



Subrogation and Reimbursement

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SUBROGATION OR REIMBURSEMENT

Subrogation is the right of a third party – usually a health or disability insurance company – to recover money paid to or on behalf of an injured person from any amount the injured person receives from the responsible party or the responsible party’s insurance company. Subrogation is based on equitable principles and considerations that the insured should not recover twice for a single injury and that the insurer should be reimbursed for payments it made that, in fairness, should be made by the wrongdoer. *Internat’l Underwriters/Brokers, Inc. v. Liao*, 548 So. 2d 163 (Ala. 1989); *Powell v. Blue Cross & Blue Shield of Alabama*, 581 So. 2d 772 (Ala. 1990). A third party insurer may also assert a “Right of Reimbursement” based on contractual principles. Unlike subrogation, which arises under equitable principles established by state law and allows the insurer to stand in the shoes of its insured, reimbursement is a contractual right whereby the injured party agrees to reimburse the insurer for benefits paid after there is a recovery. *Unisys Medical Plan v. Timm*, 98 F. 3d 971 (7th Cir. 1996). Most insurance contracts include

claims for reimbursement based on the contract, and require that the injured person cooperate with the insurer, furnish information concerning the personal injury claim, and most importantly notify the insurer before filing suit or settling any claim.

ALABAMA STATE LAW

When addressing subrogation claims, the Alabama Supreme Court has recognized that subrogation is based on equitable principles and has applied equitable principles when interpreting contractual subrogation provisions. The “made whole” doctrine and the “common fund” doctrine are the most prevalent. When the “made whole” doctrine is applicable, insurers are not allowed to pursue their subrogation rights unless and until the injured party is “made whole” or fully compensated for all of his or her losses. Where the amount recovered by the injured party is less than his or her loss (as is common when the responsible party is underinsured or uninsured) then the insured has not been made whole and the insurer may not pursue its subrogation claim. The “common fund” doctrine requires an entity asserting subrogation to pay a pro rata share of the

INTRODUCTION

Reimbursing benefit plans, insurers and government healthcare programs out of the proceeds of a personal injury settlement or judgment has become an integral part of any personal injury practice. Unfortunately, benefit plans and insurers are continuing to be aggressive when asserting claims for subrogation or reimbursement and the law controlling these claims has become increasingly complex. Employer provided ERISA health plans, disability plans and automobile insurers are all pushing hard to recover most if not all of the benefits they pay out. Likewise, government or public benefit plans such as Medicare and Medicaid have increased their efforts and become much more diligent about recovering payments when a third party is liable. These increased efforts make it more difficult than ever to deliver fair compensation to an injured client. This article will address the general principles concerning the most common subrogation and reimbursement claims and provide practical suggestions on how to deal with some of the most common problems that attorneys face when attempting to resolve claims.

attorney's fees and expenses incurred to obtain the settlement or judgment that allows for its reimbursement.

The three primary cases that control the application of the "made whole" doctrine under Alabama state law are *Internat'l Underwriters/Brokers, Inc. v. Liao*, 548 So. 2d 163 (Ala. 1989), *Powell v. Blue Cross & Blue Shield of Alabama*, 581 So. 2d 772 (Ala. 1990), and *Ex parte State Farm Fire and Casualty Co. (State Farm v. Hannig)*, 764 So. 2d 543 (Ala. 2000) ("*Hannig*"). In *Liao*, the insurer argued that the equitable "made whole" doctrine should not apply to its claim because its claim arose solely from a contract and not equity. Our Supreme Court rejected this argument and held that equitable principles including the "made whole" doctrine apply to all instances of subrogation "except when the contract expressly provides otherwise." The Court concluded that "while the doctrine of subrogation is of purely equitable origin, it may be modified by contract." *Liao* at 165-66.

The decision in *Liao* prompted most insurers to amend the language in their contracts to specifically state that the "made whole" doctrine did not apply, thus allowing the insurer to assert its subrogation interests regardless of the amount of the recovery. In *Powell v. Blue Cross*, a plurality of the court held that an insurer may not enforce contract provisions designed to avoid the application of the made whole doctrine. The decision in *Powell* was based on the conclusion that the underlying equitable principles giving rise to the remedy of subrogation were not consistent with a policy written specifically to abrogate the equitable principles of subrogation.

Ten years after *Powell*, a markedly different Supreme Court addressed the issue of policy language abrogating the made whole doctrine. In *Ex parte State Farm (Hannig)*, the court overruled *Powell* and held that the doctrine of subrogation – although purely equitable in origin and nature – may be modified by contract. This holding was reinforced in *Wolfe v. Alfa*, 880 So. 2d 1163 (Ala. Civ. App. 2003), wherein the Court of Civil Appeals held that the specific language contained in Alfa's automobile insurance contract was sufficient to preclude the application of the "made whole" doctrine to a claim involving medical payments coverage.

The ruling in *Ex parte State Farm (Hannig)* resulted in wide sweeping

implications for attorneys handling personal injury claims. Nearly every type of insurance policy has been altered to avoid the application of the "made whole" doctrine and many insurers changed their relaxed attitude towards subrogation and are aggressively asserting their interests. Obviously, the resulting reduced net recovery for clients from settlements and jury verdicts impacts the ability to accept reasonable settlement offers and achieve just and fair results for injured clients at trial – especially when the responsible party has limited liability coverage.

