



Who Gets the Benefit of Your Work?

by Ron M. Landsman

The halcyon days of personal injury litigation – if they ever did exist – are long gone. No longer the grateful client singing your praises after a stunning jury verdict as you walk off into the sunset. Awareness may have come in a big way with the widely misunderstood *Grillo* settlement,¹ but important tasks must be resolved before you even get to whether to structure a settlement or to bring in a special needs trust expert. Those two questions are only two parts of a much larger set of problems, and there are important factual questions to resolve long before those questions must be addressed.

Health insurance companies increasingly look more like bonding companies – conduits for shifting liability rather than mechanisms for sharing risk. Now when an injured person recovers compensation for damages he or she has suffered at the hands of a negligent or malevolent party, many who have had to or who might pay the injured person's medical bills line up to take a piece of the action. This is true for government programs like Medicare² and Medicaid³

and for private insurers under ERISA.⁴ To satisfy their clients, personal injury attorneys not only have to win the battle of the lawsuit, but also the war of distribution; no standing outside the courthouse door with a banner that reads, "Mission Accomplished." Knowing these risks at the outset, and taking them into account, the personal injury attorney will be able to deliver not just a legal victory, but a life victory that the client will value all the more.

of what it has paid out by claims against your client's probate estate. While this is somewhat removed from the trial attorney's primary focus, it is not at all removed from client's concerns about their welfare and that of their families after they are gone, and how a case is settled may affect the client's ability to attend to that.

I will first review the law behind the different claims that may be made against your client's recovery or against

Subrogation, liens, set-aside arrangements, ERISA and estate recovery – what you have to worry about besides special needs trusts and structured settlements – and the change in the focus of litigation.

The free-riders who want to get the benefit of your work at your client's expense (and satisfaction with you) mostly attack through subrogation claims, either when litigation is pending or resolved. Medicare, Medicaid and ERISA insurers focus on what they have already paid out for your client's care at the time of settlement or judgment; by statute or contract they claim the right to be reimbursed for the costs they paid because of defendants' negligence. At the same time, Medicare may also focus on the future and seek funds to be set aside to pay the cost of care that Medicare itself would otherwise have to pay in the future.

A second line of attack is at your client's death. Medicaid can recover much

his or her estates, and conclude with a discussion of what you must do first to facilitate an effective response to these demands.

Medicaid, Medicare and Erisa Subrogation Liens

Everybody wants to get into the act.

Medicaid. If a third party caused injury that gave rise to the need for care that Medicaid⁵ paid for, the State Medicaid program is subrogated to the Medicaid beneficiary's right to recover from the third party the cost of that care. Congress has long required State

¹ In *Grillo v. Pettiette*, 96th Dist.Ct., Tarrant Cty., TX, No. 96-145090-92, trial lawyers who settled a personal injury case for all cash were sued by their former client for failing to obtain a structured settlement, which would have provided tax savings and might also have preserved public benefits. The case was settled confidentially, so that no one outside the principals really knows what liability rules if any were involved, but the case has been flogged by structured settlement agents to push their product. For a thoughtful review of that and related issues, see Henry Strong, "The Real Lessons of *Grillo*," JOURNAL OF THE VIRGINIA TRIAL LAWYERS ASSOCIATION, Summer 2004, p. 36.

² Title XVIII of the Social Security Act of 1935, as amended, 42 U.S.C. § 1395 *et seq.*

³ Title XIX of the Social Security Act of 1935, as amended, 42 U.S.C. § 1396 *et seq.*

⁴ Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 *et seq.*

⁵ Medicaid is a Federal-State joint venture; Congress establishes minimum program requirements and provides half (or more) of the funding for State medical welfare programs for the elderly and disabled poor. *Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498 (1990). States must comply or run the risk of termination of Federal funding.

a recovery for medical expenses, Federal law “requires ... that the State [Medicaid program] be paid first out of any damages representing payments for medical care before the recipient can recover any of her own costs for medical care.” *Id.* at 1762. But its direct causation approach is plainly a significant limit on what Medicaid may claim, even if it won’t resolve every case favorably for injured plaintiffs.

v. Jain, 15 Misc.3d 1120(A), Slip Copy, 2007 WL 1118383 (Table) N.Y.Sup. (Apr 13, 2007).

