

**OVERCOMING THE FEARED ERISA LIEN OR SUPERLIEN:
HOW TO GET THE MONEY THE BILL COLLECTORS DEMAND INTO
YOUR CLIENT'S POCKET**

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I. THE PROBLEM: LIEN CLAIMS ARE MAKING SETTLEMENT AND DISBURSEMENT AWKWARD

When a case is about to settle, my client's first question is always: what am I going to net after fees, costs, and liens? And it would seem that a good lawyer could at the very least given the client a straight answer to that question. In fact, it was not so long ago when we could answer that question definitively since there was a clear distinction between those liens that had to be paid back and those that did not. Some government liens were statutorily required to be paid back, while all other private liens were prohibited by our state anti-subrogation law. Now the line (lien) is blurred.

Today, ERISA and the cases interpreting it bring arcane legal doctrine and ambiguity to the question of what liens must be paid back. Now we must decipher: 1) which health plans are promulgated pursuant to ERISA; 2) which of those ERISA plans are self-funded and thus entitled to federal preemption of the state anti-subrogation law; and 3) whether the request for reimbursement meets the requirements of equitable restitution, or whether it is merely a claim at law for money damages; 4) whether the claim for restitution is "appropriate" equitable relief.

Further, other liens, heretofore identified as "SUPERLIENS" like MEDICARE, MEDICARE SUPPLEMENT OR REPLACEMENT, MEDICAID, FEHBA and others can likewise be challenged in order to maximize benefits and minimize paybacks for our clients.

It is simply an awkward mess that leaves many lawyers advising their clients to pay the lien and move on with their lives. This paper attempts to provide an alternative solution by bringing some clarity to the question of when an ERISA or alleged

“SUPERLIEN” must be honored, when it should be ignored, and how to insulate the client and the lawyer from collateral litigation or other consequences.

II. WHY ARE WE SO AFRAID OF THE ALLEGED ERISA OR SUPERLIEN? TAMING THE BEAST

Fear is a powerful motivator, and ERISA plans and other ALLEGED SUPERLIENORS use this tool to claim entitlement to our client’s settlements. The plans and their collection agents (Primax, Rawlings, etc.) scream “Look at the plan language! Look at the law! Look at the reimbursement agreement your client signed! You must pay us back or We will sue you! We will sue your client! We will grieve you!”

It is a complete sham. Here are the facts:

1. The universe of liens that preempt the state anti subrogation law is very small. First, the plan must be promulgated under ERISA, and secondly the plan must fully self fund all medical expenses incurred by its plan participants. In many cases, Primax and others seek reimbursement for expenses paid by insurers for the plan and not the plan itself. A free source of information (although not guaranteed correct) is www.freeerisa.com. There you can examine the Form 5500 and see if the “assets” box is checked or the “insurance” box is check as the source of the payment for benefits. Also, if

the plan is operated by a Commercial Insurer some portions of state law are still applicable – thus anti-subrogation statutes can apply even if self funded.¹

THE RULE: IF AN INSURER PAYS FOR THE EXPENSES AND NOT THE PLAN, THERE IS NOT EVEN A COLORABLE ARGUMENT THAT THE PLAN SHOULD BE REPAID. THERE IS NO LIEN.²

2. Having narrowed the universe of possibly recoverable liens down to those plan participant medical expenses actually paid by an ERISA plan, the next question is what is the plan language regarding reimbursement?

The anti-subrogation law is only preempted to the extent of the plan language. Many plans require payback of 100% of the expenses paid by the plan from any settlement or award. But there are also many plans that require only limited reimbursement. For example, some require reimbursement only “to the extent that such expenses are recovered”; or only from “third party settlements” (excluding UIM cases); or “after deduction of attorneys fees and costs”.

¹ See FMC v. Holliday, 498 U.S. 52, 62 (1990) (“The ERISA plan is consequently bound by state insurance regulations insofar as they apply to the plain’s insurer.”).

² Some plans are a hybrid. They pay participant expenses up to a certain level, and then they pay premiums for an insurer to pay expenses over that amount. Only the expenses actually paid by the plan would lead to preemption of the anti-subrogation law, but even then the plan’s right to reimbursement is severely limited.

