HEALTHCARE LIEN RESOLUTION IN MASS TORTS: A GUIDE FOR JUDGES

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INTRODUCTION

Effective judicial management of mass tort litigation requires early and ongoing engagement with the substantive issues affecting the course of the litigation.[1] One such issue is often overlooked—the lien-resolution process. As explained below, until liens are resolved, cases cannot be dismissed, which means that all parties and the court must remain involved. For that reason, liens should be viewed as part of the process of the *resolution* of mass torts, and not just an afterthought.

When a mass tort is settled, it is far from over for all involved parties, including the courts themselves. There is a tedious and often acrimonious "case beyond the case" that plays out in the months or years after the parties have reached terms, and lien resolution is often the most difficult element of that process. Mass torts lien resolution is a complicated process due to the involvement of myriad government agencies and private health plans, all of which may seek to assert lien or subrogation rights against injury settlement proceeds and potentially against parties to the litigation and their counsel. Compounding the problem is the fact that Medicare, Medicaid agencies, other government agencies such as the Veterans Affairs, and private insurers are facing an unprecedented volume of mass tort claims at a time when they continue to deal with staffing issues and resource shortages. Taken together, these two factors have further extended what were already lengthy lien-resolution timelines.

This guide provides a brief overview of the common types of liens encountered in mass tort litigation, as well as lienholder rights, the lien-resolution process, and liability issues. This guide then proposes the appointment of designated steering members early in mass tort litigation so that lien resolution is a coordinated and ongoing process rather than an afterthought arising only at the end of the litigation.

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[1] MANUAL FOR COMPLEX LITIGATION (FOURTH) § 10.13 (2004).

Medicare

Medicare covers most Americans aged 65 and older, along with individuals receiving Social Security Disability Insurance, those needing continuing dialysis for end-stage renal disease, and those diagnosed with Amyotrophic Lateral Sclerosis.[2] With spending on Medicare benefits in 2022 estimated at $995.7 billion, it represents the second-largest line item in the federal budget, trailing only Social Security. Medicare is administered by the Centers for Medicare and Medicaid Services within the Department of Health and Human Services.

When a Medicare beneficiary is injured by a third party, Medicare covers the cost of medical care, just as it does for any medical treatment. However, when the medical expenses are caused by a third party, and the beneficiary pursues and successfully recovers a settlement or judgment, then Medicare is entitled to recover the payments it made on behalf of the beneficiary-plaintiff. By statute, Medicare has a priority right of recovery from all settlements, judgments, awards, or other payments made to the beneficiary.[3] If such a payment includes payment for future medical expenses, Medicare's right to recover extends to those payments also.[4] In 2007, Medicare's ability to identify and enforce its subrogation rights was strengthened when the Medicare, Medicaid, and SCHIP Extension Act made it mandatory for non-governmental health plans, liability insurers, and self-insured defendants to report third-party recoveries to Medicare.[5]

The situation is more complicated for claims relating to Medicare Part C, also known as Medicare Advantage. Medicare Part C allows for Medicare-approved private insurance plans that serves as an alternative to Medicare Part A (hospital insurance) and Medicare Part B (medical insurance). Due to the public-private nature of a Medicare Advantage plan and the lack of clear statutory guidance, there is a split among the circuits about whether private insurers providing Medicare Part C plans enjoy the same subrogation-enforcement private right of action as the federal government under Parts A and B.[6]

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2 42 U.S.C. §§ 426, 426-1.

3 42 U.S.C. § 1395y(b)(2)(B)(iv).

4 *See* 42 U.S.C. §1395y(b)(2)(A); Centers for Medicare & Medicaid Services, Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) Reference Guide 5, 9 (Version 3.6 Mar. 15, 2022), *available at* https://www.cms.gov/files/document/wcmsa-reference-guide-version-36.pdf. This is usually addressed by establishing a "Medicare Set-Aside" trust using a portion of the recovery proceeds.

5 Medicare, Medicaid, and SCHIP Extension Act of 2007 § 111, 42 U.S.C.§ 1395y(b)(7).

6 *Compare* Humana Med. Plan, Inc. v. W. Heritage Ins. Co., 832 F.3d 1229 (11th Cir. 2016) (allowing private right of action for Medicare advantage organization), *and* In re Avandia Marketing, Sales Practices and Products Liability Litigation, 685 F.3d 353 (3d Cir. 2012) (same), *with* Parra v. PacifiCare of Arizona, Inc., 715 F.3d 1146 (9th Cir. 2013) (denying private right of action for Medicare advantage organization).

