

From *Louisiana Advocates*, August 2006:

Good news, great news, and no news at all: U.S. Supreme Court decides three health insurance reimbursement cases

By Yigal Bander of Kleinpeter & Schwartzberg, LLC, Baton Rouge

2006 will be remembered as the year in which the U.S. Supreme Court decided not one but three cases having to do with a health insurer's claim for reimbursement out of the proceeds of a tort recovery. The three cases—*Arkansas Dept. of Health and Human Services v. Ahlborn*,¹ *Sereboff v. Mid Atlantic Medical Services, Inc.*,² and *Empire Healthchoice Assurance, Inc. v. McVeigh*³—were decided within 45 days of each other.

Ahlborn deals with Medicaid, *Sereboff* deals with ERISA, and *McVeigh* deals with federal employee health insurance. I will discuss the good news (*McVeigh*) first, then the great news (*Ahlborn*), then the non-news (*Sereboff*).

***McVeigh*: No federal jurisdiction or preemption**

Health benefit plans covering federal employees are governed by the Federal Employees Health Benefits Act (FEHBA), 5 U.S.C. Sect. 8902, *et seq.*, under which benefits are self-funded by the federal government and its employees but administered by private insurers contracted to the government. For many years, the government has contracted with the Blue Cross Blue Shield Association to administer benefits through its local affiliates.

FEHBA has a preemption provision that provides: “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 ... which relates to health insurance or plans.”⁴ FEHBA itself contains no provision addressing subrogation and/or reimbursement rights, but the contract between the government and Blue Cross obligates the administrators to make “a reasonable effort” to recoup amounts paid for medical care, and the individual plan descriptions all contain provisions allowing the administrators to be reimbursed out of the proceeds of any lawsuit or settlement recovery.

Joseph McVeigh, a FEHBA enrollee, was injured in a motor vehicle wreck in 1997. He was treated for his injuries until his death four years later. Empire Healthchoice Assurance Inc., the administrator of FEHBA benefits in New York State, paid a total of \$157,309 in benefits related to those injuries. McVeigh's widow settled a lawsuit against the tortfeasors for \$3.1 million.

Empire demanded full reimbursement with no deduction for its proportionate share of costs and attorney's fees, and eventually sued Mrs. McVeigh in U.S. District Court for the Southern District of New York. She moved to dismiss for lack of subject matter jurisdiction.

The district court granted her motion and the U.S. 2nd Circuit Court of Appeals affirmed, holding the reimbursement provisions contained in the contract between the government and Blue Cross do not preempt state law and do not give rise to federal jurisdiction.⁵

Around the same time and in a similar scenario, the U.S. 7th Circuit Court of Appeals reached exactly the opposite conclusion.⁶ The Supreme Court granted *certiorari* in *McVeigh*, and, in a 5-4 decision written by Justice Ginsburg (with “conservatives” and “liberals” on both sides), affirmed the 2nd Circuit and abrogated all other decisions to the contrary.

The court distinguished between FEHBA's limited granting of federal jurisdiction to disputes between enrollees and the government (making the government, not the administrators,

the proper party for benefit disputes) and ERISA's more sweeping granting of federal jurisdiction to encompass all claims by a "participant, beneficiary, or fiduciary" for violations of ERISA provisions or plan terms.⁷

The court also distinguished between FEHBA's limited preemption provision ("The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits ... shall supersede and preempt any state or local law ... which relates to health insurance or plans") and ERISA's more inclusive preemption provision (portions of ERISA "supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan").⁸

And the court rejected the idea that any federal rule or decision (or any corpus of "federal common law") governs "a carrier's claim against its insured or an alleged tortfeasor to share in the proceeds of a state-court tort action."⁹

In other words, just because the federal government contracted with Blue Cross to administer and recoup benefits, and Blue Cross put appropriate reimbursement language into its plans, does not mean Congress, which alone can add to federal jurisdiction and federal preemption, meant to create such jurisdiction and such preemption absent explicit statutory language. And just because Blue Cross is trying to recoup money that will inure to the federal government does not mean there is a federal cause of action, or that any federal law applies.

The practical effect of *McVeigh* is that reimbursement claims by FEHBA administrators against our federal employee clients who obtain tort recoveries are to be governed by **state law** and are to be heard in **state court**. This means, in Louisiana, that the "make whole" doctrine and the *Moody* principle, whereby the party seeking subrogation or reimbursement must bear its proportionate share of costs and attorney's fees, apply in all their glory.¹⁰

The Supreme Court was quite explicit on this point:

The United States observes that a claim for reimbursement may also involve as an issue "[the] extent, if any, to which the reimbursement should take account of attorney's fees expended ... " Indeed it may. But it is hardly apparent why a proper "federal-state balance" ... would place such a nonstatutory issue under the complete governance of federal law, to be declared in a federal forum. **The state court in which the personal-injury suit was lodged is competent to apply federal law, to the extent it is relevant, and would seem best positioned to determine the lawyer's part in obtaining, and his or her fair share in, the tort recovery.**¹¹

McVeigh is not just good news for federal employees. It also suggests the court may yet choose to speak, and speak positively, regarding the extent to which an offset for attorney's fees may be allowed under ERISA.

