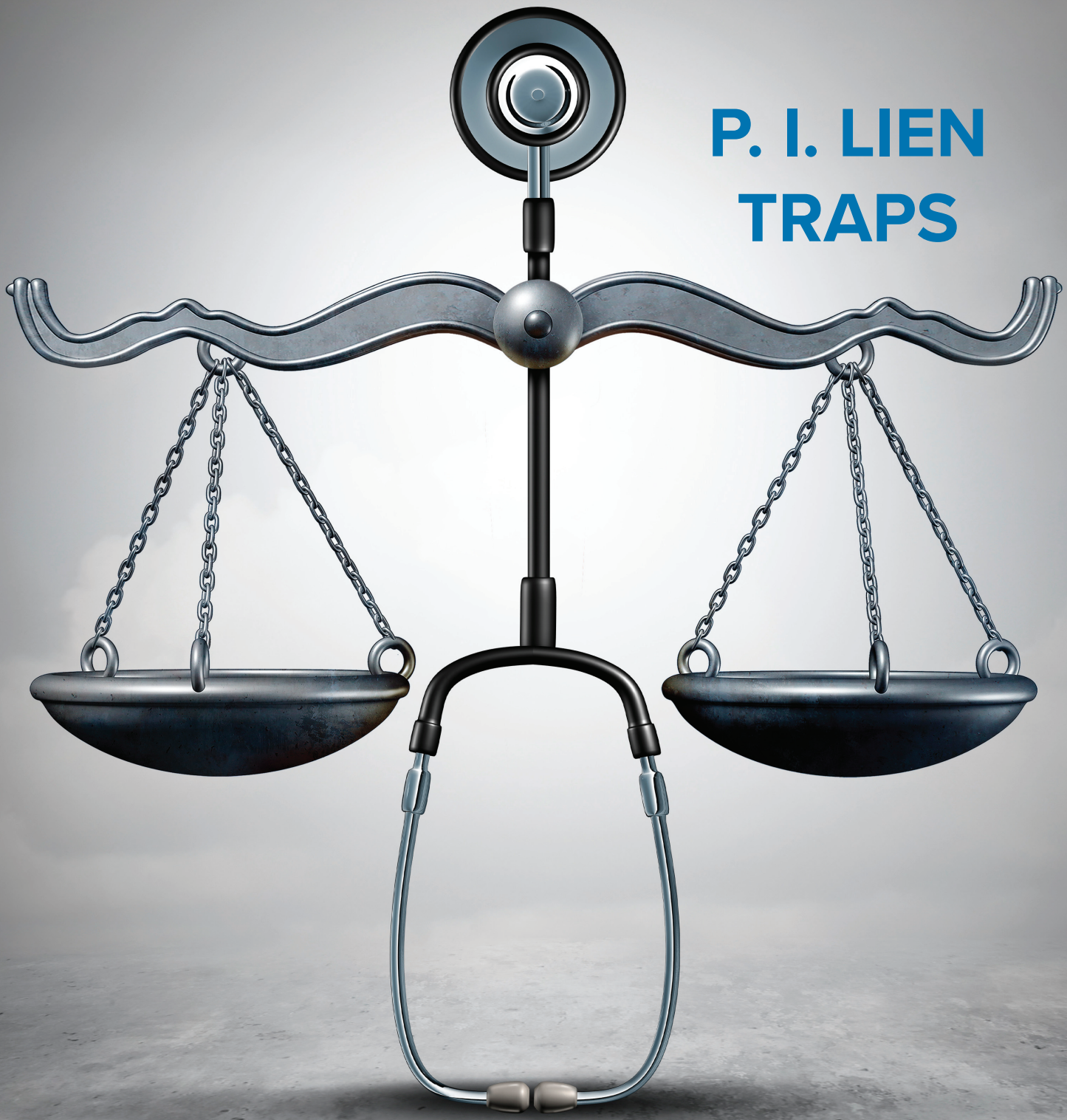
P. I. LIEN TRAPS



RISK MANAGEMENT PRACTICE GUIDE OF LAWYERS MUTUAL

LAWYERS MUTUAL | LIABILITY INSURANCE COMPANY OF NORTH CAROLINA

www.lawyersmutualnc.com

DISCLAIMER: *This document is written for general information only. It presents some considerations that might be helpful in your practice. It is not intended as legal advice or opinion. It is not intended to establish a standard of care for the practice of law. There is no guarantee that following these guidelines will eliminate mistakes. Law offices have different needs and requirements. Individual cases demand individual treatment. Due diligence, reasonableness and discretion are always necessary. Sound risk management is encouraged in all aspects of practice.*

