“Don’t Lien on Me”– The Current Status of ERISA, FEHBA, Medicare, Medicaid and Provider Claims

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ICLE Plaintiff’s Personal Injury Seminar, October 28, 2006

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1. **ERISA Reimbursement Claims**

a. **Statutory Text**

The critical text is the following:

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(a) Persons empowered to bring a civil action. A civil action may be brought—

(1) by a participant or beneficiary—

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his

rights under the terms of the plan, or to clarify his rights to future benefits under

the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for

appropriate relief under [29 U.S.C. § 1109];

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or

practice which violates any provision of this title or 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 this title or the terms of the plan; . . .

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**[29 U.S.C.] § 1144. Other laws**

(a) Supersedure; effective date. Except as provided in subsection (b) of

this section, the provisions of this title ... shall supersede any and all State laws

insofar as they may now or hereafter relate to any employee benefit plan

described in [29 U.S.C. § 1003(a)] . . . .

(b) Construction and application. . . .

(2) (A) Except as provided in subparagraph (B), nothing in this title shall

be construed to exempt or relieve any person from any law of any State which

regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in [29 U.S.C. § 1003(a)]

. . . nor any trust established under such a plan, shall be deemed to be an

insurance company or other insurer, . . . or to be engaged in the business of

insurance . . . for purposes of any law of any State purporting to regulate

insurance companies [or] insurance contracts . . . .

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The ERISA industry recently attempted to modify 29 U.S.C. § 1132 to add language that

would expressly authorize reimbursement actions, but that language was removed in

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1 It would have added the following below 29 U.S.C. § 1132(a)(9): “Actions described

under paragraph (3) include an action by a fiduciary for recovery of amounts on behalf
conference committee and did not enter the bill (P.L. 109-280) signed by the President on August 17, 2006.

**b. The Situation before Sereboff**

The Supreme Court granted certiorari in *Sereboff v. Mid Atl. Med. Servs.*, 126 S. Ct. 1869 (2006), to resolve differences among the circuits on whether a reimbursement claim could constitute “appropriate equitable relief” under 29 U.S.C. § 1132(a)(3); if so, a reimbursement claim could be valid, otherwise not.

The Supreme Court had addressed this issue earlier in *Great-West Life & Annuity Insurance Co. v. Knudson*, 534 U.S. 204 (2002), finding that the claim presented there was not equitable, but the length and scope of the decision led to a split among circuits about its precise holding. The *Knudson* court “rejected a reading of the statute that would extend the relief obtainable under § 502(a)(3) to whatever relief a court of equity is empowered to provide in the particular case at issue (which could include legal remedies that would otherwise be beyond the scope of the equity court’s authority).” *Id.*, 210. Instead, the Court concluded that 29 U.S.C. § 1132(a)(3) is limited to “the categories of relief that were *typically* available at equity.” *Id* (original emphasis). Even quintessentially equitable remedies such as injunctions were not automatically available under 29 U.S.C. § 1132(a)(3), because such relief was not typically available in equity for a “past due monetary obligation.” *Id.*, 210-211. Equity was available only in certain “rare cases”:

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of the plan enforcing terms of the plan that provide a right of recovery by reimbursement or subrogation with respect to benefits provided to or for a participant or beneficiary.” H.R. 2839, § 307.
Those rare cases in which a court of equity would decree specific performance of a contract to transfer funds were suits that, unlike the present case, sought to prevent future losses that were either incalculable or would be greater than the sum awarded. . . . Typically, however, specific performance of a contract to pay money was not available in equity.

Id., at 211. Although 29 U.S.C. § 1132(a)(3)(A) appears to authorize injunctions expressly, such was not the case.

[This] statutory reference to that remedy must, absent other indication, be deemed to contain the limitations upon its availability that equity typically imposes. Without this rule of construction, a statutory limitation to injunctive relief would be meaningless, since any claim for legal relief can, with lawyerly inventiveness, be phrased in terms of an injunction.

Id. at 211, n.1 (emphasis added). Restitutionary remedies were divided into equitable and legal restitution, and equitable restitution was described thus:

[A] plaintiff could seek restitution in equity, ordinarily in the form of a constructive trust or an equitable lien, where money or property identified as belonging in good conscience to the plaintiff could clearly be traced to particular funds or property in the defendant’s possession. . . . Thus, for 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., 213, 214. This equitable kind of restitution was treated as “[i]n contrast” with legal restitution, where “the plaintiff’s claim is only that of a general creditor,” in which case “the plaintiff cannot enforce a constructive trust of or an equitable lien upon other property of the defendant.” Id., 213-14.

The label applied to the relief was immaterial. The majority rejected Justice Ginsburg’s method of “distinguishing legal from equitable relief [in terms of] the ‘substance of the relief requested,’” because this method failed to look “to the conditions that equity attached to its provision.” Id., 216. The majority found that both dissenting opinions would lead to the “same untenable conclusion,” namely that “§ 502(a)(3)(A)’s expli-
cit authorization of injunction, which it identifies as a form of equitable relief, permits (what equity would never permit) an injunction against failure to pay a simple indebtedness.” Id.

Unfortunately, the court’s treatment of the issue was so long and diffused that differing understandings arose about what was actually decided. Eventually, two interpretations emerged. Two circuits read Knudson as holding that such claims were essentially legal, and thus invalid no matter how the plan might be drafted. Four other circuits read it as holding that such claims could be equitable if stated in a particular way. The issue was being litigated circuit by circuit, district by district, and sometimes judge by judge. The Supreme Court granted certiorari in a Fourth Circuit case that upheld an ERISA reimbursement claim.

c. **Sereboff**

Sereboff arose from an auto wreck in California. The ERISA plan provided $74,869.37 in medical benefits to the injured couple and sent letters to their attorney

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asserting a lien on proceeds of the suit. It repeated its claim in later letters. The couple’s
tort suit settled for $750,000, and their attorney distributed the funds to his clients
without satisfying the lien. The plan sued in a Maryland district court where the Sere-
boffs lived, and the parties agreed to hold $74,869.37 from the proceeds. The district
court ordered the Sereboffs to pay the full amount, and the Fourth Circuit affirmed.

On May 15, 2006, the Supreme Court decided Sereboff v. Mid Atlantic Medical
Services, Inc., ___ U.S. ___, 126 S.Ct. 1869 (2006). It noted that the plan language
required the Sereboffs to reimburse the plan “from” the settlement funds that the
Sereboffs received, without reduction due to the fact that they had not received the full
amount of damages they claimed. Id., 1872.4

The Court decided that the claim before it sought equitable relief, and thus was a
valid claim under 29 U.S.C. § 1132(a)(3). There remain yet questions concerning the
interpretation of Sereboff, but it is clear that the Court rejected the position of the Sixth
and Ninth Circuits that all such claims were inherently legal rather than equitable. In
determining whether the claim was “equitable,” the Court held that the test is still
whether the claim was one that was typically available in equity. Id., 1873. It further

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4 That different plan language might have made a difference in the outcome appears
from the Court’s recognition that the Sereboffs had produced a case in which a contract-
ual provision purporting to secure an equitable lien did not properly do so. Id., 1876,
citing Taylor v. Wharton, 43 App. D.C. 104, 109 (D.C. Cir. 1915), in which an attorney
claimed a contingent fee lien, but the contract merely used the client’s recovery as a
basis for calculating the fee rather than directing that the fee be paid out of the recovery.
The Eleventh Circuit in Popowski v. Parrott (discussed below) found that to be a critical
point, and at least one other Circuit court agrees that it is crucial. Dillard’s Inc. v. Liberty
Life Assur. Co., 456 F.3d 894 (8th Cir. 2006) (the plan’s claiming reimbursement
from a specific fund, as opposed to the party’s general assets, was “[c]entral to its hold-
ing” in Sereboff).
indicated that it would look to cases from the divided bench period and standard secon-
dary material on equity to determine whether a claim was typically available in equity.
Id., 1874, 1874-1875.⁵

The novelty in the Sereboff decision consists in its changing the focus from claims
for equitable restitution, on which all prior decisions rested,⁶ to claims for equitable
liens by agreement.⁷ These are “different species of relief.” Id., 1875.⁸ The Court found
that early equity cases enforced an equitable lien to transfer specific funds that were not
yet in existence under similar circumstances⁹ and concluded that the plan’s claim was

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⁵ The Court seems to follow entirely the following statement: “Rarely will there be need
for any more “antiquarian inquiry” . . . than consulting, as we have done, standard cur-
rent works such as Dobbs, Palmer, Corbin, and the Restatements, which make the an-

⁶ A Lexis search for cases decided before Sereboff which contained both “ERISA” and
“lien” within five words of “agreement” turned up forty-two hits, of which only two
mentioned the concept of a “lien by agreement.” In neither was the concept decisive.

