LIENS, SUBROGATION, AND THE RULES OF PROFESSIONAL CONDUCT
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WORKERS' COMPENSATION

A workers' compensation payer has a first dollar lien or privilege on the proceeds of the employee's recovery from a "third person." La. R.S. 23:1101-1103. The employer's UM insurer is such a "third person," but the employee's UM insurer is not. *The Travelers Insurance Company v. Joseph*, 95-0200 (La. 6/30/95), 656 So. 2d 1000, 1002. The employer's UM insurer can, however, exclude coverage for the benefit of a workers' compensation intervenor. *Travelers*, 656 So. 2d at 1004. This exclusion means UM proceeds are not subject to the workers' compensation insurer's lien. It also means the workers' compensation insurer does not get a future credit or offset for what the UM insurer has paid. *Bergeron v. Williams*, 1999-0886 (La.App. 1 Cir. 5/12/00), 764 So. 2d 1084, *writ denied*, 2000-1697 (La. 9/15/00), 768 So. 2d 1281; *Cleaning Specialists, Inc. v. Johnson*, 96-2677, 97-0001 (La.App. 4 Cir. 5/21/97), 695 So. 2d 562, *writ denied*, 97-1687 (La. 10/3/97), 701 So. 2d 210. This rule remains in effect even after *Bellard* and *Cutsinger* (see next paragraph).

Our Supreme Court has held the UM insurer gets a credit for benefits paid by the workers' compensation insurer. *Cutsinger v. Redfern*, 2008-2607 (La. 5/22/09), 12 So. 3d 945; *Bellard v. American Central Insurance Co.*, 2007-1335, 2007-1399 (La. 4/18/08), 980 So. 2d 654. How this actually works is unclear. There is no mention in *Cutsinger* (where there was no liability insurer) or in *Bellard* of any reimbursement made to the workers' compensation insurer. It would be absurd for a UM insurer to claim a credit for what the workers compensation insurer has paid if the comp insurer has already been reimbursed out of the underlying liability proceeds. See *Howard v. National Union Fire Ins. Co.*, 2017-1221 (La.App. 1 Cir. 2/16/18), 243 So.3d 4, *writ denied*, 2018-0435 (La. 5/11/18), 241 So.3d 1017, and *Gatlin v. Kleinheitz*, 2010-0639 (La.App. 1 Cir. 4/21/10) (an unpublished writ grant), for reiterations of the collateral source principle, and *Kelly v. Scottsdale Insurance Co.*, 2010 WL 2572078 (M.D. La. 6/23/10), *aff'd*, 465 Fed.Appx. 296 (5th Cir. 2012), for a good discussion of what *Bellard* and *Cutsinger* stand for and don't stand for. *Bellard* and *Cutsinger* did not change the rule that the workers' compensation insurer does not get a future credit or offset for what the UM insurer has paid. *Advantage Personnel and Louisiana Safety Association of Timbermen*, 2013-1618 (La.App. 1 Cir. 6/3/14), 146 So.3d 221, *writ denied*, 2014-1443 (La. 10/24/14), 151 So.3d 603. And there has never been any support for the claim occasionally made by liability insurers that they get a credit for what the workers' comp insurer has paid, or that they only have to pay medical specials at the comp rate. That was never the law and is still not the law, *Howard v. National Union Fire Ins. Co.*, 2017-1221 (La.App. 1 Cir. 2/16/18), 243 So.3d 4, *writ denied*, 2018-0435 (La. 5/11/18),

241 So.3d 1017; *Royer v. State of La., DOTD*, 16-534 (La.App. 3 Cir. 1/11/17), 210 So.3d 910, *writ denied*, 2017-0288 (La. 4/24/17), 221 So.3d 69.

The workers' compensation intervenor's recovery is reduced by the same percentage by which the employee's recovery is reduced as a result of comparative negligence. La. R.S. 23:1101(B). (This is true of legal or conventional subrogation as well - see La. Civ. Code art. 2324.2). And the workers' compensation intervenor must bear its proportionate share of attorney's fees and costs incurred in obtaining recovery from the third party, up to a limit of one third of its intervention. La. R.S. 23:1103(c)(1) (a codification of the earlier, jurisprudentially-created "*Moody* fee").

MEDICARE

Medicare is a purely federal program funded by participating taxpayers. Almost everyone who turns 65 is eligible for Medicare. Individuals who qualify for Social Security Disability are also eligible for Medicare when they have been disabled for 24 months. Entitlement to Social Security and Medicare benefits is not affected by income or assets. Medicare is administered by the Center for Medicare and Medicaid Services (CMS).

