An Overview of Current Subrogation Issues

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I. INTRODUCTION

Subrogation[1] is a topic that evokes high emotions from practitioners on both sides of the bar. Dealing with claims for reimbursement is not only tedious and frustrating, but regardless of what side you're on, you are likely to feel that somebody got something for nothing. Insurers claim that subrogation is appropriate to avoid a double recovery by the plaintiff. On the other hand, plaintiffs view subrogation as an unfair practice whereby the insurer is reimbursed for payments it made, pursuant to a contract based on an accepted risk, without a corresponding return of premiums to the injured party. Certainly, we could debate all day long whether subrogation is "fair"; but the fact of the matter is that the right of subrogation and/or reimbursement exists in many circumstances and we need to know when it is available to an entity providing medical benefits, we need to know how to deal with a claim when it arises; and we need to know how to resolve the claim before concluding any settlement with the tortfeasor.

In the last couple of years, there have been a number of developments in the subrogation and reimbursement arena. The Supreme Court has again weighed in on the issue of ERISA

[1] Actual "subrogation" means "the substitution of one person in the place of another with reference to a lawful claim, demand or right, so that he who is substituted succeeds to the rights of the other in relation to the debt or claim." Black's Law Dictionary 1279 (5th ed. 1979). The term subrogation is often used generically to refer to any right of reimbursement, which is technically incorrect, but is frequently done so here. Where necessary, this paper will describe when true subrogation is concerned as opposed to other mechanisms for reimbursement.

preemption and its unique reimbursement provisions; however, the ruling has resulted in as many questions as it purported to answer. The Supreme Court also recently issued an opinion limiting Medicaid's right of reimbursement out of settlements that include payment for non-economic damages. However, when it comes to Medicare, the right to reimbursement seems to be ever expanding, making litigants, including attorneys, at risk even after settlements have long since been reached. While there wasn't anything particularly newsworthy on the workers' compensation subrogation front, there is some anecdotal evidence to suggest that courts are finally holding trials to determine the issue of complete compensation pursuant to O.C.G.A. § 34-9-11.1, a situation that was previously mostly left up to speculation.

Unfortunately, as distasteful as subrogation may be, issues pertaining to subrogation and liens rights on the recovery of benefits from third party claims cannot simply be ignored. It is incumbent upon lawyers to consider whether there are potential third party claims to which a lien or subrogation claim might attach prior to the conclusion of a case. In fact, these issues must be addressed at an early stage in the litigation as they can have important consequences on the ultimate value of the case to the client and lawyer. Increasingly, third party claims for reimbursement are part of the entire case, with insurers being permitted to intervene to protect their "right" of recovery in a personal injury case. In other instances, a second action will ensue to determine the amount of reimbursement required out of an injured plaintiff's recovery. Finally, there are still situations in which a true subrogation right is afforded the benefit provider, which will lead to a direct action against the tortfeasor.

This paper will attempt to outline recent developments in subrogation and reimbursement law in six particular areas: Hospital Liens, Health and Benefit Plan claims, ERISA claims, Medicare and Medicaid liens, and Workers' Compensation Liens. It is intended more to provide

an overview of the current state of the law, rather than to suggest a particular practice or approach, although an occasional commentary is included.

II. HOSPITAL LIENS

Georgia has a statute for the explicit purpose of providing hospitals and nursing homes a lien against personal injury recoveries. O.C.G.A. § 44-14-470-476.

> Any person, firm, hospital authority, or corporation operating a hospital or nursing home or providing traumatic burn care medical practice in this state shall have a lien for the reasonable charges for hospital, nursing home or traumatic burn care medical practice care and treatment of an injured person, which lien shall be upon any and all causes of action accruing to the person to whom the care was furnished or to the legal representative of such person on account of injuries giving rise to the causes of action and which necessitated the hospital, nursing home, or provider of traumatic burn care medical practice care, subject, however, to any attorney's lien.

O.C.G.A. § 44-14-470(b). The statute goes on to provide that the lien is against the cause of action only, and not the injured individual or his estate.

In 2002, the statute was amended to add, specifically, individuals or entities "providing burn care medical practice." In 2004, the statute was again amended to include "physician practice" groups; thus providing a lien right for essentially any doctor. However, it is important to note that the lien provided for in Section 44-14-440 is "only a lien against such causes of action and shall not be a lien against such injured person, such legal representative, or any other property or assets of such persons and shall not be evidence of such person's failure to pay a debt."

In order to perfect the lien, the provider must file a verified statement containing certain specified information within thirty days in order to perfect the lien.[2] The lien statement is filed in the Superior Court of both the county in which the hospital is located and the plaintiff's residence. Additionally, copies of the statement must be sent to all individuals who are potentially liable for the plaintiff's injuries, in order to puts them on notice of the lien. O.C.G.A. § 44-14-471.

Significantly, the hospital's lien right requires that the patient pay only a reasonable amount for the services provided. This means that if the hospital will accept insurance payments for services in an amount less than the full charge for those services, the hospital cannot thereafter attempt reimbursement for the usual rates charged. In fact, if the hospital typically accepts insurance, it cannot choose not to submit a bill to insurance, opting instead to obtain reimbursement for a greater recover out of a third party claim.

In an interesting case in Wisconsin, a hospital's attempts to circumvent the system had severe consequences. The hospital in *Dorr v. Sacred Heart Hospital*, 597 S.W.2d 462 (Wis. App. 1999) refused to submit its bill to the plaintiff's health insurer because it did not want to accept the capitated rate. Instead, it filed a hospital lien with the court pursuant to the state's lien statute. The Wisconsin Court of Appeals not only ruled that the lien was invalid; it also held that the hospital was guilty of conversion and tortious interference with the plaintiff's health insurance contract. The court also held that the plaintiff was a third arty beneficiary to the provider contract between the hospital and the health insurer, which contained a hold harmless

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[2] Despite this requirement, at least one court has held that the failure to file within the 30-day period does not prevent the hospital from enforcing the lien against a third-party having actual notice. *Macon-Bibb Hospital Authority v. National Union Fire Insurance Co.*,793 F. Supp. 321 (M.D. Ga. 1992). Filing is therefore only an issue regarding persons with no notice of the lien.

provision prohibiting the hospital from seeking to recover from the patient amounts in excess of the capitated rates. Most damaging to the hospital's position was the court's conclusion that the conduct of the hospital in filing the lien so that it could attempt to recover the full amount of its charges out of any settlement or verdict justified the imposition of punitive damages. *See also N.C., a minor v. A.W., a minor*, 305 Ill. App. 3d 773, 713 N.E.2d 775 (1999) (holding hospital could not assert lien against the tort recovery for difference between full amount of bill and amount paid by health insurer.)

When Medicare is involved, there is no question regarding how much the hospital can seek in reimbursement. A hospital participating in the Medicare program must enter into a contract in which it promises "not to charge . . . any individual or other person for items or services for which such individual is entitled to have payment made under this subchapter. . . ." 42 U.S.C. § 1395cc(a)(1)(A). Thus, a hospital that has accepted Medicare payments is specifically precluded from seeking to recover amounts exceeding what it billed the federal government, except for deductibles and coinsurance payments.[3] However, there is nothing to prevent the hospital from seeking payment from a liability carrier, rather than through Medicare. *See, e.g., Oregon Assoc. of Hospitals v. Bowan*, 708 F. Supp. 1135 (D. Ore. 1989)(holding Health Care Financing Administration regulations were void, to extent they limited substantive rights of Medicare participant providers to recover more from liability insurers than from Medicare when liability insurer was primary payer who would pay promptly and Medicare Secondary Payer statute precluded Medicare payment.) As noted above, however, once the hospital accepts the government benefit payment, it cannot seek additional recovery from other sources. *See Evanston Hospital v. Hauk*, 1 F.3d 540 (7th Cir. 1993) (Medicaid statute allows the

[3] There are similar rules that apply to hospitals accepting benefits from Medicaid.

government to seek reimbursement from third party insurer; hospital cannot refund Medicaid payments in order to seek payment directly from third party).