THE RULE: THE PLAN LANGUAGE IS CRITICAL TO UNDERSTANDING THE EXTENT OF THE LIEN.

3. As the universe of valid liens contracts further, the impact of *Great West*³ and *Sereboff*⁴ must be taken into consideration. As we know, *Great West* severely limits the right of an ERISA plan to recover expenses it pays out. After *Great West*, an ERISA plan cannot sue a plan participant for failing to honor the reimbursement agreement in the contract. Further it cannot sue those who sign a second reimbursement agreement to obtain medical payments after an accident. The ERISA statute simply does not allow actions for breach of contract against plan participants.

THE RULE: AFTER *GREAT WEST*, ANY REIMBURSEMENT AGREEMENT SIGNED BY THE PLAINTIFF OR IN THE PLAN DOCUMENT IS UNENFORCEABLE. IT CANNOT BE THE BASIS OF A LAWSUIT AGAINST THE PLAINTIFF SINCE IT IS AN ACTION FOR BREACH OF CONTRACT.

4. So then when can a plan legitimately claim a right to be reimbursed? The answer is rarely and only under principles of equity. It is only when the plaintiff has been awarded a judgment or settled his claim in: 1) a way that

³ *Great West Life & Annuity Insurance Co. v. Knudson*, 534 U.S. 204 (2002).

⁴ *Sereboff v. MAMSI*, No. 05-260 (U.S. May 15, 2006).

clearly shows he or she received monies reimbursing expenses paid by the plan; 2) that money can be clearly shown as being in a particular fund in the possession of the plan beneficiary (i.e., specifically identifiable funds in the possession or control of the beneficiary); and 3) that the relief requested by the plan is “appropriate” equitable relief under the circumstances.

THE RULE: IF THE FUNDS ARE NOT IN THE POSSESSION OF THE BENEFICIARY (I.E. IN A STRUCTURED SETTLEMENT OR SPECIAL NEEDS TRUST), MAYBE EVEN IF THE MONIES ARE NOT TRACED DUE TO INTERMIXING OF FUNDS OR THE RELIEF REQUESTED IS NOT “APPROPRIATE” EQUITABLE RELIEF – INCLUDING DEFENSES OF MAKE WHOLE DOCTRINE, TRACEABILITY OR IF THEY HAVE BEEN DISSIPATED, THERE IS NO REIMBURSEMENT.

5. Even if settlement funds are being held by the plaintiff, the monies paid by the plan must be clearly traceable. Most settlements involve clients getting less than 100% of their damages. As such, the equitable make whole rule would have to be applied to reduce the amount claimed by the plan. Further, the reduction of costs and fee prior to disbursement would further reduce the amount clearly traceable to monies paid by the plan. Further, equitable defenses of laches, forfeiture, clean hands.

**THE RULE: EQUITABLE DOCTRINES LIKE *QUANTUM MERUIT*
AND THE MAKE WHOLE RULE CAN REDUCE THE AMOUNT
TRACEABLE TO EXPENSES PAID BY THE PLAN.**

6. In order for equitable relief to be granted it must be “appropriate”. See 29 U.S.C. § 1132(a)(3)(B). Arguments related to the appropriateness of an equitable remedy in any given case can be made and those can be asserted in addition to equitable defenses.

**THE RULE: INAPPROPRIATE EQUITABLE RELIEF WILL NOT BE
GRANTED**

The net result is that there is only a very narrow class of ERISA liens that must be repaid and often for only cents on the dollar. The only clear ERISA lien would be a verdict indicating that the plaintiff was being compensated for the exact amount of the monies paid by the plan. But even then the plaintiff would have to possess and control the identifiable fund, and the plan should only be able to collect its pro rata share of the lien after attorneys fees and costs had been deducted since such amounts would be deducted before disbursement to the plaintiff.

III. SUPERLIENS – OR SO THEY CLAIM

There are several liens that have been described as “SUPERLIENS” that don’t deserve such lofty treatment.

1. Medicare proper has a SUPERLIEN that is reduced by attorneys’ fees and pro rata portion of the costs – known as procurement costs.