⁷ This type of lien “in the final analysis will be found to be a special application of the
doctrine of specific performance to agreements to give security.” Harlan F. Stone, The
“Equitable Mortgage” in New York, 20 Col. L.Rev. 519 (1920), reprinted in Edward D.
Re, Selected Essays on Equity, 273 (1955).

⁸ Equitable liens by agreement exist to give effect to the express intent of the parties; an
equitable lien for restitution is judicially implied to prevent unjust enrichment, on the
theory that a specific fund belongs in equity and good conscience to the plaintiff. D.
Dobbs, Law of Remedies § 4.3, p. 249 (1973); H. McClintock, Principles of Equity, § 118,
p. 319 (1948).

⁹ See Peugh v. Porter, 112 U.S. 737, 742 (1885) (it is “indispensable” to an equitable lien
on a particular fund that there be “an agreement that the creditor should be paid out of
it”). By contrast, an agreement that contains no assignment of any specific interest in a
settlement fund or award and no provision creating any lien upon it or its proceeds, does
not give the plaintiff any equitable lien on the fund. Porter v. White, 127 U.S. 235, 244-
245 (1888) (initial legal employment contract that provided for a fee of 50% of the re-
covery, of which the plaintiff attorney claimed half, did not assign an interest in the
ultimate award, and therefore plaintiff had no lien on the proceeds of the suit when the
client entered into a new contract in which the defendant attorney received half of the
50% fee).

How can Sereboff be reconciled with Knudson? A difference in plan terms does not appear to explain the difference in outcomes because the Sereboff Court found that the plan in Knudson was “[m]uch like” the plan before it because it “reserved a first lien upon any recovery.” Id., 1874. A slightly more plausible difference was noted by the court in observing that the settlement proceeds in question were not in Ms. Knudson’s possession, but were in a special needs trust, whereas the proceeds were in the Sereboffs’ possession. Id. This fact would disqualify the plan’s claim in Knudson under either of the major interpretations of Knudson, but the fact that the funds were in the Sereboffs’ possession would not automatically entitle the plan to relief because, as the Court observed, the plan “must still establish that the basis for its claim is equitable.” Id. Noting the Sereboffs’ contention that the plan could not claim “equitable restitution” without showing that the funds in their possession had been improperly acquired, and observing that this contention was at least “often” true, it responded that a lien by agreement did not require such a showing. Id., 1875. Thus, although it rejected the approach of the Sixth and Ninth Circuits, it did not affirm the “equitable restitution” approach of the other Circuits. 10 Instead, it changed the frame of the debate from such

10 If anything, the Court disagreed with the other Circuits on the theory of relief because it did not cite cases illustrating that “equitable restitution” was “typically available” in these circumstances in the day of the divided bench. Instead, in deflecting the Sereboffs’ claims, it stated that the plan’s “claim is not considered equitable because it is a subrogation claim[; instead, it] qualifies as an equitable remedy because it is indistinguishable from an action to enforce an equitable lien established by agreement” which had been found to be “equitable.” Id., 1877. At least one of the “other Circuits” agrees that “equitable restitution” is not viable in this context. Larue v. Dewolff, Boberg & Assocs., 450
restitution to “equitable liens by agreement.”

d. After Sereboff

Although Sereboff's holding is limited to a very narrow field – equitable liens by agreement – it will have broad effect because it gives plan drafters a bright-line test and the language that they have been seeking to make plan terms enforceable. The effect of the Sereboff ruling is likely to trivialize Knudson into ultimate oblivion. Knudson will not apply when all plans are re-written to assert claims to the tort proceeds themselves and when plan fiduciaries assert claims using the correct terminology. Knudson will continue to apply to relatively rare cases of true restitution, but not to the claims that will typically be made against personal injury plaintiffs and their counsel.

At present, practitioners dealing with ERISA reimbursement claims should evaluate at least the following factors. This listing is not exclusive. Counsel should use their full ingenuity in addressing the meaning of the plan language and its application to the facts. New ideas in this developing area of law are likely to emerge. Counsel should remain alert.

i. Plan Terms

After Sereboff, plan language should be carefully scrutinized to determine whether it claims all or part of the settlement proceeds themselves because Sereboff is limited to equitable liens by agreement; it does not hold that other nominally equitable relief in plans is relief that was “typically available in equity.”

As shown in the recent case of Popowski v. Parrott, 2006 U.S.App. LEXIS 21587 F.3d 570, 576 (4th Cir. 2006) (observing that Sereboff demonstrates “how the absence of unjust possession is fatal to an equitable restitution claim”).
10th Cir., Aug. 24, 2006), differences in phrasing can make all the difference in the outcome. Two cases were consolidated for argument, Popowski v. Parrott, 403 F. Supp. 2d 1215 (N.D. Ga. 2004), and BlueCross BlueShield v. Carillo, 372 F. Supp. 2d 628 (N.D. Ga. 2005). Both were in virtually the same procedural posture: an ERISA plan sued plan participants or beneficiaries for reimbursement under plan terms, an ex parte temporary restraining order was granted, a hearing was held on making it permanent, but the defendants filed motions to dismiss before defensive pleadings were filed and any other discovery was conducted, and both district courts dismissed the claims because the relief sought was not “appropriate equitable relief.” There was, however, a difference in the language of the plans.

In Popowski, the plan claimed a lien “on any amount recovered by the Covered Person whether or not designated as payment for medical expenses. . . . The Covered Person . . . must repay to the Plan the benefits paid on his or her behalf out of the recovery made from the third party or insurer.” Id., *14 (emphasis added). The Court held that this was essentially the same plan text as the text discussed in Sereboff and reversed the dismissal.

On the other hand, the plan in Carillo “claim[ed] 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 does not specify that that reimbursement be made out of any particular fund, 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., *15 (emphasis added). The Court also observed that the plan sought reimbursement “in full” without limiting the
recovery to money received from the tortfeasor, which it deemed to be additional evidence that the plan sought only legal relief rather than the transfer of specific funds received from the tortfeasor. \textit{Id.}

Since the plan text may well make a difference, a lawyer for a plan beneficiary should examine the plan for contradictory language that could be construed as seeking something other than the specific funds, thus invalidating the plan, or that could be construed as limiting the plan’s recovery. Other sources to be checked for contradiction include the summary plan description that was provided to the employee and earlier versions of the plan itself, which may have been modified during the employee’s course of treatment. If nothing else, such self-contradictions can at least be used in negotiations with the plan.

\textbf{ii. Make Whole Rule?}

Some circuits have a default preference for make-whole and common fund restrictions on plan recoveries; other circuits do not. If these restrictions are the default, the plan can avoid them by language expressly rejecting them. The make-whole rule is the default rule in ERISA cases in the Eleventh Circuit\textsuperscript{11} and other circuits,\textsuperscript{12} but the text of the plan may explicitly avoid this rule.\textsuperscript{13} Where the plan provides several different means for the plan to seek reimbursement, make-whole language must appear in each

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\textsuperscript{11} Cagle v. Bruner, 112 F.3d 1510 (11th Cir. 1997).
\textsuperscript{12} Copeland Oaks v. Haupt, 209 F.3d 811 (6th Cir. 2000); Barnes v. Independent Auto. Dealers Ass’n of California Halth & Welfare Benefit Plan, 64 F.3d 1389 (9th Cir. 1994).
\end{flushright}
option in order to avoid the make-whole rule as to that option.\textsuperscript{14}

Although most plans that the author has seen reject the doctrines, a few allow either or both. The plan language should be examined to determine the status of these issues.

