

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), *writ denied*, 2000-1697 (La. 9/15/00), 768 So. 2d 1281; *Cleaning Specialists 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.

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) for a recent 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.

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").

HEALTH CARE PROVIDERS

A health care provider has a first dollar lien or privilege, with no reduction for attorney's fees and

costs, 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” (or “discount billing”) is the practice of a health care provider billing a health insurance plan at the contracted rate and then billing the patient for the difference between the contracted rate and the full posted rate (which nobody but the uninsured ever pays - another example of how the poor pay more). 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 the Health Care Consumer Billing and Disclosure Protection Act, La. R.S. 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.” This language covers both balance billing and the refusal to bill the health insurer in the first place.

Balance billing is also prohibited under Medicare, 42 USC 1395cc(a)(1)(A), and Medicaid, La. R.S. 46:437.12(a)(10). But a Medicare provider may - is, in fact, required to - collect directly from the liability insurer if it can do so within 120 days; after 120 days, it may either bill Medicare or lien the liability insurer. 42 CFR 411.52 and CMS bulletins. (The best thing for a Medicare beneficiary with a potential tort claim is for the provider to bill Medicare before there is an identified liability insurer). And while a participating Medicaid provider cannot refuse treatment, and for the most part cannot bill the patient, the provider may choose to bill the third party instead of Medicaid. La. R.S. 46:446.5. (Some providers claim Medicaid in Louisiana, through DHH, now allows balance billing through an April 2008 “Rule”, but this is of doubtful validity because (1) it contradicts explicit state statutory law, La. R.S. 46:437.12(10)(a) and 46:446.5, and (2) it contradicts federal Medicaid law. See *Miller v. Wladyslaw Estate*, 547 F.3d 273 (5th Cir. 2008).

A Louisiana Attorney General Opinion, No. 05-0056 (5/17/05), suggested a contracted health care provider may attempt to collect a lien in excess of the contracted rate from someone (such as the liability insurer or the plaintiff’s attorney) other than the patient. That opinion, which is not followed

by the AG itself, is wrong for four reasons. First, it puts form over substance, since any lien against a liability insurer is going to come at the expense of the plaintiff. Second, it contradicts La. R.S. 22:1874(B), which 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.” Third, it contradicts the reasoning of *Miller v. Wladyslaw Estate*, 547 F.3d 273 (5th Cir. 2008), where the U.S. Fifth Circuit, citing a long line of cases, assumed that liening tort proceeds after billing a contracted payer (in that case, Medicaid) is the same as balance billing. Finally, it has been superseded by *Agilus Health v. Accor Lodging North America*, 2010-0800 (La. 11/30/10), 2010 WL 4845732, where the Louisiana Supreme Court held that once a provider contracts with a PPO organization and agrees to certain rates, it is bound by its contract even if there is a statute allowing higher rates.

The Health Care Consumer Billing and Disclosure Protection Act gives us three remedies against a health care provider who attempts to balance bill or refuses to bill the health insurer in the first place, and instead sends us a lien.

First, La. R.S. 22:1874(B) provides that, if the contracted provider’s illegal “lien” rises to the level of an “action at law” - which it arguably does just by being asserted, and definitely does if it is contested in a lawsuit - the prevailing party “shall be entitled to recover all costs incurred, including reasonable attorney fees and court costs.”

Second, La. R.S. 22:1876 provides that if the contracted provider sends a report to a credit reporting agency for nonpayment of an amount the provider is prohibited from collecting, and does not send a correcting letter to the credit reporting agency within ten days of a request, the provider “shall be liable for all reasonable costs, including reasonable attorney fees and court costs, incurred by the enrollee or insured with correcting such erroneous credit record.”

Third, La. R.S. 22:1877 empowers the Consumer Protection Division of the Louisiana Department of Justice (that is, the AG’s office) to receive complaints against providers who violate the prohibitions of the Act and, if warranted, pursue remedies under the Unfair Trade Practices statutes, La. R.S. 51:1401, et seq.

MEDICARE

Medicare is a purely federal program funded by participating taxpayers. It is nearly universal, and is not means-tested. 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), but some CMS functions are contracted out.

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. Attorneys representing liability insurers or self-insurers must also deal with the new reporting requirements under the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA).

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.” It appears that, while the plan “may” assert a recovery right, there is no statutory super-lien as in Medicare itself, no special reporting requirements, no imposition of constructive knowledge of the recovery right, and no imposition of personal liability. An argument can be made that the plan must specify its recovery rights in its contract, just like a private insurer; a better argument can be made that whatever recovery rights the plan asserts are subject to procurement costs just like Medicare itself.