THE RULE: YOU MUST PAY THE GOVERNMENT BACK MINUS THEIR PROCUREMENT COSTS

2. Medicare supplement or replacement policies provided by private carriers such as CIGNA, Blue Cross and others have **no** federal right of action to assert for reimbursement. See Primax Recoveries Inc. v. Yarmosh, No. 3:03cv01931(AWT), at 8-12 (D.Conn. September 7, 2006); see also Care Choices v. Engstrom, 330 F.3d 786, 788-89 (6th Cir. 2003).

THE RULE: YOU DON’T PAY THESE PEOPLE BACK.

3. The Federal Employee Benefit Act does not allow a private carrier a right of action under federal law for reimbursement. See Empire Healthchoice Assurance, Inc. v. McVeigh, 126 S.Ct. 2121, 2127 (2006).

THE RULE: YOU DON'T PAY THESE PEOPLE BACK.

4. Medicaid repayments for medical expenses are limited to the ratio of the gross settlement payment to the amount of medical expenses that is included in the gross settlement payment. Arkansas v. Ahlborn, No. 04-1506 (U.S. May 15, 2006). Thus, if you have an underinsured case and a mediator or other competent person sets a percentage attributable to medical payments in good faith you can limit your payback to the state medicaid collection agent. You may even be able to eliminate the lien under statute if the beneficiary is not deceased. Id. at 13 n.12 (“Likewise, subsection (b) would appear to forestall any attempt by the State to recover benefits paid, at least from the .individual.”).

In death cases, however, the lien is payable but if the “support” of the next of kin is substantial the lien can be reduced or entirely eliminated. See General Statutes § 17b-95(a)

The lien is also capped under some circumstances.

Operative statutes are General Statutes §§ 17b-94 – 17b-95.

THE RULE: YOU USUALLY HAVE TO PAY THESE PEOPLE BACK SOMETHING.

IV. THE STRATEGY

1. Put the Plan on the Defense.

When a lien letter comes in, respond with a letter demanding information. It helps answer the questions: Is the plan really ERISA? Is it self funded? How much is self funded? Is the government paying? What does the agreement say about third party recoveries? It also makes the plan scurry to send the required documents and if they fail to do so, there are monetary fines that can add up. It also puts the plaintiff in a strong settlement position.

2. Do Not Assist in Making the Monies Traceable to Plan Expenses.

Avoid labeling monies received by the plaintiff as medical expenses. Do not request a breakdown of economic damages on the jury verdict form (unless Medicaid). In a settlement, where the monies received fail to make the plaintiff whole, indicate that in the settlement agreement (e.g., this settlement represents 40% of losses per Judge Smith).

3. Do not allow ERISA or alleged SUPERLIENORS to Intervene in State Tort Actions or For Defendants to Insist on Lien Repayment As a Condition of Settlement.

ERISA plans and other claimed SUPERLIENORS have no authority for intervention in state tort actions. The statute gives no such authority. Moreover, the plans have no rights against tortfeasors. See Gauntlett v. Webb, 2003 Conn. Super. LEXIS 2328 (2003). This case persuasively explains that the plan has no right of intervention, because there is no justiciable case or controversy until the plaintiff receives the money.

Further, if a carrier demands that the alleged lienor be placed on the check after settlement has occurred move under General Statutes § 52-195c to enforce the settlement and obtain interest.

4. Monies Paid By ERISA Self Funded Plans and SUPERLIENORS Are Not Collateral Sources Subject to Reducing the Plaintiff's Judgment.

During the underlying tort case, it is appropriate to claim monies paid by ERISA plans as elements of damage not set off from a settlement or award. See Gauntlett v. Webb, 2003 Conn. Super. LEXIS 2328 (2003). Moreover, since these parties are claiming a right of subrogation exists the verdict should not be reduced by the payments. See General Statutes § 52-225a.