Although the "made whole" doctrine was essentially abrogated when *Powell* was overruled, Alabama's appellate courts have consistently upheld the application of the "common fund" doctrine. See *Gov't. Employers Ins. Co. v. Capulli*, 859 So. 2d 1115 (Ala. Civ. App. 2001), *cert. denied*, *Wolfe v. Alfa*, 880 So. 2d 1163 (Ala. Civ. App. 2003) and *Mitchell v. State Farm Mutual Automobile Ins. Co.*, 118 So. 3d 693 (Ala. Civ. App. 2011) ("*Mitchell I*"), *affirmed*, in *Ex parte State Farm Mutual Automobile Ins. Co. (Mitchell v. State Farm)*, 118 So. 3d 699 (Ala. 2012) ("*Mitchell II*"). The common fund doctrine is an equitable exception to the general rule that attorney fees can be awarded only when authorized by statute or provided in a contract. See *Liao*. "The common fund doctrine is designed to compensate an attorney whose services on behalf of his client operated to create, discover, increase, preserve, or protect a fund to which others may also have a claim." *Henley & Clarke v. Blue Cross-Blue Shield*, 434 So. 2d 274, 276 (Ala. Civ. App. 1983). It permits an attorney to recover attorney fees from others – such as insurers asserting subrogation rights -- who directly benefit from the attorney's efforts in obtaining a recovery for his or her client. Thus, in personal injury cases governed by Alabama state law, an attorney may reduce the subrogation payment by a pro rata share of the attorney fees and expenses incurred in the prosecution of the claim.

In *Wolfe v. Alfa*, 880 So. 2d 1163 (Ala. Civ. App. 2003), the Court of Civil Appeals reversed the trial court because it failed to reduce Alfa's subrogation recovery by an amount equal to a pro rata share of the attorney's fees incurred to create the recovery from the tortfeasor. The same issue was addressed more recently in *Mitchell v. State Farm Mutual Automobile Ins. Co.*, 118 So. 3d 693 (Ala. Civ. App. 2011) ("*Mitchell I*") and *Ex parte State*

Farm Mutual Automobile Ins. Co. (Mitchell v. State Farm), 118 So. 3d 699 (Ala. 2012) ("*Mitchell II*") wherein the Court of Civil Appeals and our Supreme Court reviewed the application of the common fund doctrine. Concluding that the "common fund" doctrine was applicable to the facts presented, both Courts noted that there was no language in the policy that expressly abrogated the "common fund" doctrine and found that State Farm did nothing to aid its insured, her attorney or "actively participate" in producing the fund to preclude application of the "common fund" doctrine. *Mitchell I* and *Mitchell II* are significant decisions because they continue the trend of upholding the application of the common fund doctrine in personal injury cases.

Be aware that the common fund doctrine will not apply "if the attorney is simply acting on behalf of his or her client, and a benefit only incidentally comes to others. In this regard, a benefit can be an incidental, rather than an intended, result of an attorney's efforts, if the relationship between the attorney and the 'nonclient' person receiving the benefit is an adversarial one." *CNA Ins. Co. v. Johnson Galleries of Opelika, Inc.*, 639 So. 2d 1355, 1359 (Ala. 1994). Consequently, an attorney must be careful to avoid an adversarial relationship when negotiating subrogation claims as it may affect the application of the common fund doctrine. In an effort to avoid an adversarial relationship with an insurer, you should respond to a reimbursement notice by requesting a copy of the policy and agreeing to cooperate with the insurer to the extent of the applicable law in the event that a valid claim exists. This approach allows negotiation over subrogation interests without jeopardizing your right to assert the common fund doctrine.

ERISA

In the Employee Retirement Income Security Act of 1974, ("ERISA") 29 U.S.C. §1001-1461, Congress established federal laws to assure the existence of "adequate safeguards" concerning the operation of employee benefit plans that are the main provider of health and disability benefits. 29 U.S.C. §1001. Pursuant to 29 U.S.C. §1144(a), ERISA's provisions preempt and "supercede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." Since most employee benefit plans that

provide health and/or disability benefits contain reimbursement or subrogation provisions, ERISA has had a profound impact in this area. ERISA qualified benefit plans will not be “deemed” to be an insurance company so employers that self-fund or self-insure benefit plans are exempt from state regulation -- including state subrogation laws. The subrogation rights of these self-funded or self-insured plans will be governed by ERISA and the developing federal common law. *Metro. Life Ins. v. Massachusetts*, 471 U.S. 724, 105 S.Ct. 2380, 85 L. Ed. 2d 728 (1985); *FMC Corp. v. Holliday*, 498 U.S. 52, 111 S.Ct. 403, 112 L. Ed. 2d 356 (1990).

Claims under ERISA present a significant change from traditional Alabama state law claims. Since ERISA does not expressly address the subject of subrogation or reimbursement and state law is preempted, the language of the benefit plan and federal common law will control ERISA claims. Most federal courts will enforce the plain language of the plan; therefore, this language must be reviewed to determine any subrogation interest, extent of the right of reimbursement, priority of claims, and whether the plan must pay any portion of the attorney fees and expenses that allowed the recovery.