Further, patients are only responsible to reimburse hospitals for expenses related to the injury. In medical malpractice cases, it is particularly important for counsel to determine which services are related to the alleged negligence, as opposed to medical services that would have been necessary even absent any negligence. Hospitals will rarely take the time to determine which services on a given patient's bill are subject to a lien. Therefore, it is incumbent upon plaintiff's counsel to review the charges included in the claimed lien and confirm that each is subject to reimbursement. If the patient objects to a charge, the issue must be resolved before the lien is satisfied. Under the voluntary payment doctrine, the patient will be precluded from suing to recover any excess paid. *Watts v. Promina Gwinnett Hosp. System, Inc.*, 242 Ga. App. 377, 530 S.2d 14 (2000).

Although the statute does state that the attorney's lien takes first priority, counsel should keep in mind that the amount of the attorney's fee may still be disputed. The courts have held that "an attorney fee lien attaches only to 'the fruits of the labor and skill of the attorney ... so long as they are the result of his exertions.' Furthermore, '[w]hile the statute safeguards an attorney's right to a fee which has been earned, it does not control how the amount of the fee is determined.'" *Holland v. State Farm Mut. Auto Ins. Co.*, 244 Ga. App. 583, 584, 536 S.E.2d 270 (2000) (citations omitted).

The hospital lien allows a facility to recover regardless of whether the plaintiff has been made whole. *See, e.g., Holland v. State Farm Mut. Auto Ins. Co.*, 236 Ga.App. 832, 513 S.E.2d 48 (1999) (entire amount of insurance proceeds went to pay hospital and Department of Medical Assistance); *aff'd in part, rev'd in part,* 244 Ga. App. 583, 536 S.E.2d 270 (2000). According to

the Georgia Court of Appeals, the complete compensation rule has no application to hospital liens. 236 Ga. App. At 834.

III. HEALTH AND DISABILITY INSURERS

Health and disability policies often contain reimbursement provisions, which provide for recovery of benefits paid in the event of a third party recovery. In most cases, these clauses will be enforced. *See Southern General v. Watson*, 221 Ga. App. 484, 471 S.E.2d 559 (1996). However, an insurer will likely be permitted to seek reimbursement only if the policy specifically covers the issue, although the language may be somewhat ambiguous. *See Department of Medical Assistance v. Hallman*, 203 Ga. App. 615, 417 S.E.2d 218 (1992) (right of reimbursement allowed where policy provided both improper right of subrogation and right of reimbursement).

In 1997, the Georgia Legislature adopted O.C.G.A. § 33-24.56.1, which provides for reimbursement of medical expense or disability benefit providers in personal injury cases.

> In the event of recovery for personal injury from a third party by or on behalf of a person for whom any benefit provider has paid medical expenses or disability benefits, the benefit provider for the person injured may require reimbursement from the injured party of benefits it has paid on account of the injury, up to the amount allocated to those categories of damages in the settlement documents or judgment.

O.C.G.A. § 33-24-56.1(b). Thus, there is both a statutory and common law right to reimbursement. However, it is not without limitation.

Even if the clause appears to be enforceable, the amount of the claim may still be subject to traditional equitable limitations on subrogation, such as the requirement that the plaintiff be

fully compensated. O.C.G.A. § 33-24-56.1(b)(1) and (2) state that the benefit provider may seek reimbursement only if "the amount of recovery exceeds the sum of all economic and noneconomic losses. . . exclusive of losses for which reimbursement may be sought;" and further states that any recovery must be "reduced by the pro rata amount of attorney's fees and expenses of litigation incurred by the injured party in bringing the claim." Additionally, O.C.G.A. § 33-24-56.1(f) prohibits benefit providers, including insurers, from reducing liability for medical payments as a set-off against reimbursement claims or withholding benefits as a means of enforcing a reimbursement claim.

The Supreme Court in *Duncan v. Integon General Insurance Corp.*, 267 Ga. 646, 482 S.E.2d 325 (1998), decided the narrow issue of "whether the complete compensation rule, which requires that an insured be completely compensated for his losses before his insurer can exercise a right of subrogation or reimbursement, is applicable to an insurance policy provision which requires the insured to reimburse the insurer for amounts paid under medical payments coverage." *Id.* at 646, 482 S.E.2d at 325. The Court first concluded that "Georgia public policy strongly supports the rule that an insurer may not obtain reimbursement unless and until its insured has been completely compensated for his losses." *Id. at 326.* Thus, the Court concluded that the complete compensation rule does limit the application of subrogation provisions, but only where the insurance policy "does **not** contain an express provision to the contrary." The *Integon* Court did not decide whether public policy and principles of equity would require a finding that *any* insurance policy provision which modifies the complete compensation rule is unenforceable, because the policy at issue did not contain a clause requiring reimbursement.

Two years after deciding *Integon*, the Georgia Supreme Court was presented with the issue left open by its earlier decision: "whether this State's public policy of compete

compensation prevents enforcement of an insurance policy provision which expressly modifies the complete compensation rule." *Davis v. Kaiser Foundation Health Plan of Georgia*, 271 Ga. 508, 521 S.E.2d 815, 816 (1999). In *Davis*, the plaintiff had damages in excess of $100,000, but recovered only $100,000 from the tortfeasor's insurer and her UM carrier combined. Kaiser sought reimbursement for over $40,000 in benefits it had paid, and was granted summary judgment by the trial court on its claim. The Court of Appeals affirmed, focusing on the parties' right to contract. The court relied in part on O.C.G.A. § 33-24-56.1, which permits just the sort of reimbursement sought; however, because the contract at issue was entered into prior to the enactment of the statute, the court found that the policy provision regarding complete compensation contained in the statute did not bar the insurer's claim, as that was not the public policy of the state prior to the date of enactment.

The Georgia Supreme Court disagreed, concluding that O.C.G.A. § 33-24-56.2 was enacted "to make unmistakable that complete compensation is the public policy of this State." 521 S.E.2d at 818. Furthermore, that policy "will not permit insurers to require an insured to agree to a provision that permits the insurer, at the expense of the insured, to avoid the risk for which the insurer has been paid by requiring the insured to reimburse the insurer whether or not the insured was completely compensated for the covered loss." *Id.* Thus, the Court found that the public policy did override the parties' freedom of contract, and the insurance provision at issue was unenforceable as violative of that policy. *Id.*

The *Davis* case has stood the test of time, and seems to make clear that health and benefit providers may seek reimbursement only in the event an injured party is completely compensated. *See Thurman v. State Farm Mut. Auto Ins. Co.*, 278 Ga. 162, 598 S.E.2d 448 (2004) (reemphasizing Georgia's public policy of complete compensation).

Assuming that an insurer can make a case for the plaintiff having been completely compensated, it is still important to segregate charges that are related to the negligence and those that are unrelated. Again, insurers' subrogation claims will typically be for the entire amount of benefits paid, without regard to fault or apportionment of expenses caused by the tortfeasor and those that would have been incurred anyway. While arguably it is the insurer's burden to prove which charges are subject to reimbursement, the reality is that they do not attempt to do so, opting instead to seek recovery of all charges; therefore the more likely scenario is for the plaintiff to *disprove* that certain charges should even be at issue in the insurer's claim. Each item will have to be reviewed, analyzed and placed in a proper category.

IV. ERISA PLANS

The Employee Retirement Income Security Act (ERISA) is a federal law designed to provide standards for the protection of employee benefits plans. 29 U.S.C. 1001 *et seq*. It imposes on employers a variety of reporting, funding, and fiduciary obligations in the maintenance of the plans. It also expressly preempts state laws "insofar as they may now or hereafter relate to any employee benefit plan" covered by the statute, except for those state laws which regulate insurance, banking, or securities." 29 U.S.C. § 1144(a) & (b). To avoid any confusion between those two provisions, the Act specifically states that a state may not deem an employee benefit plan an "insurance company" for the purpose of the exception to the preemption clause. 29 U.S.C. § 1144(b)(2)(B).

