Paying Out the Settlement:
Resolving Liens and Reimbursement Rights

Jeffrey S. Warncke
Dietrick, Evans, Scholz & Williams, LLC
3490 Piedmont Road, NE
Suite 1200
Atlanta, Georgia 30306
404-841-9400
jswarncke@desw.com

with acknowledgment to:
Lyle Griffin Warshauer
Warshauer Thomas Thornton & Rogers, P.C.Suite 2700
75 Fourteenth Street, NE..
Atlanta, Georgia 30309
4048924900
lgw@wttrlaw.com

Paying Out the Settlement:
Resolving Liens and Reimbursement Rights

Jeffrey S. Warncke
Dietrick, Evans, Scholz & Williams, LLC
3490 Piedmont Road, NE
Suite 1200
Atlanta, Georgia 30306
404-841-9400
jswarncke@desw.com

with acknowledgment to:
Lyle Griffin Warshauer
Warshauer Thomas Thornton & Rogers, P.C.Suite 2700
75 Fourteenth Street, NE..
Atlanta, Georgia 30309
4048924900
lgw@wttrlaw.com

TABLE OF CONTENTS

I. INTRODUCTION .... -1-

II. HOSPITAL LIENS .... -3-

III. INDIVIDUAL PROVIDERS .... -7-

IV. HEALTH AND DISABILITY INSURERS .... -10-
- **A. Determining the Governing law - Does Federal Law Preempt State Law? .... -12-**
- **B. Georgia Law of Reimbursement/Subrogation .... -16-**
- **C. Self-Funded ERISA Plans - ERISA Reimbursement Remedies .... -19-**

V. MEDICARE .... -27-

- **A. Medicare's "Super Lien" .... -29-**

VI. WORKERS' COMPENSATION. .... -36-

Paying Out the Settlement:
Resolving Liens and Reimbursement Rights

Jeffrey S. Warncke

I. INTRODUCTION

Most plaintiff and defense lawyers would agree that in a perfect world, settlement should be a matter of the parties agreeing on fair value for a case, executing a release in exchange for a check, and moving on to the next case. However, increasingly, agreeing on fair value is the easy part. In many cases the real challenge can be resolving the claims of third parties who claim an interest in the proceeds of settlement. Although we tend to use the term "subrogation" broadly to describe all such claims, this is not technically accurate. Classic "subrogation" refers to "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). It is fairly rare to find a situation in which a third party is asserting classic subrogation - actually standing in the shoes of the plaintiff and directly prosecuting a claim against a tort defendant. Far more common are situations in which insurers, benefit plans, hospitals, medical providers, or Medicare are seeking reimbursement from the proceeds of the settlement obtained by the plaintiff's own efforts. While these technically are not "subrogation" claims, no one will ridicule you for using the "subrogation" term loosely to describe these situations.

Dealing with claims for reimbursement is not only tedious and frustrating, but regardless of what side you are on, you are likely to feel that somebody got something for nothing. 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; we need to know how to deal with a claim when it arises.

In the last couple of years, there have been a number of developments in the subrogation and reimbursement arena that have further complicated the issue. The United States Supreme Court has issued a series of decisions defining the scope of reimbursement rights in the ERISA context which done very little to clarify an already murky and anachronistic analytical framework. Medicare's right to reimbursement has likewise been a source of confusion, vacillating between what was for many years considered a "super lien" (which could not be overcome under any scenario), to an avoidable risk (according to an appellate decision that invoked a new twist), back to a totally unavoidable lien (thanks to Congress's revision of the Medicare Act).

As distasteful as this may be, it is incumbent upon lawyers to consider whether there are potential third-party claims to which a lien, reimbursement or subrogation claim might attach prior to the conclusion of a case. In fact, it is far better to address these issues head-on 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.

This paper will attempt to outline recent developments in subrogation and reimbursement law in six particular areas: Hospital Liens, Individual Providers' claims, Health and Benefit Plan claims, ERISA claims, Medicare 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. While the specific topic to be addressed is how to resolve liens and

reimbursement claims at the time of settlement, it is impossible to know how that should be done without a basic understanding of what subrogation/reimbursement rights might exist and to what extent recovery is or is not warranted under the circumstances.

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, *et seq*..

> 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 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.

Not less than 15 days prior to filing with the court, the hospital provider must provide a verified statement to the patient and, to the best of the claimant's knowledge, "the persons, firms, corporations, and their insurers claimed by the injured person or the legal representative of the injured person to be liable for damages" setting forth certain specified information.[1] The lien statement is filed in the Superior Court of the county/counties in

---

[1]Despite this requirement, at least one court has held that the failure to file within the formerly-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.

which the hospital is located and in which the plaintiff resides. Additionally, copies of the statement must be sent to all individuals who are potentially liable for the plaintiff's injuries, in order to put them on notice of the lien. O.C.G.A. § 44-14-471.

The lien statute does not give a hospital or nursing home a new right of action against the injured person. *Hospital Authority of Augusta v. Boyd*, 96 Ga. App. 705, 101 S.E.2d 207 (1957). Similarly, the hospital or nursing home has no right of action against the tortfeasor directly. O.C.G.A.§ 44-14-476; *Integon Indemnity corp. v. Henry Medical Ctr.*, 235 Ga. App. 94, 97 (1998). The lien right created by the statute is analogous to a creditor's remedy by garnishment, i.e., the ability to recover the amount owed from funds belonging to the debtor in the hands of a third person. Just as a creditor seeking garnishment may also seek to recover from the debtor, so may a hospital lien holder attempt to collect from the patient.