Attorneys representing injured Medicare beneficiaries must deal with two exposures: (1) "Conditional payment" recoveries, i.e., Medicare's "lien", or right to be reimbursed out of the proceeds of a beneficiary's liability recovery for what it has already paid in related benefits, and (2) Medicare's right to be protected from paying benefits in the future for treatment for which a third party is responsible, since Medicare is by law a "secondary payer." Attorneys representing liability insurers or self-insurers must also deal with reporting requirements under the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA), also known as "Section 111."

Under the Medicare Secondary Payer (MSP) provisions, 42 USC 1395y(b)(2), Medicare has a right to recover whatever it has paid, subject to a reduction for its proportionate share of attorney's fees and costs ("procurement costs"). 42 CFR 411.37. The right is enforceable against workers' compensation, liability, and no-fault insurance or self-insurance proceeds, but not against individual tortfeasors (unless they have set money aside in a manner which rises to the level of self-insurance; compare *Thompson v. Goetzmann*, 337 F.3d 489 (5th Cir. 2003) with *United States v. Baxter*, 345 F.3d 866 (11th Cir. 2003). The right does not have to be formally asserted in order to be enforceable, and an attorney may be held personally liable for his failure to honor Medicare's right. The right is enforceable against any and all judgment or settlement proceeds without regard to the allocation between general and special damages and without regard to any "hit" taken by the plaintiff for comparative liability. The right is enforceable against proceeds from medical malpractice insurance and self-insurance. *Brown v. Thompson*, 374 F.3d 253 (4th Cir. 2004). Medicare will entertain a request for a "waiver" (reduction) of its "overpayment" (the amount it paid out for services for which someone else will pay).

The recovery rights of "Medicare Advantage" plans are set forth at 42 USC 1395-22(a)(4) and 42 CFR 422.108. According to 42 CFR 422.108, a Medicare Advantage plan exercises "the same rights to recover from a primary plan, entity, or individual that the Secretary exercises under the MSP regulations." A U.S. Third Circuit decision, with a Supreme Court cert denial,

held a Medicare Advantage plan has the same private right of action as Medicare itself. *In re Avandia Marketing, Sales Practices and Products Liability Litigation*, 685 F.3d 353 (3rd Cir. 2012), *cert. denied*, 569 U.S. 918, 133 S.Ct. 1800 (2013). A later U.S. Ninth Circuit decision, *Parra v. PacifiCare of Arizona, Inc.*, 715 F.3d 1146 (9th Cir. 2013), declined to follow *Avandia.* At least one U.S. district court in Louisiana has chosen to follow *Avandia* rather than *Parra. Collins v. Wellcare Healthcare Plans, Inc.*, 73 F.Supp. 3d 653 (E.D.La. 2014) Even under *Avandia*, it's not clear whether other provisions - the special reporting requirements, the imposition of constructive knowledge of the recovery right, and the imposition of personal liability - also apply. In any event, a Medicare Advantage plan claiming recovery rights must also recognize procurement costs.

Under certain circumstances, it's not enough to reimburse Medicare for past benefits paid. Medicare's interest in remaining a "secondary payer" in the future must be considered, even if Medicare has not yet paid any benefits. This may mean nothing more than documenting the unlikelihood of Medicare having to pay benefits in the future for accident-related treatment, but it may mean the setting up of a special fund, called a Medicare Set-Aside (MSA), from which to pay for future treatment that Medicare would otherwise pay for.

Medicare doesn't actually **require** MSAs in any situation; it requires that its interest in remaining a "secondary payer" be considered, and has recommended the MSA as a means to accomplish this. CMS has a mechanism in place to review and approve MSAs only in workers compensation cases, and only when (1) the claimant is a current Medicare beneficiary and the settlement (including past settlements, and including any accompanying tort settlement) is 25K or greater, or (2) there is a "reasonable expectation" of being a Medicare beneficiary within 30 months - i.e., the client has applied for or received Social Security Disability, or is 62.5 years old - and the settlement is 250K or more.

In 2017, CMS announced, rescinded, and then again announced its intention to start rejecting medical claims submitted after resolution of a liability settlement. CMS has not said when or how this might happen, or whether MSAs will become the recommended vehicle for protecting Medicare's interest and ensuring continued coverage in liability situations. Some lien resolution specialists are now recommending an MSA or similar funding arrangement in liability cases, even though CMS does not have a mechanism for reviewing and approving MSAs in liability cases and even though CMS hasn't said or done anything to move forward in that direction.