ERISA's preemption of state laws is significant in the subrogation arena because health benefit plans provided by employers and unions frequently contain a right of subrogation allowing the plan to recover medical benefits given to an employee if the employee has received a personal injury recovery. Plans will also often provide that if the employee's injuries were

caused by the negligence of a third party, no medical benefits will be paid at all unless and until the employee agrees in writing to reimburse the plan from any recovery. There are a number of other restrictions that may be contained in a group benefit plan, such as prohibiting payment of medical expenses caused by automobile collision injuries. Many of these provisions are directly contrary to state laws, which prohibit or limit an insurer's right of reimbursement.

The first thing a lawyer should do when faced with a subrogation claim from a group provider is to determine if the plan is self-funded. In 1990, the United States Supreme Court considered ERISA's preemption provision and determined that group plans funded entirely by the employer are exempt from state laws restricting subrogation; however, plans that are funded by insurance remain subject to state laws. *FMC Corp. v. Holliday*, 498 U.S. 52 (1990). Unfortunately, the distinction between a self-funded plan and plans filed through insurance is not always apparent. It is important to obtain the plan documents to ascertain the true nature of the plan, as well as any clauses pertaining to subrogation. In many cases the plan will include a right of subrogation in one clause, but will also have a caveat or limiting clause elsewhere in the plan. It is the plan with the broad subrogation rights that is most likely going to be enforced.

If the plan is not entirely self-funded, the next step is to determine whether the state law at issue actually "regulates insurance" within the meaning of ERISA's savings clause. The Supreme Court has offered some guidance into this inquiry (sometimes referred to as the three McCarran-Ferguson factors):

> First, we ask whether, from a "common-sense view of the matter," the contested prescription regulates insurance . . . . Second, the Court considers three factors employed to determine whether the regulation fits within the "business of insurance" as that phrase is used in the McCarran-Ferguson Act:

> whether the regulation (1) has the effect of transferring or spreading a policyholder's risk, (2) is an integral part of the policy relationship between the insurer and the insured, and (3) is limited to entities within the insurance industry.

Unum Life Ins. Co. of Am. v. Ward, 119 S.Ct. 1380, 1386 (1999)(citations omitted). It is not necessary for all three factors to be satisfied for a state law to be considered as "regulating insurance" under the savings clause. *Id.* at 1389. In *Thompson v Federal Express Corp.*, 809 F. Supp. 950 (M.D. Ga. 1992), the court determined that ERISA preempted Georgia's prohibition against subrogation claims in personal injury cases; however, that case was decided before *Unum* and it is unclear what a court might do in construing the provision in light of the factors set forth in the Supreme Court's *Unum* opinion.

In 2002, the Supreme Court issued an opinion that set off a major debate about how to deal with ERISA claims. *Great-West Life & Annuity v. Knudson*, 534 U.S. 204, 122 S. Ct. 708 (2002) addressed what remedy the plan has against a participant who refuses to reimburse the plan out of a tort recovery. The underlying facts in *Knudson* are as follows. The plaintiff was rendered quadriplegic in a car wreck. The health plan, which did contain language allowing the plan a right of recovery from amounts paid by a third party, paid over $400,000 in medical expenses. The plaintiffs eventually negotiated a settlement of $650,000. Nearly all of the recovery, except attorneys fees and Medicaid reimbursement, was paid directly to a special needs trust for the plaintiff. Great-West thereafter sued the Knudsons in federal court under ERISA, claiming that it was entitled to the full amount it had paid in benefits – essentially seeking a judgment for the amount it claimed. The Court had to consider whether ERISA afforded the plan the type of remedy it sought.

29 U.S.C. § 1132(A)(3) authorizes a civil action:

> By a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of [ERISA] or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to address such violations or (ii) to enforce any provision of [ERISA] or the terms of the plan.

The Court had previously determined that the words "other appropriate equitable relief" meant that Congress intended to allow only "those categories of relief that were typically available in equity." *Martens v. Hewitt Associates*, 508 U.S. 248, 113 S. Ct. 2063 (1993). What Great-West sought, in essence, was to impose personal liability on the participant for a contractual obligation to pay money – a relief that was not typically available in equity. "A claim for money due and owing under a contract is 'quintessentially an action at law.'" *Knudson* at 713. As such, the Court found that the claim was not permitted under ERISA and upheld the dismissal of the insurer's claims.

It is important to note that in *Knudson* the proceeds from the settlement were not in the possession of the plaintiffs. This is significant because the Court's discussion of this fact left open the possibility that a carrier could recover under different circumstances. "[F]or restitution to lie in equity, the action generally must seek not to impose personal liability on the defendant, but to restore to the plaintiff particular funds or property in the defendant's possession." *Id.* at 715. Justice Scalia left wide open what might occur in other situations:

> We express no opinion as to whether petitioners could have intervened in the state-court tort action brought by respondents or whether a direct action by petitioners against respondents asserting state-law claims such as breach of contract would have been pre-empted by ERISA. Nor do we decide whether

> petitioners could have obtained equitable relief against respondents' attorney and the trustee of the Special Needs Trust.

It appears, then, that if a plan claims the beneficiary holds *particular* funds that arguably belong to the plan, a claim for reimbursement would be "equitable – the imposition of a constructive trust or equitable lien on particular property," and thus it would be allowed. *Id.*

That is, in fact, what occurred in *Sereboff v. Mid Atlantic Medical Services, Inc.*, 126 S.Ct. 1869 (2006), the most recent pronouncement by the Supreme Court on the issue. In *Sereboff*, the plaintiffs received health insurance under her employer-sponsored plan that was administered by Mid Atlantic Medical Services, Inc. and covered by ERISA. The contract contained an "Acts of Third Parties" provision that applied when a third party's act or omission caused a beneficiary's illness or injury. In the event a beneficiary receives benefits under the plan for such injuries, the beneficiary must "'reimburse [Mid Atlantic]' for those benefits from '[a]ll recoveries from a third party (whether by lawsuit, settlement, or otherwise).'" Shortly after their involvement in an automobile accident, the Sereboffs filed a tort action, and Mid Atlantic notified the Sereboffs repeatedly during the litigation of its intention to claim a lien on the Sereboffs' recovery equivalent to the $74,869.37 in benefit payments it previously issued to the couple. When the Sereboffs declined to pay Mid Atlantic after settling the litigation for $750,000, Mid Atlantic filed suit in District Court under ERISA § 502(a)(3). The tort claim was eventually settled and the settlement proceeds were distributed.

However, the plaintiffs set aside the amount sought by the plan fiduciary in a special account pending resolution of the fiduciary's claim for reimbursement. [4]

[4] Because the Sereboffs had already received the proceeds from their settlement, Mid Atlantic requested a temporary restraining order and a preliminary injunction from the District Court requiring the couple to set aside the disputed amount. The Sereboffs

The Court was again asked to consider the circumstances in which a fiduciary may sue a beneficiary for reimbursement under ERISA. The difference in *Sereboff*, of course, was that the funds at issue were not protected within a trust, as they were in *Knudson*. Instead, "Mid Atlantic sought "specifically identifiable' funds that were 'within the possession and control of the Sereboffs." Thus, once Mid Atlantic established that the basis for its claim was equitable, it was entitled to recover the sums paid under the plan out of the settlement.

> Mid Atlantic could rely on a "familiar rule[e] of equity" to collect of trhe medical bills it had paid on the Sereboffs' behalf. *[cit]* This rule allowed them to "follow" a portion of the recovery "into the [Sereboffs'] hands" "as son as [the settlement fund] was identified," and impose on that portion a constructive trust or equitable lien.