Medicaid

Medicaid is an assistance program for low-income persons, regardless of age, which is jointly administered by states and the U.S. government. Federal law requires Medicaid recipients to assign their rights to payment for any medical care paid for by a Medicaid program.[7] But in contrast to Medicare, the applicable state's law controls the operation of Medicaid liens, which means that Medicaid lien-resolution involves the interpretation and application of many laws (and the cases interpreting them), rather than just one.

Medicaid liens are also subject to the U.S. Supreme Court's decision in *Arkansas Dep't of Health & Human Services v. Ahlborn*, where the Supreme Court held that a state's recovery for Medicaid payments is limited to the portion of a settlement that represents payments for medical care.[8] Additionally, in *Gallardo v. Marstiller* the Supreme Court held that states may seek reimbursement of past medical care payments from settlement funds allocated to future medical care.[9] The *Ahlborn* decision does not provide a formula to decide what portions of negotiated mass tort settlements represent payments for medical care rather than other damage categories like pain and suffering. Those disputes must therefore be resolved before settlement proceeds are paid to a claimant. If the parties cannot stipulate to the amount representing medical care, as was done in *Ahlborn*,[10] it is left to the court to determine the proper allocation, resulting in potentially time-consuming ancillary proceedings.

ERISA

Most individuals who are not covered by Medicare or Medicaid will receive health insurance through a plan that is subject to the Employee Retirement Income Security Act of 1974, more commonly referred to as ERISA.[11] In contrast to Medicare and Medicaid, ERISA is not itself a benefits program, but instead provides minimum standards and oversight relating to private employee-benefits plans.[12] As the Supreme Court helpful summarized in *N.Y. Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*:

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7 *See* 42 U.S.C. § 1396k(a)(1)(A); 42 C.F.R. § 433.146(a). Note, however, that if the amount retained through the assignment exceeds the amount necessary to reimburse the state-payor, the individual is entitled to the difference. *See* 42 U.S.C. § 1396k(b).

8 547 U.S. 268, 291–92 (2006).

9 No. 20-1263, 596 U.S. ____ (June 6, 2022).

10 *Id.* at 269–70.

11 29 U.S.C. §§ 1001 et seq.

12 *See* H.R. Rep. No. 93-533, *reprinted in* 1974 U.S.C.C.A.N. 4639, 4655–56.

> ERISA's comprehensive regulation of employee welfare and pension benefit plans extends to those that provide "medical, surgical, or hospital care and benefits" for plan participants or their beneficiaries "through the purchase of insurance or otherwise." § 3(1), 29 U.S.C. § 1002(1). The federal statute does not go about protecting plan participants and their beneficiaries by requiring employers to provide any given set of minimum benefits, but instead controls the administration of benefit plans, see § 2, 29 U.S.C. § 1001(b), as by imposing reporting and disclosure mandates, Secs. 101-111, 29 U.S.C. Secs. 1021-1031, participation and vesting requirements, § 202-211, 29 U.S.C. Secs. 1051-1061, funding standards, Secs. 301-308, 29 U.S.C. Secs. 1081-1086, and fiduciary responsibilities for plan administrators, § 401-414, 29 U.S.C. Secs. 1101-1114. It envisions administrative oversight, imposes criminal sanctions, and establishes a comprehensive civil enforcement scheme. Secs. 501-515, 29 U.S.C. Secs 1131-1145. It also pre-empts some state law. § 514, 29 U.S.C. § 1144.[13]

Most such plans include a contractual right of subrogation or reimbursement for funds paid by the plan if the beneficiary recovers those funds from a third party, such as a personal injury defendant. What would otherwise be a state-law contractual right becomes more complicated in the context of ERISA, which provides a federal cause of action to a plan administrator "to obtain . . . equitable relief . . . to enforce any provisions of [ERISA] or the plan."[14]

Importantly, the Supreme Court has interpreted a healthcare plan's action to recover funds paid to a plan beneficiary to be one for "equitable relief" allowed under ERISA.[15] Because such relief is equitable in nature, however, it is potentially susceptible to equitable defenses, at least where such defenses are not foreclosed by the terms of the benefit plan itself.[16] For example, counsel for plaintiffs may argue that the common-fund doctrine—the concept that one "who recovers a common fund for the benefit of persons other than himself" is due "a reasonable attorney's fee from the fund as whole"[17]—justifies a reduction of the claimed subrogation amount. The availability of such a defense for each plaintiff, however, depends on the language of the particular benefit plan itself, which can render the resolution of ERISA liens in mass torts a monumental task due to the sheer number of plans that may be implicated.