\textbf{iii. Anti-subrogation rules that survive preemption}

If a state law prohibits or limits reimbursement claims, it will be useful only if it survives preemption. ERISA preempts state laws in at least two ways relevant to this question. First, the express preemption provision (29 U.S.C. § 1144) preempts state laws, including common law, that “relate to” an ERISA plan, but it saves from preemption any law that “regulates insurance,” provided that the employer’s plan itself cannot be deemed to be an insurance company. The net result is that if the plan is funded by an insurance policy, arguably including re-insurance policies, state law can regulate the contents of the policy, but not the other documents that manifest the plan. Second, where ERISA and the state law address the same subject matter, conflict preemption will invalidate the state law. Under the Supreme Court’s interpretation of § 1144 since 2003, an anti-subrogation rule that is specifically directed at insurance companies and that “affects the risk-pooling arrangement” between insurer and insured should survive preemption.\textsuperscript{15}

The critical question is whether O.C.G.A. § 33-24-56.1 survives preemption. Although the Eleventh Circuit has yet to address this question, practitioners should con-


Rarely will there be need for any more ‘antiquarian inquiry’ . . . than consulting, as we have done, standard current works such as Dobbs, Palmer, Corbin, and the Restate-

Twenty five jurisdictions are cited in Rinaldi, Apportionment of Recovery Between Insured and Insurer, 29 Tort & Ins. L. J. 803, nn. 19-43 (1994), and more (including Georgia) can be added since 1994.

In Davis v. Kaiser Found. Health Plan, 271 Ga. 508 (1999), the Georgia Supreme Court held that an “insurer is not entitled to subrogation unless and until the insured has been made whole for his loss. . . . This rule better reflects the underlying equitable principles that give rise to the remedy of subrogation itself. . . . The cases that originally applied subrogation to insurance contracts did so on behalf of the insurer only after the insured had been fully compensated. These cases never envisioned the use of subroga-
tion as a device to fully reimburse the insurer at the expense of leaving the insured less than fully compensated for his loss. Where either the insurer or the insured must to some extent go unpaid, the loss should be borne by the insurer for that is a risk the insured has paid it to assume.” Id., 511 (emphasis added).

iv.  Equitable Defenses

Equitable relief will be granted only to the extent that it is equitable to do so. The same standard references on equity that the Supreme Court has found decisive on the meaning of “equitable relief” in ERISA contain discussions of the limits that equity has traditionally imposed on such awards. Counsel should review them in light of the facts of the case to determine how likely they are to defeat all or part of the reimbursement claim. For instance, a majority of state supreme courts require a make-whole rule, and many do so expressly because equity requires it. Equity will not enforce an uncon-
scionable or overly harsh contract. If the plan terms fit this description, this provides a complete defense to the claim. Laches is available if the plan’s delay in asserting a claim causes the client some prejudice. The plan must do equity to seek equity, and it must have clean hands. Equity will not enforce a forfeiture.

Determining whether it is equitable to enforce the claim will involve a fact-specific evaluation, but the equities will frequently exhibit a lack of complete compensation, a forfeiture of compensation for other legitimate injuries if the plan is enforced,\(^{19}\) the plan’s assumption of the risk (often compensated) of loss, and the unexpected nature or extent of the loss to the client, who would be further victimized by full enforcement. In making the client’s case it is well to observe that ERISA requires that the equitable relief be “appropriate.”\(^{20}\) This is the same term used in the introductory statement of ERISA’s purpose, which is “to protect . . . the interests of participants in employee benefit plans . . . by providing for appropriate remedies . . .” 29 U.S.C. § 1001(a). The measuring stick for appropriate relief is therefore what protects the interests of plan participants and beneficiaries.

\[ \text{v. Dissipation of Funds} \]

In addition to reviewing the chances of attacking the claim, counsel should assess the client’s exposure under the claim. This involves at least two inquiries, the property at risk and the health coverage at risk.

\(^{19}\) Note the Supreme Court’s unanimous observation in Arkansas Dep’t of Health & Human Services v. Ahlborn, 126 S.Ct. 1752 (2006), that requiring reimbursement of workers compensation benefits from a consortium claim would be “absurd and fundamentally unjust.” Id., 1765 n.18, citing a Wisconsin case.

\(^{20}\) This claim was only made by the Sereboffs in the Supreme Court, which declined to consider it there.
The Knudson and Sereboff line of cases do not impose personal liability on the client; instead, they allow the imposition of a constructive trust or lien on specific funds which will be enforced by court orders and contempt. If those specific funds are previously commingled with other funds or spent on other property, equitable tracing rules are likely to be used to reach the proceeds. Counsel will need to assess the likely methods of tracing that will be employed and determine what property remains that is subject to the equitable reimbursement claim.

vi. Client’s needs for health insurance

Likewise, the client may need to have continuing coverage under the plan. Many plans have provisions allowing the plan to deny future benefits until it has been reimbursed. ERISA gives plans a great deal of freedom to define and limit their benefits, so if such a provision exists, or if it could be added by a valid amendment to the plan, and if state law regulating insurance does not prohibit it, a participant who needs further cov-

21 Such rules are standard. O.C.G.A. § 23-2-74 is titled “Burden of distinguishing mingled property,” and it provides: “If a party who has charge of the property of others shall so confound it with his own that the line of distinction cannot be drawn, all the inconvenience shall be thrown upon him who causes the confusion; and he shall distinguish his own property or lose it.”

22 Counsel’s own exposure should also be considered, but it has not yet been examined in a post-Sereboff setting. Favorable language appears in Chapman v. Klemick, 3 F.3d 1508 (11th Cir. 1993). Leaving aside other possible claims, to the best of this writer’s knowledge, an ERISA-based claim to impose a constructive trust on the fee paid to the attorney would rest on theory that the attorney for the personal injury plaintiff stands in the same position as someone dealing with a constructive trustee (the plaintiff), and in such position, the attorney may be made to return funds obtained by a breach of the client’s fiduciary duty. The problem with this theory is that the client does not have the ability to control the attorney’s right to take a fee before paying the funds to the client, and therefore the client cannot be found to have breached any fiduciary duty with respect to the funds over which the client had no right of control. Whether this view is correct remains to be tested.
verage under this plan may need to negotiate on the plan’s terms. If the client still needs health coverage, counsel should assess the ability of the client to obtain it from other sources.

2. **FEHBA Reimbursement Claims**

   a. **Statutory Text**

   The Federal Employees Health Benefits Act of 1959 (FEHBA), which establishes a comprehensive program of health insurance for federal employees, is found in 5 U.S.C. § 8901 et seq. For reimbursement issues, the primary focus is on § 8902(m)(1).

   § **8902. Contracting authority**

   (a) The Office of Personnel Management may contract with qualified carriers offering plans described by section 8903 or 8903a of this title, without regard to section 5 of title 41 or other statute requiring competitive bidding. . . .
   
   (d) Each contract under this chapter shall contain a detailed statement of benefits offered and shall include such maximums, limitations, exclusions, and other definitions of benefits as the Office considers necessary or desirable. . . .
   
   (h) The benefits and coverage made available under subsection (g) of this section are noncancelable by the carrier except for fraud, overinsurance, or nonpayment of periodic charges. . . .
   
   (i) Rates charged under health benefits plans described by section 8903 or 8903a of this title shall reasonably and equitably reflect the cost of the benefits provided. . . .
   
   (m) (1) The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.
   
   (2) (A) Notwithstanding the provisions of paragraph (1) of this subsection, if a contract under this chapter provides for the provision of, the payment for, or the reimbursement of the cost of health services for the care and treatment of any particular health condition, the carrier shall provide, pay, or reimburse up to the limits of its contract for any such health service properly provided by any person licensed under State law to provide such service if such service is provided to an individual covered by such contract in a State where 25 percent or more of the population is located in primary medical care manpower shortage areas designated pursuant to section 332 of the Public Health Service Act (42 U.S.C. . . .