126 S.Ct. at 1875 (quoting *Barnes v. Alexander*, 232 U.S. 117, 121-123.)

Even before *Sereboff* was decided, the loop-hole created in the *Knudson* opinion was effectively utilized to the benefit of the plan. In *Great-West Life & Annuity Ins. Co. v. Brown*, 192 F. Supp. 2d 1376, 1381 (M.D. Ga. 2002) the court distinguished *Knudson* because the funds at issue were placed in the plaintiff's attorney's trust account and as such were "identified and clearly traceable to the award from third parties." Therefore, the court held that Great-West was entitled to restitution (equitable relief under ERISA) with respect to the funds and granted summary judgment to the plan administrator. The court rejected the participant's argument that the "make whole" doctrine precluded recovery, finding that, as a default rule, the doctrine would apply only if the plan precluded operation of the doctrine, which it did not.

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complied and placed the money in an investment account pending the District Court's decision and all subsequent appeals.

Brown is significant because it appears to be the first decision in Georgia to recognize that an ERISA plan may enforce a reimbursement provision under ERISA by seeking restitution from identifiable and traceable funds that are in the control of a party to the action. Courts in other jurisdictions have also followed suit. *See, e.g. IBEW-NECA Southwestern Health & Benefit Fund v. Douthitt*, 211 F. Supp. 2d 812 (N.D. Tex. 2002) (plan's action to recover funds under reimbursement provision was within the subject matter jurisdiction of district court under ERISA to order restitution in equity, where plan was seeking to impose constructive trust over funds being held by beneficiary's attorney); *Administrative Committee of Wal-Mart Stores, Inc. v. Varco*, 2002 WL B1189717 (N.D. Ill. October 2, 2002) (plan could recover monies in plaintiff's possession; however, claim would be reduced by proportional share of attorney's fees).

Clearly, it is the location of the funds that is the crucial inquiry. In *Brauhaus USA, Inc. v. Copeland*, 292 F.3d 439 (2002), decided after *Brown*, the settlement required the tortfeasor to pay an amount sufficient to cover all liens into the registry of the court, and all parties with claims against the money were to be served with process in an interpleader action. An interpleader action did not ensue; instead, the plan administrator sued all parties directly in federal court, seeking a declaratory judgment that it was entitled to reimbursement out of the proceeds. The court dismissed the case, finding the facts indistinguishable from *Knudson*, to the extent the funds were not in the possession of any of the parties in the case. *See also Unicare Life & Health Ins. Co. v. Saiter*, 37 Fed. Appx. 171 (6th Cir. June 10, 2002)(ERISA did not authorize action against beneficiary to enforce its reimbursement rights nor against tortfeasor and his insurer to enforce subrogation rights); *Sheet Metal Local #24 Anderson v. Newman*, 35 Fed. Appx. 204 (6th Cir. May 21, 2002) (where apprentice was allowed to

participate in training, with agreement that she would repay costs of training or work off the costs, trustee of funds could not seek reimbursement because apprentice was not wrongfully holding funds that needed to be returned). Cases that held to the contrary were clearly abrogated by the Supreme Court in *Sereboff*. *E.g. Westaff (USA), Inc. v. Arce*, 298 F.3d 1164 (9th Cir. 2002); *Moore v. CapitalCare, Inc.*, 461 F.3d 1 (D.C. Cir. 2006).

The Eleventh Circuit has not been a particularly friendly place for plaintiffs seeking to avoid ERISA subrogation. Recently, the Court held that an employee benefit plan, which sought reimbursement of medical benefits paid out of funds recovered by beneficiary in tort settlement, could sue under ERISA to recover a specifically identified fund in the possession of the plan beneficiary's conservator by suing the conservator directly, finding the plan sought "other appropriate equitable relief" cognizable under ERISA. *Administrative Committee for Wal-Mart Stores, Inc. Health Plan v. Horton*, 513 F.3d 1223 (11th Cir. 2008).

V. MEDICARE

Medicare is a federal program of health insurance administered by the Centers for Medicare and Medicaid Services (CMS), formerly known as the Health Care Financing Administration (HCFA). The program is available to persons over 65, or individuals who have received Social Security disability benefits for at least 24 months. To determine if an individual is entitled to benefits, the Social Security Administration contracts with private insurers to process claims, to maintain beneficiary records, and to investigate fraud and abuse. Under 42 U.S.C. § 1395y(b((2)(A)(ii), Medicare is deemed a "secondary payor" with regard to payments made under workers' compensation, or by an automobile or liability insurance policy or plan, or from uninsured or underinsured coverage, all of which are considered "primary plans" under the Statute.

In certain circumstances, Medicare participants who are injured by a third party may have some or all of their medical expenses paid by Medicare. As such, Medicare has a lien or subrogation right, and may pursue a direct action, or intervene in an action, to seek reimbursement for payments it has made as a secondary payor. Medicare is distinguishable from other health care insurers, including Medicaid, in that federal regulations allow Medicare subrogation and lien rights believed to be far superior to any other interest on a settlement or judgment proceeding. 42 U.S.C. § 1395y(b) (Supp. 1998). Thus, the term "super lien" is often used to refer to Medicare subrogation. It is important to note that there is no formal requirement that Medicare even give notice of its interest or advise the beneficiary of the obligation to repay. *See* 42 C.F.R. 411.21. Assuming you know about the lien, negotiating these claims can be particularly daunting -- one commentator has even referred to the process as "the war of cockatrice."[5]

Administration of the Medicare program is delegated, primarily, to private organizations called "fiscal intermediaries" and "carriers." These entities determine the amounts of compensation due, make the actual payments and enforce any rights of subrogation. 42 U.S.C. §§ 1395h, 1395u. The Medicare program is divided into two parts: Part A, which handles hospital payments; and Part B, which manages payments involving doctors and individual providers. Each Part is administered by a different insurance company.

A. Medicare's "Super Lien"

Although Medicare is a secondary payor, and generally payment may not be made for any item or service for which payment has been made or can reasonably be expected to be made through another source, payments can be made in the event that a recipient will not receive

[5] Kauffman, "The War of Cockatrice," 60 Tex. B.J. 310 (1997).

prompt payment from a third-party payer or from the proceeds of liability settlement or judgment. 42 U.S.C. § 1395y(b)(2)(A). Importantly, however, these "conditional payments" are subject to the qualification that Medicare *will* be reimbursed if and when payment for the same services is received from a liability or no-fault insurer. Specifically, a person who receives a conditional payment must reimburse Medicare within 60 days after the settlement of a personal injury claim. 42 C.F.R. § 411.25 (h). The same time limit applies to reimbursement from payments received from no-fault or med-pay insurance.

Of utmost significance is the fact that Medicare's subrogation right is not limited to recovering from the injured person. The statute and regulations give the Agency the ability to seek payment from a wide range of individuals who knew or should have known about its payments (although Medicare is not required to give notice of such payments). It is commonly believed that if Medicare's interest is not repaid, anyone who could have protected Medicare's interest may be liable for the repayment. 42 U.S.C. § 1395y(b)(2)(B)(ii) provides that an action may be brought against an entity responsible for payment or "*any other entity . . . that has received*" a third party payment. **Under the regulations, this includes even lawyers whose fees are paid from settlement proceeds.** Under 42 CFR § 411.24(g), Medicare has a right of recovery from parties who receive third party payments. "HCFA 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 third party payment." 42 C.F.R. § 411.24(2)(g).

Fortunately, Medicare does not insist on reimbursement for the full amount of benefits paid, but will initially reduce the claim by its proportionate share of the costs and attorney's fees incurred in obtaining the recovery. 42 C.F.R. § 411.37. The Medicare *statute* does not require

Medicare to allow for procurements costs; however, by *regulations*, Medicare will reduce its subrogation by its pro rata share of attorney's fees in disputed claims, whether through settlement or by judgment. There is a specific method set out for determining the amount of reimbursement:

(1) Determine the ratio of the procurement costs to the total judgment or settlement payment.

(2) Apply the ratio to the Medicare payment. The product is the Medicare share of the procurement costs.

(3) Subtract the Medicare share of procurement costs from the Medicare payments.