Subrogation or reimbursement clauses in ERISA plans are often read to allow a broad right of recovery for the plan. Language claiming reimbursement out of “any recovery relating to injury” or “any funds” has been held to extend to any recovery even if the recovery did not include medical expenses. *McIntosh v. Pacific Holding Co.*, 992 F.2d 882 (8th Cir. 1993), cert. denied, 510 U.S. 965 (1993). Proceeds from uninsured/underinsured motorist coverage may be subject to ERISA subrogation claims. *Wendy's Int'l., Inc., v. Karsko*, 94 F.3d 1010 (6th Cir. 1996) (ERISA plan providing that it must be reimbursed if beneficiary “recovers monies from a third party . . . on account of such injury” can reasonably be construed, under arbitrary and capricious standard, to permit subrogation against UM policy). The plan does not have to reduce subrogation claim for payment of attorneys’ fees or costs in absence of plan language providing for reduction. *Walker v. Wal-Mart Stores, Inc.*, 159 F.3d 938 (5th Cir. App. 1998) (holding that “any and all” language in plan means that plan is entitled to the first dollar of recovery (any) and 100% recovery (all) of the funds received by the

plaintiff in the settlement, up to [sic] full amount of the benefits paid).

When working on a potential ERISA subrogation claim, the language in the plan must be examined carefully. Upon request, a plan administrator has 30 days to supply requested information or statutory penalties of up to \$110 per day can accrue. 29 U.S.C. 1132(c). It is important to request and obtain the Master Plan Document as well as the Summary Plan Description from the plan administrator. In many instances, the Master Plan Document will not contain the same language as the Summary Plan Description. This can be critical because the Summary Plan Description does not constitute the terms of the plan and will not be enforced as the terms of the plan itself. *Cigna Corporation v. Amara*, 131 S. Ct. 1866 (2011).

The importance of obtaining the Master Plan Document was demonstrated recently by the Pennsylvania District Court’s ruling on remand in *U.S. Airways v. McCutchen*. In 2013, the United States Supreme Court, ruled in favor of U.S. Airways in a claim for reimbursement under ERISA, holding that neither general principles of unjust enrichment or specific equitable doctrines can override the specific plan language. *U.S. Airways v. McCutchen*, 133 S. Ct. 1537 (2013). However, on remand to the District Court, it was determined that U.S. Airways never produced the Master Plan Document in discovery and that the Supreme Court’s ruling was based solely on the interpretation of the language in the Summary Plan Description. Accordingly, the District Court allowed McCutchen to amend his complaint so that it can examine the language in the Master Plan Document. Memorandum Order, *U.S. Airways v. McCutchen*, 2:08 CV 1593 (W.D. Penn. 2014), on remand, 133 S.Ct. 1537 (U.S. 2013). It is expected that review of this language will drastically change the outcome of the case.

After receiving all the applicable plan documents, it is necessary to determine if the plan is governed by ERISA and to examine the specific language concerning subrogation or reimbursement. Five elements must be established before ERISA governs a plan or policy benefit (29 U.S.C. § 1003(a) and 29 U.S.C. § 1144(a)):

1. There must be a plan, fund, or program;
2. It must be established or maintained;
3. This must be done by an employer en-

- gaged in interstate commerce or in an activity affecting interstate commerce;
4. The purpose of the plan is to provide benefits;
5. The recipients of the benefits are participants or their beneficiaries as defined by ERISA.

Next, you must determine the actions available to the plan administrator seeking reimbursement. Section 502(a)(3) of the Employee Retirement Income Security Act of 1974 (ERISA), 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...the terms of the plan, or (B) **to obtain other appropriate equitable relief** (i) to redress such violations or (ii) to enforce any provisions of...the terms of the plan.

Therefore, if the administrator is in fact a fiduciary, ERISA provides for a limited form of action for reimbursement. Suit may only be filed “**to enjoin any act or practice**” or “to obtain other appropriate equitable relief.” Claims may only be filed in a federal district court according to ERISA § 502(e).

The United States Supreme Court, in *Mertens v. Hewitt Assoc.*, 508 U.S. 248, 256 (1993) initially explained that ERISA 502(a)(3), 29 U.S.C § 1132(a)(3), authorized suit to be filed for “those categories of relief that were typically available in equity,” and conversely, did not support claims at law for “compensatory damages.” Later, in *Great West Life and Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002), the Court clarified that a fiduciary may file suit for equitable relief, but not for legal relief. The Court held that the provision authorizing the plan to bring civil actions to obtain “appropriate equitable relief” did not authorize the plan to bring “legal” action for specific performance of the reimbursement provision of plan, and to compel the plan participant who had recovered from the third-party tortfeasor to make restitution. Because the statute only authorizes “appropriate equitable relief,” the plan could not impose personal contractual liability on the plan participant who recovered from the tortfeasor.

The Supreme Court discussed equitable relief for reimbursement under ERISA again in *Sereboff v. Mid-Atlantic Medical Services, Inc.*, 126 S. Ct. 1869 (2006). The Sereboffs recovered \$750,000 from a tort-

feasor, but refused to pay Mid-Atlantic \$75,000 in accident related medical bills it had paid. The plan fiduciary filed suit and the Sereboffs agreed to set aside the reimbursement amount of \$75,000 pending a final court ruling. The federal district court, as well as the 4th Circuit Court of Appeals, ruled in favor of Mid-Atlantic. The Supreme Court affirmed, finding that Mid-Atlantic sought reimbursement from “specifically identifiable” funds that were in the possession and control of the Sereboffs. The Supreme Court emphasized that not only must an equitable remedy be sought, but that the basis for the claim must also be equitable. The Court further discussed the distinction between equitable liens involving a contractual agreement or assignment and restitution. If there is a contract to convey specific property before it is acquired, equitable rules will make the contracting party a trustee of the property as soon as he or she gets title. In instances involving restitution, the plan would need to trace the funds at issue to the fund against which the lien is asserted. Because the Sereboff’s plan provisions identified the fund that was the target of the lien as “all recoveries from a third party”, this was an equitable lien by agreement or assignment. As such, it was not necessary to trace the funds.