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(B) The provisions of subparagraph (A) shall not apply to contracts entered into providing prepayment plans described in section 8903(4) of this title. . . .

§ 8912. Jurisdiction of courts
The district courts of the United States have original jurisdiction, concurrent with the United States Claims Court [United States Court of Federal Claims], of a civil action or claim against the United States founded on this chapter.

b. Empire HealthChoice v. McVeigh

Lower federal courts were divided on the question of whether reimbursement claims based on FEHBA-governed contracts were analogous to those arising under ERISA-governed plans or whether they were governed by state law. If the former, state limitations on reimbursement would likely be preempted; if the latter, state limits would likely apply. The question was phrased in terms of federal jurisdiction not because the forum was terribly important, but because ERISA has been construed to completely preempt the field of employee welfare benefit plans, thus converting claims that are stated in terms of state insurance and contract law into claims for benefits arising under 29 U.S.C. § 1132, thus giving federal courts jurisdiction over the claim. State law claims would be preempted under the Supreme Court’s view that the “six carefully integrated civil enforcement provisions [of § 1132] . . . provide strong evidence that Congress did not intend to authorize other remedies that it simply forgot to incorporate expressly.” See, e.g., Massachusetts Mut. Life Ins. Co. v. Russell, 473 U.S. 134 (1985); Mertens v. Hewitt Assoc., 508 U.S. 248 (1993). Although FEHBA contained no provisions remotely similar to the detail of 29 U.S.C. § 1132, several courts construed FEHBA analogously

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23 Nothing after McVeigh prevents a FEHBA plan from seeking reimbursement in federal court if diversity is present and the jurisdictional amount is satisfied.
with ERISA, thus preempting state law, though other courts reached the opposite conclusion.

A few months ago, the Supreme Court resolved the conflict. Empire Healthchoice Assurance, Inc. dba Empire Blue Cross Blue Shield v. McVeigh, 126 S.Ct. 2121 (June 15, 2006). In this case, Empire Health Choice sought reimbursement of $157,309 that it had paid on behalf of Joseph McVeigh, who was injured in an auto accident in 1997, and whose claim generated a tort settlement of $3,175,000. Empire sought recovery of the full sum without reduction for attorney’s fees or other litigation costs, and it pled that the federal district court had jurisdiction because the claim arose under FEHBA. The district court dismissed the claim for lack of federal question jurisdiction, and the Second Circuit affirmed. The Supreme Court affirmed by a 5-4 vote. Although the decision clearly focused on federal jurisdiction, which a federal court must do first, the Court clearly distinguished the preemptive effect of FEHBA from that of ERISA.

[C]laims of this genre, seeking recovery from the proceeds of state-court litigation, are the sort ordinarily resolved in state courts. Federal courts should await a clear signal from Congress before treating such auxiliary claims as “arising under” the laws of the United States.

24 The McVeigh Court cited these cases as upholding federal jurisdiction: Blue Cross & Blue Shield of Illinois v. Cruz, 396 F.3d 793, 799-800 (7th Cir. 2005), Caudill v. Blue Cross & Blue Shield of North Carolina, 999 F.2d 74, 77 (4th Cir. 1993), and Medcenters Health Care v. Ochs, 26 F.3d 865 (8th Cir. 1994). There were also other cases relying on ERISA’s preemption provision to interpret and apply FEHBA’s preemption provision: Pharm. Care Mgmt. Ass’n v. Rowe, 429 F.3d 294, 299 n.2 (1st Cir. 2005) (holding that FEHBA’s preemption is “nearly identical” to ERISA’s); Botsford v. Blue Cross & Blue Shield of Mont., Inc., 314 F.3d 390, 393 (9th Cir. 2002); Blue Cross & Blue Shield, Inc. v. Department of Banking & Finance, 791 F.2d 1501, 1504 (11th Cir. 1986).

25 The plan stated: “All recoveries you obtain (whether by lawsuit, settlement, or otherwise), no matter how described or designated, must be used to reimburse us in full for benefits we paid.”
Id., 2127. In part, this difference between ERISA and FEHBA was based on the difference between jurisdictional provisions in both statutes: ERISA gives full jurisdiction over all claims under 29 U.S.C. § 1132 to district courts (§ 1132(e)), whereas FEHBA gives jurisdiction to district courts only for claims against the federal government (§ 8912). Id., 2129, 2134-35. The Court also relied heavily on the difference between the scope of preemption clauses. FEHBA’s clause (8902(m)(1)) literally “displace[s state law] on matters of ‘coverage or benefits.’” Id., 2128-29. Unlike ERISA’s § 1144, it “does not purport to render inoperative any and all State laws that in some way bear on federal employee-benefit plans.” Id., 2135-36 (original emphasis). Because displacement of applicable state law is “atypical,” if Congress intends to accomplish this result, it must make the intention sufficiently clear, which it had not done. Id., 2135.

Although the Court did not precisely decide whether a FEHBA plan could assert in a state court proceeding that its reimbursement rights preempt state law limitations under § 8902(m)(1), the above analysis of the difference between preemption provisions indicates that such a claim should not succeed. In addition to that analysis, the Court “made clear [again] that uniform federal law need not be applied to all questions in federal government litigation, even in cases involving government contracts.” Id., 2131. It agreed with the Second Circuit’s conclusion that Empire Healthcare’s showing failed to demonstrate a “significant conflict . . . between an identifiable federal policy or interest and the operation of state law” to require displacement of state law. Id., 2132-33. And because “the reimbursement right in question, predicated on a FEHBA-authorized contract, is not a prescription of federal law,” id., 2134, there should be no need for a state court to use any law except state law to determine the validity and extent
of a FEHBA reimbursement claim.

In this regard, the Georgia Supreme Court’s decision in *Thurman v. State Farm Mut. Auto. Ins. Co.*, 278 Ga. 162, 165 (2004), must be re-evaluated. Interpreting the uninsured motorist statute, the *Thurman* Court held that a tortfeasor would be “uninsured” because FECA and FEHBA required the tortfeasor’s insurer to pay federal reimbursement claims in first priority. Although there is no reason to disagree with the Court’s analysis of FECA reimbursement claims, the *Thurman* Court’s understanding of FEHBA claims was informed by federal authority (specifically *Medcenters Health Care v. Ochs*, 26 F.3d 865 (8th Cir. 1994)) that the *McVeigh* Court overruled.

3. **Medicare Reimbursement Claims**

   a. **Statutory Text**

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<td>(A) In general. Payment under this title may not be made, except as provided in subparagraph (B), with respect to any item or service to the extent that--</td>
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<td>(i) payment has been made, or can reasonably be expected to be made, with respect to the item or service as required under paragraph (1), or</td>
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<td>(ii) payment has been made or can reasonably be expected to be made under a workmen’s compensation law or plan of the United States or a State or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance.</td>
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In this subsection, the term “primary plan” means a group health plan or large group health plan, to the extent that clause (i) applies, and a workmen’s compensation law or plan, an automobile or liability insurance policy or plan (including a self-insured plan) or no fault insurance, to the extent that clause (ii) applies. An

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26 In 2004, Congress removed the words “promptly (as determined in accordance with regulations)” at this point. P.L. 108-173, § 301.
entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.\textsuperscript{27}

(B) Conditional payment.

(i)\textsuperscript{28} Authority to make conditional payment. The Secretary may make payment under this title with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.

(ii) Repayment required. A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service.\textsuperscript{29} A primary plan’s responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient’s compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan’s insured, or by other means. If reimbursement is not made to the appropriate Trust Fund before the expiration of the 60-day period that begins on the date notice of, or information related to, a primary plan’s responsibility for such payment or other information is received, the Secretary may charge interest (beginning with the date on which the notice or other information is received) on the amount of the reimbursement until reimbursement is made (at a rate determined by the Secretary in accordance with regulations of the Secretary of the Treasury applicable to charges for late payments).

(iii) Action by United States. In order to recover payment made under this title for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may re-

\textsuperscript{27} This last sentence was inserted in 2004, expanding the scope of “primary plans” to include the truly planless as well as the large corporations that managed their own risks.

