

Trial Lawyers Association
Of Metropolitan Washington, DC

DC TRIAL

TRIAL LAWYERS ASSOCIATION OF METROPOLITAN WASHINGTON, D.C.

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President's Message

by Laurie A. Amell,
TLA-DC President 2009-2010



HARSH TIMES CALL FOR NOVEL SOLUTIONS

All of us are concerned about the future of our profession. In view of the negative outcomes of many trials in the last several years, where even strong cases seem to be rejected by juries, it has created a situation where people who have suffered devastating injuries secondary to negligence are not being fairly compensated. This atmosphere of concern also hampers settlement and mediation efforts because the probability of achieving a plaintiff's verdict has been so dramatically diminished. This situation requires all of us to develop new strategies that are thoughtful and scientific and to examine ourselves to ensure that we are taking responsibility to improve the current situation for the sake of our profession and our clients.

We have to develop a better understanding of how we can improve our trial strategies to obtain results that support our clients' justifiable claims. We have to analyze what we can do to improve outcomes for our clients. We need to learn what has gone wrong with our jury pools and with their ability to have compassion for other citizens who have been the victims of negligence. We need to try to remedy the situation where cases that seem virtually indefensible, wind up with defense verdicts, despite the fact that the outcome is absolutely inconsistent with the evidence presented to the jury.

It is obvious to all of our members that there also has to be a thorough consideration of our ethical behavior, especially when it comes to client solicitation, advertising our services, and the manner in which we present the fine results we achieve for our clients. We clearly have to go from emphasizing the "lawyer" and the "multi-million dollar verdicts" to focusing on the "victim" and "a reality assessment" of what happens to innocent people after they are severely injured and how desperate their lives become, especially when they do not get a fair shake legally.

Of course, novel solutions will also call for significant political assessment of our public leaders and financial contributions by all of us to prevent the passage of legislation that is going to harm the citizens of the District of Columbia—who are your clients and future clients. I want to use this President's Message to strongly urge all of you to sup-

port D.C. Legal, the political arm of TLA-DC, as well as the AAJ PAC. We all know the herculean efforts made by AAJ's Linda Lipsen every day to preserve our clients' rights. AAJ strongly needs our continued financial support. D.C. Legal has been chaired by Barry Nace, one of our stalwarts, for many years. A couple of years ago, Barry wrote an article in DC Trial that set forth the mission of D.C. Legal. I would like to quote several of Barry's passages as no one can capture the true spirit of what D.C. Legal means to us and does for us like Barry. He eloquently wrote:

Fortunately, for your clients and your future clients, there are attorneys in the District of Columbia who do care about what a candidate would propose, how that candidate would debate the issue, and whether that candidate already has an opinion formulated that is harmful to your clients and future clients. They care enough to learn about the candidates and then to assist them in getting elected for the good of the citizens they do and may represent.

Many of those attorneys who care that their clients are going to be properly represented are contributors to D.C. Legal. They care about good government and they understand the necessity of being involved in the political process to be sure that the candidates favorable to their clients' interests protect their citizens. D.C. Legal is the political action committee for citizens of the District of Columbia. It is difficult for one voice to be heard. It is much easier for hundreds of voices to collectively be heard. Are you a contributor? It is not a question of what your partner thinks or what your firm believes—the question is YOU. Do you care enough about your clients to provide a consistent contribution from your earnings from representing the citizens of the District of Columbia to assist those who have already given their commitment? Do you care enough about those rights? Or are you willing to let someone else do it? That we respectfully suggest is not enough. The burden is on you.

In response to a request from Barry Nace, Jim Taglieri, and Ken Trombly (three active members of the TLA-DC Legislative Committee and D.C. Legal) the TLA-DC Board of Governors on January 7, 2010 unanimously voted to require: (a) all TLA-DC Officers to contribute \$250 per month on a PAC card (previously there was no requirement), (b) all Board of Governors members are required to contribute \$150 per month on a PAC card (previously was \$100 per month), (c)

(continued on page 5)

MARYLAND MEDICAID REIMBURSEMENT CLAIMS

By Ron M. Landsman

Fellow, National Academy of Elder Law Attorneys

Maryland Medicaid's current practice in claiming reimbursement in personal injury cases is to demand all and negotiate nothing. This essay reviews the highlights of the discussion of Maryland practices at the January 22 Workhorse Seminar, including the audience's thoughtful questions and astute observations, and provides some further thoughts on remedies to protect clients' rights and claims.