***Ahlborn*: Medicaid's lien limited**

Medicaid is a program established under federal law, 42 U.S.C. Sect. 1396, *et seq.*, 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.

The rules for Medicaid are different from the rules for Medicare, which is a purely federal program geared to a different population and funded directly by participating taxpayers

rather than out of general federal and state revenues.

One of each state's obligations in the Medicaid program is to seek reimbursement of benefits paid whenever there is some liable "third party," which includes a beneficiary's own UM or med pay insurer as well as tortfeasors and their liability insurers.

Each state enacts its own laws to enforce its recovery rights, consistent with the federal statutory mandate that each state "seek reimbursement for [medical] assistance to the extent of [the third party's] legal liability."¹² The federal statute specifically prohibits states from trying to recover from the property of the beneficiary himself.¹³

Louisiana's Medicaid lien statute is La. R.S. 46:446, *et seq.* By its terms, it allows the state, through Department of Health and Hospitals, to be reimbursed from the entire proceeds of a tort recovery without regard to the allocation between general and special damages, without regard to any "hit" taken by the plaintiff for comparative liability, and—unlike Medicare—without a reduction for a proportionate share of costs and attorney's fees (which Medicare recognizes as "procurement costs").

The issue in *Ahlborn* was whether Arkansas's Medicaid lien statute, which is similar to Louisiana's in most respects, comports with the federal statutory scheme.

A car wreck left Heidi Ahlborn, a young college student and aspiring teacher, severely and permanently injured and left brain damaged. Medicaid paid a total of \$215,645 for her medical care. Ahlborn filed suit against two alleged tortfeasors and, because of liability issues, settled for a total of \$550,000. The parties stipulated that the entire claim—past and future medicals, past wage loss and future loss of earning capacity, and past and future general damages—was valued at \$3,040,708, that the claim was settled for approximately one-sixth of that sum, and that approximately one-sixth of past medicals would amount to \$35,581.

Medicaid demanded its full \$215,645. Ahlborn filed suit for declaratory judgment in the U.S. District Court for the Eastern District of Arkansas. The district court granted the state's motion for summary judgment, and the U.S. 8th Circuit Court of Appeals reversed, holding the Arkansas statute conflicted with the federal statute and Medicaid could only recover that amount of the tort settlement that was earmarked for past medical expenses, *i.e.*, \$35,581.¹⁴

The Supreme Court granted *certiorari*. The United States and 36 individual states filed amicus briefs in support of Arkansas's position; only the Association of Trial Lawyers of America (ATLA) filed an amicus brief in support of Ahlborn.

In a unanimous decision written by Justice Stevens and based on a strict reading of the federal statutory text, the Supreme Court affirmed the 8th Circuit and made it clear that individual states could go no further in their Medicaid reimbursement attempts than federal law allows.

Stated generally, the court held that (1) Medicaid is limited to that part of a plaintiff's settlement or judgment attributable to past medical expenses, and that (2) if there is a settlement or judgment based on less than 100 percent of damages, then Medicaid's recovery is limited to that same proportion.

The court also called into question the validity of state law provisions—such as Louisiana's—imposing full reimbursement liability on parties who fail to cooperate with Medicaid, limiting the "duty to cooperate" to proceedings initiated **by Medicaid itself** to recover from liable third parties.¹⁵

Ahlborn is a tremendous victory for Medicaid recipients and for ATLA. It has important and immediate implications for our Medicaid clients here in Louisiana.

Medicaid can no longer touch the money our clients recover for lost wages and general

damages, and has to take the same liability “hit” our clients take. And our own “duty to cooperate” with Medicaid and the personal liability imposed on us for not fulfilling that duty are largely eviscerated—though we need to remember we still have duties imposed by Rule 1.15 of the Rules of Professional Conduct.

I do not believe *Ahlborn* has any implications for Medicare (which, as explained above, is a very different program with a different reimbursement scheme), for state hospital liens or for medical provider liens. But it’s great news for our Medicaid clients. I would like to think it strengthens our hand a little when dealing with ERISA reimbursement claims. Let’s hope Congress will refrain from tampering with the Medicaid statute and legislatively overruling this important decision.

***Sereboff*: No news at all**

And now for *Sereboff*, the most eagerly anticipated but ultimately least newsworthy of the three cases.

Instead of resolving the split in the circuits as to whether an ERISA plan seeking recovery of benefits paid is subject to the “make whole” doctrine and to a deduction for its proportionate share of costs and attorney’s fees, the court confined itself to holding that, under the facts before it, the ERISA plan was seeking “equitable” relief and could therefore sue in federal court.¹⁶

A little background: The federal Employee Retirement Income Security Act of 1974 (ERISA) covers almost all non-governmental employee health plans. If an ERISA plan is “self-insured” or “self-funded” (*i.e.*, uses its members’ contributions to pay out benefits, with an insurance company often acting as plan administrator but not as insurer of the risk), then state law is totally preempted and the reimbursement provisions of the plan can be enforced with no consideration given to such state law doctrines as “make whole” and what we in Louisiana know as a “*Moody fee*.”