Insurers facing the possibility of paying both the plaintiff and the provider routinely insist as part of any settlement that a plaintiff warrant that there are no outstanding hospital liens and promise to indemnify the insurer in the event such a lien claim arises later.

It is important to note that 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, the hospital cannot thereafter attempt reimbursement for the higher, "usual rate" it charges. In fact, if the hospital typically accepts insurance, it cannot elect to refrain from submitting a bill to insurance, opting instead to obtain reimbursement for a greater recovery out of a third-party claim. *See, Constantine v. MCG Health, Inc.*, 275 Ga. App. 128, 619 S.E.2d 718

(2005)(dismissing hospital lien running contrary to terms of hospital's contract with the patient's health insurer).[2]

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*, 591 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 tortuous interference with the plaintiff s health insurance contract. The court also held that the plaintiff was a third-party beneficiary to the provider contract between the hospital and the health insurer, which contained a hold harmless provision prohibiting the hospital from seeking to recover from the patient amounts in excess of the capitated rates. In fact, the court concluded the hospital's conduct in filing the lien was so culpable that imposition of punitive damages was justified. *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 the plaintiff is Medicare eligible and the hospital accepts Medicare as to that patient's charges, Medicare rates will also govern the hospital lien. The hospital 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

---

[2] A practical corollary of this holding: where your client faces a hospital lien and has health insurance, obtain a copy of the contract between insurer and provider to determine if the lien claim is consistent with the agreement.

subchapter ...” 42 U.S.C. § l395cc(a)(l)(A). Thus, where a hospital has accepted Medicare payments on behalf of a patient, it may only file a lien as to appropriate Medicare deductibles and coinsurance payments.[3] However, the hospital may also elect not to accept Medicare as to a patient, seeking payment instead from a liability carrier, in which case usual provider rates will apply. *See, e.g., Oregon Assoc. of Hospitals v. Bowan*, 708 F. Supp. 1135 (D. Ore. l989)(holding Health Care Financing Administration regulations were void, to extent they limited substantive rights of Medicare participant providers to recover more from the liability insurers than from Medicare when liability insurer was primary payer who would pay promptly and Medicare Secondary Payer statute precluded Medicare payment.)

A hospital lien should only seek reimbursement 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.E.2d 14(2000).

---

[3] There are similar rules that apply to hospitals accepting benefits from Medicaid. *See, Evanston Hospital v. Hauk*, 1 F.3d 540 (7th Cir. 1993) (Medicaid statute allows the government to seek reimbursement from third-party insurer; hospital cannot refund Medicaid payments in order to seek payment directly from third-party).

The Court of Appeals has recently held that a hospital lien only attaches to claims brought by the patient or the patient's representative and does not attach to a wrongful death claim brought by the survivor(s) of the deceased patient. *Nash v. Allstate Insurance Co.*, 256 Ga. App. 143, 146, 567 S.E.2d 748 (2002). Therefore, in a death case, the Plaintiff can potentially defeat a lien by electing to file only a wrongful claim and not filing a claim at all on behalf of the decedent estate.

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).

Finally, 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.*, 244 Ga. App. 583, 536 S.B.2d 270 (2000)(entire amount of insurance proceeds went to pay hospital and Department of Medical Assistance.) According to the Georgia Court of Appeals, the complete compensation rule has no application to hospital liens. *Id.*

III. INDIVIDUAL PROVIDERS

Unlike hospitals and nursing homes, individual medical care providers in Georgia, such as doctors and chiropractors, do not benefit from a statutory lien. Nor is there a

common law lien afforded to an individual who provides medical care to an injured person.[4] Some doctors and other medical providers proactively seek "assignments" from patients for a portion of the patient's personal injury recovery prior to providing services. These "assignments" typically direct the plaintiff's attorney to withhold from any settlement the amount the provider is owed and to pay the medical provider out of the recovery. While the patient may be obligated to the provider, however, an attorney in Georgia generally is not required to serve as the collection agent despite the existence of an assignment.[5]

The Court of Appeals has addressed the issue of whether a chiropractor could enforce an "assignment" against his patient's lawyer in at least two cases. *Cooper Chiropractic Health Clinic, LLC v. Quezada*, 263 Ga. app. 214, 587 S.B.2d 392 (2003) and *Santiago v. Klosik,* 199 Ga. App. 276, 404 S.E.2d 605 (1991). The patient in *Santiago* executed an "assignment" and lien statement in favor of the chiropractor. When the plaintiff's attorney requested a copy of the chiropractor's records and a medical report, the chiropractor sent the lien to the attorney and advised him that he would be required to sign the statement before he could obtain the records. The attorney signed the lien and returned it to the chiropractor, but he never received the records or the report. When the patient's claim was subsequently settled, the attorney disbursed the proceeds without paying the chiropractor. The chiropractor sued the attorney (not the patient) for the costs of his services.

---

[4] *See generally* Annot., "Physicians and Surgeons Liens," 39 A.L.R. 5th (1996).

[5] The situation is different when the attorney directly executes a "letter of protection" indicating that the provider's bill will be paid in the event of a recovery. In such a case the attorney, not the client, has promised to pay and must abide by that representation.

First, the Court of Appeals found that the "assignment" did not violate O.C.G.A. § 44-12-24, which prohibits the assignment of personal injury action, because the "assignment" only gave the chiropractor an interest in any recovery rather than the right to bring suit himself. However, the court refused to enforce the purported assignment against the plaintiff's attorney, concluding there was no consideration supporting any agreement between the parties.