Summary. Maryland Medicaid's heightened aggressiveness in claiming reimbursement rights in personal injury actions does not change the basic context. It is an additional claimant to the funds your client recovers; its claim is based on certain facts and legal theories. As far as trial lawyers are concerned, Medicaid as another party complicates the case, but the game is still played on your home court—fact-finding trial courts with procedures available to you to compel Medicaid to make its position known, to force it to prove its facts, and to settle on terms that your client can live with.

Background: Where we are now. After many years of reasonable accommodation, last year the Division of Recoveries and Financial Services (DRFS) of Maryland Medicaid adopted a lawless strategy of filing liens against personal injury settlements without regard to the legal validity of those claims. To be sure, it begins with a claim for the amount Medicaid has spent on the plaintiff/beneficiary's medical care, but it refuses to acknowledge any limit on the claim arising from federal law as determined by the Supreme Court, a body with some authority in that realm. And it takes advantage of its potential threat against plaintiff's attorneys to effectively freeze the funds, forcing the plaintiff to negotiate from a position of need or to initiate additional, potentially costly litigation.

I assert that this is a consciously illegal strategy because the same office pursued a blatantly lawless strategy recently in another area within its jurisdiction. Last March, under the label "Guidelines," DRFS issued a set of Draconian rules sharply restricting how the special needs trustees could use funds for their beneficiaries' welfare. Aside from generally prohibiting *any* use of funds for food, clothing or shelter, it imposed a wide range of other limitations based on no more than someone's whim about how Medicaid beneficiaries should live their lives.¹

SNT lawyers responded by telling DRFS that SNT attempt to create new mandatory rules without appropriate rule-making was plainly illegal and that we were advising our clients to disregard the "Guidelines" as a legal nullity. Cooler heads in DRFS apparently prevailed and in July it admitted its error and withdrew the "Guidelines."

I make this point not to disparage that office—that is the last thing on my mind—but to review the past for some

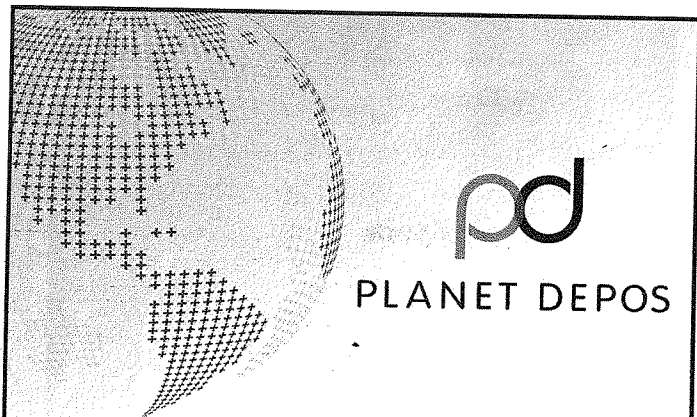
light on how to deal with the present manifestation of lawless administrative action. In fairness, DRFS strategy may be simply without regard to its legality, rather than intentionally illegal, but as Yossarian said when told that all of that anti-aircraft fire was not directed at him, personally, "What difference does that make"?

The present lawless strategy may be neatly countered in some cases, but for most it is more complicated.

The state of the law. The Supreme Court in *Ahlborn* (*Arkansas Department of Health and Human Services v. Ahlborn*, 547 U.S. 268, 164 L.Ed.2d 459, 126 S.Ct. 1752 (2006)) made clear that State Medicaid agencies' subrogation right is limited to the beneficiary/plaintiff's claim for medical services, and did not allow Medicaid agencies to recover from plaintiff's money they may have received for, for example, lost wages or pain and suffering. Where the plaintiff recovered less than their full medical expenses, Medicaid could recover from the plaintiff no more than the plaintiff recovered from the defendant.

There were three significant limitations to the decision, two express and one tacit:

—It did not have to address how to determine how much of a settlement was attributable to medical expenses. The Medicaid agency in that case stipulated how much of the



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settlement was for medical expenses. The Court said these were factual questions that could be resolved by trial courts—that is what they are there for—or that the States might craft other procedures for making these determinations. “[T]he 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.” It noted that some states already have “special rules and procedures” where private insurers’ rights are involved, although “we express no view” on their legality. 126 S.Ct. at 1765 & n. 17.

—It said it did not have to reach the question whether the anti-lien provision barred Medicaid agencies from simply making after-the-fact demands. The right to bring an action against a liable defendant could be just that, and no more, bounded by the broad Congressional policy against *inter vivos* recovery from beneficiaries of benefits properly paid. The Court specifically reserved that question for another day. 126 S.Ct. at 1763 n. 12. One Federal district court has included, in dicta, that the anti-lien provision ties the hands of Medicaid agencies. *Tristiani v. Richman*, 609 F. Supp. 2d

423 (W.D.Pa. 2009).