\textsuperscript{28} This clause was inserted in 2004.

\textsuperscript{29} For this reason, cigarette manufacturers were not found liable to reimburse the government until it is adjudged liable or settled a claim based on an alleged tort. \textit{Glover v. Liggett Group, Inc.}, 459 F.3d 1304 (11th Cir. 2006).
cover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan’s payment to any entity. The United States may not recover from a third-party administrator under this clause in cases where the third-party administrator would not be able to recover the amount at issue from the employer or group health plan and is not employed by or under contract with the employer or group health plan at the time the action for recovery is initiated by the United States or for whom it provides administrative services due to the insolvency or bankruptcy of the employer or plan.

(iv) Subrogation rights. The United States shall be subrogated (to the extent of payment made under this title for such an item or service) to any right under this subsection of an individual or any other entity to payment with respect to such item or service under a primary plan.

(v) Waiver of rights. The Secretary may waive (in whole or in part) the provisions of this subparagraph in the case of an individual claim if the Secretary determines that the waiver is in the best interests of the program established under this title.

(vi) Claims-filing period. Notwithstanding any other time limits that may exist for filing a claim under an employer group health plan, the United States may seek to recover conditional payments in accordance with this subparagraph where the request for payment is submitted to the entity required or responsible under this subsection to pay with respect to the item or service (or any portion thereof) under a primary plan within the 3-year period beginning on the date on which the item or service was furnished.

(C) Treatment of questionnaires. . . .

(3) Enforcement.

(A) Private cause of action. There is established a private cause of action for damages (which shall be in an amount double the amount otherwise provided) in the case of a primary plan which fails to provide for primary payment (or appropriate reimbursement) in accordance with paragraphs (1) and (2)(A).

(B) [Excise tax].

(C) Prohibition of financial incentives not to enroll in a group health plan or a large group health plan. . . .

(4) Coordination of benefits. . . .

(5) Identification of secondary payer situations. . . .

(6) Screening requirements for providers and suppliers. . . .

b. History and Current Status

The Medicare program is funded by the federal government to cover certain types of medical services for certain individuals, mainly those who are 65 years of age or older.
and those who have received Social Security disability benefits for at least 24 months. See 42 U.S.C. § 1395 et seq. Before 1980, Medicare was the primary payer of health care costs, but the Medicare Secondary Payer Act of 1980 (“MSP”) sought to lower costs by making Medicare the “secondary payer” after any other entity obligated to pay for an individual’s primary health care (the “primary payer”), including group health plans, workers’ compensation, or an automobile or other liability policy or plan. Those changes are reflected in 42 U.S.C. § 1395y(b)(2). If payment for covered services has been or is reasonably expected to be made by a primary payer, Medicare should not pay. §1395y(b)(2)(A). If Medicare does pay for a service that was or should have been covered by a primary payer, the payment is “conditional,” and Medicare may recover such payments. § 1395y(b)(2)(B).³⁰

Before 2004, there was a split in the Circuits about Medicare’s right to recover reimbursements from tort settlements because the statutory text defined “primary payers” in terms of the likelihood that they would pay for medical expenses “promptly,” which appeared in § 1395y(b)(2)(A)(ii). “Promptly” was defined by regulations to require payment within 120 days, and this would commonly exclude the typical tort settlement. The leading decision holding that the government could not recover for this reason was Thompson v. Goetzmann, 337 F.3d 489 (5th Cir. 2003). The Eleventh Circuit took the opposition position in United States v. Baxter Int’l, Inc., 345 F.3d 866, 885-93 (11th Cir. 2003), holding inter alia that the reimbursement provisions of § 1395y(b)(2)(B), which lacked a limitation like the term “promptly,” were independent

³⁰ In addition, the health care provider is prohibited for charging the individual for such services. 42 U.S.C. § 1395cc(a)(1)(A).
Signed by the President on December 8, 2003, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 301 (2003) amended § 1395y(b)(2) to remove the text which had been cited as a basis for removing tort settlements from the concept of “primary payers” and from the scope of Medicare reimbursement. Since that enactment, courts have uniformly held that the government may seek reimbursement of medicare payments from tort claims. Brown v. Thompson, 374 F.3d 253, 261 (4th Cir. 2004); Glover v. Philip Morris, 380 F. Supp. 2d 1279, 1284-85, 1295-98 (M.D. Fla. 2005).

Medicare reimbursement rights attach to recoveries of uninsured motorist insurance as well as typical liability insurance. 42 C.F.R. § 411.50(b) and § 411.52. Reimbursement to Medicare must be made even though the plaintiff is not completely compensated. 42 C.F.R. §§ 411.24-411.26. The attorney and the liability insurer are liable for failure to reimburse Medicare payments. 42 U.S.C. § 1395y(b)(2)(b)(iii); 42 C.F.R. § 411.24(i)(2).

c. Lien reduced by procurement costs

Relevant regulations are as follows:

§ 411.37 Amount of Medicare recovery when a primary payment is made as a result of a judgment or settlement.
(a) Recovery against the party that received payment -- (1) General rule. Medicare reduces its recovery to take account of the cost of procuring the judgment or settlement, as provided in this section, if --
   (i) Procurement costs are incurred because the claim is disputed; and
   (ii) Those costs are borne by the party against which CMS seeks to recover.
   (2) Special rule. If CMS must file suit because the party that received payment opposes CMS's recovery, the recovery amount is as set forth in paragraph (e) of this section.
(b) Recovery against the primary payer. If CMS seeks recovery from the primary payer, in accordance with § 411.24(i), the recovery amount will be no greater than the amount determined under paragraph (c) or (d) or (e) of this section.

(c) Medicare payments are less than the judgment or settlement amount. If Medicare payments are less than the judgment or settlement amount, the recovery is computed as follows:

(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 procurement costs.

(3) Subtract the Medicare share of procurement costs from the Medicare payments. The remainder is the Medicare recovery amount.

(d) Medicare payments equal or exceed the judgment or settlement amount. If Medicare payments equal or exceed the judgment or settlement amount, the recovery amount is the total judgment or settlement payment minus the total procurement costs.

(e) CMS incurs procurement costs because of opposition to its recovery. If CMS must bring suit against the party that received payment because that party opposes CMS's recovery, the recovery amount is the lower of the following:

(1) Medicare payment.

(2) The total judgment or settlement amount, minus the party's total procurement cost.

d. Reduction or waiver of lien

Applicable statutory and regulatory provisions are as follows:

§ 1395gg. Overpayment on behalf of individuals and settlement of claims for benefits on behalf of deceased individuals

(a) Payments to providers of services or other person regarded as payment to individuals.

(b) Incorrect payments on behalf of individuals; payment adjustment.

(c) Exception to subsection (b) payment adjustment. There shall be no adjustment as provided in subsection (b) (nor shall there be recovery) in any case where the incorrect payment has been made with respect to an individual who is without fault, if such adjustment (or recovery) would defeat the purposes of title II or title XVIII or would be against equity and good conscience. Adjustment or recovery of an incorrect payment (or only such part of an incorrect payment as the Secretary determines to be inconsistent with the purposes of this title against an individual who is without fault shall be deemed to be against equity and good conscience if (A) the incorrect payment was made for expenses incurred for items or services for which payment may not be made under this title by reason of the
provisions of [42 USCS § 1395y(a)(1) or (9)] and (B) if the Secretary’s determination that such payment was incorrect was made subsequent to the third year following the year in which notice of such payment was sent to such individual; except that the Secretary may reduce such three-year period to not less than one year if he finds such reduction is consistent with the objectives of this title [42 USCS §§ 1395 et seq.].

(d) Liability of certifying or disbursing officer for failure to recoup. . . .

(e) Settlement of claims for benefits under 42 USCS §§ 1395 et seq. on behalf of deceased individuals. . . .

(f) Settlement of claims for section 1395k benefits on behalf of deceased individuals. . . .

(g) Refund of premiums for deceased individuals. . . .