Given the uncertainties, it's a good idea to obtain specialized help when there is a need to address Medicare's interest in a very large case. The specialist may not be right, but at least there will be someone else to blame if he or she is wrong. In smaller cases, the best thing may be to follow the guidelines applicable in workers' comp situations. If the workers comp threshold is met, either document Medicare's non-interest or document the mechanism for protecting that interest.

MEDICAID

Medicaid is a program established under federal law in which the federal and state governments share in the cost of paying for health care for poor citizens. The federal government pays for most of the costs each state incurs; in return, each state pays its share and complies with certain

statutory requirements for making eligibility determinations, collecting and maintaining information, and administering the program. Under the Affordable Care Act, eligibility for Medicaid is generally determined by income level only without regard to assets (except for the elderly going into a nursing home). Medicaid in Louisiana is administered by the Dept. of Health and Hospitals (DHH) and its private contractors.

By its terms, Medicaid, through DHH, has a right to recover what it has paid, including from UM and med pay proceeds. La. R.S. 46:446. Unlike Medicare, the right is enforceable against individual tortfeasors, not just insurers and self-insurers. The U.S. Supreme Court ruled in *Arkansas Dept. of Health and Human Services v. Ahlborn*, 547 U.S. 268, 126 S. Ct. 1752 (2006), that Medicaid's recovery is limited by statute to that part of the plaintiff's settlement or judgment attributable to past medical specials, taking into account any reduction for comparative fault. So, for example, if the plaintiff settles or wins a judgment for a total of $200,000 based on medicals of $50,000, but with a finding or stipulation that the defendant is only 50% at fault, then Medicaid's recovery is limited to $25,000.

Congress overruled *Ahlborn* in 2013 by amending the law to provide that Medicaid can assert its lien against all proceeds, but then repeatedly voted to delay implementation of the amendment until it finally repealed the amendment in February of 2018. So *Ahlborn* is once again the law.

According to La. R.S. 46:446, the plaintiff's attorney is required to serve DHH with a copy of any suit and obtain DHH's consent to any settlement, whether or not he has received notice, and may be held personally liable if he doesn't. But *Ahlborn* may have effectively eviscerated this "duty to cooperate" as well as the imposition of personal liability for not fulfilling that duty (though we do need to remember we still have duties imposed by Rule 1.15 of the Rules of Professional Conduct). Medicaid does not automatically allow a reduction for procurement costs, but this is negotiable.

Obtaining an itemization of Medicaid's lien in Louisiana is a two-step process. First you contact DHH itself, which advises of any lien it has and also advises which private contractor administers benefits for your client. Then you contact the contractor.

HEALTH CARE PROVIDERS

A health care provider has a first dollar lien or privilege, with no reduction for attorney's fees and costs (except in the Medicare situation described above), on the net amount payable to an injured person by "another person on account of such injuries" or by "any insurance company under any contract providing for indemnity or compensation to the injured person." La. R.S. 9:4752. The privilege must be asserted in accordance with the prescribed manner prior to the payment of proceeds, La. R.S. 9:4753, and an itemized statement must be furnished on request. La. R.S. 9:4755. There is no privilege on health or disability insurance benefits. La. R.S. 22:1015 (formerly 22:646); *Muse v. St. Paul Fire and Marine Insurance Co.*, 328 So. 2d 698 (La.App. 5th Cir. 1976). The attorney's privilege primes the health care provider's. La. R.S. 9:4752. See *Sam v. Direct General Insurance Co.*, 2006-1116 (La.App. 3 Cir. 2/7/07), 951 So. 2d 482, for a good discussion of this issue.

Failure to honor a perfected health care provider lien, or guarantee given to a health care provider, subjects the attorney to personal liability and is a violation of Rule 1.15 of the Rules of Professional Conduct. If there's a dispute with the health care provider over the amount of his entitlement, the funds in dispute can be held in the client trust account for a short period of time while negotiations proceed, but if the dispute can't be resolved, the funds must be deposited in the registry of the court and a rule or concursus provoked.