—It referred throughout to “medical services,” not distinguishing past from future medical services. Given the references in the lower court pleadings to future as well as past medical expenses, and the references to other categories of damages, it is hard to avoid the inference that the Court achieved unanimity by not addressing Medicaid’s right to recover for future medical expenses.

In the wake of *Ahlborn*, Medicaid agencies around the country have focused on the uncertainty in how much a settlement reflects past medical expenses. A few courts rely on *Ahlborn* to require a *pro rata* approach—a settlement of 23.2% of the total claim limits Medicaid’s recovery to 23.2% of total medical costs paid. Others have relied on state statutes that give the Medicaid agency one-third of the recovery (or one-half net of fees and expenses) as a kind of legislative approximation.² And one state supreme court decision, from Idaho, which DRFS seems to have adopted, relies on *Ahlborn*’s failure to specify past as opposed to future medical expenses as *carte blanche* to subject recovery for future medical expenses to Medicaid’s reimbursement claim—even with



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admitting Medicaid has no claim for future medical expenses it might have to pay.³ Even where the plaintiff put in expert testimony on the value of the elements of his claim in light of the contingencies of litigation, a Florida appellate court said—I think correctly—that that alone does not indicate how much the plaintiff accepted in settlement of the medical costs element of its claim.⁴

The facts, ma'am, just the facts. The underlying question is, "What did the plaintiff receive as compensation for past medical expenses?" As the Supreme Court noted in *Ahlborn*, what portion of a settlement reflects medical expenses is a question of fact. If there is a jury verdict with specific findings, that should be controlling. Confusion arises where the case is settled without a verdict.

There are both procedural and substantive issues buried in this question of how to determine how much of any given settlement reflects subrogatable (*sic*) medical expenses or some other element of damages not exposed to a subrogee's claim. Since any good case turns in the first instance on assessing what you can prove, let me start with the facts you will need to establish and then move forward in time to how to proceed to get a determination shaped by what you can show.

Until recently neither plaintiffs nor their counsel thought much about allocation when settling a claim since it had little practical consequence. The plaintiff has suffered significant losses, there is some chance of recovering from a defendant for them, and the only question is how to maximize the claim. Except for taxability, the category of damages was not of great significance.

Why does a plaintiff settle for less than the full amount of his or her loss? The reasons include general aversion to uncertainty of jury verdicts even where all elements of the case are strong; uncertainty about establishing liability; and "policy limits," limited liability insurance coverage of relatively impecunious defendants.

The plaintiff should be prepared to show not only the value of the claim, but the process by which he or she accepted less than all of what he or she was entitled to. How? One possibility is expert testimony. Someone who has litigated hundreds of cases, or who has decided or mediated them, would be competent to explain why a claim of \$1 million for—pick your category: future medicals, past and future lost wages, past medicals, pain and suffering—was worth only \$100,000 given the questions about liability or contributory negligence. IRS accepts such testimony when evaluating estate tax issues, and the logic is exactly the same.

The same logic would apply to a case settled because of insurance policy limits, although there is an important difference. Consider the plaintiff who was injured in an automobile collision where the other driver was clearly negligent, and she (the plaintiff) was not, suffering \$100,000 in past medical bills, \$100,000 in future medicals, \$100,000 in

total lost wages, and \$100,000 in pain and suffering, and the defendant's policy limit is \$100,000. Will she settle her \$100,000 claim for past medical expenses for \$100,000? She would be a fool to do so if it meant Medicaid would get every cent. She would be willing to settle any one of the other claims for \$100,000, but of course the defendant will not agree to that without also getting a release of the medical expense claim.

Theoretically, one solution is to find out what the defendant will pay, out of the \$100,000, for all claims other than medical expenses. If there is an amount the parties can agree upon, it seems to me that Medicaid would be hard-pressed to say that it is entitled to anything more than what the plaintiff left on the table; if it wants to sue the defendant, it is free to do so. But it is hard to imagine an insurer willing to settle with a plaintiff for fewer than all of the claims. Given that most settlements cover all claims "from the beginning of time," settling less than all makes no sense.

Of course, the problem here is that the situation is (to use current jargon) asymmetrical. The insurer is out \$100,000 no matter what, and has no incentive to settle anything other than the whole claim. It would not reduce its offer any amount to leave past medicals off the table—but it also wouldn't reduce its offer to leave out future wages, either. It is somewhat like the legal fiction of "tenants by the entirety"—where each spouse owns an undivided 100% interest in the whole, but which still adds up only to 100%.