The 11th Circuit provided further guidance regarding reimbursement actions in *Popowski v. Parrot/Blue Cross Blue Shield of South Carolina v. Carillo*, 461 F.3d 1367 (11th Cir. 2006). In this opinion involving two distinct cases, the court looked particularly at the plan language. In *Popowski*, the plan language specifically allowed reimbursement for “benefits paid on his or her behalf out of the recovery made from the third party or insurer.” As this language was nearly identical to the language in *Sereboff*, the 11th Circuit had no difficulty allowing a reimbursement action under ERISA 502(a)(3), 29 U.S.C. § 1132(a)(3). In the *Blue Cross* part of the opinion, however, the court noted that the plan claimed a right to reimbursement “in full, and in first priority, for any medical expenses paid by the plan relating to the injury or illness...”, but did not specify that reimbursement was to be made out of any particular fund distinct from the beneficiary’s general assets. Therefore, no equitable lien had been established by either agreement or assignment.

This precedent makes it clear that careful attention to the plan language

is necessary to determine your client’s obligation for reimbursement to insurers under ERISA. Absent policy language creating an equitable assignment from specific funds to be recovered, it is much more difficult for the plan to assert “appropriate equitable relief.”¹

Efforts to protect a client’s settlement proceeds by placing the funds with another person or entity have not been successful. In *Wal-Mart Stores, Inc. v. Horton*, 513 F.3d 1223 (11th Cir. 2008), the court allowed a claim by a plan seeking full reimbursement against a conservator holding the proceeds of a tort settlement. Finding that the plan language created an equitable lien as discussed in *Popowski v. Parrot*, the court held that the claim sought equitable restitution of specifically identifiable funds in the possession of the conservator that could be traced to the tort settlement proceeds. The Fifth Circuit in *ACS Recovery v. Griffin*, 723 F.3d 518 (2013), *cert. denied*, 134 S. Ct. 618 (2013), issued a similar ruling, holding that a plan could recover from the proceeds of a personal injury settlement that were placed in a special needs trust.

Although, the 11th Circuit has held that the “made whole” doctrine will apply to limit a plan’s subrogation rights when the participant has not been made whole and the plan does not expressly preclude or reject the made-whole doctrine, it has ruled that an ERISA plan may override the “made whole” doctrine if it includes language “specifically allowing the Plan the right of first reimbursement out of any recovery [the participant] was able to obtain even if [the participant was] not made whole.” *Cagle v. Bruner*, 112 F.3d 1510 (11th Cir. 1997), see also, *Barnes v. Indep. Auto. Dealers Ass’n.*, 64 F.3d 1389 (9th Cir. 1995). The 11th Circuit has also indicated that a plan may avoid the application of the “common fund” doctrine with plan language that “unambiguously disclaims” the doctrine. *Zurich American Ins. Co. v. O’Hara*, 604 F.3d 1232 (11th Cir. 2010). See also, *Johnson Controls, Inc. v. Flaherty*, 408 Fed. Appx. 312 (11th Cir. 2011). However, if the plan does not specify who will bear the costs of recovery (including attorney’s fees), then “the common fund doctrine provides the appropriate default.” *U.S. Airways v. McCutchen*, 133 S. Ct. 1537, 1548 (2013) (holding that neither general principles of unjust enrichment or specific equitable doctrines can override the contract language even though a plan

asserted an equitable lien and claimed “appropriate equitable relief” pursuant to § 502(a)(3)).

Claims seeking to hold plaintiff’s counsel personally liable for reimbursement claims on theories of breach of contract, breach of fiduciary duty to plan, intentional interference with contract and conversion have not had much success. See *Great West v. Bullock*, 202 F. Supp. 2d 461 (2002); *Primax Recoveries v. Sevilla*, 324 F.3d 544 (7th Cir. 2003); *Chapman v. Klemick*, 3 F.3d 1508 (11th Cir 1993)(holding that the attorney for the beneficiary of ERISA plan was not an “ERISA fiduciary” even though he received settlement proceeds as to which plan asserted subrogation rights); See also *Useden v. Acker*, 947 F.2d 1563 (11th Cir. 1991) *cert. denied* 508 U.S. 959 (1993) and *Treasurer, Trustees of Drury Indus., Inc. Health Care Plan v. Goding*, 692 F.3d 888 (8th Cir. Sept. 7, 2012), *cert. denied*, 1335 S. Ct. 1644 (holding that a plan could not enforce a subrogation agreement against a law firm that was not a party to the agreement where the firm never agreed to honor the plan’s subrogation right). However, the Seventh Circuit recently addressed a situation where a law firm and its clients willfully ignored a plan’s claim against the proceeds of a settlement and the district court’s orders to retain the funds in trust. Concluding that both the clients and the attorneys were in contempt of court for failing to comply with the court’s orders and that their conduct was “outrageous,” the court indicated that the attorneys had likely violated the rules of professional conduct and directed the district court to determine whether they should be jailed until they comply with the court’s initial orders. *Cent. States, Se. & Sw. Areas Health & Welfare Fund v. Lewis*, --- F.3d ---, No. 13-2214, 2014 WL 943412 (7th Cir. Mar. 12, 2014).