ERISA itself contains no substantive rules for subrogation and/or reimbursement, and the different federal circuits split on whether federal common law requires the application of the “make whole” (or “common fund”) doctrine and/or a proportionate reduction for costs and attorney’s fees.

The U.S. 5th Circuit held that ERISA plans may enforce their contractual recovery provisions as written.¹⁷

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.”¹⁸ In *Great-West Life & Annuity Insurance Company v. Knudson*,¹⁹ 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 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.²⁰

Since then, the 5th Circuit applied *Knudson* to **allow** a plan to recover against funds held in a plaintiff attorney’s trust account under a theory of constructive trust²¹ and to **deny** a plan’s attempt to obtain reimbursement out of funds paid by the tortfeasor into the registry of the court.²²

The issue in *Sereboff* was whether a plan fiduciary could obtain reimbursement out of tort

settlement proceeds that had already been disbursed to the beneficiary but that the beneficiary agreed to set aside and preserve in a separate investment account. **This was the only issue.**²³

(In retrospect, one wonders why so many amicus briefers on both sides—including the Bush administration, Chamber of Commerce, National Association of Manufacturers and Blue Cross in support of the plan, and ATLA in support of the Sereboffs—saw this case as an opportunity to make law on substantive issues).

Not surprisingly, the court, through Chief Justice Roberts, held unanimously that in this case the remedy sought was “equitable” because, unlike in *Knudson*, the plan sought recovery out of a specifically identified fund. Not a tough call, really.

Sereboff did **not** reject the contention (so ably briefed by ATLA) that if a plan seeks an “equitable” remedy, the beneficiary should be able to assert such “equitable” defenses as “make whole” and the bearing of a proportionate share of costs and attorney’s fees. Rather, the court “declined to consider” the issue because, in its opinion, it was not properly raised in the lower courts.²⁴ And it should be noted that the plan at issue in *Sereboff* **did** provide for a deduction for the plan’s share of costs and attorney’s fees.²⁵

So we’re no worse off after *Sereboff* than we were before—and we’re actually better off, because we now know of one more situation to avoid.

Editor’s note: (For a fuller discussion of subrogation and reimbursement issues, see “Liens, Subrogation, Reimbursement, and Rule 1.15: A Current Perspective from Kleinpeter & Schwartzberg”, www.kleinpeter-schwartzberg.com/publications).

ENDNOTES

1. ___ U.S. ___, 126 S.Ct. 1752 (2006).
2. ___ U.S. ___, 126 S.Ct. 1869 (2006).
3. ___ U.S. ___, 126 S.Ct. 2121 (2006).
4. 5 U.S.C. Sect. 8902(m)(1).
5. 396 F.3d 136 (2nd Cir. 2005), 402 F. 3d (2nd Cir. 2005).
6. *Blue Cross and Blue Shield of Illinois v. Cruz*, 396 F.3d 793 (7th Cir. 2005).
7. *McVeigh*, 126 S.Ct. at 2134-2135.
8. *Id.* at 2135-2136.
10. See “Liens, Subrogation, Reimbursement, and Rule 1.15: A Current Perspective from Kleinpeter & Schwartzberg”, www.kleinpeter-schwartzberg.com/publications).
11. *McVeigh*, 126 S. Ct. at 2137.
12. 42 U.S.C. Sect. 1396a(a)(25).
13. 42 U.S.C. Sects. 1396a(a)(18) and 1396p.
14. 397 F.3d 620 (8th Cir. 2005).
15. *Ahlborn*, 126 S.Ct. at 1764-1765.
16. *Sereboff v. Mid Atlantic Medical Services, Inc.*, ___ U.S. ___, 126 S.Ct. 1869 (2006).
17. *Walker v. Wal-Mart Stores, Inc.*, 159 F.3d 938 (5th Cir. 1998); *The Sunbeam-Oster Company, Inc. Group Benefits Plan v. Whitehurst*, 102 F.3d 1368 (5th Cir. 1996).
18. 29 U.S.C. Sect. 1132(a)(3).
19. 534 U.S. 204, 122 S.Ct. 708 (2002).
20. *Id.*, 534 U.S. at 210, 122 S.Ct. at 708.
21. *Bombardier Aerospace Employee Welfare Benefits Plan v. Ferrer, Poirot and Wansbrough*, 354 F.3d 348 (5th Cir. 2003), *cert. denied*, 124 S.Ct. 2412 (2004).

22. *Bauhaus USA, Inc. v. Copeland*, 292 F. 3d 439 (5th Cir. 2002).
23. *Sereboff*, 126 S. Ct. at 1872-1873.
24. *Id.*, 126 S.Ct. at 1877, FN2.
25. *Id.*, 126 S.Ct. at 1873.