Helpfully, the Maryland statute – unlike the Arkansas statute at issue in *Ahlborn* – is cast in causative terms limited to liability for medical services provided. It provides for subrogation to a beneficiary’s cause of action against another person “to the extent of any payments made by the Department...

Medicare like Medicaid enjoys a subrogation right to recover the cost of care for which it has paid and for which someone else was liable.

The Court noted at the outset that everyone agreed that a litigated determination of allocation, whether to judge or jury, would be binding, *id.* at 1762, and dismissed as solvable the potential problem – not presented here because of the parties’ stipulation – of how to determine allocation in the context of settlements. The risk of post-settlement manipulation is easily solved, it said. The State Medicaid program agrees to an allocation or the issue can be submitted to the court. In any event, the Court said, there is as much to be concerned with over-allocation as under-allocation, “unfair to the recipients” in the former situation.

This appears to be a back-door approval of equitable contribution. As in *Ahlborn* itself, a settlement that reflects a discount on reasonably claimed losses because of all of the many risks of litigation should affect how much of the recovery is attributed to medical costs as it is to any other element of damages. That is exactly where the early subsequent cases have gone. *See, e.g., Lugo ex rel. Lugo v. Beth Israel Medical Center*, 819 N.Y.S.2d 892, 13 Misc.3d 681, 2006 N.Y. Slip Op. 26340 (N.Y.Sup. Jul 21, 2006). They have held hearings to value the case, and then applied to the total Medicaid expenditures the same percentage reduction as the settlement is to the total value of the case. *Chambers*

that result from the occurrence that gave rise to the cause of action.” Md. Health-Gen., § 15-120(a). Although the words are not identical to the Federal statute, their tenor is the same, and in any event they are constrained by it.

Medicare. Medicare like Medicaid enjoys a subrogation right to recover the cost of care for which it has paid and for which someone else was liable. The statute providing that system has had a long, difficult history, although recent (2003) Congressional amendments may resolve what Medicare has viewed as problems. Unlike Medicaid, however, Medicare also seeks to resolve its responsibility for future care when worker’s compensation or large personal injury matters are settled; the mechanism for this is the “Medicare set-aside arrangement” under the Medicare Secondary Payor Act (MSP).

These provisions apply where a plaintiff is a Medicare beneficiary and Medicare pays for services for which someone else – *e.g.*, a workmen’s compensation, health or liability insurer or third-party tortfeasor (other than a private individual) – is liable. A plaintiff may be getting Medicare because he or she is 65 years or age or older and qualifies for Social Security retirement benefits, because he or she is disabled, was disability insured at the time the disability started, and has gotten income

benefits for more than two years, or because he or she is the disabled adult child of a Social Security participant. Under the MSP, Medicare has a statutory right to reimbursement for the medical expenses it pays on behalf of a beneficiary when the beneficiary later receives a personal injury settlement or judgment. 42 U.S.C. §1395y(b)(2). It may bring an action against any entity that is required to pay for the medical services under a primary plan, or against any other entity – a provider, supplier, physician, attorney, State agency or private insurer -- that has received payment from the entity required to pay under the primary plan. 42 U.S.C. §1395y(b)(2)(B)(ii). As amended, Medicare

1. Is secondary payor after primary insurers – group health plans (except those exempted), workmen’s compensation plans, no-fault and other automobile insurance, and liability insurance including self-insured plans. 42 U.S.C. § 1395y(b)(2)(A). Self-insured plans include a business, trade or professional entity that carries its own risk – that is, a tortfeasor other than a private individual.
2. Can make payments for care when the primary insurer’s payments are not expected to be prompt, but those Medicare payments are conditional. *Id.*, § 1395y(b)(2)(B)(I).
3. Is entitled to reimbursement, for any payments it made, by a primary plan that is responsible, evidenced by, for example, a judgment or payment conditioned upon a compromise, waiver or release, even without an admission of liability. Interest accrues 60-days after notice. *Id.*, § 1395y(b)(2)(B)(ii).
4. Requires third party payors (usually insurance companies) to notify Medicare if they learn that Medicare has made a payment for the injured person’s expenses, and Medicare has a direct right of action against them to recover payments they should have made. *Id.*, §

1395y(b)(2)(B)(iii) and (iv).