When negotiating with the collection agencies or “healthcare mercenaries” seeking reimbursement for a plan, it may be helpful to remind them about ERISA’s Anti-Inurement Protection: ERISA, 29 U.S.C. § 1103(c) that states “the assets of a plan shall never inure to the benefit of any employer and shall be held for the exclusive purpose of providing benefits to participants in the plan and their beneficiaries and defraying reasonable expenses of administration.” In the event a plan should choose to litigate its claim for reimbursement, any beneficiary has

a right to claims and conduct discovery into the details of the plan and its operation, including the amounts paid in, the amounts recovered, the administration costs charged by the plan and the specific allocation of the plan assets. Because ERISA provides strict regulations for plan administration, it is not likely that the plan administrator would be comfortable disclosing or discussing these details in litigation.

From a practical perspective, it is essential to obtain an itemization of the charges paid by the plan and confirm that the claim for reimbursement is for treatment that is related to alleged wrongful act or omission. Keep in mind that the plan can only seek reimbursement from the settlement for related treatment. Meticulous analysis of the specified treatment and/or diagnosis codes can often reveal unrelated or questionable charges. Also, remember that the entities that you are dealing with are actually collection agencies that are paid on the amounts collected. Many such organizations will often settle a claim rather than hire counsel and initiate litigation.

MEDICARE

During the initial client interview it is important to determine every entity that has paid or will pay the client's medical expenses. This allows you to immediately recognize reimbursement and subrogation issues and plan your course of action. This is especially important in cases involving Medicare because you are not likely to receive notice from Medicare and failing to recognize a Medicare subrogation claim can expose an attorney to personal liability.

Medicare has a statutory right to subrogation pursuant to 42 U.S.C. § 1395 (b)(2). These rights are enforced against "an injured person and any amounts he recovers in a lawsuit ... No exclusion or limitation in state law can affect Medicare's rights." *Kimberly-Clark Corp. v. Golden*, 486 So. 2d 435 (Ala.Civ.App. 1986). Medicare has a lien against any third party payments for medical bills regardless of whether it sent notice of the lien. 42 C.F.R. § 411.24 (g). This is true even if the tort award has already been disbursed. 42 C.F.R. § 411.24 (i). Further, the federal government is authorized by regulations to sue any attorney who knowingly disregards a Medicare right of reimbursement. 42 C.F.R. § 411.24. The

government has six years from notice of a recovery to pursue its subrogation claim. 42 C.F.R. § 411.24.

When Medicare's involvement is confirmed, you should contact the Coordination of Benefits Contractor (COBC) immediately to inform them of your representation, the facts of the case, and the injuries your client suffered.² Initially, Medicare will send a Rights and Responsibilities letter (RAR) that specifies the actions that you must take to protect Medicare's interest. Next, Medicare will provide a Conditional Payments Letter (CPL) with an itemized list of the payments it made on behalf of your client and a total of the amount paid to date. The CPL is generated automatically within 65 days of the issuance of the RAR letter. It is important to review the CPL and identify any treatment that is not related to the accident as well as any accident related treatment that is not included. You will also need to update the CPL if your client has additional treatment. The reimbursement amount listed in a CPL is subject to increase at any time and the reimbursement amount is not binding on CMS until a final payment letter is issued.

Once a case is settled or a judgment is entered, you will need to provide Medicare with an itemization of the legal costs, a copy of the settlement agreement showing the date and total amount of the settlement, a copy of the signed release, a copy of the attorney/client agreement, an itemization of the expenses incurred and an itemization of the disbursement. Medicare will review this information and send a final payment letter. Medicare uses a regulatory formula for reducing its subrogation claim that basically discounts its claim by the same portion of the gross recovery as the plaintiff's recovery is reduced by attorney's fees and disbursements. 42 C.F.R. § 411.37. E.g., if fees and disbursements are 35% of the gross recovery, Medicare will accept 65% of its lien. However, Medicare will not discuss reduction of its subrogation claim until the case has been settled or a judgment entered. Payment is due within 60 days of the date of the final demand letter. When submitting payment to Medicare you should confirm that the amount paid is full and final satisfaction of Medicare's subrogation claim and/or obtain an executed release.

Although the foregoing process is currently in operation, the SMART (Strengthening Medicare and Repay-

ing Taxpayers) Act – signed into law in January 2013 and scheduled to roll out incrementally over the next 3 years– will drastically alter Medicare reimbursement procedures. The SMART Act amends the Social Security Act and alters the handling of reimbursement claims. In an initial effort to comply with the SMART Act, Medicare has developed a web based portal that will allow beneficiaries and representatives to access claim information after receiving a CPL. This website provides details about payments and updates on payments no later than 15 days after they have been made. The portal can also be used to dispute claims and request an updated CPL.

Another important provision of the SMART Act allows attorneys to learn the exact amount claimed by Medicare prior to the time of settlement. Under this provision, once an attorney notifies CMS of a potential settlement, CMS must post its final lien amount on the website within 65 days. Once CMS has posted the lien amount, then the posted amount is final so long as the settlement takes place within 3 days. The act also sets a three year statute of limitations for CMS to seek reimbursement.³ Unfortunately, we do not know when all the changes set forth the SMART Act will be implemented as CMS has not yet issued complete final regulations that will control the new policies.