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13 514 U.S. 645, 650–51 (1995).

14 29 U.S.C. § 1132(a)(3).

15 Sereboff v. Mid Atlantic Medical Services, Inc., 547 U.S. 356, 361–69 (2006).

16 *See* US Airways, Inc. v. McCutchen, 569 U.S. 88, 106 (2013).

17 Boeing Co. v. Van Gemert, 444 U.S. 472, 478 (1980) (citations omitted).

Other Liens

Along with Medicare and Medicaid liens, other federal statutory lien provisions may apply if the claimant is a federal employee,[18] an active member of the military, or a military veteran.[19] The Federal Medical Care Recovery Act, codified at 42 U.S.C. § 2651 et seq., contains a catchall lien-recovery provision that allows the United States to sue tortfeasors directly if they cause injuries to persons for whom the United States furnishes or pays for medical treatment.[20] Unlike the liens discussed above, the government only has a right to recover against third parties, not the beneficiary, and at least one federal circuit has so held.[21] Yet the possibility of government intervention to recover paid benefits counsels in favor of addressing them during the lien-resolution process.

A number of liens are available under state laws as well. For example, most states have statutory liens for hospitals or healthcare providers who care for persons injured through another's negligence.[22] Many states allow liens against personal injury settlements for delinquent child support payments.[23] Finally, even non-ERISA health insurance plans contain contractual subrogation language that grants at least partial reimbursement of benefits paid as a result of tortious conduct. Thus, any litigation involving more than a handful of injured claimants raises the prospect of a labyrinthine lien search and resolution process that will consume scare time and resources.

THE LIEN-RESOLUTION PROCESS

The lien-resolution process itself can be broken down into four parts: identification, auditing, dispute, and finalization. In the first phase, the claimant's representative identifies all health insurers that may have a lien or subrogation claim against the claimant's settlement. Next, the representative reaches out to government and private group health plans to determine whether a claimant has health insurance with a plan that may require further lien investigation and resolution, a process known as entitlement (or eligibility) verification. Having done so, the second phase entails obtaining claimed lien amounts from the government agency, the health plan, or their collection contractors. These claims ledgers are audited to ensure all claimed medical charges are related to compensated injuries, and the claimant may raise anti-subrogation, made-whole, and other legal arguments to diminish the lien amount. The third phase entails the negotiation and

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18 *E.g.*, 5 U.S.C. § 8131.

19 *See* 10 U.S.C. § 1095(a)(1); 32 C.F.R. § 199.12(a)(2).

20 42 U.S.C. § 2651(a).

21 In re Dow Corning Corp., 280 F.3d 648, 660 (6th Cir. 2002), *cert. denied*, 537 U.S. 816 (2002).

22 *See, e.g.*, CAL. CIV. CODE § 3045.1.

23 *See, e.g.*, GA. CODE ANN. § 15-19-14; TEX. FAM. CODE § 157.317(a)(3).

resolution of disputed claims or claim amounts, as the lienholder may disagree with the representative's assessment that some payments by the health plan were for unrelated claims, or there may be disputes over the application of relevant law. In the last phase, finalization, the lien-holding agency or health plan issues a final lien determination and payment instructions to both the plaintiff and the defendant, and the lien is paid out of the claimant's recovery. It is only at that point that the case can be dismissed.

In the mass tort context, liens are often resolved on a group basis. In such cases, the lien-resolution process is handled by specialized, private lien-resolution administration companies. Medicare, for example, has a global resolution program in which the lien-resolution administrator provides demographic, injury, and other information, and in turn, Medicare will conduct samples to identify types of injuries, treatments, and treatment dates, which are used to determine particular claimants' reimbursement obligations, which in turn may be a flat fee or a percentage of a claimant's recovery.