5. Requires individual beneficiaries to cooperate with Medicare recovery efforts, 42 C.F.R. § 411.23, but relieves them of liability unless they received payments to reimburse them for the cost of services provided. *Id.*, § 1395y(b)(1)(F). Whether an attorney for the beneficiary has the same duty to cooperate is problematical. *U.S. v. Sonowski*, 822 F.Supp. 570 (W.D.Wis. 1993) (judgment against plaintiff and his attorney).

As a matter of administrative convenience, Medicare disregards settlements and judgments under \$250,000 and does not require notice for determining its subrogation claim at all. On the other hand, and beyond what Medicaid does, in all worker's compensation cases it does, and in large settlements it could, require notice so that it can determine what it believes to be the *future* cost of medical care associated with the injury that would otherwise be paid by Medicare. It then requires that funds be set aside, in a Medicare Set-Aside Arrangement, to pay the costs, as they arise, that Medicare would have paid for. There are commercial services available to serve as Medicare set-aside trustees. After the set-aside funds are exhausted, the individual can again use Medicare for all services covered by it.

The MSP statute also gives individuals – including insureds – a private right of action with double damages against a plan that “fails to provide for primary payment (or appropriate reimbursement)” for services covered by both the insurance plan and Medicare. 42 U.S.C. § 1395y(b)(3)(A). A double damages claim was successful in *Manning v. Utilities Mutual Ins. Co.*, 2004 U.S. Dist. Lexis 1674 (No. 98 Civ. 4790 (RCC), S.D.N.Y.)⁶; a workman's compensation insurer refused to pay a claim that it litigated extensively while Medicare paid. The parties settled their

WC claim after ten years of litigation for \$1.9 million, apparently without any arrangement for re-paying Medicare; this was before the 2003 amendments. The disabled worker then filed his claim for double damages and prevailed; the insurer's claim against the worker for reimbursement under the settlement was denied summary judgment. Other private right of action claims have not been effective.⁷

ERISA INSURERS. Health care benefits under ERISA may also be subject to subrogation claims, although the precise wording of the underlying statute has prompted the Supreme Court, over vigorous but unavailing dissents, to fashion the right to recover only where the cause of action could fit into a form of relief that would have been available under equity practice before the merger of law and equity. The closeness of the question is reflected in the two most recent Supreme Court decisions, *Great West Life & Annuity Ins. Co. V. Knudson*, 534 U.S. 204 (2002), which declined relief to

⁷ *E.g.*, in *Glover v. Liggett Group*, 459 F.3d 1304 (11th Cir. 2006), the 11th Circuit held that the underlying cause of action did not arise until liability had previously been determined, relying on the provision for establishing liability by a judgment or settlement, including one excluding liability.

the insurer/subrogee where the funds it sought were in the hands of a third party special needs trustee, and not that of the plaintiffs, and *Sereboff v. Mid Atlantic Medical Services, LLC*, 126 S.Ct. 1869 (2006), where the Supreme Court approved the Fourth Circuit's finding that a claim against the proceeds of a suit still in the hands of plaintiffs could constitute an equitable lien permitted by ERISA.

A subsequent D.C. case, *Moore v. Capital Care, Inc.*, D.C. Cir., No. 04-7121, decided August 29, 2006, addressed the related question of application of the “made whole” doctrine as a default Federal common law rule in the face of an ERISA plan provision that gave the plan “any rights of recovery of a participant,” and required participants to pay “all amounts recovered by suit, settlement, or otherwise from any third party or his insurer to the extent of the benefits provided under this Contract.” Slip op. At 15.