The remainder is the Medicare recovery amount. 42 C.F.R. § 411.37(c). Unfortunately, if the amount owed to Medicare equals or exceeds the recovery, Medicare can demand that the entire amount of the recovery, less fees and costs, be paid. 42 C.F.R. § 411.37(c). As is probably obvious by now, Medicare is not governed by the "made whole" doctrine and has the right to demand that an injured party return the entire amount if it chooses.

However, Medicare does have the statutory authority to waive its subrogation right, or compromise its clam, if it "determines that the waiver is in the best interest of the program." 42 U.S.C. § 1395y(b)(2)(B)(iv). Medicare must base its recommendation on whether to compromise its claim on:

(a) the inability of the debtor to pay the full amount within a reasonable time;

(b) the inability of the government to collect within a reasonable time when the debtor refuses to pay.

4 C.F.R. 131.1(a).

When evaluating the debtor's inability to pay, Medicare considers:

a) the debtor's age and health;

(b) the debtor's present and potential income;

(c) the debtor's inheritance prospects;

(d) whether the debtor has concealed or improperly transferred assets;

(e) whether assets or income are available which could be realized by enforced collection proceedings.

4 C.F.R. 131.1(b).

Medicare may obtain a sworn statement, executed under the penalty of perjury, showing the beneficiary's assets, liabilities, income, and expenses if it does not have reasonably up-to-date credit information.

In evaluating the government's inability to collect, Medicare considers:

(a) applicable exemptions of debtors under applicable state and federal law;

(b) uncertainty as to the price property will bring at forced sale;

(c) the availability of witnesses;

(d) the chances of prevailing;

(e) the likelihood of collecting;

(f) the cost of litigating;

(g) the attorney's fees likely to be paid before recovery is had.

4 C.F.R. 131.1(c).

There must be real doubt concerning the government's ability to prove its case either because of the legal issues involved or a bona fide dispute as to the facts. *Id.*

The amount offered to compromise Medicare's claim must bear a reasonable relationship to the amount that could be recovered by enforced collection proceedings, considering the

exemptions available to the debtor and the time collection will take. 4 C.F.R. 131.1(c). The amount accepted should, also, fairly reflect the probability of prevailing on the legal issues involved.

The regulations strongly discourage settlements involving installment payments. 4 C.F.R. 103.2(c). Therefore, the amount of the lump sum payment necessary to pay Medicare's lien should be ascertained before entering into a structured settlement.

As noted above, Medicare can also waive its entire claim if doing so would be in the best interest of the Medicare secondary payor program. 42 U.S.C. § 1395gg (c). Intermediaries can consider requests for waiver under Section 1870(c) of the Social Security Act, which is a request based strictly on financial hardship. Under Section 1870(c), Medicare may waive all or part of its recovery when:

(a) the claimant is without fault;

(b) recovery would either:

(i) defeat the purpose of the Old Age Dependant's, Survivor's and Disability Insurance Benefits or hospital supplementary medical insurance benefits; or

(ii) be against equity and good conscience. 42 U.S.C. § 1395gg (c).

The beneficiary must satisfy both elements (a) and (b) in order for Medicare to waive its claim.

In determining whether a person lacks fault, Medicare considers:

(a) the individual's age and intelligence;

(b) any mental, physical, educational, or linguistic limitations;

(c) whether the individual made a statement he or she knew or should have known was incorrect;

(d) whether the individual failed to furnish information he or she knew or should have known was material. 20 C.F.R. 404.507.

Medicare deems the claimant without fault for the act of settling a liability claim. However, it is conceivable for the foregoing rules to become applicable based on any misrepresentations made by the beneficiary to Medicare.

A refusal to waive the Medicare claim defeats the purpose of Medicare when it deprives a person of income required for ordinary and necessary living expenses. 20 C.F.R. 404.508(a). Such refusal deprives a person of such income when he or she depends upon all of his or her current benefits for ordinary and necessary needs, and lacks sufficient income or financial resources for more than such needs. *Id*. Ordinary and necessary expenses include:

(a) fixed living expenses such as food and clothing, rent, mortgage payments, utilities, maintenance, insurance, taxes, installment payments, etc.;

(b) medical, hospitalization, and other similar expenses;

(c) expenses for the support of others for whom the individual is legally responsible; and

(d) other miscellaneous expenses which may reasonably be considered as part of the individual's standard of living. *Id*.

After gathering the relevant information regarding a claim, or waiver request, the intermediary will make a recommendation to the regional office of the Health Care Financing Authority as to how the request should be dealt with. That agency then makes recommendations to the Authority's headquarters. This is a very slow process – typically taking more than six months to resolve. Lawyers need to keep in mind that it is their responsibility to provide the necessary information to evaluate the claim, including a medical authorization from the injured

participant. 5 U.S.C. § 522(b)(6). Failure to provide the required information may delay the final disbursement of the recovery proceeds.

A refusal to waive the Medicare claim violates equity and good conscience when such refusal would be unfair. The courts apply the common and ordinary meaning of the terms "equity" and "good conscience," which are of "unusual generality." By choosing such general terms, Congress intended to broaden the availability of waivers.

Although it appears that the client, not the attorney, has a duty to advise Medicare of a pending settlement or recovery, Medicare actually has collection rights as to personal injury recovery monies actually in the hands of the attorney. It is possible that Medicare has a right to collect from an attorney even after the settlement proceeds have been distributed to the client, although the argument could be made that the statutes and regulations provide no such right. However, it is important to note that the government has given notice that it will pursue a recovery of Medicare reimbursement against the attorney as well as against the client even after funds have been distributed. The problem extends to the defense attorney, who must be aware that the claimant's attorney has no direct duties to Medicare, and that Medicare's subrogation rights can extend to a liability insurer.

B. <u>But Is There Really A Lien?</u>

All this being said, several years ago there was a group of lawyers who advocated that Medicare is not the “super lien” we have all come to believe it is, and that Medicare “liens” can and should be avoided where the funds are from a third party’s liability insurance. There is some authority for this position. In *Zinman v. Shalala,* 835 F. Supp. 1163, (N.D. Cal. 1993), *aff'd*, 67 F.3d 841 (9th Cir. 1995), a nationwide class action, the California district court held that Medicare does not possess a lien right.

> The MSP statute does not state that Medicare has a lien, it articulates Medicare's right as a claim to recover from entities who, pursuant to the statute, are required to pay primary . . . . [T]he MSP statute does not give the government a claim against property. The statute states that the government may bring an action against any entity which is responsible to pay primary . . . [T]he Court concludes that Medicare does not have a lien interest in the settlement awards.

835 F. Supp. 1163, 1171. In addition, the court flatly ordered Medicare to stop using the term "lien." "[A]s Medicare does not have a 'lien' on the settlement awards, the Secretary and Medicare contractors shall cease using that term to describe MSP recovery claims in communications with beneficiaries and attorneys." *Id.* Nevertheless, the court still held that the administration was entitled to recovery the amounts it had paid – regardless of what the right of recovery was called.

Based on *Zinman* and a careful review of the statutes, regulations, case law, codes of professional responsibility and actual practice, it has been suggested that the dreaded *Super Lien* is not a true lien and cannot be enforced as such. The law in this area is far from settled, however, and attorneys should proceed with caution. There are still reasons for concern. It is absolutely advisable for attorneys settling cases with outstanding Medicare *liens* to attempt to resolve Medicare claims before paying out the proceeds of settlement to the client. This will protect the claimant's attorney from later MSP collection efforts by the government and should enable the claimant to maximize his bargaining position with Medicare intermediaries.