OCTOBER 2018

P.I. Lien Traps

Risk Management Practice Guide of Lawyers Mutual

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LAWYERS MUTUAL LIABILITY INSURANCE COMPANY OF NORTH CAROLINA

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COMMON PERSONAL INJURY LIEN PROBLEMS

A great deal has changed since we at Lawyers Mutual last tackled the topic of medical and personal injury lien traps in North Carolina. Rulings concerning ERISA, Medicare, Medicaid, and State Employees Health Plan liens have shifted the entire approach an attorney should take when handling cases involving these liens. A common inquiry we receive from our insureds is whether an attorney's disbursement duty lies with his client or a potentially valid lienholder when both parties demand disbursement. A recent ethics opinion from the State Bar has illuminated this issue. 2017 Formal Ethics Opinion 4 rules that a lawyer is prohibited from disbursing settlement funds pursuant to the client's directive if the funds are subject to a perfected lien. Potential malpractice claims from a client are not an attorney's sole concern. Rulings in ERISA reimbursement cases have made an attorney's fee subject to disgorgement in favor of a valid lienholder's interest. Some have even gone as far as allowing an attorney and his client to become de facto collection agents for the lienholder. This means an attorney could be

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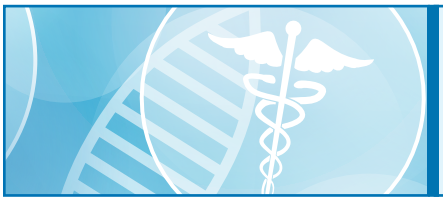
subject to malpractice claims from both the client and the lienholder if disbursement is not handled correctly. It is now more important than ever to perform a thorough analysis of whether you should take a personal injury case involving certain liens if the value is high enough to jeopardize your clients' recovery. All lienholders should be searched out and contacted before filing your case to ensure that you have the opportunity to negotiate with them while you still have leverage. You may regret taking the case if a previously unknown lienholder presents a valid lien after settlement. Once a settlement is finalized, all leverage is gone. Without a pre-arranged agreement with the lienholder, a case could result in a negative return for your efforts.

It is of utmost importance to research and stay abreast of new statutes and case law concerning personal injury liens because the landscape is constantly changing. This manuscript is not intended to be a complete treatment of the topic. We will address only the personal injury liens that prompt the most questions from our insured. For an excellent treatment of a fuller array of personal injury liens, we recommend North Carolina Personal Liens Manual, currently in its fourth edition, and edited by Chris Nichols. This is an indispensable resource for all personal injury lawyers. The following is a list of the liens that will be addressed in this manuscript.

- ERISA Health Plans: 29 U.S.C. 20 § 1001 et seq. & Sereboff, 547 U.S. 356 (2006)
- Medicaid: N.C. Gen. Stat. § 108A-57 & 42 U.S.C. § 1396p(a)(1)
- Medicare: 42 U.S.C. § 1395(b)(2)(A)
- Teachers' and State Employees' Health Plan, Cost Plus Plans & NC Health Choice Plan:N.C. Gen. Stat. § 135-40.13, N.C. Gen. Stat. § 108A-57(c) & N.C. Gen. Stat. § 58-65-135
- Health Care Providers: N.C. Gen. Stat. §§ 44-49, 50
- N.C. Workers' Compensation: N.C. Gen. Stat. § 97-10.2
- TRICARE: 10 U.S.C. § 1095
- Vocational Rehabilitation: N.C. Gen. Stat. § 143-547
- Ambulance Service Liens: N.C. Gen. Stat. § 44-51.8
- Child Support Liens: N.C. Gen. Stat. §58-3-172



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REIMBURSEMENT CLAIMS BY ERISA HEALTH PLANS

Preface

This information was originally published in December 2013. In 2016, the United States Supreme Court decided *Montanile v. Bd. of Trs. of The Nat'l Elevator Indus. Health Ben*. Plan, 136 S. Ct. 651 (2016). This case is refenced at various points in this updated guide. Every lawyer dealing with a potential ERISA lien claim should read Montanile. It may provide another arrow in the quiver of the lawyer seeking to present his or her client in the face of a potential ERISA lien claim.

