien statute but do have common law reasonableness protections. Similarly, Florida's hospital liens, my home state, are governed by county ordinance, adding another layer of complexity with variations by county within the same state. Generally, though, most states either have some statutory law or common law which limits a lien to the reasonable charges.

The Resolution Process: Best Practices and Strategy

Best practices for negotiations related to resolving hospital charges is to open a dialogue with the healthcare organization at the earliest stage of litigation so that you can maximize leverage. Attempts to settle the hospital's claim after you reach a settlement in principle with the defense may make negotiating with the hospital more difficult since you have lost leverage. In terms of leverage, understanding the nuances of state-specific hospital lien laws becomes crucial. In certain jurisdictions, hospitals need to "perfect" the lien by filing a notice with the local court. Unless the hospital meets the requirements stipulated by the state's hospital lien statutes, it cannot enforce a perfected lien. But let's not forget an essential caveat here: a non-enforceable

lien does not absolve the client from their responsibility for the bill. It merely implies that the hospital cannot claim a lien against the client's settlement proceeds, instead it would be a debt.

From a strategic standpoint in negotiating these types of liens, the challenge revolves around the reasonableness arguments related to charges. The problem is that “reasonable charges" aren’t singularly defined. It can vary from a percentage above the cost of care to being defined in no-fault insurance statutes or by third-party administrators (TPAs) as a certain percentage above Medicare rates. The criterion is typically set by benchmarking the charges to those offered to patients with insurers like Medicare, Tricare, Blue Cross, or others. Even charges rendered to uninsured patients are considered in this context. At least one court has defined reasonableness based on the presentation of evidence related to things such as relevant market price for hospital services, usual and customary rates received for the services and the internal cost structure of the facility. The best practice to determine a reasonable charge is to consider the actual cost of care coupled with a reasonable amount of profit.

Best practices are to use a reasonable reimbursement rate analysis backed by internal cost data from all hospitals, nationwide, which allows you to estimate cost of care and thereby, estimate reasonable value. Ideally, you should employ professionals who are well-versed in medical billing, coding, and the law on reasonable value to help achieve the best possible outcome. The adoption of this approach will help to ensure that the charges are fair and justifiable for the injury victim.

In terms of a generalized process map, the following is an outline of the steps for resolving these types of reimbursement claims by a hospital (process would be similar for a provider):

1) Identify and verify the existence of any hospital lien claims versus just a debt.
2) Once identified, check to see if the hospital has properly "perfected" the lien under appropriate state law. Also, determine under your state law the legal limitations on a hospital's right to reimbursement.
3) Confirm whether the hospital has already received any payments from insurance and whether there is a balance.
4) Dispute any attempts to balance bill if payments were received from insurance.
5) Engage in negotiations using the following as a guide to different available arguments (Note: Not all will apply, assess your case and use appropriate arguments):
    a. Challenge any unrelated charges in the hospital billing. Scrutinize the hospital bills for any unrelated or excessive charges.
    b. Use reasonableness arguments for the charges. Compare the hospital's charges with the usual rates accepted by health insurance carriers for similar services. This data can be a powerful tool in negotiations to lower the lien amount. Be aware of legal precedents in your jurisdiction that limit recovery to the reasonable value of medical services, regardless of the billed amount.
    c. Make any arguments available under state statutes for limitations on reimbursement. Apply any statutory caps on recovery that might exist in your jurisdiction. Some states limit hospital liens to a percentage of the total settlement after attorney fees and other costs.
    d. Argue equitable doctrines like common fund or made whole, if available under state law. Raise arguments related to client hardship, limited insurance policy limits, and comparative fault to negotiate further reductions in the lien.

e. Use pro rata share types of arguments in cases with multiple lienholders, argue for a pro rata distribution of a set amount of the settlement pool of funds.

6) Finalize resolution by obtaining a complete release of the lien from the hospital.