(h) Notwithstanding subsection (f) or any other provision of law, the Secretary shall permit a provider of services or supplier to appeal any determination of the Secretary under this title [42 USCS §§ 1395 et seq.] relating to services rendered under this title [42 USCS §§ 1395 et seq.] to an individual who subsequently dies if there is no other party available to appeal such determination.

§ 411.28 Waiver of recovery and compromise of claims.

(a) CMS may waive recovery, in whole or in part, if the probability of recovery, or the amount involved, does not warrant pursuit of the claim.

(b) General rules applicable to compromise of claims are set forth in subpart F of part 401 and § 405.376 of this chapter.

(c) Other rules pertinent to recovery are contained in subpart C of part 405 of this chapter.

§ 902.2 Bases for compromise.

(a) Agencies may compromise a debt if the Government cannot collect the full amount because: (1) The debtor is unable to pay the full amount in a reasonable time, as verified through credit reports or other financial information; (2) The Government is unable to collect the debt in full within a reasonable time by enforced collection proceedings; (3) The cost of collecting the debt does not justify the enforced collection of the full amount; or (4) There is significant doubt concerning the Government’s ability to prove its case in court.

(b) In determining the debtor’s inability to pay, agencies should consider relevant factors such as the following: (1) Age and health of the debtor; (2) Present and potential income; (3) Inheritance prospects; (4) The possibility that assets have been concealed or improperly transferred by the debtor; and (5) The availability of assets or income that may be realized by enforced collection proceedings.

(c) Agencies should verify the debtor’s claim of inability to pay by using a credit report and other financial information as provided in paragraph (g) of this section. Agencies should consider the applicable exemptions available to the debtor.
under state and Federal law in determining the Government’s ability to enforce collection. Agencies also may consider uncertainty as to the price that collateral or other property will bring at a forced sale in determining the Government’s ability to enforce collection. A compromise effected under this section should be for an amount that bears a reasonable relation to the amount that can be recovered by enforced collection procedures, with regard to the exemptions available to the debtor and the time that collection will take.

(d) If there is significant doubt concerning the Government’s ability to prove its case in court for the full amount claimed, either because of the legal issues involved or because of a bona fide dispute as to the facts, then the amount accepted in compromise of such cases should fairly reflect the probabilities of successful prosecution to judgment, with due regard given to the availability of witnesses and other evidentiary support for the Government’s claim. In determining the litigative risks involved, agencies should consider the probable amount of court costs and attorney fees pursuant to the Equal Access to Justice Act, 28 U.S.C. 2412, that may be imposed against the Government if it is unsuccessful in litigation.

(e) Agencies may compromise a debt if the cost of collecting the debt does not justify the enforced collection of the full amount. The amount accepted in compromise in such cases may reflect an appropriate discount for the administrative and litigative costs of collection, with consideration given to the time it will take to effect collection. Collection costs may be a substantial factor in the settlement of small debts. In determining whether the cost of collecting justifies enforced collection of the full amount, agencies should consider whether continued collection of the debt, regardless of cost, is necessary to further an enforcement principle, such as the Government’s willingness to pursue aggressively defaulting and uncooperative debtors.

(f) Agencies generally should not accept compromises payable in installments. This is not an advantageous form of compromise in terms of time and administrative expense. If, however, payment of a compromise in installments is necessary, agencies should obtain a legally enforceable written agreement providing that, in the event of default, the full original principal balance of the debt prior to compromise, less sums paid thereon, is reinstated. Whenever possible, agencies also should obtain security for repayment in the manner set forth in part 901 of this chapter.

(g) To assess the merits of a compromise offer based in whole or in part on the debtor’s inability to pay the full amount of a debt within a reasonable time, agencies should obtain a current financial statement from the debtor, executed under penalty of perjury, showing the debtor’s assets, liabilities, income and expenses. Agencies also may obtain credit reports or other financial information to assess compromise offers. Agencies may use their own financial information form or may request suitable forms from the Department of Justice or the local United States Attorney’s Office.
On the basis of the above waiver provisions, the Third Circuit has recently summarized that the government “may waive recovery when the beneficiary was not at fault and recovery would defeat the purposes of the Medicare Act or be against equity or good conscience,” and that “the purposes of the Medicare Act would be defeated if recovery would deprive a person of income required for ordinary and necessary living expenses,\textsuperscript{31} including medical expenses.” \textit{Fanning v. United States}, 346 F.3d 386, 401 n.14 (3d Cir. 2003).

Although the government will not give credence to a voluntary allocation of settlement proceeds between medical and non-medical damages,\textsuperscript{32} where a court allocates an award of damages to medical and non-medical expenses, Medicare will not impose a lien on the non-medical portion of the award.

The only situation in which Medicare recognizes allocations of liability payments to nonmedical losses is when payment is based on a court order on the merits of the case. If the court or other adjudicator of the merits specifically designates amounts that are for payment of pain and suffering or other amounts not related to medical services, Medicare will accept the Court’s designation. Medicare does not seek recovery from portions of court awards that are designated as payment for losses other than medical services.


\textsuperscript{31} Under 20 C.F.R. § 404.508(a), a individual’s “ordinary and necessary expenses” include: “(1) Fixed living expenses, such as food and clothing, rent, mortgage payments, utilities, maintenance, insurance (e.g., life, accident, and health insurance including premiums for supplementary medical insurance benefits under title XVIII), taxes, installment payments, etc.; (2) Medical, hospitalization, and other similar expenses; (3) Expenses for the support of others for whom the individual is legally responsible; and (4) Other miscellaneous expenses which may reasonably be considered as part of the individual’s standard of living.”

\textsuperscript{32} Whether this position survives the analysis in \textit{Ahlborn}, infra, is an open question.

\textsuperscript{33} Available for download at http://www.cms.hhs.gov/Manuals/PBM/itemdetail.asp?

4. **Medicaid Reimbursement Claims**

   a. **Statutory text**

   § 1396a. **State plans for medical assistance**
   
   (a) Contents. A State plan for medical assistance must--
   
   (25) provide--
   
   (A) that the State or local agency administering such plan will take all reasonable measures to ascertained the legal liability of third parties (including health insurers, self-insured plans, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service) to pay for care and services available under the plan, including-- . . .
   
   (B) that in any case where such a legal liability is found to exist after medical assistance has been made available on behalf of the individual and where the amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery, the State or local agency will seek reimbursement for such assistance to the extent of such legal liability; . . .
   
   (H) that to the extent that payment has been made under the State plan for medical assistance in any case where a third party has a legal liability to make payment for such assistance, the State has in effect laws under which, to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished to an individual, the State is considered to have acquired the rights of such individual to payment by any other party for such health care items or services; and . . .

   § 1396k. **Assignment, enforcement, and collection of rights of payments for medical care; establishment of procedures pursuant to State plan; amounts retained by State**
   
   (a) For the purpose of assisting in the collection of medical support payments and other payments for medical care owed to recipients of medical assistance under the State plan approved under this title, a State plan for medical assistance shall--
(1) provide that, as a condition of eligibility for medical assistance under the State plan to an individual who has the legal capacity to execute an assignment for himself, the individual is required--

(A) to assign the State any rights, of the individual or of any other person who is eligible for medical assistance under this title and on whose behalf the individual has the legal authority to execute an assignment of such rights, to support (specified as support for the purpose of medical care by a court or administrative order) and to payment for medical care from any third party; . . .

(C) to cooperate with the State in identifying, and providing information to assist the State in pursuing, any third party who may be liable to pay for care and services available under the plan, . . .; and . . .

(b) Such part of any amount collected by the State under an assignment made under the provisions of this section shall be retained by the State as is necessary to reimburse it for medical assistance payments made on behalf of an individual with respect to whom such assignment was executed (with appropriate reimbursement of the Federal Government to the extent of its participation in the financing of such medical assistance), and the remainder of such amount collected shall be paid to such individual.

§ 1396p. Liens, adjustments and recoveries, and transfers of assets
(a) Imposition of lien against the property of an individual on account of medical assistance rendered to him under a State plan.

(1) No lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan, except--

(A) pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual, or

(B) in the case of the real property of an individual— . . .

(b) Adjustment or recovery of medical assistance correctly paid under a State plan.