LIABILITY MEDICARE SET ASIDE ARRANGEMENTS

Although Medicare Set Aside Arrangements have become common place when closing medical benefits in workers' compensation claims when an injured plaintiff is receiving or is likely to receive SSD benefits, the applicability of set aside arrangements in liability cases is uncertain. On September 29, 2011, the Centers for Medicare and Medicaid Services (CMS) issued a memo regarding Liability Medicare Set-Aside Arrangements (LMSAs) pertaining to liability insurance settlements, judgments, or other payments. This memo is CMS's first instruction on LMSAs and is the first official indication that set aside arrangements may be needed in liability cases. The very brief memo sets out a situation where Medicare will consider its interest with respect to future medical benefits satisfied. According to the memo, Medicare's interest will be satisfied "[w]here the beneficiary's

treating physician certifies in writing that the treatment for the alleged injury related to the liability insurance “settlement” has been completed as of the date of the settlement and that future medical items and/or services for that injury will not be required.” The beneficiary does not need to submit the certification or proposed LMSA for review and CMS “will not” provide the settling parties confirmation that Medicare’s interest has been satisfied. The beneficiary is instructed to maintain the physician’s certification for confirmation that Medicare’s future interest has been considered and satisfied.

The glaring omission from the memorandum is any direction about whether LMSAs are mandatory in liability cases where future medical treatment is possible or expected or in cases where there has been no physician certification. As such, the impact of this memo is uncertain and its effects are unknown. However, one Federal District Court has stated that this memo lacks the force and effect of law and specifically held that “no federal law requires set-aside arrangements in personal injury claims for future medical expenses.” *Sipler v. Trans Am Trucking, Inc.* 881 F. Supp 2d 635 (D. N.J. 2012).

Because CMS has not issued any formal regulations mandating set aside agreements in liability cases, it is not possible to provide complete and accurate information at this time. Proposed rules indicate that set aside agreements may be required in cases where future medical care is claimed as damages in the pleadings or addressed in the release or judgment, the defendant has accepted responsibility for future medical costs and there are funds available to pay for medical costs that Medicare would otherwise cover.⁴ Until we have more formal direction, attorneys will have to make decisions on a case by case basis. Conventional wisdom is that attorneys should consider Medicare’s interest when resolving any claim for a Medicare beneficiary.⁵ This analysis should include an evaluation of the past medical treatment, the potential for future medical treatment, the relationship of future treatment to the incident, any limitations on the recovery and any allocation of the recovery. There are a number of law firms that offer “lien resolution services” that may assist attorneys with this analysis. In many situations it may not be necessary to establish a formal set aside agreement, but the best practice at

this time should include a case analysis as well as documentation and an explanation as to how Medicare’s interest was considered under the facts of the case.

MEDICAID

Medicaid is a cooperative federal-state venture providing medical benefits based on need and is administered by an appropriate state agency in almost every state. States are voluntary participants in the Medicaid program and are “obligated to comply with the requirements of the Medicaid Act and corresponding regulations.” *McClendon v. Georgia Dept. of Community Health*, 261 F.3d 1252 (11th Cir. 2001); *Fla. Assoc. of Rehab Facilities, Inc. v. Fla. Dept. of Health & Rehab. Servs.*, 225 F.3d 1208 (11th Cir. 2000). In Alabama, Medicaid is administered by the Alabama Medicaid Agency.

Pursuant to § 22-6-6 Ala. Code (1975): “If medical assistance is provided to a recipient under the Alabama Medicaid Program for injuries, disease or sickness caused under circumstances creating a cause of action in favor of the recipient against any person, firm or corporation, then the State of Alabama shall be subrogated to such recipient’s rights and shall be entitled to recover the proceeds that may result from the exercise of any rights of recovery which the recipient may have against any such person, firm or corporation to the extent of the actual amount of the medical assistance payments made by the Alabama Medicaid Program.”

In order to alert Medicaid of potential subrogation claims, Medicaid requires that providers obtain approval from Medicaid’s Third Party Division prior to releasing information (claims, charges, and medical records) regarding a patient’s care. This approval can be obtained by simply writing Medicaid.⁶ Once contact has been established, Medicaid will respond by sending a subrogation notice and a list of providers and payments. This list should be reviewed carefully and the amounts confirmed before entering into any settlement. In order to further protect subrogation claims, Medicaid recipients are required to notify the agency within ten days of filing suit against a third party and prior to entering any settlement with a third party.⁷

Because Medicaid is a need based public benefit provider, it pays healthcare providers at a significantly discounted rate – approximately 20-40% of the amount

charged. The reduction in benefits paid means Medicaid subrogation claims are rarely substantial and are usually easy to resolve. The Alabama Medicaid Agency Third Party Division’s “policy” allows a 15% reduction of its subrogation claim for attorney’s fees and expenses. However, an attorney may also assert the “common fund” and/or “made whole” doctrines as Alabama case law makes it clear that Medicaid’s subrogation rights are subject to equitable principles. *See Smith v. Alabama Medicaid Agency*, 461 So. 2d 817 (Ala.Civ.App. 1984). Where extraordinary hardship can be demonstrated, Medicaid will often negotiate further and may waive its interest.