If you want to fight the issue, however, there are some arguments for not reimbursing Medicare. Although the Medicare statute and regulations clearly give Medicare a right of action to recover conditional payments from an attorney who has the settlement or judgment proceeds in

his or her possession, the penalty provisions giving the agency a right of action against an entity that has transferred proceeds without paying Medicare specifically apply only to insurance companies and do not specify that Medicare has a right to seek transferred proceeds from attorneys who have paid out a settlement to their client. 42 C.F.R. § 411.24(2)(g) & (i). The regulations' special rule for insurance companies has been widely assumed to apply also to attorneys. However, the rule specifically states:

> *In the case of liability insurance settlements and disputed claims under employer group health plans and no-fault insurance, the following rule applies:* If Medicare is not reimbursed as required by paragraph (h) of this section, the third party payer [liability insurance, employer health plans and no-fault insurance] must reimburse Medicare even though it has already reimbursed the beneficiary or other party."

42 C.F.R. § 411.24(2)(i)(1) (emphasis added). No such special rule applies to parties who merely receive third party payments other than insurance companies and employer heath plans. Under the precise terminology of the regulations, Medicare is given no specific right of action against attorneys who distribute funds to their clients after properly advising them of potential MSP recovery claims. The relevant part of the statute reads:

> In order to recover payment under this subchapter for such an item or service [paid conditionally by Medicare], the United States may bring an action against an entity which is required or responsible [under this subsection] to make payment with respect to such item or service (or any portion thereof) under a primary plan (and may, in accordance with paragraph (3)(A) collect double damages against the entity), or against any other entity (including any physician

or provider) that has received payment from that entity with respect to the item or service.

42 U.S.C. § 1395y(b)(2)(B)(ii).

When one reads all of the regulations together, § 411.24(g) might well be read as authorizing recovery against attorneys only when they are still holding insurance proceeds that they received for the beneficiary. Unfortunately, however, no case law or agency interpretation currently confirms such a reading of the statute and regulations. The case of *United States v. Sosnowski*, 822 F. Supp. 570, 574 (W.D. Wis. 1993) seems to support the claim that Medicare *does have* a cause of action against the lawyer and/or the client for recovery of third party payments received in settlement and disbursed to the client. In *Sosnowski*, the court granted summary judgment to the government in a claim against a Medicare recipient and his lawyer, jointly and severally, for failing to reimburse Medicare after receiving judgment proceeds in a personal injury case.

Of concern is the fact that the court specifically acknowledged that the proceeds of settlement had been disbursed; thus there is no real distinction between situations where the funds are still being held by the attorney and those where the proceeds are disbursed. *Sosnowski*, 822 F. Supp. at 574. However, the case was decided on the unrelated, disputed issues of estoppel and default. The defendants did not appear to challenge the right of the government to seek funds apparently no longer in the hands of the attorney. The court did hold that the double damage provisions were not applicable against the Medicare client and his attorney, but rather that the double damage provisions were only applicable against insurance companies. On the one hand, this case is certainly some authority that Medicare's claim is enforceable against plaintiff's attorneys who have received and disbursed insurance proceeds on behalf of their client. On the

other hand, no case has squarely held that the Medicare statutes and regulations give Medicare a right to recover proceeds of settlement or judgment from a plaintiff's attorney previously received and disbursed to the client.

C. Protecting Future Benefits

The latest impediment to recovery in a tort settlement where Medicare is involved concerns a beneficiary's entitlement to future benefits after receiving a personal injury settlement. Please note that this pertains directly to workers' compensation settlements! The Centers for Medicare & Medicaid Services ("CMS") developed a set-aside process to ensure that Medicare would not pay for future medical care that was compensated for by a workers' compensation settlement, judgment, or award, but would pay for medical care once the set-aside funds were properly exhausted.

All parties in a Workers' Compensation case have significant responsibilities under the Medicare Secondary Payer (MSP) laws to protect Medicare's interests when resolving WC cases that include future medical expenses. The recommended method to protect Medicare's interests is a Workers' Compensation Medicare Set-aside Arrangement, which allocates a portion of the WC settlement for future medical expenses. The amount of the set aside is determined on a case-by-case basis and should be reviewed by CMS, when appropriate. Once the CMS determined set aside amount is exhausted and accurately accounted for to CMS, Medicare will agree to pay primary for future Medicare covered expenses related to the WC injury.

A Medicare Set-Aside is necessary whenever an injured party is a Medicare beneficiary, regardless of the amount of the settlement; or, whenever the total amount of the settlement is greater than $250,000.00, and it is reasonably expected that the injured party will become a

Medicare beneficiary within 30 months of the settlement. Note that a MSA is not necessary when resolution of the WC claim leaves the medical aspects of the claim open.

The amount that must be allocated to the Set-Aside trust will be determined by analyzing the claim and the medical needs of the injured party, and will take into consideration the following factors:

* Date and nature of injury
* Type and extent of injury or illness
* Rated age of the injured party and life expectancy
* Date and basis of Medicare entitlement
* Review of medical payment history
* Comprehensive review of medical records
* Physician's recommendations
* Extent of disability
* Medicare coverage limitations
* Workers' compensation fee schedules
* Future medical needs for treatment of the injured party through life expectancy

While the client ultimately makes the decision concerning what settlement to accept, the claimant's attorney needs to recognize the ethical and legal obligations under federal law to adhere to Medicare's interests in any personal injury case. As this is a relatively new issue to consider, it is recommended that the Regulations be reviewed before determining that a Set-Aside is not necessary in a given case. *See* 42 C.F.R. 411.24(e).

1. Liability claims

The fundamental statutory principle requiring settling parties to protect Medicare's interests in workers' compensation settlements appears to apply to liability settlements as well. The MSP provisions say Medicare is always secondary to workers' comp and other insurance -- including no-fault and liability insurance. Under the Social Security Act, payment "may not be made under Medicare for covered items or services to the extent that payment has been made, or can reasonably be expected to be made promptly, under a liability insurance policy or plan."

Also, Medicare's authority to review liability settlements arises under the same statute as its authority to review workers' comp settlements does.

While MSA may well be applicable to liability settlement, it is clearly more difficult to fairly apply the set-aside requirement to personal injury settlements paid by liability insurers. Unlike workers' compensation plans, which cover a worker's lifetime injury-related care, liability insurance policies generally have caps, and the doctrines of comparative fault and contributory negligence inherent in personal injury cases work to offset the damages to an amount less than full value. Currently, CMS's calculation methodologies are geared toward the full-value, "no fault" nature of workers' comp statutes. The types of damages in workers' comp cases, such as "indemnity" and "medical" payments, are readily delineated, but in personal injury settlements, an array of damages can be categorized as "general" and "special."

Even though no formal set-aside process exists for liability settlements, there is nevertheless an obligation to protect Medicare's interests when a settlement includes compensation for future medical expenses. The regulations appear to give CMS the power to disregard a settlement and assess penalties to any party that attempts to shift payment responsibility inappropriately to Medicare.

Clearly, lawyers must recognize and protect Medicare's interests. It is thus advisable that you carefully consider the risks involved in settling a case that may be interpreted as including future benefits without setting aside a portion of that settlement for payment of those expenses. Unfortuantely, there are no clear guidelines.

VI. MEDICAID

Medicaid is a joint federal/state program to provide medical benefits to the poor. The federal government provides grants to establish “medical assistance plans,” which are partially

funded and administered by the states. *See* 42 U.S.C. § 1396 *et seq*. In Georgia, participation is through the Georgia Department of Medical Assistance. The program is governed by O.C.G.A 49-4-140, *et seq*. In exchange for providing over half of the program's cost, the federal government has set forth certain statutory requirements for recovery of benefits when there is third party liability. Specifically, state agencies are required to "take all reasonable measure to ascertain the legal liability of third parties . . . to pay for care and services available under [Medicaid]." The primary method for accomplishing this goal is the assignment statute, which requires recipients to assign to Medicaid, their rights to payment for medical care form any third party. However, the federal mandate is not without restriction, as it does preclude placing a lien against the recipient's property.

For years, states, including Georgia, have sought reimbursement out of the entire amount of the entire amount of a personal injury recovery, regardless of the designation of type of damages recovered. Medicaid also claimed the first dollar, such that a plaintiff often was left with nothing after paying the state's claim. The inequity of this approach was challenged in a number of venues, based on a variety of arguments to no avail, until just recently.