"

The bottom line in North Carolina: If medical bills are paid by a health plan obtained through a private employer, and if the health plan is "self-funded," the plan provisions regarding reimbursement will generally be honored by a federal court.

Introduction [1,2]

For the practice of personal injury law, one cannot understate the evolved preeminence of the reimbursement claim by ERISA health plans. Personal injury attorneys must accept that most health plans have judicially recognized claims for reimbursement — enforceable through an "equitable lien by agreement"[3] — and these claims can only be ignored at the peril of both their clients and themselves. Defense attorneys and liability insurers must know that ERISA plans cannot sue tortfeasors and their liability insurers for a recovery — ERISA creates reimbursement rights, not subrogation rights — and plans can only obtain reimbursement through a recovery by a participant or beneficiary.

The bottom line in North Carolina: If medical bills are paid by a health plan obtained through a private employer, and if the health plan is "self-funded," the plan provisions regarding reimbursement will generally be honored by a federal court.[4] Claimants and their attorneys are left to their own devices in negotiating with plan administrators in such circumstances. How to determine what is a valid claim for reimbursement, and what to do about it, is beyond the scope of this article. This article limits its discussion to the evolved preeminence of the reimbursement claim by the self-funded health plan.

Federal courts want nothing to do with deciding what is fair or equitable in the division of a settlement recovery

1 © Jerome P. Trehy, Jr.

2 For a somewhat different and perhaps contrary view, see "Status of Reimbursement/Lien Claims of ERISA Covered Self-Insured Health Plans in North Carolina," North Carolina Personal Injury Liens Manual, (Fourth Edition) p. 443.

3 *Sereboff v. Mid-Atlantic Medical Services*, Inc., 547 U.S. 356, 364-65, 126 S. Ct. 1869, 1875, 164 L. Ed. 2d 612, 620-21 (2006) (applying the "equitable claim by agreement" to enforce provisions of the plan agreement reached with employer).

4 For reasons beyond the scope of this article, for plans that are not "self-funded" or "self-insured" but instead are funded by an insurance policy to pay medical bills, the plan's policy is subject to 11 NCAC 12 .0319 ("Life or accident and health insurance forms shall not contain a provision allowing subrogation of benefits."). In states without insurance laws or regulations for subrogation and reimbursement, the federal courts simply enforce the plan provisions as written and construed.

between a claimant, her attorney, and her insurance plan. Except in those increasingly rare situations in which the construction of plan provisions are helpful to the participants or beneficiaries, the only negotiating leverage enjoyed by such claimants and their attorneys are practical ones. For most personal injury claimants with ERISA health plans, the options are stark and onerous. The plan participant or beneficiary can either:

(a) decline benefits from the health plan, and pursue the personal injury or wrongful death claim;
(b) accept benefits, and decline to sue rather than work for the health plan; or
(c) accept benefits, pursue the personal injury or wrongful death claim, and deal with the plan and its ERISA reimbursement claim.[5]

After decades of interpretation of ERISA by the U.S. Supreme Court and other federal courts,[6] and particularly after *2013's U.S. Airways v. McCutchen* decision,[7] North Carolina attorneys must conclude that claimants and their attorneys who face reimbursement claims by self-funded ERISA plans can rarely look to the courts for equity or justice. Except in those increasingly rare situations in which the construction of plan provisions is helpful to the participants or beneficiaries, the tools for negotiation leverage enjoyed by such claimants and their attorneys are practical ones, sometimes including the claimant's decision to refrain from actively pursuing her own claim and the attorney's decision to decline the case.

We can now say:

If the plan is "self-funded" by its terms,

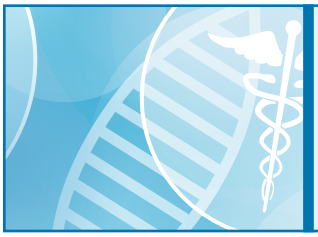
And

If the plan language correctly sets forth a claim for reimbursement,

Then, upon actual or constructive delivery of a recovery, that money is held — by the person or entity holding it — under a lien that is created under federal law and protected by the federal courts.