It is unclear whether the "lien" at issue in *Santiago* would have been enforceable if the chiropractor had sent the records. At least one court in another state has held an attorney liable for the provider's fee under similar circumstances, where the attorney signed an assignment and thereafter received a narrative report from the doctor. *See, Heffelfinger v. Gibson*, 290 A.2d 390 (D.C. App. 1972).[6] If the doctor only provides copies of his records - to which the plaintiff has a statutory right - an assignment would arguably still be unenforceable in Georgia under the *Santiago* analysis, since there would be no consideration for the assignment beyond payment of the appropriate fee for the records themselves.

This was precisely the issue before the court in *Quezada*. In that case, attorney *Quezada* represented a patient of Cooper Chiropractic in a car wreck case. Before agreeing to treat the patient, the Clinic entered into a contract with the patient in which the Clinic agreed to provide treatment without immediate payment in exchange for the patient's promise to pay the Clinic out of any proceeds of a settlement. The contract also purported to require the attorney to pay these charges out of a third-party recovery. The attorney

[6] See also Conyers v. Lee, 32 Colo. App. 337, 511 P.2d 506 (1973).

negotiated a settlement in the underlying action without paying the clinic, and the clinic subsequently sued. The Court of Appeals held that the agreement failed for lack of consideration because the attorney received no benefit from the clinic's treatment of his client and was under no obligation to pay his client's medical expenses.[7]

IV. HEALTH AND DISABILITY INSURERS

Reimbursement claims by health and disability policies seem to represent the fastest growing and fastest changing area of law. Health and disability plan reimbursement provisions also vary widely in their terms. Some state that the insurer should be reimbursed from the first dollar of a tort settlement or verdict, regardless of whether the plaintiff has been made whole. Some specify that reimbursement will pay a proportional share of the costs of obtaining the recovery, including attorney fees. Some specify the contrary. Some merely claim the right of reimbursement and are entirely silent on these other issues.

Regardless of how these provisions are drafted, they may or may not be enforceable according to their terms depending upon several factors. A major, if not the major factor, is whether the issue will be governed by Georgia law or by federal law, typically the Employee Retirement Income Security Act of 1974, 29 U.S.C.A. § 1001, *et seq.* (ERISA).

The differences between federal and state law are best understood with reference to Georgia's anti-subrogation statute, O.C.G.A. § 33- 24-56.1. The heart of O.C.G.A. § 33-24-

[7] See also Judge Frank Eldridge's decision in *Arnold v. Nugent,* Civil Action No. E41261 (Fulton County Sup. Ct., 1/4/96), which rejected an argument that consideration supported a chiropractor's "lien" because the doctor had sent the patient's record to his lawyer. Judge Eldridge found that the lawyer could not be compelled to pay the chiropractor for medical services, rejecting an argument that the lien constituted a unilateral contract, since all the services had been provided prior to the date of the lien.

56.1 contains a broad prohibition of classic subrogation, and a placement of procedural and substantive limits on reimbursement claims. The statute codifies the "make whole doctrine," previously recognized both by Georgia common law and by the federal common law of the Eleventh Circuit.[8] The statute also codifies the equitable "common fund" doctrine, "which rests on the perception that persons who obtain the benefit of a lawsuit without contributing to its costs are unjustly enriched at the successful litigants' expense." *Boeing Co. v. Van Gemert*, 444 U.S. 472, (1980).

Importantly, O.C.G.A. § 33-24-56.1 specifically disallows insurers and benefit plans from contracting around the rule of "complete compensation." O.C.G.A. § 33-24-56.1(j). By comparison, federal common law under ERISA, while recognizing the "made whole" and "common fund" doctrines as default rules, allows an insurer to adopt "clear language rejecting" the doctrines. *Cagle,* 112 F.3d at 1521-22.[9, 10]

---

[8] The make whole doctrine means that "an insured who has settled with a third-party tortfeasor is liable to the insurer-subrogee only for the *excess* received over the total amount of his loss." *Cagle v. Bruner,* 112 F.3d 1510, 1520-1521(citations omitted)(also noting that "State courts generally treat the make whole doctrine as a default rule that is read into insurance contracts, except where it is explicitly excluded."); *See also* 16 *Couch on Insurance* § 61:64 (2d ed. 1983) (if an insurer pays less than the insured's total loss, the insurer cannot exercise a right of reimbursement or subrogation until the insured's entire loss has been compensated). *Davis v. Kaiser Foundation Health Plan of Georgia, Inc.*, 271 Ga. 508, 521 S.E.2d 815)(1999)(O.C.G.A. § 33-24-56.1 codifies Georgia's pre-existing law and public policy concerning the rule of "complete compensation").

[9] For a benefit plan to escape the make whole doctrine, "it need only include language in the plan explicitly providing the [plan] with the first right of recovery, even when a participant or beneficiary is not made whole." *Id.* at 1522. The ERISA plan at issue in *Cagle* did not contain clear language rejecting the make-whole doctrine, so the doctrine applied to that case. The plan was not allowed to recover from any third party until the beneficiary was made completely whole. *Id.*

[10] While at least two other circuits have agreed with the *Cagle* decision,(*See e.g.***,** *Cope/and Oaks v. Haupt,* 209 f.3d 811, 813 **(**6th Cir. 200W; *Barnes v. Independent Auto Dealers of California Health and Welfare Benefit Plan.* 64 F.3d 1389. 1395 **(**9th Cir. 1995)), the majority of federal circuits have rejected the made-whole doctrines application to ERISA plans., *See. e.g., Harris* v. *Pilgrim healthcare,* 208 F.3d 274, 279 (1" Cir. 200); *Waller v. Horme/ Foods,* 120 F.3d 138, 140 (8th Cir. 1997); *Sunbeamn-Oster Co.v. Whitehurst,* 102 F.3d 1368, 1374-76 **(**5th Cir. 1996); *In re Paris,* 211 f.3d 1265 **(**4th Cir. 2000).