"Balance billing" is the attempt of a health care provider to bill a health insurance plan at the contracted rate and then bill the patient for the difference between the contracted rate and the full rate. Both balance billing and the attempt to collect the full, undiscounted amount directly from the patient without billing the health insurer are prohibited by the provider contracts of most health plans, and by Louisiana's Health Care Consumer Billing and Disclosure Protection Act, La. R.S. 22:1871, et seq. La. R.S. 22:1874(A)(1) of the Act explicitly prohibits a contracted provider from "discount billing, dual billing, attempting to collect from, or collecting from an enrollee or insured a health insurance issuer liability or any amount in excess of the contracted reimbursement rate for covered health care services." La. R.S. 22:1874(B) provides that "[n]o contracted health care provider may maintain any action at law against an enrollee or insured for a health insurance issuer liability or for payment of any amount in excess of the contracted reimbursement rate for such services." This includes a lien. *Anderson v. Ochsner Health System*, 2013-2970 (La. 7/1/14), 172 So.3d 579; *Emigh v. West Calcasieu Cameron Hospital*, 2013-2985 (La. 7/1/14), 145 So.3d 369. Violation of the anti-balance billing statute gives rise to a private right of action against both the provider and the insurer. *Id.*

Balance billing is not allowed in Medicare. 42 USC 1395cc(a). A provider can elect not to bill Medicare, and is encouraged to try to collect from the liability insurer instead of billing Medicare if it can do so within 120 days of rendering the service. After 120 days, the provider can either bill Medicare or wait to collect from the liability insurer. If the provider fails to bill Medicare within a year of rendering the service, it loses its right to be paid by Medicare and, according to CMS, must release its lien against the liability insurer for any services covered by Medicare, except for deductibles and co-pays. See "Billing in Medicare Secondary Payer (MSP) Liability Insurance Situations", CMS MLN Matters No. SE17018.

Balance billing is not allowed in Medicaid either, but the provider can elect not to bill Medicaid. *Miller v. Wladyslaw Estate*, 547 F.3d 273 (5th Cir. 2008); *Taylor v. State of Louisiana, Through the Dept. of Health and Hospitals, et al.*, 09-1068 (M.D.La. 3/19/2013).

A provider who fails to timely bill a health insurer may be in breach of its contract with the patient, thereby losing its right to collect from the patient in a suit on open account. *Retail Merchants Ass'n, Inc. v. Forrester*, 47,936 (La.App. 2 Cir. 5/15/13), 114 So.3d 1175, *writ not considered*, 2013-1455 (La. 9/27/13), 123 So.3d 179.

STATE HOSPITALS

State and state-supported hospitals have a privilege grounded in La. R.S. 46:8 as well as La. R.S. 9:4751 et seq.

HEALTH INSURERS

A health insurer's (or auto insurer's) right to recover medical benefits paid arises only out of the contractual provisions of the policy. The right, in other words, is purely contractual, not legal; there is no "lien" or "privilege" by operation of law. *Martin v. Louisiana Farm Bureau Casualty Insurance Company*, 94-0069 (La. 7/5/94), 638 So. 2d 1067. Theoretically, the insurer's right can be one of subrogation or one of reimbursement only, depending on policy provisions. *Barreca v. Cobb*, 95-1651 (La. 2/28/96), 668 So. 2d 1129. Under subrogation, the insurer stands in its insured's (the plaintiff's) shoes and has a right of action against the third party tortfeasor; under reimbursement, the insurer only has a right of action against its insured. *Id.* In practice, insurers are careful to word their contracts so as to provide for both subrogation and reimbursement. Under both subrogation and reimbursement, the insurer must bear a proportionate share of the costs and attorney's fees associated with recovery from the tortfeasor, in accordance with *Moody v. Arabie*, 498 So. 2d 1081 (La. 1986) and *Barreca v. Cobb*, 95-1651 (La. 2/28/96), 668 So. 2d 1129. But, according to case law, the insurer is assessed attorney's fees only if it received timely notice of the insured's suit against the tortfeasor and relied on the efforts of the insured's counsel. *Barreca*, 668 So. 2d at 1132. If the insurer intervenes, and its own counsel is an active participant in the suit against the tortfeasor, it may not be responsible for its share of the insured's attorney's fees. *Id; Doucet v. Gayden*, 07-183 (La.App. 5 Cir. 10/16/07), 971 So.2d 382.

The insurer's recovery is, at any rate, reduced by the same proportion by which the plaintiff's recovery is reduced for comparative fault. La. Civ. Code art. 2324.2.

A health insurer probably can't recover against the employee's UM or med pay benefits. La. R.S. 22:994 (formerly 22:663); *Peters v. Prudential Insurance Co. of America*, 511 So. 2d 37 (La.App. 3rd Cir. 1987). The U.S. Fifth Circuit in *Arana v. Ochsner Health Plan, Inc.*, 352 F.3d 973 (5th Cir. 2003), after holding that then-22:663 was inapplicable to HMOs, went on to suggest that even as to health insurance the statute only forbids "coordination of benefits", not subrogation. But the Fifth Circuit's interpretation of Louisiana law is not binding on Louisiana courts.