In *Richards v. Georgia Dept. of Community Health,*[6] the plaintiffs sought to avoid reimbursement under O.C.G.A. § 49-4-149, which describes a lien in favor of the Medicaid program, by arguing the that Georgia provision is preempted by Federal law. In particular the plaintiffs alleged that Federal anti-lien statutes forbid liens or recoveries against recipients. The plaintiffs also argued, at a minimum, that the State should only be allowed to seek reimbursement out of settlement proceeds that are attributable to the medical expenses claimed. The Georgia Supreme Court rejected all of the arguments. Fortunately, however, the United

[6] 278 Ga. 757, 604 S.E.2d 815 (2004).

States Supreme Court disagreed with the Georgia Court's interpretation in a similar case filed in Arkansas. In *Arkansas Dep't of Health & Human Services v. Ahlborn*,[7] the Court limited Medicaid and the corresponding state programs' recoveries from third-party settlements to the proceeds representing repayment of medical expenses. This difference perhaps was the fact that the plaintiff in *Ahlborn* did not try to avoid the lien entirely, but sought to limit the source of the proceeds from which the State could recover. The *Ahlborn* decision was good news for plaintiffs here and everywhere; however, it is yet to be seen how the decision will impact the manner in which the States go after tort recoveries.

As far as the practical application of the rule, we still need to consider how the State goes about obtaining its recovery out of the portion of third party settlement attributable to medical expenses. Consistent with the federal requirement, Georgia has statutes governing measures to be followed by the Department of Medical Assistance to recover medical expenses it has paid under circumstances involving third party liability. O.C.G.A. §§ 49-4-148 & 149. Accordingly, the Department is subrogated to the rights of the injured participant. Historically it has sought to recover directly from the wrongdoer and is actually entitled to use the liens available to private hospitals. Additionally, the Department has a lien "upon any moneys or other property accruing to the recipient . . . due to the liability of a third party" and may perfect and enforce its lien pursuant to procedures set forth in O.C.G.A. § 49-4-149(a). The Department's lien must be filed within one year after the date of the last medical benefit provided and must be filed in the county where the recipient resides as well as in Fulton County. O.C.G.A. § 49-4-149(b). Similarly, the

[7] 126 S.Ct. 1752 (2006). The Court considered the issue precisely because there were differing opinion from the states on how to handle Medicaid liens. *See Martin v. City of Rochester*, 642 N.W.2d 1 (Minn. 2002), but the theory has been rejected by others. *Cf. Houghton v. Department of Health*, 57 P.3d 1067 (Utah 2002); *Grey Bear v. North Dakota Department of Human Services*, 651 N.W.2d 611 (2002).

Department has only one year to enforce its lien right after liability is determined or a settlement reached. O.C.G.A. § 44-14-473(a).

Georgia law has long been assumed, perhaps incorrectly, to provide for a right of subrogation; but is there also a right of reimbursement? This question arose in *Department of Medical Assistance v. Hallman*, 203 Ga. App. 615, 417 S.E.2d 218 (1992). In that case, the Department timely filed its lien, the case was settled and disbursement checks were issued to the injured party, his lawyers and the Department. The Department did nothing to enforce its lien right for over a year, at which time the plaintiff's lawyer sought a declaratory judgment that the Department had waived its right by failing to initiate requisite legal action. The Department filed a counterclaim, on the grounds that it was entitled to payment from the plaintiff, who had received the benefits. The Court of Appeals affirmed summary judgment against the Department, concluding that the Department had no right to be reimbursed from the injured party, finding that the doctrine of money had and received applied. Furthermore, the Department had not pursued an action directly against the tortfeasor, and the statute of limitations on that right of enforcement had expired.

Thereafter, the Legislature amended O.C.G.A. § 9-2-21 to require an attorney representing an injured person who has received Medicaid benefits to notify the Department of Medical Assistance before filing a third party claim. The attorney must also give notice to the Department before any communication with the tortfeasor concerning the claim. Interesting, however, such notice is not prerequisite to fling a lawsuit.

As with Medicare, the Department has a good bit of discretion in dealing with its recovery of medial expenses. The Department "may compromise, settle, and execute a release of any such claim or waive, expressly, any such claim, in whole or in part, for [its] convenience."

O.C.G.A. § 49-4-148. Unfortunately, the regulations do not dictate how the Department's power will be effectuated and anyone who has ever dealt with one of these claims can certainly attest to the inefficiency of the process.

Both federal and state statutes are silent on whether Medicaid is entitled to receive the full amount of the benefits paid or whether it is responsible for its proportionate share of costs and attorney's fees incurred in obtaining the third party recovery. The applicable regulations don't address the issue either. Although there is not a great deal of case law in Georgia dealing with the issue, there *is* considerable support from other jurisdictions for the suggestion that Medicaid claims are subject to the same general equitable principles that apply to other similar claims, and that Medicaid is therefore required to pay its share of the costs incurred and may even be subject to the made whole doctrine. *Ahlborn* also answered this issue as well, noting that the amount the state of Arkansas was entitled to recover was not only reduced to represent the amount of the settlement reasonably related to medical expenses, but also the proportionate share of attorneys' fees expended in obtaining that recovery.

VII. WORKERS' COMPENSATION SUBROGATION

One might easily suggest that each one is worse than the last. As if negotiating complex ERISA pans and navigating the bureaucratic nightmare of Medicare were not enough, now you have to face the workers' compensation lien! With respect to the workers' compensation subrogation statute, one thing is certain: everyone hates it. Many have noted that workers' compensation subrogation statute has created an endless stream of litigation, which in turn has failed to adequately explain the application of the statute. The Court of Appeals has considered the matter multiple times with mixed results. Despite a call to either revamp the statute, or get

rid of it all together, as of today it is still in place and we therefore have to consider how workers' compensation liens may affect the resolution of tort cases.

A workers' compensation carrier that has paid benefits to an injured employee in Georgia has a statutory right of subrogation to recover benefits paid when a third party is responsible for the claimant's injuries. O.C.G.A. § 34-9-11.1. This is a hybrid subrogation/reimbursement provision. During the first year after an injury, the employee has the exclusive right to bring suit against the third party tortfeasor. O.C.G.A. § 34-9-11.1(c). Although the statute does not require notice to the carrier of the suit, the carrier nonetheless is afforded the absolute right to intervene. O.C.G.A. § 34-9-11.1(b); *Canal Ins. Co. v. Liberty Mutual Ins. Co.*, 256 Ga. App. 866, 570 S.E.2d 60 (2002) (failure to allow intervention in a claimant's tort suit is an abuse of discretion by trial court). As an intervenor, the carrier can seek to recover for benefits paid out of any recovery obtained from the third party. If, however, the employee fails to file suit within the first year, the employer and/or insurer has the right to sue the tortfeasor directly, and may do so in its own name or the name of the employee. The employee still has the right to file within the second year, in which case notice is required to the party not filing, and that party may intervene.

While the employer and insurer are not *required* to intervene in a claimant's tort action, failure to do so will greatly affect the carrier's right to reimbursement. There are situations where a plaintiff will negotiate a lien even where no intervention occurs; however, there is nothing in the statute that requires the plaintiff to cooperate in this fashion. Nevertheless, it might be in the plaintiff's best interest to cooperate and avoid intervention, so as to have better control of the litigation, because there is nothing in the statute that "give[s] specific guidance about what litigation tactics are permissible as an intervenor strives to protect its lien."

International Maintenance Corp. v. Inland Paper Board & Packaging, Inc., 256 Ga. App. 752, 569 S.E.2d 865 (2002) (recognizing that the intervenor might actually do something to prejudice the plaintiff's recovery). However, if the plaintiff does not cooperate in the end, the carrier does not have any further recourse against the responsible party; it cannot file a separate action against the liability insurer after a plaintiff settles his tort action. *Canal Ins. Co. v. Liberty Mutual Ins. Co.*, 256 Ga. App. 866, 570 S.E.2d 60 (2002).