Conclusion

Resolving hospital liens requires a multifaceted approach, combining local knowledge of the law with negotiation skills. The challenge of hospital/provider lien resolution is not insurmountable. It is a maze, yes, but with the right strategy, leverage and understanding of the healthcare system's billing practices, trial lawyers can navigate it effectively. By assessing the reasonableness of charges, challenging balance billing practices, and leveraging statutory and equitable arguments, attorneys can effectively reduce the impact of hospital liens on their clients' recoveries. This ensures that injured parties receive fair compensation, while hospitals are appropriately compensated for the medical services they provide.

KEY TAKEAWAY: Optimal resolution of hospital and provider liens depends on the correct negotiation strategy. Using a reasonable reimbursement rate analysis backed by internal cost data from all hospitals, nationwide, allows you to estimate cost of care and thereby, estimate reasonable value. Ideally, you should employ professionals who are well-versed in medical billing, coding, and the law on reasonable value to help achieve the best possible outcome. In the end you really need deep experience with the right negotiation tactics to apply the right pressure points to get the desired end result.

Hospital Lien Resolution Practice Tip:

The process of resolving hospital reimbursement claims involves several steps:

1. Identifying and verifying any hospital lien claims.
2. Assessing if the hospital has perfected the lien according to state law.
3. Confirming any insurance payments and the balance remaining.
4. Disputing balance billing if insurance payments have been made.
5. Utilizing various arguments in negotiations, such as challenging unrelated charges, employing reasonableness arguments, applying statutory limitations, and invoking equitable doctrines.
6. Finalizing the resolution with a complete lien release.

As it relates to reasonableness arguments, negotiating hospital charges down from full billed charges is a losing strategy. Starting from reasonable value, which would be cost of care plus a profit, eliminates starting off the negotiations with an extremely inflated "pie in the sky" number. Discounts will be much deeper when you start from reasonable value versus paying some percentage off full billed charges.

Conclusion

The process of resolving liens in personal injury cases is a multifaceted and demanding task that requires careful attention to detail, strategic planning, and an in-depth understanding of various legal issues at play. Throughout this guide, we have explored the fundamental aspects of lien resolution, emphasizing the importance of ethical outsourcing, identifying and negotiating liens, and comprehensively understanding the types of liens that personal injury law firms may encounter.

We began by discussing the critical role of lien resolution in personal injury cases and the significant advantages of outsourcing this task. However, we underscored the necessity of maintaining ethical standards when outsourcing, ensuring that client interests are protected, and professional responsibilities issues are avoided. Identifying which liens are appropriate for outsourcing versus those best handled in-house is essential for an efficient and effective firmwide lien resolution process. By evaluating the complexity and nature of each lien type, law firms can make informed decisions that optimize resource allocation and enhance client outcomes.

The challenges of working on liens are significant, but they can be mitigated through structured processes for identifying and resolving liens. This guide provides detailed steps and strategies for managing healthcare liens, Medicare conditional payments, Medicare Advantage (Part C) liens, Medicaid liens, ERISA liens, FEHBA/military liens, and hospital/provider liens. A thorough understanding of the different types of liens and their specific legal requirements is foundational to effective lien resolution. Each lien type presents unique challenges and demands tailored strategies to ensure compliance and achieve favorable resolution.

Ultimately, the goal of any lien resolution internal process is to protect the interests of clients and maximize their net recovery. By employing the principles and strategies outlined in this guide, personal injury law firms can navigate the complexities of lien resolution with confidence, ensuring that their clients receive their just net recovery. Lien resolution demands a high level of expertise, diligence, and processes. By continuously improving lien resolution internal/external processes and staying abreast of legal developments, personal injury law firms can enhance their service to clients, mitigate risks, and get the best possible outcome for the injured.

For continued learning and staying updated on the latest practices in lien resolution, personal injury law firms should explore additional resources and training opportunities. Staying informed about changes in laws, regulations, and best practices will ensure that firms remain at the forefront of effective lien resolution. Synergy is a thought leader in the lien resolution space and is always available to help guide your firm.

By embracing the comprehensive approaches detailed in this guide and working with experts in lien resolution like Synergy, personal injury firms can successfully manage the complexities of lien resolution. Learn more about partnering with Synergy for lien resolution at www.PartnerWithSynergy.com