Under both subrogation and reimbursement, the insurer can recover from the insured only if the insured recovers the full amount of his damages from the tortfeasor. La. Civ. Code art. 1826; *Southern Farm Bureau Casualty Insurance Company v. Sonnier*, 406 So. 2d 178 (La. 1981); *Great West Casualty Company v. Manning*, 95-2359 (La.App. 1 Cir. 6/28/96), 687 So. 2d 416 (relying on *Smith v. Manville Forest Products Corporation*, 521 So. 2d 772 (La.App. 2nd Cir.), *writ denied*, 522 So. 2d 570 (La. 1988)). This is the "partial subrogation" or "make whole" doctrine, and applies regardless of the wording of the contract. *Id.*; *New Orleans Assets, L.L.C. v. Woodward*, 363 F.3d 372 (5th Cir. 2004). See also *Antin v. Temple*, 2006-2454 (La.App. 1 Cir. 12/21/07), 2007 WL 4480638. But a plaintiff who settles for less than the policy limit may be unable to claim he was not made whole. *See American Postal Workers Union, AFL-CIO Health Plan v. Tippett*, 2011-881 (La.App. 3 Cir. 12/7/11), 82 So.3d 379.

Louisiana Commissioner of Insurance Directive Number 175 of January 8, 2003 (incorporating Regulation 78) makes it clear the Commissioner will not approve insurance policies which

attempt to circumvent the "make whole" and *Moody* doctrines. *See American Postal Workers Union AFL-CIO Health Plan v. Tippett*, 2011-881 (La.App. 3 Cir. 12/7/11), 82 So.3d 379.

Under the federal Employee Retirement Income Security Act of 1974 ("ERISA"), almost all employer and union health plans are "completely" preempted by ERISA, which means the federal courts have jurisdiction over cases involving such plans. *Arana v. Ochsner Health Plan, Inc.*, 338 F.3d 433 (5th Cir. 2003). Individual health insurance plans, professional association plans, and plans sponsored by governmental employers (including school boards) and - usually - religious employers are **not** covered by ERISA. Almost all plans sponsored by large private employers are.

If an ERISA plan is "self-insured" or "self-funded" (i.e., uses its members's contributions to pay out benefits, with an insurance company acting as plan administrator but not as insurer of the risk), then there is "conflict" preemption as well, which means no consideration is given to the Louisiana statutory and jurisprudential rules discussed above. *Arana v. Ochsner Health Plan, Inc.*, 338 F.3d 433 (5th Cir. 2003). ERISA itself contains no substantive rules for subrogation and/or reimbursement. The U.S. Supreme Court has held that plans may enforce their contractual reimbursement provisions as written without regard to the "make whole" doctrine and without a proportionate reduction for costs and attorney's fees, which only apply if the plan is silent. *US Airways, Inc. v. McCutchen*, 569 U.S. 88, 133 S.Ct. 1537 (2013).

If the plan is "insured" (i.e., underwritten and issued by an insurance company), ERISA "conflict" preemption does not apply and state law is "saved" from preemption to the extent it seeks to regulate insurance. *FMC Corp. v. Holliday*, 498 U.S. 52, 111 S. Ct. 403 (1990). The test is whether a state law provision (1) regulates insurance, and (2) affects the "risk-pooling arrangement" between the insurer and the insured. *Kentucky Association of Health Plans, Inc. v. Miller*, 538 U.S. 329, 123 S. Ct. 1471 (2003). State law provisions governing subrogation, reimbursement, and other matters affecting benefits are clearly "saved" from "conflict" preemption. So if we're dealing with an "insured" plan, state law provisions such as "make whole" and *Moody* will apply even if we're in federal court. *Benefit Recovery, Inc. v. Donelon*, 07-30414 (5th Cir. 3/11/08), 521 F.3d 326.

ERISA authorizes a plan fiduciary to bring a civil action "to enjoin any act or practice which violates … the terms of the plan, or … to obtain other appropriate equitable relief." In *Great-West Life & Annuity Insurance Company v. Knudson*, 534 U.S. 204, 122 S. Ct. 708 (2002), an employee benefits plan sought reimbursement from its beneficiary from the proceeds of tort recovery funds that had already been disbursed to the beneficiary and were therefore no longer specifically identifiable. The U.S. Supreme Court ruled that ERISA does not authorize an employee benefits plan to sue a beneficiary in federal court under these circumstances because this would be tantamount to imposing personal liability for a contractual obligation to pay money, which is a "legal" rather than an "equitable" remedy. In *Sereboff v. Mid Atlantic Medical Services, Inc.*, 547 U.S. 356, 126 S. Ct. 1869 (2006), the Court expanded its definition of "equitable" remedy to allow an action against beneficiaries who had already been disbursed their tort settlement proceeds but put some of the money aside in a separate investment account. But in *Montanile v. Board of Trustees of the National Elevator Industry Health Benefit Plan*, 136

S.Ct. 651 (2015), the Court made it clear, again, that there is no "equitable" remedy against a beneficiary's general assets, including tort recovery funds which have already been spent.