The insurance company would have no motive to settle except with a complete release. But what about the tortfeasor? The plaintiff has a real reason for forcing the issue, and the defendant has real motives for avoiding a judgment that exposes him to garnishment of his wages for the rest of his life. To be sure, he faces some risk that Medicaid will rear its ugly head, but that is speculation against the plaintiff's immediate presence.

In sum, how much a plaintiff is willing to settle each element of his claim for is a question of fact and how much Medicaid might get is part of the plaintiff's calculation. Now that you know Medicaid is going to come knocking, trial lawyers have to advise their clients about the real value of a settlement. If policy limits without Medicaid's reimbursement claim is acceptable, but otherwise not, you need to craft a settlement that reflects the reality of that choice, and a procedure that reflects that choice.

Getting there. The procedural questions are not, fortunately, the subject of abstract logic. I would suggest the following considerations and guidelines for litigating a case with a looming Medicaid reimbursement claim:

—Does the client have a *bona fide* cause of action that does not include past medicals as an element of the claim? And merely excluding a claim for past medicals is not likely to fool many defendants when it comes to write the settlement agreement. As to whether you can ever settle with the defendant without getting a release, see the discussion

above. To some extent that will depend on the nature of the injury and claim.

—Treat Medicaid like a party. Serve it with the complaint; copy it on all discovery requests; notify it of all hearings; serve it with all pleadings (and if the defendant doesn't serve Medicaid with its pleadings, serve them yourself and file a praecipe showing that you have done so); when scheduling hearing dates, solicit its participation, and when it declines to participate, or fails to show, put that in the record.

—Make Medicaid a party. If Medicaid's claim stops increasing, because the client has gone off Medicaid, or gotten Medicare coverage, or a special needs trust has been established, you have a present dispute with Medicaid as to the value of its claim; consider filing suit against Medicaid and consolidating that action with your underlying suit. Consider your discovery against Medicaid: make it prove its expenditures; ask it to identify the experts who will address the settlement value of each element of damages.

—If the case goes to trial, whether or not Medicaid participates, plaintiff should ask for special verdicts addressing what the jury is awarding for each element of damages. A subrogee like Medicaid should be bound by those findings every bit as much as the plaintiff is. Giving Medicaid the opportunity to participate and prove its claim should be sufficient to bind it, as the Court of Appeals has held in the closely analogous uninsured coverage context. *Nationwide Mutual Insurance Company v. Webb*, 291 Md. 721, 436 A.2d 465 (1981). The plaintiff has no incentive to claim less than the full amount of its claim for past medicals, and it would be profoundly unfair to subject him to a new jury that might come to a different conclusion but unable to alter the result of the first verdict.

—Bring Medicaid in to settlement discussions. Here, you have an institutional problem. Medicaid has little incentive to bargain seriously because the people who are doing the negotiating are not worse off if they get nothing because they forced the plaintiff to trial and the verdict was for defendant. They still get their salaries, they still have their health insurance, and no one criticizes them for rolling the dice and getting nothing. (I say this not as personal criticism, but rather as an observation on institutional incentives. If I or anyone reading this article worked for DRFS, we would respond to the same incentives, or lack of them.) The point is not to get Medicaid to lower its claim; the point is to get an amount from the defendant net of Medicaid's claim to satisfy your client. Defendants want to settle, too, and the impact of Medicaid's intransigence *may* be to increase the offer, at least somewhat, enough to meet your client's needs.

The settlement without Medicaid's involvement that purports to allocate the settlement to the different elements of damages will not carry any real weight. Consider the analogous situation—how much of a settlement is untaxed damages for personal physical injury or sickness as opposed to

taxable financial recovery. While the case law recites that will accept the allocation in a settlement agreement if arm's length and in good faith, in fact the Tax Court is to look behind the settlement to the intent of the parties is not bound by allocations in an order. *Robinson Commissioner*, 70 F.3d 34 (5th Cir. 1995).

But consider one possible scenario—a hearing approval of the settlement where Medicaid is on notice, possibly even participates. The plaintiff (if not competent the next friend or guardian) testifies that she is settling claim on specific terms and that she would not settle if got less than \$X for all claims other than past medicals. Medicaid can cross-examine her and the judge can decide what the terms of the acceptable settlement are.