While this only scratches the surface of the many differences in substance and procedure between Georgia law and federal law governing subrogation/reimbursement, it also highlights the importance of determining quickly which law should apply. How, then, do we make this determination?

A. Determining the Governing law - Does Federal Law Preempt State Law?

ERISA is a federal law designed to provide standards for the protection of employee benefits plans. ERISA is also designed to provide some semblance of national uniformity in the law for the benefit of plan administrators and the employers who sponsor plans, and for this reason ERISA contains broad preemption of state laws.

The threshold ERISA preemption question is whether ERISA even applies, in other words, whether the benefit provider claiming the reimbursement interest is an "Employee Welfare Benefit Plan" within the meaning of ERISA, 29 U.S.C. § 1002(1). ERISA preemption must be considered if, and only if, a benefit plan is an "Employee Welfare Benefit Plan." Otherwise, state law will apply.

What exactly constitutes and employee welfare benefits plan is far to broad a topic to be adequately addressed in this paper. Broadly speaking, however, one should be concerned that an "Employee Welfare Benefit Plans" is at stake if the health or disability plan has been sponsored by the plaintiff's employer. It is worth noting, however, that the ERISA statute contains a number of exceptions for benefit plans which <u>are not</u> "Employee Welfare Benefit Plans," and as to which ERISA preemption never becomes an issue. These include "governmental plans" (29 U.S.C.A. § 1002(32))(i.e. federal, state and county

agencies, and even county school boards) and "church plans" (29 U.S.C.A. § 1002(33)). Moreover, certain plans which at first blush may "look like" they are sponsored by an employer may fall within ERISA's "safe harbor" regulation, thereby taking them completely outside ERISA's control. 29 C.F.R. § 2510.3-1(a)(1) (1998).[11]

Assuming that the benefit provider is in fact an "Employee Welfare Benefit Plan," then the ERISA preemption analysis begins. ERISA's preemption provisions are codified at 29 U.S.C. §1144, in three parts. The first provision states that Congress intended ERISA to preempt state laws which relate to employee benefit plans:

> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan ..." 29 U.S.C. §1144(a).

The general preemptive effect of subsection (a) is specifically limited by subsection (b), commonly referred to as the "savings clause":

> Except as provided in subparagraph B, nothing in this subchapter shall be construed to exempt or relieve any person from any law of any state which ***regulates insurance***, banking or securities." 29 U.S.C. §1144(b)(2)(A)(emphasis supplied).

The preemption law also contains the so-called "deemer clause," which exempts self-funded[12] (non-insured) plans from state laws regulating insurance:

---

[11] Excluding plans and policies from ERISA coverage if: (1) the employer makes no contribution to the policy; (2) employee participation in the policy is completely voluntary; (3) the employer's sole functions are, without endorsing the policy, to permit the insurer to publicize the policy to employees, collect premiums through payroll deductions and remit them to the insurer; and (4) the employer receives no consideration in connection with the policy other than reasonable compensation for administrative services actually rendered in connection with the payroll deduction.

[12] *See, FMC Corp. v. Holliday*, 498 U.S. 52, 58, 111 S.Ct. 403, 407, 112 L.Ed.2d 356 (1990)("State laws that directly regulate insurance are 'saved' but do not reach self-funded plans because the plans may

> "Neither an employee benefit plan ... nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any state purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies." 29 U.S.C §1144(b)(2)(B).

Directly on point, in a recent case of first impression, *Smith v. Life Ins. Co. of North Am.,__ F.Supp.2d ___* (Civil Action No. 1:05-CV-2215-JEC, N.D. Ga., Sept. 28, 2006), Judge Carnes specifically held that O.C.G.A. § 33-24-56.1 is a "law regulating insurance" within the meaning of 29 U.S.C. §1144(b)(2)(A), thereby surviving ERISA preemption.[13] The Court analyzed the revised ERISA preemption criteria developed by the United States Supreme Court in *Kentucky Assn. of Health Plans, Inc. v. Miller,* 538 U.S. 329, 341-342, 123 S.Ct. 1471, 155 L.Ed.2d 468 (2003).[14] Under *Miller,* laws "regulating insurance" within the meaning of ERISA's "savings clause" must satisfy two criteria. "First, the state law must be specifically directed toward entities engaged in insurance." *Id.* Judge Carnes noted

---

not be deemed to be insurance companies, or engaged in the business of insurance for purposes of such state laws. On the other hand, employee benefit plans that are insured are subject to indirect insurance regulation.")

[13] *Summerlin v. Georgia-Pacific Corp. Life, Health And Acc. Plan,* , 366 F.Supp.2d 1203, 1208 (M.D. Ga. 2005), considered, but did not reach the issue. Because the plan at issue was self-funded, the court held the "deemer clause" prevented application of state laws otherwise regulating insurance.