STATE AND LOCAL GOVERNMENT EMPLOYEES

State employees are covered under different plans offered under the auspices of the Office of Group Benefits (OGB). OGB has promulgated a regulation, LAC 32:513, in which it asserts full subrogation and reimbursement rights over any and all proceeds. La. R.S. 22:971.1(A) exempts OGB from the authority of the Department of Insurance to regulate "the coordination of medical, surgical, and hospital benefits of a self-insurance plan with such benefits of any other insurance plan", but that doesn't exempt OGB from the substantive provisions of the Insurance Code (Title 22). See *Capitol Anesthesia Group, P.A. v. Watson*, 2008-1159 (La.App. 3 Cir. 3/4/09), 7 So.3d 51, *writ denied*, 2009-1088 (La. 9/18/09), 17 So.3d 974, in which OGB was tagged for penalties and attorney's fees under La. R.S. 22:657 (now 22:1821). And La. R.S. 42:858 provides relative to OGB that "[a]ll group insurance contracts effected pursuant hereto shall conform and be subject to all the provisions of any existing or future laws concerning group insurance."

Furthermore, the "make whole" doctrine is grounded in the "partial subrogation" provision of Article 1826(B) of the Civil Code, not Title 22, and "Moody" outside of the workers' compensation context is a purely jurisprudential doctrine. The Insurance Commissioner's Directive 175 did not create "Moody" and "make whole"; it simply reflected those longstanding Civil Code and jurisprudential provisions, which apply to OGB even if the Commissioner of Insurance has no jurisdiction over OGB. Since legislation and controlling jurisprudence trump regulations, OGB plans should be subject to "Moody" and "make whole" despite LAC 32:513.

Similarly, local government self-funded plans, which are explicitly exempt from being deemed "insurance" for most Title 22 purposes under La. R.S. 33:3062(B), should also be subject to "Moody" and "make whole", which are not found in Title 22 and are not insurer-specific.

To date there is no case law on this subject.

FEHBA AND MCRA

Health plans covering federal employees are governed by the Federal Employees Health Benefits Act ("FEHBA"), 5 USC 8902. FEHBA programs are generally contracted out to private carriers. 5 C.F.R. 890.106(b)(1) requires carriers to make their "right to pursue and receive subrogation and reimbursement recoveries . . . a condition of and a limitation on the nature of benefits or benefit payments and on the provision of benefits under the plan's coverage."

The U.S. Supreme Court ruled in *Empire HealthChoice Assurance, Inc. v. McVeigh*, 547 U.S. 677, 126 S. Ct. 2121 (2006), that FEHBA reimbursement provisions do not give rise to federal jurisdiction. But then the Court ruled in *Coventry Health Care of Missouri, Inc. v. Nevils*, __ U.S. __, 137 S.Ct. 1190 (2017), that those provisions preempt state law. So federal law applies even though there's no federal jurisdiction.

Under the Medical Care Recovery Act (MCRA), 42 USC 2651, the federal government has a super-lien, granting both subrogation and an independent right of action, to recover medical benefits paid when a tort claim is involved. The MCRA and its administrators, such as Tricare,

do not recognize procurement costs. But, under 42 USC 2652(c), they appear to be subject to the "make whole" doctrine, or at least to proration on the basis of comparative fault and/or policy limits. Compare *United States of America v. USAA*, 2:10-cv-01252 (W.D.La. 7/7/11) with *Allen v. United States*, 668 F.Supp. 1242, 1257-1258 (W.D.Wis. 1987).

The VA has its own recovery statute, 38 USC 1729.