Private lien-resolution programs are also common in mass torts. Generally, large health plans contract with third-party collection companies to pursue their subrogation rights. Because there are relatively few such companies, it is possible for lien-resolution administrators to negotiate with a handful of collectors and reach resolutions that affect thousands of claimant-plaintiffs.

LIABILITY FOR LIENS

Since federal law requires that plaintiffs receiving compensation in a personal injury settlement identify and repay Medicare, Medicaid, military, and other government health plans for payments made to any medical provider to treat compensable physical injuries suffered as the result of the alleged tort, a carefully constructed lien-resolution process is essential.[24] Even if a plaintiff did not receive medical services from a health plan, or is not seeking recovery of them, the obligation for plaintiffs, defendants, their attorneys, and insurers to report to these agencies and plans may still exist.[25] As part of the representation of any party involved, then, an attorney has an ethical duty to ensure that such liens are resolved and distribution of settlement funds does not expose the client to liability.[26] Additionally, a claimant's attorney may have an express ethical duty to withhold settlement funds separate from the duty not to expose their client to liability. For example, the rules of professional conduct for the State of Maryland require attorneys holding settlement funds in which a third party has an interest (1) to promptly notify the third party upon

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[24] *See, e.g.*, 42 U.S.C. § 1395y(b)(2)(B)(ii); 42 U.S.C. § 1396k(a)(1)(C); 42 C.F.R. § 433.147.

[25] *See, e.g.*, 42 U.S.C. 1395y(b)(8) (requiring insurers and some defendants to submit information to Medicare for all claimants "entitled to benefits under the program . . . on any basis").

[26] *See, e.g.*, Iowa Supreme Ct. Att'y Disciplinary Bd. v. Silich, 872 N.W.2d 181, 188 (Iowa 2015).

receiving the funds and, in the instance of a dispute, (2) to withhold the funds until any dispute over its ownership is resolved.[27]

Attorneys also face financial liability for failing to resolve outstanding liens; a lienholder's right of recovery can reach beyond the injured party and reach that party's attorneys, doctors, insurers, and even state agencies.[28] The U.S. Department of Justice actively works to recover Medicare reimbursements from attorneys' offices.[29] Additionally, there are conflicting federal opinions concerning whether and under what circumstances ERISA plans may pursue equitable actions against beneficiaries' attorneys, which renders distribution of such funds without agreement of the lienholder a risky enterprise.[30] Liability for lien reimbursement can even extend to the defendant tortfeasor, its attorneys, or its insures,[31] regardless of whether it has paid money to the claimant in settlement.[32] For this reason, defendants often require plaintiffs to indemnify them for any lien-resolution mistakes as a condition of settlement.

EARLY AND ACTIVE LIEN RESOLUTION

Liens are ubiquitous in mass tort litigation, and lien-resolution issues affect not only mass tort plaintiffs, but also their attorneys, defendants and their counsel, and third-party insurers. Prompt and efficient lien resolution benefits all involved, including the lienholders themselves.

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[27] MARYLAND ATTORNEYS' RULES OF PROFESSIONAL CONDUCT AND ATTORNEY TRUST ACCOUNTS 19-301.15(d), (e).

[28] *See* 42 C.F.R. § 411.24(g) (providing the Centers for Medicare & Medicaid Services "a right of action to recover its payments from any entity, including a beneficiary, provider, supplier, physician, attorney, State agency or private insurer that has received a primary payment").

[29] *See, e.g.*, United States v. Harris, 2009 WL 891931 (N.D. W. Va. Mar. 26 2009); https://www.justice.gov/usao-edpa/pr/philadelphia-based-personal-injury-law-firm-agrees-resolve-allegations-unpaid-medicare; https://www.justice.gov/usao-md/pr/maryland-law-firm-meyers-rodbell-rosenbaum-pa-agrees-pay-united-states-250000-settle.