[14] For a time, the Supreme Court also required courts to "consider" the three factors used to determine whether a regulation fits within the "business of insurance" as that phrase is defined in the McCarran-Ferguson Act, 59 Stat. 33, as amended, 15 U.S.C. § 1011 *et seq.:* "first, whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry." *Metropolitan Life,* 471 U.S., at 743, 105 S.Ct. 2380; *see also Pilot Life,* 481 U.S., at 48-49; *Unum v. Ward*, 526 U.S. at 367-368. The Court soon began moving away from these factors, noting they were merely "considerations [to be] weighed" in determining whether a state law regulates insurance, *Pilot Life,* 481 U.S., at 49, and"[n]one of these criteria is necessarily determinative in itself," *Union Labor Life Ins. Co. v. Pireno,* 458 U.S. 119, 129, 102 S.Ct. 3002, 73 L.Ed.2d 647 (1982). Finally, in 2003, the Court acknowledged the difficulties inherent to this analysis, abandoning it outright in favor of a simpler, two part inquiry. *Kentucky Assn. of Health Plans, Inc. v. Miller,* 538 U.S. 329, 341-342, 123 S.Ct. 1471, 155 L.Ed.2d 468 (2003).

that O.C.G.A. § 33-24-56.1 is located within Title 33 of the Georgia Code, titled "Insurance." *(Smith* opinion at p. 35-36.) She also noted that the text of the statute applies only to "benefit providers," defined as "any insurer or other entity" which "provides for payment or reimbursement of health care expenses, health care services, disability payments, lost wage payments, or any other benefits under *a policy of insurance or contract with an individual or group*." *Id* (emphasis in original). Thus, the first prong of the *Miller* "savings clause" test was met.

The second prong under the *Miller* test states that " . . . the state law must substantially affect the risk pooling arrangement between the insurer and the insured." *Miller,* 538 U.S. 329, 341-342. Although it is not strictly necessary for state law to "alter or control the actual terms of insurance policies," to be considered a law regulating insurance, a state law clearly "affects the risk pooling arrangement between the insurer and insured" when it "alter[s] the scope of permissible bargains between insurers and insureds." *Id* at 338. In short, laws directly controlling insurance contract terms would be the clearest example of insurance regulation "affecting the risk pooling arrangement." O.C.G.A. § 33-24-56.1 specifically dictates permissible insurance policy terms[15], and is therefore a prime example of state insurance regulation. *(Smith* order at p. 36.)

Ultimately, Judge Carnes found that the plaintiff had not been completely compensated for his injuries, and applied O.C.G.A. § 33-24-56.1 to deny the insurer a right of reimbursement as a matter of law because: (1) the statute fits within ERISA's savings

[15] The statute provides, "No benefit provider contracts or policies containing or incorporating provisions in conflict with this Code section may be issued in this state, and no policy or contract provisions for subrogation or reimbursement in conflict with this Code section may be enforced by a benefit provider with regard to claims or injuries." O.C.G.A. § 33-24-56.1(j).

clause as a law regulating insurance, and (2) this Plan was insured.

Self-funded Plans, on the other hand, are not subject to state laws regulating insurance - the federal common law of ERISA will apply here. *See, FMC Corp. v. Holliday,* 498 U.S. 52, 111 S.Ct. 403, 112 L.Ed.2d 356 (1990)(finding that Pennsylvania's anti-subrogation statute "regulated insurance" and survived ERISA preemption under the "savings clause", but refusing to apply it to a self-funded plan based upon the"deemer" clause).

O.C.G.A. § 33-24-56.1, like Pennsylvania's anti-subrogation statute, is "aimed at" the insurance industry and survives ERISA preemption. However, whether the state law will apply to a given plan depends entirely on the manner of funding of the Plan. Where the underlying plan is self-funded, however, it appears that federal law will preempt state law. The only reliable way to determine the manner of funding of a benefit plan is to make a written request to the plan administrator for the official plan documents (usually in care of the employer's Human Resources department). The plan documents should state clearly whether the plan is insured or self-funded.

B. Georgia Law of Reimbursement/Subrogation

Prior to the enactment of O.C.G.A. § 33-24-56.1, reimbursement clauses were clearly enforceable in Georgia. *See, Southern General v. Watson*, 221 Ga. App. 484. 471 S.B.2d 559 (1996). O.C.G.A. § 33- 24-56.1 provides 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 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)(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."

The statute also appears to deal with the increasingly common insurance practice of refusing to pay claims until the insured agrees to execute a reimbursement agreement. Subsection (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.

Despite the statute's prohibition against reimbursement without complete compensation, the Court of Appeals has nevertheless made clear that the statute may operate to preclude a plaintiff from a double recovery of the same *category* of damage. In *Yates v. Dean*, 244 Ga. App. 333, 535 SE.2d 335, 336 (2000), a jury rendered a special verdict against an uninsured motorist carrier awarding the plaintiff specific damages for medical expenses already paid by the same insurer, presumably under a med-pay provision. The Court held that the verdict was properly reduced by the amount of the medical bills actually paid by the defendant to avoid a "double recovery" by the plaintiff.

Although no reported cases have yet acknowledged this, the statute also contains some interesting procedural provisions where reimbursement claims are disputed. The statute provides:

> (c) In the settlement of any claim for personal injury, under circumstances *where it is claimed* that the amount of the recovery does not exceed the sum of all economic and

> noneconomic losses incurred as a result of the injury, a benefit provider which has paid benefits to or on behalf of the injured person *may* seek a declaratory judgment pursuant to Code Section 9-4-2 as to what extent it may equitably share in said settlement. If the court determines said settlement does not fully and completely compensate the injured party, the benefit provider has no right of reimbursement.

O.C.G.A. § 33-24-56.1(c)(emphasis supplied). By using the permissive "may," the statute does not seem to require use of the declaratory judgement process to resolve a disputed reimbursement claim, but instead gives the benefit provider that option. However, the statute does preclude several other possible means of enforcing a reimbursement provision by self-help, stating, "(f) No benefit provider shall be entitled to reduce the amount for which it is liable under an insured party's coverage for . . .disability. . .payments. . .as a setoff against any claim for reimbursement under subsection (b) of this Code section, *nor shall any benefit provider be entitled to withhold or set off insurance benefits as a means of enforcing a claim for reimbursement*." O.C.G.A. § 33-24-56.1(f). By this language the statute seems to eliminate unilateral "self-help" from the insurer's arsenal for enforcing a reimbursement claim. In short, reading these two subparagraphs together, the argument could be made that where there is a settlement and a dispute over a claim for reimbursement, Georgia's anti-subrogation statute limits an insurer exclusively to seeking a declaratory judgement as to whether the claimant has been made whole.