UM/ MED PAY

The "make whole" doctrine applies, so that a client who settles or obtains a judgment for liability policy limits does not owe his auto insurer reimbursement for UM or med pay benefits paid. *Egros v. Pempton*, 606 So. 2d 780 (La. 1992); S*outhern Farm Bureau Casualty Insurance Company v. Sonnier*, 406 So. 2d 178 (La. 1981); *Durham Life Insurance Company v. Lee*, 625 So. 2d 706 (La.App. 1st Cir. 1993); *New Orleans Assets, L.L.C. v. Woodward*, 363 F.3d 372 (5th Cir. 2004). An auto insurer seeking reimbursement/subrogation for UM and/or med pay payments to its insured must also bear its proportionate share of costs and attorney's fees, based on *Durham***.** Again, Louisiana Commissioner of Insurance Directive Number 175 of January 8, 2003 (incorporating Regulation 78) makes it clear the Commissioner will not approve insurance policies which attempt to circumvent the "make whole" and *Moody* doctrines.

Our Supreme Court has held the UM insurer gets a credit for benefits paid by the workers' compensation insurer. *Cutsinger v. Redfern*, 2008-2607 (La. 5/22/09), 12 So. 3d 945; *Bellard v. American Central Insurance Co.*, 2007-1335, 2007-1399 (La. 4/18/08), 980 So. 2d 654. How this actually works is unclear. There is no mention in *Cutsinger* (where there was no liability insurer) or in *Bellard* of any reimbursement made to the workers' compensation insurer. It would be absurd for a UM insurer to claim a credit for what the workers compensation insurer has paid if the comp insurer has already been reimbursed out of the underlying liability proceeds. See *Gatlin v. Kleinheitz*, 2010-0639 (La.App. 1 Cir. 4/21/10), an unpublished writ grant, for a First Circuit reiteration of the collateral source principle, and *Kelly v. Scottsdale Insurance Co.*, 2010 WL 2572078 (M.D. La. 6/23/10) for a good discussion of what *Bellard* and *Cutsinger* stand for and don't stand for.

OUR ETHICAL OBLIGATIONS

Rule 1.1(a) of the Louisiana Rules of Professional Conduct requires us to be competent:

> A lawyer shall provide competent representation to a client. Competent representation requires the legal knowledge, skill, thoroughness and preparation reasonably necessary for the representation.

It is not enough to know how to evaluate, develop, litigate, and try or settle an injured client's claim. We have to be familiar with, inform our client of, and protect our client from, the consequences of the judgment we seek or the settlement we enter into on the client's behalf. We may not be ERISA lawyers, or health care lawyers, but we need to be able to deal with the ever-increasing claims (legitimate and otherwise) of Medicare, Medicaid, health insurers, and medical providers as they affect personal injury proceeds, in order to maximize our client's recovery and minimize our client's exposure to punitive sanctions for non-compliance with statutory or

contractual obligations. This is part of the knowledge and skill we must have if we're going to practice personal injury law.

This doesn't mean we have to be experts in these other areas of law. We will probably want to hire someone else, for example, to do a trust if indicated, or to work up a Medicare Set-Aside proposal, or maybe even to help us negotiate with a stubborn lienholder or subrogation claimant. But we have to be able to recognize these issues when they arise, and deal with them appropriately.

Legitimate lienholders and subrogation claimants are third persons whose "property" - i.e., interest in tort settlement proceeds - we have an obligation to safeguard under Rule 1.15 of the Louisiana Rules of Professional Conduct. Rule 1.15(d) and (e) provide as follows:

> (d) Upon receiving funds or other property in which a client or third person has an interest, a lawyer shall promptly notify the client or third person. For purposes of this rule, the third person's interest shall be one of which the lawyer has actual knowledge, and shall be limited to a statutory lien or privilege, a final judgment addressing disposition of those funds or property, or a written agreement by the client or the lawyer on behalf of the client guaranteeing payment out of those funds or property. Except as stated in this rule or otherwise permitted by law or by agreement with the client, a lawyer shall promptly deliver to the client or third person any funds or other property that the client or third person is entitled to receive and, upon request by the client or third person, shall promptly render a full accounting regarding such property.
>
> (e) When in the course of representation a lawyer is in possession of property in which two or more persons (one of whom may be the lawyer) claim interests, the property shall be kept separate by the lawyer until the dispute is resolved. The lawyer shall promptly distribute all portions of the property as to which the interests are not in dispute.

Comment 4 to the ABA Model Rule 1.15 explains this further:

> Paragraph (e) also recognizes that third parties may have lawful claims against specific funds or other property in a lawyer's custody, such as a client's creditor who has a lien on funds recovered in a personal injury action. A lawyer may have a duty under applicable law to protect such third-party claims against wrongful interference by the client. In such cases, when the third-party claim is not frivolous under applicable law, the lawyer must refuse to surrender the property to the client until the claims are resolved. A lawyer should not unilaterally assume to arbitrate a dispute between the client and the third party, but, when there are substantial grounds for dispute as to the person entitled to the funds, the lawyer may file an action to have
> a court resolve the dispute.