In *Ahlborn vs. Arkansas Department of Health*, 547 U.S. 268 (2006), the United States Supreme Court held that Medicaid’s claim is limited to reimbursement from only that portion of the judgment or settlement that represents payment for medical expenses. The court’s decision was based on the plain language of the statutory language that only allowed Medicaid to recover from payments for health care items or services and/or medical care. Unfortunately, the result of this decision prompted a legislative change that may nullify the *Ahlborn* ruling as of its effective date in October 2014. Specifically, in 2013, Congress amended the applicable statutory language to extend Medicaid’s claims to any payments from a third party. See 42 U.S.C. § 1396a(a)(25)(H) and 42 U.S.C. § 1396k(a)(1)(A).

WORKERS’ COMPENSATION

When money is recovered from a responsible party and the injured person has received workers’ compensation benefits for that same injury, the recovery is divided between the injured employee, the employer (or its insurance company), and the plaintiff’s attorney pursuant to the Workers’ Compensation act. In allocating the money received from the third party, there are three critical areas that must be considered. The first area is the offset or “credit” against “compensation” or amounts payable or paid for permanent partial disability or permanent total disability. Alabama Code § 25-5-11 reads:

“If the injured employee, or in the case of death, his or her dependents, recover damages against the other party, the amount of the damages recovered and collected shall be credited upon the liability of the

employer for compensation. If the damages recovered in collection are in excess of the compensation payable under this chapter, there shall be no further liability on the employer to pay compensation on the account of injury or death. To the extent of the recovery of damages against the other party, the employer shall be entitled to reimbursement for the amount of compensation theretofore paid on account of injury or death.”

This language makes it clear that the employer is entitled to reduce its liability for “compensation” (amounts payable for permanent partial disability or permanent total disability) by the amount of the third party recovery. For example, if an injured employee is entitled to \$30,000.00 in permanent partial disability benefits and he received \$15,000.00 from a third party as a result of his injury, the compensation carrier’s liability for permanent partial disability would be \$15,000.00.

The second area that must be considered when distributing amounts recovered from third parties is the statutory right of subrogation for medical care and vocational benefits paid by an employer. Alabama Code § 25-5-11(a) provides “For the purposes of this amendatory act, the employer shall be entitled to subrogation for medical and vocational benefits expended by the employer on behalf of the employee; ...”

This right of subrogation was added in the 1992 amendments, and clearly allows subrogation on amounts “expended” by the employer. Because “expended” is past tense, most practitioners contended that the employer’s right of subrogation was limited to amounts it had paid at the time the third-party action was concluded. This issue was addressed in numerous opinions before it was resolved by our Supreme Court. In *Ex parte BE & K Const. Co.*, 728 So. 2d 621 (Ala. 1998), the court held that the word “expended” did not limit an employer’s subrogation rights and that an employer was not required to pay future medical expenses until the employee had exhausted the amount he or she received from the third party for future medical expenses. The Court recognized its holding requires a recovery from a third party to be apportioned “so as to designate how much of the recovery is past and future” and gave the trial courts

responsibility for apportioning the recovery. *Id.* at 624.

In *Ex parte Miller and Miller Const. Co., Inc. v. Madewell*, 736 So. 2d (Ala. 1999), the court followed *Ex parte BE & K Const. Co.*, holding that an employer is entitled to be subrogated to that portion of the employee’s third-party recovery that is attributable to the future medical expenses that the employer would be legally required to pay. When the portion of the third-party medical expenses is exhausted, the employer will be required to resume payment of medical expenses. *Ex parte Miller and Miller Const. Co.* at 1105.

It is important to note that the offset or credit and subrogation provisions of § 25-5-11(a) are not subject to the “made whole” doctrine. In *Powell vs. Blue Cross and Blue Shield of Alabama*, 581 So. 2d 772, 779 (Ala. 1990), the court stated “our holding in this case in no way interferes with the legislatively mandated scheme provided for under the [Workers’ Compensation] Act.” In *Maryland Casualty Co. v. Tiffin*, 537 So. 2d 469 (Ala. 1988), the Supreme Court rejected application of the “made whole” doctrine to workers’ compensation cases, stating:

“We do not agree that § 25-5-11(a) permits an employer to be reimbursed for sums paid under the Workmen’s Compensation Act only when an employee, or his dependents in the case of his death, has recovered from two sources an amount that exceeds the employee’s damages. Clearly the words of § 25-5-11(a) do not limit an employer’s recovery in such a way.”

Tiffin at 474. (overruling *Holder vs. Weatherly*, 456 So. 2d 812, (Ala. Civ. App. 1984), and *Jackson vs. Weaver*, 516 So. 2d 702 (Ala. Civ. App. 1987).

As many third party claims involve automobile accidents, many cases concern the application of the subrogation and credit provisions of § 25-5-11 to amounts received from uninsured/underinsured motorist insurance coverage. There is no question that section § 25-5-11 permits the employer to subrogate on amounts recovered and collected from a third party, however, recovery under uninsured/underinsured motorist coverage is not a recovery from a third party. In *Bunkley v. Bunkley Air Conditioning, Inc.*, 688 So. 2d 827, (Ala. Civ. App. 1996), the Court stated

“our Supreme Court has interpreted the subrogation and credit

provisions of Section 25-5-11 and its predecessors to apply to the proceeds of judgments recovered and collected against a ‘third party wrongdoer’ where such third party wrongdoer is the person or persons whose wrongful act proximately caused the worker’s injuries. It follows that subrogation under § 25-5-11 does not extend to recovery of damages under contracts of insurance that are separate and apart from the wrongful conduct that injures the worker.”