Under certain circumstances, it is not enough to reimburse Medicare for past benefits paid. Medicare’s future exposure has to be addressed, and Medicare’s interest has to be considered, even if Medicare has not yet paid any benefits. If workers’ compensation is involved, then a special “Medicare Set-Aside” (MSA) has to be calculated and submitted to CMS (which administers Medicare) for approval in each of two circumstances: (1) the client 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.

Generally, an MSA does not have to be submitted for approval, and will not be considered for

approval, except in a workers' comp situation which meets one of the two thresholds (either current beneficiary and 25K, or reasonable expectation of being a beneficiary within 30 months and 250K). Some providers of MSA services claim the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) requires MSAs in liability settlements as of July 1, 2009, but nothing in MMSEA suggests this. All MMSEA does is to impose new reporting requirements on liability insurers. It doesn't change anything for us or for our clients.

What is true is that in theory, the same statutory authority by which Medicare requires MSAs in some situations could allow it, in the future, to begin requiring MSAs in other situations as well. This statutory authority is questionable - see, for example, *Bradley v. Sebelius*, 621 F.3d 1330 (11th Cir. 2010) (CMS's manuals and bulletins, unlike its regulations, are not entitled to *Chevron* deference) - but, even so, Medicare's interest in not being exposed to future medicals in any situation should always be "considered." This may mean nothing more than documentation of the unlikelihood of Medicare paying future medicals, and the saving of such documentation for a very long time. Or it might possibly mean, in rare circumstances, some kind of set-aside which is not submitted for approval but is still set up.

MEDICAID/DHH

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. Recipients of Supplemental Security Income (SSI) benefits are automatically eligible for Medicaid provided they do not exceed income and asset limits. In Louisiana, those limits are generally \$579 per month in income and \$2000 in assets. Entitlement to SSI and Medicaid is affected by changes in income or assets. Medicaid in Louisiana is administered by the Dept. of Health and Hospitals (DHH).

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. However, the U.S. Supreme Court has ruled, in *Arkansas Dept. of Health and Human Services v. Ahlborn*, 547 U.S. 268, 126 S. Ct. 1752 (2006), that Medicaid is limited to that part of the plaintiff's settlement or judgment attributable to 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.

According to the statute, 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* has effectively eviscerated this "duty to cooperate" as well as the imposition of personal liability for not fulfilling that duty (though we need to remember we still have duties imposed by Rule 1.15 of the Rules of Professional Conduct). DHH does not generally allow a reduction for procurement costs, but may reduce its recovery if circumstances

warrant.

While a participating Medicaid provider cannot refuse treatment, and cannot bill the patient, the provider may choose to bill the third party instead of Medicaid. La. R.S. 46:446.5.

DHH purports to have amended its regulations to allow balance billing through an April 2008 “Rule”, but this amendment has to be considered inoperative because (1) it contradicts explicit state statutory law, La. R.S. 46:437.12(10)(a) and 46:446.5, and (2) it contradicts federal Medicaid law. *Miller v. Wladyslaw Estate*, 547 F.3d 273 (5th Cir. 2008) (where the U.S. Fifth Circuit, in a Louisiana case involving Baton Rouge General, cited a long line of cases (including *Spectrum Health Continuing Care Group v. Anna Marie Bowling Irrevocable Trust*, 410 F.3d 304 (6th Cir. 2005)) in holding that liening tort proceeds is the same as balance billing and is against the law).

Also of concern is the effect of a tort recovery - or any acquisition of assets - on the client’s continued eligibility for Medicaid, given the \$2000 asset limit. This problem may be addressed through the creation of a Special Needs Trust and the placing of tort recovery proceeds into the trust. The funds can then be used, within the beneficiary’s lifetime, for health care and other goods or services intended to enhance the Medicaid beneficiary’s quality of life, and which are not provided by need-based government programs. The big drawback to a Special Needs Trust is that whatever is left in the trust at the time of the beneficiary’s death (not to exceed the amount of Medicaid benefits paid to the beneficiary) passes to the state. A simple “spend-down” may be better - the idea is that once the acquired assets are spent, the beneficiary becomes eligible again.

STATE HOSPITALS

State and state-supported hospitals such as LSU/Earl K. Long have a privilege grounded in La. R.S. 46:8 as well as La. R.S. 9:4751 et seq. They generally send us lien notices through their attorneys, with whom we can negotiate.

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” 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. 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.*

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.