The court did not address whether this was rather more than subrogation. Rather, the claim looks like the one limited by the Court in *Ahlborn*, a lien on the entire cause of action without regard to whether the recovery was for the cost of medical services or something else or a combination of the two. The reasoning of *Ahlborn* does not apply, of course,

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⁶ My thanks to Richard Neuworth of Lebau and Neuworth for directing me to this interesting case.

resting as it does on the affirmative and negative aspects of Congress' regulation of state recoveries under Medicaid, but there seems to be reason to attack such expansive claims.

Estate recovery

While trial lawyers may naturally feel most concerned about what comes out of a settlement up front – in the form of Medicaid subrogation claims – they should be equally concerned about what happens at the back end through Medicaid estate recoveries. Where the injured person has already died so that his estate is the plaintiff, estate recovery looms at least as large as subrogation. This is also true where the plaintiff estate pays in whole or part to the estate of someone who had received Medicaid (typically a spouse). Clients may not feel they have gotten much benefit of litigation counsel's work in settling a claim for an estate where most or all of the recovery is lost to an estate recovery claim by Medicaid.

Congress did not require any estate recovery until 1993, but both D.C. and Maryland already had broad estate recovery programs under the prior permissive Federal law. In that year, Congress required some estate recovery in all States, but continued or added a number of limitations:

- It requires estate recovery for nursing home services, "home and community-based services," and related hospital and drugs services in all States.⁸ *Id.*, § 1396p(b)(1)(B)(I).
- Other services can also be the subject of recovery, but only if specified in the State's "Medicaid State Plan." *Id.*, § 1396p(b)(1)(B)(ii).

⁸ "Home and community-based services" refers to services provided under a so-called waiver program for people who required institutional care but could be managed less expensively in their home or in assisted living; related hospital and drug services are those services for institutionalized individuals.

- But no recovery is permitted:
 - Until after the death of a surviving spouse. *Id.*, § 1396p(b)(2).
 - If there is a surviving child under age 21 or who is blind or disabled. *Id.*, § 1396p(b)(2)(A).
 - For services provided when the beneficiary was under 55 years of age. 42 U.S.C. § 1396p(b)(1)(B).
 - To the extent application of the recovery rule would work an "undue hardship." *Id.*, § 1396p(b)(3).

Estate recovery is fundamentally different from subrogation: it applies to all assets, now matter how or when acquired, *e.g.*, a home owned prior to eligibility or an inheritance acquired afterward, even after death. On the other hand, these specific limits on recovery are designed to protect others who fit within the appropriate category, without their own independent showing of need (except for hardship) or satisfying Medicaid eligibility requirements.

There are a number of strategies available to limit or avoid recovery:

- For individuals who are not expected to survive, assigning their cause of action, if possible, to, *e.g.*, a revocable living trust may avoid recovery. Even if the plaintiff is at the time a Medicaid beneficiary, such an assignment should not result in a loss of benefits for long term or waiver care (the only kind subject to the Medicaid anti-transfer rules) since the value of the cause of action at that point is so speculative.
- Where the estate is the plaintiff, distributing its cause of action to a person entitled to take it without recovery would avoid the problem presented by the latter's death. That is, if the decedent's spouse has survived but is not in good health, distributing the cause of action to the spouse while she is living avoids the adverse effect of loss of the defense if she passes away before settlement and distribution. This would be effective if she is not herself a Medicaid beneficiary, or

in any event if the claim against her estate would be substantially less.

- Likewise the distribution to a child under age 21 or a disabled child. But if the disabled child him or herself needs Medicaid benefits, the cause of action is only protected by placing it in a special needs trust with payback for the disabled child.
- Although causation is not an issue, the other limits on recovery should be reviewed closely – were any benefits provided before age 55, was the Medicaid program entitled to recover for these services at the time they were provided, etc.
- Assignment of interests in an estate to the hardship claimant may preserve more of the recovery than could be done in any other way.
- Disclaimer, if it can be done timely, by the recipient estate where one estate is paying to a second (usually a spouse) with Medicaid recovery exposure. The disclaimer is a transfer for Medicaid purposes, for which the only remedy is loss of future benefits – hardly significant for an estate.