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 have to question whether 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.

C. Self-Funded ERISA Plans - ERISA Reimbursement Remedies

There is little question that an insured has less rights and protections under federal law than under Georgia law. Self-funded ERISA health and disability plans frequently contain aggressive rights of subrogation/reimbursement which explicitly reject the "made whole" and "common fund" doctrines - meaning the plan may seek reimbursement from the first dollar of any gross settlement or verdict, whether or not the injured victim has been compensated and whether or not the plaintiff's lawyer gets paid for his work in obtaining the recovery. These terms are generally enforceable under the federal law of the Eleventh Circuit, as long as they are clear and explicit in their intention. *Cagle, supra*. ERISA plans also commonly demand that the employee agree in writing to reimburse the plan from any third party recovery, under threat of refusal to pay further benefits. These provisions are commonly enforceable under federal law, whereas they are directly contrary to many state laws prohibiting or limiting an insurer's right to take unilateral action to enforce a contractual reimbursement right. *See,* e.g, O.C.G.A. § 33-24-56.1(f), supra.

If the plaintiff settles his claim without resolving the ERISA plan's reimbursement claim, the plan fiduciary may sue the plaintiff under ERISA. The latest battlefront in federal subrogation litigation deals with the scope of remedies available to the plan fiduciary when it files such a lawsuit. Under ERISA, the plan fiduciary's remedies are

statutorily limited under 29 U.S.C. § 1132(a)(3) to filing suit "(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 provisions of [ERISA] or term of the plan."

In 1993 the United States Supreme Court held that the words "other appropriate equitable relief" meant that Congress intended to allow only "those categories of relief that were typically available in equity." *Mertens v. Hewitt Associates*, 508 U.S. 248, 113 S. Ct. 2063 (1993). Much to the chagrin of lawyers and judges everywhere, this holding has resulted in a revival of the archaic distinction between legal and equitable remedies - breathing new intellectual life into a long dead corpse. Suffice to say that this distinction cannot adequately be resolved in this limited paper, if indeed it can ever adequately be resolved with an infinite amount of writing by an infinite number of legal scholars. What follows is a basically a discussion of the federal courts' struggles to categorize relief as "traditionally equitable" or "traditionally legal" in the wake of *Mertens*.

In *Great West Life & Annuity v. Knudson*, 534 U.S. 204, 122 5. Ct. 708 (2002) the Court addressed for the first time the remedies available to a plan where a participant refused to reimburse the plan out of her tort recovery. In *Knudson* the plaintiff was rendered quadriplegic in a car wreck. The health plan paid over $400,000.00 in medical expenses. The plaintiffs eventually negotiated a settlement of $650,000.00. Importantly, nearly all of the recovery, except attorneys fees and Medicaid reimbursement, was paid directly to a special needs trust for the plaintiff, meaning the plaintiffs did not have legal possession of these funds. 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.

Justice Scalia, writing for the majority, noted that Great-West in essence sought to impose personal liability on the Knudsons for a contractual obligation to pay money — a form of relief not "typically available in equity." "A claim for money due and owing under a contract is quintessentially an action at law." *Knudson*, 122 S.Ct. at 713. As such, the Court found that the claim was not permitted under ERISA, and upheld the dismissal of the insurer's claims.

The Supreme Court's entire resolution of this case hinged on the statutory language found in ERISA, i.e., whether the suit was "equitable," and whether the plan was authorized to bring this sort of suit by the ERISA statute. Id at 209. The Court did not discuss the propriety of allowing reimbursement as a policy matter, and did not consider the issue of whether the plaintiffs were made whole. According to the *Knudson* majority, whether reimbursement would be available in other cases was to remain an open question:

> We note, though it is not necessary to our decision, that there may have been other means for petitioners to obtain the essentially legal relief that they seek. We express no opinion as to whether petitioners could have intervened in the state-court action brought by the 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, since petitioners did not appeal the District Court's denial of their motion to amend their complaint to add these individuals as codefendants. *Id* at 220.

The Court also hinted that "[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. (Emphasis supplied). This language, in particular, proved to be prophetic in predicting the future of ERISA reimbursement litigation.

Not entirely surprisingly, the lower courts that later attempted to interpret *Knudson* reached diametrically opposed results.[16] Some courts held that the timing of the action could be dispositive.[17] Other courts have held that the dispositive factor is whether the plaintiff controls the money.[18]

The potential loop-holes Justice Scalia articulated in the *Knudson* opinion were utilized successfully by a plan in a Georgia opinion. 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.[19]

---

[16] See, e.g., *Bauhaus USA, Inc. v. Copeland,* 292 P.3d *439,* 445 (5" Cir. 2002)(prohibiting action because funds not in plaintiff's possession): *IBEW-NECA Southwestern Health & Benefit Fund* v. *Douthitt,* 211 F.Supp.2d 812, 816 (N.D. Texas 2002) (permitting action because funds held in plaintiff's attorney's trust account).