It is not clear whether a health insurer can recover against the employee's UM or med pay benefits. La. R.S. 22:994 (formerly 22:663) has been interpreted as forbidding this, *Peters v. Prudential Insurance Co. of America*, 511 So. 2d 37 (La.App. 3rd Cir. 1987), but the U.S. Fifth Circuit in *Arana v. Ochsner Health Plan, Inc.*, 352 F.3d 973 (5th Cir. 2003), after distinguishing between health "insurance" and HMOs, and holding that then-22:663 is inapplicable to HMOs, went on to suggest that even as to health insurance the statute only forbids "coordination of benefits", not subrogation. The Fifth Circuit's interpretation of Louisiana law is, of course, 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.

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.

However - and it's a big "however" - 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 (at least within the Fifth Circuit) the federal courts have jurisdiction over **all** 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 often acting as plan administrator but not as insurer of the risk), then there is "conflict" preemption as well, which means the contractual provisions can be enforced with no consideration 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, and the different federal circuits are 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 Fifth Circuit has ruled that plans may enforce their contractual reimbursement provisions as written. *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); *A. Copeland Enterprises, Inc. v. Slidell Memorial Hospital, Inc.*, 94-2011 (La. 6/30/95), 657 So. 2d 1292.

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. The Fifth Circuit applied *Knudson* to **allow** a plan to recover against funds held in a plaintiff attorney’s trust account under a theory of constructive trust. *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). The Fifth Circuit also applied *Knudson* to **deny** a plan’s attempt to obtain reimbursement out of funds paid by the tortfeasor into the registry of the court. *Bauhaus USA, Inc. v. Copeland*, 292 F. 3d 439 (5th Cir. 2002). In *Sereboff v. Mid Atlantic Medical Services, Inc.*, 547 U.S. 356, 126 S. Ct. 1869 (2006), the Supreme 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. The Court has still not spoken on the substantive issue of whether federal common law allows “equitable” defenses such as *Moody* and “make whole” in defense of actions seeking “equitable” remedies.

STATE AND LOCAL GOVERNMENT EMPLOYEES

State employees are covered under different plans offered under the auspices of the Office of Group Benefits (OGB). La. R.S. 22:2(F) exempts OGB from regulation by the Department of Insurance. But 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 should apply to OGB even if the Commissioner has no jurisdiction over OGB. Furthermore, 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.” For either or both of these reasons, OGB plans are probably subject to “Moody” and “make whole.” OGB disagrees.

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 nonetheless be subject to “Moody” and “make whole”, which are not found in Title 22 and are not insurer-specific.

FEHBA AND MCRA

Health plans covering federal employees are governed by the Federal Employees Health Benefits Act (“FEHBA”), 5 USC 8902. FEHBA reimbursement provisions do not preempt state law and do not give rise to federal jurisdiction. *Empire HealthChoice Assurance, Inc. v. McVeigh*, 547 U.S. 677, 126 S. Ct. 2121 (2006).

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 to military personnel and veterans when a tort claim is involved. The MCRA and its administrators, such as Tricare, do not recognize procurement costs. But they are apparently subject to the “make whole” doctrine pursuant to 42 USC 2652(c).

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); *Southern 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) for a recent 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 Special Needs Trust, 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. Whatever else may be true of liens, subrogation claims, Medicare, Medicaid, ERISA, etc., and whatever trouble we may cause our clients by our lack of familiarity with these issues, our biggest fear as attorneys should be that a mishandling of these issues may result not only in a malpractice suit but in the loss of our license to practice. We have to get these issues right for our own sakes as well as for our clients's.

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. But even without any lien, promise, or guarantee, if we are aware of the provider's unpaid bill - as we must be if we used the bill to settle or prove or defend against an injury claim - we may then have a duty under Rule 1.15(e) to safeguard the provider's claim, as well as a more general duty not to expose our client to liability for the bill. See *In re Donald Ray Smith*, 2009-1141 (La. 9/25/09), 2009 WL 3048999; *In re Mayeux*, 1999-3549 (La. 5/16/00), 762 So. 2d 1072.

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), bearing in mind the distinction between *Bombardier* (funds in our possession can be seized under ERISA) and *Bauhaus* (maybe funds in the registry of the court can't).

PRACTICE TIPS FOR PLAINTIFF LAWYERS

(1) 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.

(2) 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.

(3) If Medicare and/or Medicaid is involved, make sure the medical providers have billed them before you attempt to settle the case. With a Medicare client, you may want to keep a low profile vis-a-vis providers until you're sure Medicare has been billed.

(4) Remember, you have more leverage with third person 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.

(5) 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. Legally, 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. Even Medicare does not require its name on the check. See *Tomlinson v. Landers*, 3:07-cv-01180 (M.D. Flor. 4/29/09).