The Effective Response To Anticipated Claims

ATLA's Center for Constitutional Litigation, in its post-*Ahlborn* memorandum, provided useful general advice on how to approach potential claims from both Medicare and Medicaid. Give the government agency notice, including reliance on *Ahlborn*, and ask for an accounting of costs. Decide as a tactical matter whether to seek recovery for medical costs paid by the government; be clear in your pleadings about that decision; factors to consider include the collateral source rule in your local jurisdiction, the possible size of any judgement/recovery, and the willingness of the government to contribute to litigation costs, etc. If you cannot get a satisfactory equitable apportionment of with the government agency, apply

to the court for an order that equitably allocates any court settlement among categories of damages.

Medicaid. Each State Medicaid program has an office for pursuing subrogation and estate recovery claims. These claims have similarities and differences. Both of course require that the services actually be provided to the client/decedent, but the former requires a causal relationship between the tort and the incurred medical expense, while the latter does not. And there is relief from estate recovery obligations if there is a surviving spouse or young or disabled child, or the services were provided prior to age 55, but none of those facts (except to the extent they make out a hardship defense) are relevant to subrogation claims.

The practical steps to take in either the subrogation or estate recovery claim include requiring the agency to provide a bill as it were – a detailed statement of all charges and all goods and services paid for, to be reviewed for accuracy and make sure all of the charges are in fact for your client and in fact related to the injury upon which suit is based. You should review those claims against the billing and service records of all providers to identify discrepancies, and require strict proof by the claimant that it has paid the claims its computer records report.

The context of the Medicaid claim will provide the procedure for resolution. A subrogation claim in a personal injury suit will be resolved, if all else fails, by the trial court. An estate claim arises by definition in a probate proceeding; the personal representative denies the claim and the Medicaid agency files a complaint with the probate or orphan's court for payment. At that point, the estate can require proofs of payment, and if not settled at that stage, can be resolved by the court.

Medicare. The nation-wide Medicare program is vastly more complicated and formal than the fifty-one Medicaid programs. A Coordination of Benefits (COB) contractor will take a report of a possible claim, send a "Medicare right

of recovery" letter and an information release form for the beneficiary to sign and return, and will open an MSP file for the beneficiary in the CMS database. The COB contractor will identify all claims paid for the beneficiary, a time consuming process, and determine which are related to the injury for which liability may be claimed in a personal injury suit. The COB will provide a list of claims it believes to be related to the suit; as with Medicaid claims, the first task is to review the COB report to weed out goods and services not arising from the cause of action.

Medicare shares procurement costs – expert witness fees, cost costs, and attorneys fees – ratably with the entire recovery, but it insists on being paid first, and appears to claim priority over Medicaid, as well as everyone else. 42 CFR §§ 411.24 through 411.26. If total fees and expenses of a recovery equal 39.4% of the total recovery, then Medicare's claim is also reduced by that much. But absent a court decision to the contrary, Medicare anticipates getting the first dollar of recovery. If the recovery exceeds the amount recovered, Medicare expects 100% payment after deducting its share of fees. If the recovery is less than the amount recovered, Medicare expects to receive the entire amount less fees and expenses.

If dissatisfied with the results, the plaintiff can sue the primary insurer or refuse to pay and let Medicare sue him or her, appeal, or seek waiver or compromise. The injured party is entitled to double damages where a primary plan fails to pay or to reimburse Medicare. Or, the client could appeal under 42 U.S.C., § 1395ff and 42 C.F.R. § 404.900, which is appropriate if a claim otherwise settled quickly and the client did not want to/could not use the trial court for a determination of which costs were due to the tort. Alternatively, the client can seek compromise under 31 U.S.C. § 3711; the claim here turns on the cost of collection, the liable party's inability to pay within a reasonable time, and the extent to which the prospect of successful litigation is uncertain. These are handled