[17] See *Primax Recoveries, Inc. v. Goss,* 240 F.Supp.2d 800, 803 (N.D. Ill. 2002) (prohibiting ERISA plan form seeking to impose a trust on potential proceeds); *Primax Recoveries, Inc. v. Carey,* 2002 WL 1968339 (S.D.N.Y. 2002) (barring plan's request for an equitable lien against future settlement); *Primax Recoveries, Inc. v. Du.ffy,* 204 F.Supp.2d 1111 (N.D. Ill.2002) (prohibiting plan fiduciary from recovering against funds already received but not prohibiting a lien on specific funds yet t be received).

[18] See *Welmark, Inc. v.Deguara,* 257 F.Supp. 2d 1209, 1216 (S.D. Iowa 2003)(permitting declaratory judgment action on reimbursement claim because the funds were in the insured's attorney's trust account).

[19] *See, also 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);

For time after *Knudson*, plaintiffs' attorneys concluded that the safest course in settling a case around a reimbursement claim was to disburse the settlement proceeds to the plaintiff with instructions to "comingle" and/or spend the funds as quickly as possible. While this still may be the "best" advice to a client intent on fighting a reimbursement claim, it is certainly not foolproof.

The Supreme Court's latest word on a plan's remedies under ERISA came in 2006 in *Sereboff v. Mid-Atlantic Medical Services, Inc.*, 200 U. S. 321, 126 S.Ct. 1869, 164 L.Ed.2d 612 (2006). In this case the plan paid approximately $75,000 for the treatment of injuries suffered by a plan participant, Marlene Sereboff, and her spouse, who subsequently received $750,000 pursuant to a third-party tort settlement. The plan required reimbursement to the plan from any third party recovery, without reduction for failure to receive the full damages claimed. Mrs. Sereboff refused to comply with this reimbursement provision despite repeated, written demands by the fiduciary. At the trial level the fiduciary obtained a preliminary injunction requiring the Sereboffs to set aside sufficient funds from the settlement, pending a final ruling on the merits.

As in *Knudson*, the Court's opinion in *Sereboff* turned on whether the relief the plan fiduciary sought constituted "equitable relief" within the meaning of Section 502(a)(3) of ERISA. In a unanimous opinion authored by the newly appointed Chief Justice Roberts, the court neatly avoided arcane distinctions between actions at law versus equitable actions by regarding the plan's action as one seeking an *equitable lien imposed by agreement*, on

---

Administrative Committee of Wal-Mart Stores, Inc. v. Varco, 2002 ~Q 31189717 (N.D. Ill. October 2, 2002), *rev'd on other grounds*,338 F.3d 680 (7th Or. 2003) (plan could recover monies in plaintiff's possession; however, claim would be reduced by proportional share of attorney's 'fees).

specifically identifiable funds in the possession of the Sereboffs. The opinion seems to rest largely on the language of the plan as being sufficient to create such an equitable lien, and on the fact that Mid Atlantic sought "specifically identifiable" funds that were "within the possession and control of the Sereboffs"— namely, "that portion of the tort settlement due Mid Atlantic under the terms of the ERISA plan, set aside and 'preserved [in the Sereboffs'] investment accounts.'" *Id*, 126 S.Ct. at 1874. Highlighting further the importance of "identifiable funds," the Court stated:

> This Court in Knudson did not reject Great-West's suit out of hand because it alleged a breach of contract and sought money, but because Great-West did not seek to recover a particular fund from the defendant. Mid Atlantic does. *Id*.

Counsel for Sereboff argued that *Knudson* imposed a strict "tracing requirement" on all recoveries – i.e., that traditional rules of equity imposed a duty on the plan directly trace the funds sought to those the plan had advanced. Justice Roberts, however, distinguished between an "equitable lien sought as a matter of restitution" and an "equitable lien imposed by agreement." Only the former requires strict tracing. *Id* at 1875.

The Sereboffs also made a "timing" argument - asserting that an equitable lien could not be imposed by agreement because at the time the beneficiary agrees to the plan reimbursement provision there are no funds to which the lien could attach. However, Justice Roberts, citing a 1914 attorney lien case, cited "the familiar rul[e] of equity that a contract to convey a specific object even before it is acquired will make the contractor a trustee as soon as he gets a title to the thing." *Id* at 1874. All that is required is that the plan document (as well as, presumably, the summary plan description) must clearly obligate the participant to reimburse the plan *from specifically identifiable funds*. *Id* at 1875. The Court concluded that the Mid-Atlantic plan met this requirement, identifying a particular

fund, distinct from the Sereboffs' general assets, namely "'[a]ll recoveries from a third party (whether by lawsuit, settlement, or otherwise)'— and a particular share of that fund to which Mid Atlantic was entitled—'that portion of the total recovery which is due [Mid Atlantic] for benefits paid.'" *Id.*

The Court also appeared to limit *Knudson* to its facts, stating it was not necessary in *Knudson* "to catalog all the circumstances in which equitable liens were available in equity; Great-West claimed a right to recover in restitution, and the Court concluded only that equitable restitution was unavailable because the funds sought were not in Knudson's possession." *Id* at 1876.

The *Sereboff* Court left open the question fo whether a plan may obtain reimbursement even though the participant ends up with less than a complete recovery. Sereboff in fact argued that, if the participant receives less than a full recovery, the relief cannot be characterized as "truly equitable" within the meaning of ERISA Section 502(a)(3). However, the Court brushed aside this argument, not on its merits, but because it had not been raised below. *Id* at 1877.

Because of the factual context of *Sereboff*, with identifiable funds being placed into the registry of court, there is still room to argue that settlement, disbursement and comingling or spending of funds might prevent the "equitable lien by agreement" from attaching to "identifiable funds."