(1) No adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan may be made, except that the State shall seek adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan in the case of the following individuals:

(A) In the case of an individual described in subsection (a)(1)(B), . . .

(B) [Nursing home payments]

(C) [Long-term care insurance]

(2) Any adjustment or recovery under paragraph (1) may be made only after the death of the individual’s surviving spouse, if any, and only at a time— . . .
§ 49-4-148. Recovery of assistance from third party liable for sickness, injury, disease, or disability; compromise or waiver of claim; compliance; effective date

(a) Should medical assistance be paid in behalf of a recipient of medical assistance on account of any sickness, injury, disease, or disability for which another person is legally liable, the Department of Community Health may seek reimbursement for such medical assistance from such other person. The department shall be subrogated, but only to the extent of the reasonable value of the medical assistance paid and attributable to such sickness, injury, disease, or disability, to the rights of the recipient of medical assistance against the person so legally liable; the commissioner of community health may compromise, settle, and execute a release of any such claim or waive, expressly, any such claim, in whole or in part, for the convenience of the Department of Community Health. This Code section is cumulative of the remedies of the Department of Community Health which specifically include, but are not limited to, the use of hospital liens as provided in Code Sections 44-14-470 through 44-14-477; and further, the payment of medical assistance to a hospital provider shall in no way be construed to discharge the obligation of a third party to satisfy a hospital lien.

§ 49-4-149. Lien of Department of Community Health against third parties; subrogation to recipients’ insurance claims; assignment of recipients’ claims

(a) The Department of Community Health shall have a lien for the charges for medical care and treatment provided a medical assistance recipient upon any moneys or other property accruing to the recipient to whom such care was furnished or to his legal representatives as a result of sickness, injury, disease, disability, or death, due to the liability of a third party, which necessitated the medical care.

(b) The department may perfect and enforce any lien arising under subsection (a) of this Code section by following the procedures set forth for hospital liens in Code Sections 44-14-470 through 44-14-473; except that the department shall have one year from the date the last item of medical care was furnished to file its verified lien statement; and the statement shall be filed with the appropriate clerk

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35 Under O.C.G.A. § 9-2-21(c), DCH must be notified of any claim before a recipient of medicaid, or the recipient’s attorney, “initiat[es] recovery action,” which is defined to include any communication with a party who may be liable or someone financially responsible for that liability.

36 “Third party” was construed to include the Board of Regents in a medical malpractice action in Padgett v. Toal, 261 Ga. App. 154, 155 (2003).
of court in the county wherein the recipient resides and in Fulton County. The verified lien statement shall contain the following: the name and address of the person to whom medical care was furnished; the date of injury; the name and address of the provider or providers furnishing medical care; the dates of services; the amount claimed to be due for the care; and, to the best of the department’s knowledge, the names and addresses of all persons, firms, or corporations claimed to be liable for damages arising from the injuries. This Code section shall not affect the priority of any attorney’s lien.  

(c) The department shall be subrogated, but only to the extent of the reasonable value of the medical assistance paid and attributable to any sickness, injury, disease, or disability, to the rights of medical assistance recipients to any benefits provided such recipients by virtue of private health care insurance contracts; provided, however, the right of subrogation does not attach to any recipient’s rights to benefits paid or provided under private health care coverage prior to the receipt of written notice, by the carrier who issued the health care contract, of the exercise by the department of its subrogation rights.

(d) A recipient of medical assistance who receives medical care for which the department may be obligated to pay shall be deemed to have made assignment to the department of any rights of such person to any payments for such medical care from a third party, up to the amount of medical assistance actually paid by the department; provided, however, assignment does not attach to a recipient’s right to any payments provided under private health care coverage prior to the receipt of written notice, by the carrier who issued the health care coverage, of the exercise by the department of its assignment. This subsection shall apply to a recipient only if notice of this subsection is given to the recipient at the time his application for medical assistance is filed. The assignment created by this subsection shall be effective until the recipient of medical assistance is no longer an eligible recipient for medical assistance.

b. **Arkansas HHS v. Ahlborn**

Until recently, it was believed that reimbursement rights under Medicaid could be enforced in full against a plaintiff’s cause of action. *Holland v. State Farm Mut. Auto. Ins. Co.*, 236 Ga. App. 832 (2) (1999) (allowing a full recovery for reimbursement of

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37 *Holland v. State Farm Mut. Auto. Ins. Co.*, 236 Ga. App. 832 (1999), held that the attorney’s lien was superior to the Medicaid lien. *Padgett v. Toal*, 261 Ga. App. 154, 155 (2003), held that the Medicaid lien did not need to be reduced to take account of the attorney’s fees in generating the award. *Ahlborn* may substantially ameliorate this result for the individual.
medicaid payments even though the plaintiff was not made whole); Richards v. Georgia Dept. of Community Health, 278 Ga. 757 (2004) (relying on the district court decision in Ahlborn to conclude that the statutory intent to recover the full amount of medicaid outlays required an interpretation of the statute as applying to all recoveries, not just those allocated to medical expenses). These cases are no longer authoritative. Under the Supreme Court’s decision in Arkansas Department of Health and Human Services v. Ahlborn, 126 S.Ct. 1752 (2006), the state may only recover the portion of an award or settlement attributable to medical expenses. In addition, it remains to be seen whether the state can subrogate to anything at all. Id., 1763, n.12, citing 42 U.S.C. § 1396p(b) and Martin v. City of Rochester, 642 N.W.2d 1 (Minn. 2002) (42 U.S.C. § 1396p preempted state medicaid lien).

Under the statutes set out above, Arkansas passed statutes entitling it to reimbursement of medicaid payments in full, even if the individual was not made whole. Arkansas Medicaid paid $215,645.30 for Ahlborn, who later obtained a tort settlement of $550,000 which did not allocate medical and non-medical damages. Ahlborn filed a declaratory judgment action in federal court, and the parties stipulated that the settlement was approximately one-sixth of the reasonable value of the recipient’s claim.\(^{38}\) Ahlborn contended that Arkansas should recover only one-sixth of its claim, while Arkansas sought 100%. The district court ruled for Arkansas, but the Eighth Circuit reversed, agreeing with Ahlborn’s position. Finding a conflict in lower court decisions, the U.S. Supreme Court granted certiorari and affirmed the Eighth Circuit. Ahlborn, 126

\(^{38}\) The Court deemed the situation as equivalent to a finding that, because of contributory negligence, the plaintiff could recover only one-sixth of her damages. Id., 1761, n.9.
The Court noted that the federal statutes quoted above required participating states to seek reimbursement, but in each case the statute identified the sum to be recovered with the medical assistance payments that the state made, as opposed to amounts recovered for other items of the individual’s loss. Id., 1760-61. The Court rejected the state’s interpretations of the federal statutes as allowing a recovery of the full amount of its expenditures before the individual recovered for the individual’s other losses, id., 1761-62, and pointed to other statutory language that showed an intent to limit recoveries. Id., 1762-63. In particular, it observed the anti-lien provisions of § 1396p(a) which, if “[r]ead literally and in isolation . . . would appear to ban even a lien on that portion of the settlement proceeds that represents payment for medical care.” Id., 1763. It read § 1396p(a) together with the other provisions quoted above as prohibiting liens generally, but allowing an “exception to the anti-lien provision” on that portion of the individual’s recovery representing reimbursement of medical expenses, while not allowing a lien for “any other portion of [the individual’s] property.” Id.

The Court then addressed the issue of the allocation of damages in the tort recovery. It had earlier noted that the government would respect an allocation made by a judge or jury and seek reimbursement only from the part allocated to medical expenses (id., 1762, n.11), but the government resisted giving the same treatment to voluntary settlements on grounds that those could be manipulated. Although no manipulation occurred in Ahlborn,

[T]he risk that parties to a tort suit will allocate away the State’s interest can be avoided either by obtaining the State’s advance agreement to an allocation or, if necessary, by submitting the matter to a court for decision.
For just as there are risks in underestimating the value of readily calculable damages in settlement negotiations, so also is there a countervailing concern that a rule of absolute priority might preclude settlement in a large number of cases, and be unfair to the recipient in others.