The most nebulous aspect of the workers' compensation lien statue is the requirement that the employer and/or insurer establish that the employee has been fully and completely compensated for all damages, economic and noneconomic, by the total recovery. Unless the employer can establish complete compensation, it has no right of reimbursement. *Paschall Truck Lines, Inc. v. Kirkland*, 287 Ga. App. 497, 651 S.E.2d 804 (2007) (an employer cannot enforce a subrogation lien against a claimant's personal injury settlement absent showing that claimant had been fully and completely compensated, and it is the employer's duty to make such a showing). This is particularly problematic in the context of a settlement, because there is no determination, or itemization, by the jury as to amount of damages awarded.[8] Despite the difficulties in proof, the Court of Appeals recently held that the burden of proving complete compensation exists in the case of a settlement, just as with a jury verdict. *Hartford Ins. Co. v. Federal Express Corp.*, 253 Ga. App. 520, 559 S.E.2d 530 (2002); *City of Warner Robins v.*

[8] Where the case is tried, a special verdict form can be used to address this very problem. *See Department of Administrative Services v. Brown*, 219 Ga. App. 27, 464 S.E.2d 7 (1995). If the carrier is going to seek recovery out of the judgment, the intervenor must specifically request the special verdict form. *See Ferqueron v. State Farm Mut. Ins. Co.*, 271 Ga. App. 572, 610 S.E.2d 184 (2005). The court can determine whether an employee has been completely compensated for an item of damage, such as medical expenses, even if all other damages are not covered fully by the verdict. The lien will attach only to those items of damage for which the plaintiff has been fully compensated. *See, e.g., North Brothers Company v. Thomas*, 236 Ga. App. 839, 513 SE.2d 251 (1999).

Baker, 244, Ga. App. 601, 565 S.E.2d 919 (2002). In *Hartford*, the Court suggested that an item-by-item analysis is necessary in the context of a settlement, just as with a special verdict. This was confirmed in *Baker*. In *Baker*, the employer was aware of the claimant's suit against the tortfeasor, but nevertheless chose not to intervene, even when it learned of settlement negotiations between the parties. The employer sought to enforce its lien after the settlement was reached, but the trial court held that it had no right of reimbursement because it failed to establish the claimant was completely compensated. The employer argued that it was not its burden to prove full compensation in the event of a settlement, only in the context of a jury trial where they are permitted to participate as intervenors. The Court of Appeals rejected this view, emphasizing that the right to intervene is always voluntary and the employer has the same ability to participate in the process whether or not there is a jury trial.

> The statute does not differentiate between jury awards and compromise settlements. It speaks in terms of a claimant's "recovery." Neither does the law differentiate between jury awards and settlements.

244 Ga. App. 601, 605.

It is possible for the claimant to waive the complete compensation requirement. In *Georgia Electric Membership Corp. v. High-Ranger, Inc.* 275 Ga. 197, 563 S.E.2d 841 (2002) the injured employee and his employer filed suit in federal court jointly against the third party manufacturer responsible for the plaintiff's injuries. The plaintiff settled his claim and dismissed the defendant with prejudice, but the employer sought to continue its claim for reimbursement. The Eleventh Circuit certified the question of whether a claim for repayment of workers' compensation benefits against a third party tortfeasor is extinguished by the employee's settlement of his claims and execution of a release. The Georgia Supreme Court contrasted

subsection (b) of the lien statute, in which the employer may intervene after the employee files suit, in which case the employer has to prove complete compensation, with subsection (c), where the employer asserts the employee's cause of action, in which case it is only required to pay the employee any amount in excess of its benefits paid. In the latter situation, the employer does not have to establish full and complete compensation where the employee chooses not to participate. The Court held that the employer's claims remained pending,[9] and that the employee's release amounted to a waiver of his right to prove that he was completely compensated.

When settling a case it is important to take note of future damages, both special and general, which may have the effect of establishing that the plaintiff has not been completely compensated. For example, in *Hartford Ins. Co. v. Federal Express Corp.*, 253 Ga. App. 520, 559 S.E.2d 530 (2002) the employee received workers' compensation benefits totaling $65,000. This included medical expenses, indemnity benefits and a lump sum settlement. Thereafter, the claimant filed suit against the tortfeasor and settled that case for $75,000 prior to trial. The Court of Appeals affirmed the trial court's finding that the plaintiff had not been fully compensated, based in large part on the fact that the employee would likely incur future medical expenses, pain and suffering and lost wages.

It goes without saying that the lien applies only to benefits that have already been **paid** at the time the case is resolved. There is no right to assert a lien for **future** workers' compensation benefits not yet paid. *Harrison v. CGM Ins. Co.*, 269 Ga. App. 549, 604 S.E.2d 615 (2004). However, it is possible for future benefits to be paid, in which case they would be subject to a subsequent the lien if other requirements are met. *CGU Ins. Co. v. Sabel Industries, Inc.*, 255

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[9] This portion of the Court's opinion seems to conflict with other holdings that the employer and insurer cannot continue against the third party tortfeasor. *See, e.g. International Maintenance Corp. v. Inland Paper Board & Packaging, Inc.*, 256 Ga. App. 752, 569 S.E.2d 865 (2002).

Ga. App. 236, 564 S.E.2d 836 (2002). The converse is also true, in that if the plaintiff settles his tort case before the carrier pays any benefits, the settlement could extinguish the lien, or rather, the lien would never exist. *Georgia Star Plumbing v. Bowen*, 225 Ga. App. 379, 484 S.E.2d 26 (1997). Also, only benefits that are paid under the Georgia statute have a lien. Therefore, there is no subrogation right afforded to a carrier who paid benefits pursuant to another state's workers' compensation law. *Johnson v. Comcar Industries, Inc.*, 252 Ga. App. 625, 556 S.e.2d 148 (2001).

It is not uncommon for an employer and insurer to argue that the fact of settlement alone connotes full compensation. This argument has not been accepted by the courts and, quite frankly, ignores the reality of settlement as a compromise of the claim. As the Court of Appeals recently explained:

> As a matter of common sense, the decision to proceed to trial presents significant risk , and a decision to settle for an amount less than what is perceived to be full value of the claim is often made simply to minimize risk. Such a decision certainly does not always indicate that the claimant has been "fully and completely compensation."

Id. At 605.

Finally, with respect to attorneys fees in workers' compensation subrogation claims, O.C.G.A. § 34-9-11.1(d) provides for a reasonable attorneys fee for the attorney representing the injured employee in the tort case. The attorney for the employer and insurer can apply to the court to apportion the fee between counsel for the employee and the carrier in proportion to services rendered. The plaintiff's attorney's lien has priority over the claims of either the employee or the employer or insurer. *Hamond v. Lee*, 244 Ga. App. 865, 536 S.E.2d 231 (2000).

If counsel for the lien holder is unsuccessful in recovering any benefits, no attorney's fee will be awarded. *Simpson v. Southwire Co.*, 249 Ga. App. 406, 548 S.E.2d 660 (2001).

With respect to third-party claims arising out of an on-the-job injury, the claimant's attorney has a unique opportunity to protect his client from the risk of weighty reimbursement claims. Although this cannot always be done, it is imperative that the claimant's attorney at least attempt to get a waiver of any subrogation claim by the workers' compensation carrier at the time of settlement of the comp claim. A complete waiver is certainly the best case scenario; however, any variation on that theme can help in the resolution of the third-party claim if and when that occurs.

VIII. CONCLUSION

When settling a case, the goal is certainly to conclude the matter and close the file. However, to reach that goal, liens and subrogation issues cannot be relegated to the end of a case. Potential lien and claim holders must be identified early and a plan made to deal with them at the outset of the case. Clearly, ignorance is not bliss. With the proper legwork, claims for reimbursement can be addressed and resolved at the time of settlement without extreme frustration and the need for perpetual litigation.