Workers' compensation payers (La. R.S. 23:1101-1103), Medicare (42 USC 1395y(b)(2)), Medicaid (La. R.S. 46:446), state hospitals (La. R.S. 46:8), and medical providers with perfected

liens (La. R.S. 9:4751, et seq.) are squarely covered by Rule 1.15(d). We do not necessarily have to pay them what they demand, but if we cannot resolve our dispute with them, we must deposit the disputed funds into the registry of the court and provoke the appropriate legal action. (Medicare and Medicaid impose on us additional obligations, discussed above). "My client instructed me not to pay" is not an acceptable reason for unilaterally arbitrating the dispute instead of letting the court decide.

A medical provider without a perfected lien and without a guarantee from us may still be covered by Rule 1.15(d) if our client has signed the standard assignment of benefits/promise to pay which is at the bottom of all intake forms.

Again, a health **insurer's** (or auto insurer's) right to recover medical benefits paid arises only out of the contractual provisions of the policy. The right, in other words, is purely contractual, not legal; there is no "lien" or "privilege" or any other claim by operation of law. *Martin v. Louisiana Farm Bureau Casualty Insurance Company*, 94-0069 (La. 7/5/94), 638 So. 2d 1067. This is true of ERISA plans as well, whether insured or self-funded, so it is never accurate for an ERISA claimant to state it has a "lien." It could be argued that the beneficiary's acceptance of the plan's coverage is also an acceptance of the plan's reimbursement provisions, and is therefore tantamount to a Rule 1.15(d) guarantee to reimburse the plan. But this strained argument is unnecessary, because, as with unliened and unguaranteed medical bills, we can't just ignore subrogation and reimbursement claims even if our client wants us to. Rule 1.15(**e**) requires us to safeguard all non-frivolous claims against funds in our custody, whether liened or guaranteed or not. We must either resolve our differences with the claimant or deposit the disputed funds into the registry of the court with a Petition for Declaratory Judgment (if no suit has been filed) or a Rule to Show Cause (if suit has been filed and is not yet dismissed, and we like our judge).

PRACTICE TIPS FOR PLAINTIFF LAWYERS

(1) This isn't a subrogation issue, but it's important: Under *Hoffman v. 21st Century North America Insurance Company*, 2014-2279 (La. 10/2/15), 209 So.3d 702, the collateral source rule doesn't apply to attorney-negotiated write-offs or discounts. So if you send a client to a provider, make sure the full charge is shown on the bill even if you hope to obtain a reduction for your client **after** settlement or judgment.

(2) This is also important: There is a line of La. First Circuit cases holding the plaintiff must get a waiver or assignment of subrogation rights from the health insurer in order to recover for what they've paid - that is, in order to recover the full, undiscounted provider charges. (This also applies to property damage subrogation). I've never had a defendant assert this but it's a good idea to make sure you've got the waiver or assignment if you're going to trial, especially if the defendant has listed health insurance documents or witnesses in the pretrial order.

(3) What you don't know **can** hurt you. Find out right away, when you sign your client up, what insurance benefits and what government benefits apply. Look at the medical bills you obtain to

see who is being billed and who is paying. You want your client's bills to be paid by someone other than him/her or you.

(4) Don't hide from Medicare, Medicaid, or health insurers. Contact them early on, not at the last minute. This will facilitate resolution when the time comes.

(5) If Medicare and/or Medicaid is involved, make sure the medical providers have billed them before you attempt to settle the case.

(6) Remember, you have more leverage with lien and subrogation claimants **before** you settle with the liability insurer than you do after you've already settled and recovery is a sure thing. If liability or medical causation are problematic, it is especially important to make third person claimants part of the deal.

(7) Don't let settling liability insurers put a third person claimant's name on the check. Either provide them with documentation of an amount they can pay to the claimant in a separate check, or give them your promise to honor (by payment or judicial contest) legitimate third person claims, or have them issue one check to you and your client and another check to the registry of the court for the amount in dispute with the third person claimant. There is a case holding a settling insurer has no right or duty to put a subrogee or even a lienholder on the check. See La. R.S. 22:1892(C)(1) and *Block v. Bernard, Cassisa, Elliott & Davis*, 2004-1893 (La.App. 1 Cir. 11/4/05), 927 So. 2d 339.

(8) It is an impermissible conflict of interest for an attorney to sign his own personal indemnity agreement with respect to liens or subrogation claims.