Id., 1765 (footnotes omitted).

In the course of the discussion, the Court also briefly discussed 42 U.S.C. § 1396p(b), which would also restrict the state’s recovery of any medicaid payments.

Id., 1763, n.12, citing Martin v. City of Rochester, 642 N.W.2d 1 (Minn. 2002) (42 U.S.C. § 1396p preempted state medicaid lien). Since neither of the parties briefed that point or insisted upon it, the Court “le[ft] for another day the question of its impact on the analysis.” Id. Although it is plausible that the Court would construe § 1396p(b) in the same way that it construed § 1396p(a), the question is at least open for now.

5. Provider Reimbursement Claims

a. Statutory Text

§ 44-14-470. Lien on causes of action accruing to injured person for costs of care and treatment of injuries arising out of such causes of action

(a) [Definitions]

(b) Any person, firm, hospital authority, or corporation operating a hospital, nursing home, or physician practice\(^{39}\) or providing traumatic burn care medical practice\(^{40}\) in this state shall have a lien for the reasonable charges for [provider’s] care and treatment of an injured person, which lien\(^{41}\) shall be upon any and all

\(^{39}\) Added in 2004.

\(^{40}\) Added in 2002.

\(^{41}\) O.C.G.A. § 44-14-476 specifies that the providers do not obtain an independent right of action against the tortfeasor.
causes of action\textsuperscript{42} accruing to the person to whom the care was furnished or to the legal representative of such person on account of injuries giving rise to the causes of action and which necessitated the [provider’s] care, subject, however, to any attorney’s lien.\textsuperscript{43} The lien provided for in this subsection is only a lien against such causes of action and shall not be a lien against such injured person, such legal representative, or any other property or assets of such persons and shall not be evidence of such person’s failure to pay a debt. This subsection shall not be construed to interfere with the exemption from this part provided by Code Section 44-14-474.\textsuperscript{44}

\textbf{§ 44-14-471. Filing of verified statement; contents; notice}

(a) In order to perfect the lien provided for in Code Section 44-14-470, the operator of the [provider]:

(1) Shall, not less than 15 days\textsuperscript{45} prior to the date of filing the statement required under paragraph (2) of this subsection, provide written notice 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 arising from the injuries and shall include in such notice a statement that the lien is not a lien against the patient or any other property or assets of the patient and is not evidence of the patient’s failure to pay a debt. Such notice shall be sent to all such persons and entities by first-class and certified mail or statutory overnight delivery, return receipt requested; and

(2) Shall file in the office of the clerk of the superior court of the county in which the [provider] is located and in the county wherein the patient resides, if a resident of this state, a verified statement setting forth the name and address of the patient as it appears on the records of the [provider]; the name and location of the [provider] and the name and address of the operator thereof; the dates of admission and discharge of the patient therefrom or with respect to a physician practice, the dates of treatment; and the amount claimed to be due for the [provider], which statement must be filed within the following time period:\textsuperscript{46}

\textsuperscript{42} O.C.G.A. § 44-14-475 precludes liens on settlements that occur before the services for which a lien is sought are provided.


\textsuperscript{44} O.C.G.A. § 44-14-474 excludes workers compensation benefits.

\textsuperscript{45} Reduced from 30 days in 2006.

\textsuperscript{46} These deadlines were set in the 2006 amendment. Under the 2004 amendment, this deadline was set as no sooner than 30 days after the written notice in subsection (a)(1). Because the deadlines in (a)(1) and (a)(2) related circularly to each other, no deadline
for starting this process was stated in the statute, and only the one-year period of limitation provided an end-date, making prompt settlements difficult in many cases. The 2006 amendment corrected this problem.

This exception was added in 2006.

(A) If the statement is filed by a hospital, nursing home, or provider of traumatic burn care medical practice, then the statement shall be filed within 75 days after the person has been discharged from the facility; or

(B) If the statement is filed by a physician practice, then the statement shall be filed within 90 days after the person first sought treatment from the physician practice for the injury.

(b) The filing of the claim or lien shall be notice thereof to all persons, firms, or corporations liable for the damages, whether or not they received the written notice provided for in this Code section. The failure to perfect such lien by timely complying with the notice and filing provisions of paragraphs (1) and (2) of subsection (a) of this Code section shall invalidate such lien, except as to any person, firm, or corporation liable for the damages, which receives prior to the date of any release, covenant not to bring an action, or settlement, actual notice of a notice and filed statement made under subsection (a) of this Code section, via hand delivery, certified mail, return receipt requested, or statutory overnight delivery with confirmation of receipt.

§ 44-14-473. Effect of covenant not to bring an action; action to enforce lien; limitation; affidavit of payment

(a) [Releases are invalid against the lien] unless the holder thereof shall join therein or execute a release of the lien; and the claimant or assignee of the lien may enforce the lien by an action against the person, firm, or corporation liable for the damages or such person, firm, or corporation’s insurer. If the claimant prevails in the action, the court may allow reasonable attorney’s fees. The action shall be commenced against the person liable for the damages or such person’s insurer within one year after the date the liability is finally determined by a settlement, by a release, by a covenant not to bring an action, or by the judgment of a court of competent jurisdiction.

(b) No release [is] effective against the lien perfected in accordance with Code Section 44-4-471, if such lien is perfected prior to the date of the release . . . unless consented to by the lien claimant; provided, however, that any [settling tortfeasor] which first procures from the injured party an affidavit as prescribed in subsection (c) of this Code section shall not be bound or otherwise affected by the lien except as provided in subsection (c) of this Code section, regardless of when the settlement . . . was consummated.

(c) The affidavit shall affirm:

(1) That all [provider] bills incurred for treatment for the injuries for which a
settlement is made have been fully paid; and

(2) The county of residence of such affiant, if a resident of this state;
provided, however, that the person taking the affidavit shall not be protected
thereby where the affidavit alleges the county of the affiant’s residence and the
lien of the claimant is at such time on file in the office of the clerk of the superior
court of the county and is recorded in the name of the patient as it appears in the
affidavit.

b. Analysis

Before 2002, only hospitals and nursing homes could claim the benefits of a lien
on the patient’s tort recoveries. In 2002, the door was opened for burn treatment cen-
ters, and in 2004, it opened to all physician practices. This history led to a convoluted
statutory text that is elided above.

Several cases have determined the scope of claims to which the lien applies. The
lien has been construed to apply to a plaintiff’s right to recover on an uninsured motorist
policy. Thomas v. McClure, 236 Ga. App. 622, 624 (2) (1999). It does not, however,
apply to the rights of plaintiffs in wrongful death claims to recover for the full value of
the same plaintiffs can assert both their own rights of recovery for wrongful death, to
which the provider lien does not apply, and the claims of the decedent, to which the lien
would apply, they may choose to assert only the former and avoid the lien. Id., 145-146.
held that a lien would apply to a consortium claim in spite of the injured spouse’s stated
intent to forego his own claim, the result may have been different if the consortium
claim had been stated independently and settled independently.

Must the injured party be made whole? The provider lien was construed to re-
quire repayment in full to the provider even if the injured party is not made whole. Holland v. State Farm Mut. Auto. Ins. Co., 236 Ga. App. 832, 834 (2) (1999). In Holland, the Court did little more than declare that the “made whole” rule applies only in the context of insurers who take premiums from the injured party. In view of the U.S. Supreme Court’s decision in Ahlborn, however, this result is dubious. It was quite significant in Ahlborn that the medicaid statute authorized a lien for the medical services provided, but excepted the individual’s other “property” from the lien. O.C.G.A. § 44-14-470(b) provides that this lien is “shall not be a lien against . . . any other property or assets of such [injured] persons.” Although the language of the two statutes differs in some respects, the same methods of statutory construction may yield the conclusion that the provider lien applies only to the amount of the recovery attributable to the provider's bills. The provider lien is in derogation of common law and therefore “must be construed strictly against the creditor and in favor of the debtor.” Integon Indem. Corp. v. Henry Med. Ctr., 235 Ga. App. 97, 99 (1998).