5. Upon Receipt of Settlement Funds, The Attorney Should Immediately Disburse The Net Funds To The Client With A Caveat.

Since a key element of the plan's claim in an alleged ERISA lien case or a SUPERLIEN case is the existence of identifiable funds, an attorney would be remiss to hold the funds in an escrow account unless that is what the client prefers. Ordinarily the funds should simply be disbursed to the client with instructions to commingle the funds. This should only be done after the client is warned about possible legal actions that may be brought against him or her. This warning should be placed boldly and clearly on the settlement statement or in an acknowledgement for the client to sign: "I HAVE ASKED MY ATTORNEY TO DISBURSE ALL SETTLEMENT FUNDS TO ME INCLUDING THOSE AMOUNTS CLAIMED AS A LIEN BY MY ERISA OR SUPERLIEN PLAN TOTALLING _____. I UNDERSTAND THAT LEGAL ACTION MAY BE BROUGHT AGAINST ME BY THIS PLAN AND I MAY BE HELD RESPONSIBLE FOR THE LIEN ASSERTED PLUS ATTORNEYS FEES AND COSTS. MY ATTORNEYS HAVE SAID THEY WILL NOT PAY THIS ALLEGED LIEN IF A JUDGMENT IS ENTERED AGAINST ME. NOTWITHSTANDING THE RISK I DIRECT MY ATTORNEYS TO PROVIDE ME WITH THE ENTIRE SETTLEMENT PROCEEDS."

We also agree to represent our clients for free in the event they are sued for an alleged "lien". This rarely happens and we have never paid a dime to the bill collectors.

6. Plans That Engage in Self Help Should Be Sued For Violating ERISA, CUTPA or FDCPA.

Some plans have attempted to collect their liens by refusing to pay future benefits. This action is usually done without any language in the plan supporting such

an action, and is not allowed by the ERISA enforcement statute. Moreover, there is no right for prospective penalties arising under any of the SUPERLIEN statutes. See Primax Recoveries, Inc. v. Yarmosh, supra, at 14-15 (denying Primax's motion to dismiss counterclaims under CUTPA, General Statutes § 42-110b, and the Fair Debt Collection Practices Act, 15 U.S.C. § 1692k).

7. Plans That Refuse To Pay Benefits Because The Injury Was Caused By A Third Party Should Be Sued. Class Action Counterclaims are Strong Weapons.

Plans that refuse to cover medical bills caused by the act of a third party are acting arbitrarily, and are acting unconscionably by leaving plan participants without coverage based on the mere fact that a third party caused the harm. It is much too overbroad and not clearly defined as such it should be challenged.

Further, in the few instances that our clients have been sued we have instituted class action counterclaims – which if proven would cripple the bill collector companies or their carrier backers. This is a strong incentive for a bill collector to abandon the collection practices. The statutory bases are CUTPA and FDCPA. See Primax Recoveries, Inc. v. Yarmosh, supra, at 14-15.

8. If The Lien Is Negotiated, *Quantum Meruit*, Procurement Cost Reduction and the Make Whole Rule Should Be Argued Strenuously.

The best case scenario for the plan is that the court will order monies held by the plaintiff to be repaid to the plan. After disbursement to the plaintiff by the attorney, the most the plaintiff could have is 50-66% of the total expenses paid by the plan. That should become the maximum exposure with the make whole rule knocking the negotiated amount down further.

9. General Statutes § 52-225c Prohibits Reimbursement to Benefit Payor.

Under Pajor v. Wallingford, 47 Conn. App. 365 (1997), a reimbursement provision in an insurance contract is invalid because it conflicts with General Statutes § 52-225c. This will block the claims of claimed ERISA leinors and SUPERLIENORS if their claims are not firmly rooted in a federal statute that provides preemption. If no federal statute preempts then “the HMO’s remedy, if any, is under state contract law.” Primax Recoveries Inc. v. Yarmosh, supra, at 12. These claims are barred under state law. Pajor, supra; General Statutes § 52-225c.

10. Ethical Concerns: Attorney Disbursement of the “Lien”.

The only ethical concern that I have in dealing with these liens is if I have personally signed a reimbursement agreement indicating that I will pay monies to the plan upon settlement. In those cases, it would be a violation of the rules of professional conduct to disburse to the client. An interpleader or negotiated settlement would be the strategy at that point.

IV. CONCLUSION

We can do better for our clients. In most cases, with client understanding and consent, we can totally avoid the alleged “lien” or purported “superlien”. In others, we should be able to negotiate from a position of strength vis-à-vis the plan, and significantly reduce the claimed lien.