[30] *Compare* AirTran Airways v. Elem, 767 F.3d 1192, 1199 (11th Cir. 2014), *vacated on other grounds*, 577 U.S. 1116 (2016); Longaberger Co. v. Kolt, 586 F.3d 459, 467–68 & n.8 (6th Cir. 2009), *abrogated on other grounds by Montanile v. Board of Trustees of Nat. Elevator Industry Health Benefit Plan*, 577 U.S. 136, 139 (2016); Bombardier Aerospace Emp. Welfare Benefits Plan v. Ferrer, Poirot & Wansbrough, P.C., 354 F.3d 348, 354 (5th Cir. 2003), *abrogated on other grounds by Sereboff n Mid Atlantic Medical Services, Inc.*, 547 U.S. 356, 362 (2006), *with* Treasurer, Trustees of Drury Indus., Inc. Health Care Plan & Tr. v. Goding, 692 F.3d 888 (8th Cir. 2012); Emp. Benefit Plan of Compass Grp. USA, Inc. v. Miller, Rosnick, D'Amico, Aug. & Butler, P.C., 2019 WL 4760360, at *5 (D. Conn. Sept. 30, 2019).

[31] *See* 42 U.S.C. § 1395y(b)(2)(A)(ii) (defining a responsible "primary plan" to include not just insurers but also "[a]n entity that engages in a business, trade, or profession . . . [that] carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part"); 42 C.F.R. §§ 411.21, 411.22(a), 411.24(e), 411.24(g). Indeed, the fact of the settlement itself may be used offensively to demonstrate the amount of the insurer's payment responsibility. *See* 42 C.F.R. § 411.22(b)(3).

[32] *See, e.g.*, 42 C.F.R. § 411.24(i); TEX. PROP. CODE § 55.003(a)(1); United States v. Stricker, 2010 WL 6599489 (N.D. Ala. Sept. 30, 2010) (discussing counsels' and insurers' liability for Medicare payments).

For plaintiffs, the benefit is faster compensation for their injuries, as well as a more informed discussion about what they will receive after attorney's fees, costs, and liens are accounted for. For defendants, it is a quicker exit from litigation and freedom from potential litigation relating to their settlement payments. For counsel, it is freedom from legal and ethical perils. Lienholders also benefit because they are reimbursed more quickly at less administrative cost. And since these lienholders are government entities or private healthcare providers, the general public enjoys this benefit as well. Finally, court systems also benefit from efficient lien-resolution. Cases with outstanding liens cannot be closed and so remain on court dockets. The time courts spend working on "the case after the case" represents substantial actual and opportunity costs associated with litigation that has been, substantively, resolved.

In the early stages of consolidated mass tort litigation, representative counsel for plaintiffs and defendants are appointed, usually in the form of multi-attorney steering committees.[33] These steering committees may be divided into subcommittees, for example, committees on discovery, law and briefing, science, and settlement. Yet despite lien resolution's importance in mass tort litigation, it is often a literal afterthought—something to be considered and addressed only at the end of the process.

Expeditious resolution of liens requires that they be identified and categorized early. The main stakeholders—counsel, courts, and lienholders—must be active and engaged in this process. Given the importance of lien resolution in mass torts and the need for early involvement and coordination, it would be helpful to appoint a plaintiffs' steering committee member or subcommittee in the initial organizing order charged with the specific task of handing these lien-related issues. A lien committee could:

1. Consider the nature of the product at issue, the types of injuries, and the demographics of the claimants to identify trends and determine the types of liens likely to be involved in the litigation. For example, in the 3M Military Earplug litigation,[34] one would expect to see a large number of Veterans Affairs liens.
2. Gather data through formal or informal censuses or direct communication with lienholders to determine claimed lien amounts.
3. Coordinate with stakeholders to identify, discuss, and settle any lien-related issues that are ripe for resolution during the course of the litigation, rather than at the end.
4. Provide regular updates to the court on lien-related issues requiring judicial involvement.

As part of the regular status conferences held in mass tort litigation, a short amount of time could be devoted to lien-related issues to ensure that they are being actively managed, just as other elements of the litigation. This active management would ensure speedier and more efficient

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[33] *See* MANUAL FOR COMPLEX LITIGATION (FOURTH) § 22.62 (2004) (describing early organization of counsel as a "critical case-management task").

[34] In re 3M Combat Arms Earplug Prods. Liab. Litig., MDL No. 2885 (N.D. Fla.).

resolution of liens affecting the litigation, benefitting not only the parties and lienholders, but also the court.