Bunkley at 831-32.

Because proceeds of uninsured/underinsured coverage are recovered pursuant to a contract between the injured employee and an insurance company -- not from the third party wrongdoer -- our courts have repeatedly held that an employer has no right of subrogation against underinsured/uninsured motorist coverage. See *State Farm Mutual Auto. Ins. Co. v. Cahoon*, 287 Ala. 462, 252 So. 2d 619 (1971); *Bunkley v. Bunkley Air Conditioning*, 688 So. 2d 827 (Ala. Civ. App. 1996); and *River Gas Corporation v. Sutton*, 701 So. 2d 35 (Ala. Civ. App. 1997).

The final major area of concern in a third party action is the allocation of attorney fees for the injured employee’s attorney. This matter is addressed in Alabama Code § 25-5-11(e):

“In a settlement made under this section with a third party by the employee or, in case of death, by his or her dependents, the employer shall be liable for that part of the attorney’s fees incurred in the settlement with the third party, with or without a civil action, in the same proportion that the amount of the reduction in the employer’s liability to pay compensation bears to the total recovery had from the third party. For purposes of the subrogation provisions of this subsection only, “compensation” includes medical expenses, as defined in Section 25-5-77, if and only if the employer is entitled to subrogation for medical expenses under subsection (a) of this section.”

For a comprehensive interpretation of this section, please refer to an article by G. Whit Drake: *Employer’s Subrogation in Third-Party Cases: Does Anyone Really Understand It?*, *The Alabama Lawyer* (November 2007). This article provides an

excellent explanation of the language in § 25-5-11(e).⁸

It is important to note that the allocation of fees provided in § 25-5-11(e) controls both the subrogation for amounts paid for permanent partial and permanent total disability as well as amounts paid for medical treatment and vocational rehabilitation. In addition, the employer cannot preclude the injured employee's attorney from collecting a fee by intervening in the third party action. *Lewis Trucking Co. v. Skinner*, 671 So. 2d 696 (Ala.Civ.App 1995). The employer does not, under any circumstance, have to pay any portion of the expenses incurred by the injured employee's attorney. See *Ins. Co. of North America*, 523 So. 2d 447 (Ala.Civ.App. 1988).

- 1 In the absence of plan language creating an equitable assignment, counsel may consider whether to disburse the funds to complicate any plan efforts to trace the funds. When making this decision, counsel should be mindful of Alabama Rule of Professional Conduct 1.15(b). Most state bar associations or disciplinary committees have indicated that similar rules create an obligation to hold funds until the dispute is resolved if you have actual notice of a just claim.
- 2 Medicare – Coordination of Benefits, P.O. Box 33847, Detroit, Michigan 48232-5847
- 3 The three year statute of limitations begins to run on the date that a likely settlement is reported under Section 111 of the MMSEA.
- 4 Proposed Rules for LMSAs are available at: <https://www.federalregister.gov/articles/2012/06/15/2012-14678/medicare-program-medicare-secondary-payer-and-future-medicals#p-71>
- 5 A comprehensive evaluation of the evolution of LMSAs can be found at: [http://www.rgilbertadr.com/Considering%20Medicare's%20Interests%20in%20Third-party%20Liability%20Cases%20\(Gilbert-%20with%20attachments-%20August%205,%202013\).pdf](http://www.rgilbertadr.com/Considering%20Medicare's%20Interests%20in%20Third-party%20Liability%20Cases%20(Gilbert-%20with%20attachments-%20August%205,%202013).pdf)
See also: http://www.americanbar.org/content/dam/aba/publishing/health_lawyer/health_mo_premium_hl_healthlawyer_v26_2601_authcheckdam.pdf
- 6 Alabama Medicaid Agency, 501 Dexter Avenue, P.O. Box 5624, Montgomery, Alabama 36103-5624
- 7 Alabama Administrative Code, Medicaid Agency, Chapter 560-X-20.
- 8 http://www.alabar.org/publications/articles/Nov07/does_anyone_understand.pdf



Michael Timberlake is a native of Huntsville, Alabama and is the son of local attorney, Kenan Timberlake. Michael earned his undergraduate degree from Birmingham Southern in 1989 and his law degree from Cumberland School of Law in 1995. Following law school, Michael worked as a clerk for William Robertson, Chief Justice of the Alabama Court of Civil Appeals. After finishing his clerkship he has practiced in Huntsville and is currently a partner in the firm of Siniard, Timberlake & League, P.C. His practice is devoted to helping persons injured as a result of medical malpractice, nursing home abuse, motor vehicle wrecks and industrial accidents. Mr. Timberlake is a member of the Alabama State Bar, the Huntsville Bar Association, the Alabama Association for Justice and the America Association for Justice. Mr. Timberlake is a graduate of the American Trial Lawyers Association Trial College and has frequently served as a speaker for continuing legal education seminars in Alabama. He is currently licensed to practice in Alabama and in the United States District Court for the Northern District of Alabama.

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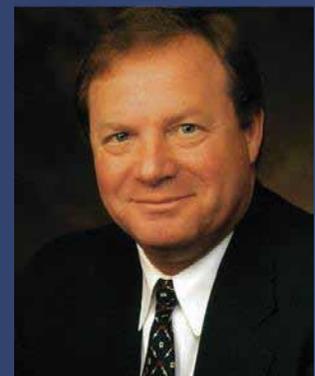
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