only by CMS offices – home or regional – and not by fiscal intermediaries or others. You can also ask the COB to waive claims where the Medicare beneficiary was "without fault" (but see the following sentence), where recovery would defeat the purpose of Social Security or Medicare laws, or would be against "equity and good conscience." 42 U.S.C. § 1395gg©. The "without fault" standard is really a means or needs test based on the beneficiary's out of pocket expenses, ability to pay Medicare, considering income, assets and expenses, and his or her age and physical or mental handicaps. Medicare Secondary Payor Manual, 7-§ 50.6.3. Defeating the purpose of the two laws means causing financial hardship so that a beneficiary cannot meet ordinary and necessary living expenses, e.g., settlement or insurance proceeds have been spent and only basic income remains. *Id.*, §§ 50.6.5 and 50.6.5.1. "Equity and good conscience" looks to whether the beneficiary did not, or Medicare did, contribute to the overpayment; whether recovery would cause undue hardship; and whether waiver would unjustly enrich, or the beneficiary was harmed by relying on incorrect information from Medicare. *Id.*, §§ 50.6.5 and 50.6.5.2 (with examples). Judicial review is available. 42 U.S.C. § 1395gg. Finally, CMS can waive recovery if it is "the best interest of the Medicare program," *id.* § 1395y(b)(2)(B)(iv); regional offices can handle claims up to \$100,000, above that the CMS central office in Baltimore must decide. CMS says these waivers are not reviewable. 42 C.F.R. § 405.705(d).

Assuming no resolution by any of the preceding steps, Medicare has a number of remedies, including the following, including a direct right of recovery against third-party payor, even if the payor then has to pay twice, 42 C.F.R. § 411.24(i)(1), indeed double damages are provided for; against anyone who has received payment from the primary plan, including the beneficiary, especially if he or she fails to cooperate with CMS' collection efforts, *id.*, §§ 411.23 and 411.24(k)(1) and (2), his or her attorney, *Thompson v. Goetzmann*, 315 F.3d 457 (5th Cir. 2002),

and others. And although Social Security benefits are non-assignable and cannot be garnished by anyone else, Medicare can offset MSP payments due against future Social Security and Medicare benefits.

ERISA claims. ERISA plan beneficiaries' recoveries are exposed only to equitable claims of ERISA insurers, and thus the question is what equitable (in the technical, not popular sense) right does the insurer have to property of the insured? To be sure, there does not appear to be a substantive limit on what rights the insurer might have. Does it have a right to be reimbursed out of the insured's existing assets, such as life savings or an inheritance? If not, that must because the remedy must to some extent shape the right, and if the claim is based on the tort that gave rise to the injury, the equitable remedy sounds in subrogation. The statute at issue in *Ahlborn* was cast in terms of causation and assignment (42 U.S.C. § 1396k(a)(1)(A)(State shall

require applicants as a condition of eligibility "to assign the State any rights ... to payment for medical care from a third party"), which would appear to be a statutory version of subrogation designed to eliminate the restrictions or limitations that might otherwise apply to the State's subrogation claim. The practical result would look like the result in *Ahlborn* – the insurer can recover only to the extent its obligation arose from another's tort, and then only to the extent that the insured plaintiff recovered from the tortfeasor for medical expenses for which the insurer paid.

Conclusion

The potential for losing the benefit of a successful personal injury requires plaintiffs' counsel to attend to the problems and risks from the outset. The exposure to subrogation and recovery claims would appear to be as much a part of the assessment of such claims as physician

review to determine whether there was malpractice in the first place. Whether or not properly anticipated, the defense against those claims requires a whole new area of knowledge, analysis and possibly litigation to get clients the recovery they sought in the first place. ■

About the Author

Ron M. Landsman, the principal of Ron M. Landsman, P.A., is a founding member and fellow of the National Academy of Elder Law Attorneys and a member of the Special Needs Alliance, an association of lawyers who specialize in drafting, implementing, managing and advising trustees of special needs trusts. He is lead counsel in *Brown v. Payne*, D.C. Superior Court, a proposed class action challenging Washington, DC Medicaid's estate recovery practices. His office is in Rockville and he practices throughout Maryland and in Washington, DC.

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