The Eleventh Circuit has recently weighed in on these issues, in an opinion that demonstrates that the Plan language itself determines whether an "equitable lien by agreement" has been created, thereby controlling the enforceability of the claimed reimbursement right. *Popowski v. Parrott*, 461 F.3d 1367 (11th Cir. 2006). *Popowski* is

especially illuminating, as it involved two companion cases with similar facts, but with the only relevant distinction being the plans' reimbursement language, leading to opposite outcomes.

One of the companion cases involved the United Distributors health plan, which provided for reimbursement by way of a "lien on any amount recovered by the Covered Person whether or not designated as payment for medical expenses." *Id* at 1370. The Plan further stated that "[t]hese rights provide the Plan with a priority over *any* funds paid by a third party to a Covered Person relative to the Injury or Sickness, including a priority over any claim for non-medical or dental charges, attorney's fees, or other costs and expenses." *Id* (emphasis in original). The Eleventh Circuit found this language sufficient to create an enforceable form of "equitable relief" within the holding of *Sereboff*. The Court noted that "specifies both the fund (recovery from the third party or insurer) out of which reimbursement is due to the plan and the portion due the plan (benefits paid by the plan on behalf of the defendant)." *Id* at 1373. The Court also noted that,

> unlike in *Knudson,*"a significant portion of the funds specified went directly into the [plaintiff's] bank account and, thereby, was in their possession for purposes of this case. Thus, at the time they filed their suit, Popowski and the Commerce Group sought "not to impose personal liability on [Parrott], but to restore to the plaintiff[s] particular funds or property in [Parrott's] possession." *Id*.

By this language the Eleventh Circuit seemed to indicate that the location of the funds after settlement is still important, even after *Sereboff*. However, by footnote, the Court also made clear that its holding "did not depend on comingling or dissipation of settlement funds." *Id*, FN 8. Thus, there are still unanswered questions about the effect of the plaintiff comingling and/or spending his settlement monies.

The *Popowski* Court found the second Plan, sponsored by Mohawk Carpets, to have an unenforceable reimbursement provision. In relevant part, the Plan stated, "If, however, the Covered Person receives a settlement, judgment, or other payment relating to the accidental injury or illness from another person, firm, corporation, organization or business entity paid by, or on behalf of, the person or entity who allegedly caused the injury or illness, the Covered Person agrees to reimburse the Plan in full, and in first priority, for any medical expenses paid by the Plan relating to the injury or illness." *Id* at 1371. The Court found at least two fatal flaws in the drafting. First, the Plan did not identify any particular fund from which reimbursement should occur, "as distinct from the beneficiary's general assets. Instead, it makes receipt of 'a settlement, judgment, or other payment relating to the accidental injury or illness' a trigger for the general reimbursement obligation." *Id* at 1374. Further, the Plan, in requiring reimbursement "in full," failed "to limit recovery to a specific portion of a particular fund." *Id.*

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. § l395y(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.”[20]

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. §§ l395h, 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.

In 1996, congress passed the Health Insurance Portability and Accountability Act

---

[20]Kauffman, “The War of Cockatrice,” 60 Tex. B.J. 310 (1997).

(HIPAA). The Act was primarily known for increasing the portability of health insurance when Americans change employers, but it also enacted measured to ensure the solvency of the Medicare Program. One of these measures instructed HCFA to hire a Coordinator of Benefits (COB) contractor to manage all of HCFA's claims, including Medicare reimbursement claims. The COB Contractor is currently GHI Medicare.[21] Though the initial contact regarding a Medicare lien should be with the COB Contractor, the COB Contractor with then appoint an appropriate fiscal intermediary to provide the actual handling of the client's case. These organizations actually determine the amounts of compensation due, make the actual payments, and enforce any rights of subrogation. The fiscal intermediary for Medicare in Georgia is Blue Cross/Blue Shield.[22]

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 he made in the event that a recipient will not receive 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

---

[21]Contact information: Medicare-Coordinator of Benefits, P.O. Box 5041. New York, N.Y. 10274-5041; 800-999-1119.

[22]Contact information: P.O. Box 9048. Columbus, George 706-571-5273. Note, however, that in any given case, you should confirm with the COB Coordinator the appropriate entity to contact before proceeding.

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.

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 claim, if it "determines that the waiver is in the best interest of the program." 42 U.S.C. § 1395y(b)(2)(B)(iv).[23] 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 tine When the debtor

refuses to pay.

---

[23] A waiver is only available after the client has settled with the tortfeasor.

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.

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

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. l3l.l(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. 2 0 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 Individuals 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 bands 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.

VI. Workers' Compensation.

Employers and insurers have a right of subrogation against any recovery received by the employee, but only if the employee has been "fully and completely compensated". O. C.G.A. § 34-9-11.1, *Bennett vs. Williams Electrical Construction Company*, 215 Ga. App. 423, 450 S.E. 2d 873 (1994) and *Davis vs. Kaiser Foundation Health Plan of Georgia, Inc.*, 271 Ga. 508, (1999).

If there are any outstanding claims for medical expenses for which the employee would be liable, or there are other such items for which damages are recoverable from the tortfeasor and for which the workers compensation provides no benefits, then the employee has not been 'filly and completely compensated" under 0.C.G.A. §34-9-11.1. *North Bros. Co. vs. Thomas,* 236 Ga. App. 839, 513 S.E. 2d 251(1999)]

When faced with subrogation issues, a bifurcated trial would normally be pursued. Utilization of a special verdict form is suggested. There can be no subrogation lien against the amount recovered for pain and suffering. *Hammond v. Lee*, Ga. Ct. of Appeals, A00A0435 (Decided June 22, 2000)].