And consider another scenario: plaintiff and defendant settle all other elements of damage except past medicals and take that to trial, where of course Medicaid has opportunity to present evidence and to cross examine parties' witnesses? The question is whether and to what extent defendants and their insurers would be willing to leave that claim open while settling the rest of the case. Other than that, procedurally it would force Medicaid to recognize the limited value of its claim. To be sure, in many cases this may go into the same category as that other question "Other than that" question ("Other than that, Mrs. Lincoln, how was the play?"), but if there are cases where it works for the plaintiff, it does not matter that it does not work for some of them.

The risk of throwing down the gauntlet on Medicaid's illegal claims. DRFS's improper threat to special needs trusts was successfully challenged passively, as it were. SNT lawyers knew the "Guidelines" were illegal and unenforceable, and in that posture, could hazard to advise their clients not to comply.

DRFS' illegal lien threats are not so easily dealt with. In theory, plaintiff's lawyers could advise DRFS of the illegality of its claims and decline to pay, but then what? Maryland is not subject to the statute of limitations in the same way as other parties, although the line is not perfectly clear. For example, agencies acting in their proprietary capacity, with contracts, are subject to statutes of limitation. *Baltimore County v. RTKL Associates, Inc.*, 380 Md. 670, 850 A.2d 433 (2004). The Court in *RTKL* discussed and cited with approval *Goldberg v. Howard County Welfare Board*, 260 Md. 351, 272 A.2d 397 (1971), which allowed a state welfare agency to pursue a recovery claim garnishing a note payable to a former beneficiary, and which relied on the proprietary versus governmental function distinction.

But here the nature of the State's claim becomes important. Federal law prohibits all liens by State Medicaid agencies against the personal property of Medicaid beneficiaries for benefits property paid.⁵ The right (and obligation) to pursue reimbursement against tortfeasors whose conduct resulted in imposing costs on the Medicaid program is

limited exception to the lien prohibition, and one that may not permit States to file claims against beneficiaries for funds recovered in personal injury actions. That is the question left open by *Ahlborn* that *Tristiani* answered in the negative. The structure of the Federal mandate also requires some focus on the government-proprietary distinction, if only to note that the distinction is somewhat artificial in this context, where the right to recover welfare benefits turns on a decidedly non-governmental right to recover in tort.

It's not a new game—it's the same old game with one more player. Medicaid's involvement in personal injury actions through its reimbursement claim does not change the nature of what trial lawyers do—pursue through legal process claims for injured clients, settling on terms acceptable to the client if they can, and litigating when they cannot settle. To be sure, adding a new party who is adverse to both other parties is a real increase in complexity. And a key element of that third party's claim is the client's state of mind. The same evidentiary and procedural tools you use to deal with defendants are available to deal with Medicaid. And, frankly, you are the pros at this and enter into the conflict at a tremendous advantage.


¹ The "Guidelines" limited cell phones to basic service and only when necessary for the beneficiary's well being; limited the use of a credit card for incidentals to \$100 per month; prohibited paying monthly utility bills except in cases of extreme hardship, e.g., electricity cut off, and even then only with special permission "given upon receiving a written request"; limited expenditures for vacations to \$3,000 per year without prior approval; and limited funds for recreation to \$2,000 per calendar year.

² *Andrews v. Haygood*, 362 N.C. 599, 669 S.E.2d 310 (2008), cert. den., 129 S.Ct. 2792 (2009). Some states establish the percentage as a rebuttable presumption, e.g., Oklahoma and Pennsylvania, 63 Ok.St. Ann. § 5051.1D.(1)(d)(2005) and 62 P.S. §§ 1409 and 1409.1.


³ *Idaho Dept. Of Health and Welfare v. Matey*, 213 P.3d 389 (Idaho 2009)

⁴ *Russell v. Agency for Health Care Administration*, 2010 WL 21167 (Fl. App., 2nd Dist., No. 2D07-2691, Jan. 6, 2010).

⁵ 42 U.S.C. § 1396p(a)(1)(A) and (B); it permits liens against real property only in the case of those getting long term care benefits.



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FOOD DRIVE REPORT

D.C. Trial Lawyers Truly Care

This year's food drive took a little longer, but generated record proceeds. The record-breaking total amount of money donations was \$1,715.00. In addition, our organization donated over 650 pounds of food. This is a very generous donation for which our organization should be truly proud.

There was broad participation among our firms and our individual membership. Very substantial contributions were received from Regan Zambri & Long, Koonz, McKenney, Johnson & Lightfoot, Pat Malone, Jack Olender and Associates and Stein Mitchell and Muse.

Many thanks to Victor Long for organizing this wonderful event.