Determining whether the plan is self-funded, and whether the plan terms include the magic language for creation of the lien, are now tasks that comprise part of the due diligence required of North Carolina trial lawyers.

Disbursement without dealing with a valid lien — the ERISA lien by agreement is a valid lien, and therefore attorneys are subject to the RPCs and ethical commentary regarding liens and moneys held in trust — is perilous for the client and the attorney. As for the client, the plan can follow the money, and put liens on what the recovery was used for: the house for which the mortgage was paid, the car that was purchased, the realty purchased, the annuity benefits



Determining whether the plan is self-funded, and whether the plan terms include the magic language for creation of the lien, are now tasks that comprise part of the due diligence required of North Carolina trial lawyers.

5 See Administrative Comm. for the *Wal-Mart Stores, Inc. Associates' Health and Welfare Plan v. Salazar*, 2007 U.S. Dist. LEXIS 61273, pp. 21-22 (D. Ariz. 2007) (in enforcing equitable lien by agreement, court notes employee did not have to participate in plan or accept benefits).

6. See *Mertens v. Hewitt Assocs*., 508 U.S. 248, 113 S. Ct. 2063, 124 L.Ed.2d 161 (1993) (limiting available remedies to equitable relief as understood in when courts were divided between law and equity); *Great West Life & Annuity Insurance Co. v. Knudson*, 534 U.S. 204, 122 S. Ct. 708, 151 L. Ed. 2d 635 (2002) (denying ERISA reimbursement claim, but explaining how a reimbursement claim can be pursued); Sereboff, 547 U.S. at 364-65, 126 S. Ct. at 1875, 164 L. Ed. 2d at 620-21 (2006) (applying the "equitable claim by agreement" to enforce reimbursement claim, and eliminating traceability of the res as a requirement for recovery); *Popowski v. Parrott*, 461 F.3d 1367 (11th Cir. 2006) (allowing equitable relief against third parties); The *Longaberger Co. v. Kolt,* 586 F.3d 459 (6th Cir. 2009) (requiring dissipated settlement funds to be replenished); *U.S. Airways, Inc. v. McCutchen*, U.S., 133 S. Ct. 1537, 185 L. Ed. 2d 6 ___54 (2013) (denying equitable defenses for the equitable relief under ERISA).

7. McCutchen, U.S., 133 S. Ct. 1537, 185 L. Ed. 2d 654.

to be received, the settlement or special needs trust that was created, etc.[8] As for the attorney, even within the Fourth Circuit, a federal judge is likely to enforce an equitable claim against a claimant's attorney, as this is the rule for a growing consensus among the other circuits. Attorneys have been ordered to replace dissipated funds after money was moved from an IOLTA account in the firm operating account.

North Carolina plaintiff 's counsel should deal with the ERISA health plan and negotiate in advance of settlement. A claimant's greatest negotiation leverage for working out a sharing of procurement and recovery occurs in advance of filing a lawsuit, and perhaps in advance of making the claim, at all. A claimant's negotiation strength weakens the closer the claimant gets to a finalized settlement with the liable, third-party/employer/insurer. And, once a recovery is in hand, claimants are left to supplicate or to wrangle for concessions by the ERISA health plan.

What Should the Attorney Do?

For many years, commentators, including this author, have argued for and promoted ways to thwart ERISA reimbursement claims, based upon the loyalty owed to clients, the traditional proscriptions against subrogation for insurance, the practical difficulties in negotiating settlements, and the inequities of allowing insurance to enjoy reimbursement for a loss after premiums have been paid to cover the loss. The question for attorneys facing ERISA reimbursement claims used to be: What is the attorney legally required to do?

Given the obvious direction of federal courts in accepting and protecting ERISA's "equitable lien by agreement," the question for attorneys facing ERISA reimbursement claims has perhaps become: What is the attorney ethically required to do?

Personal injury attorneys are required to represent zealously and diligently the interests of their clients, but they must do so as officers of the court and in accordance with the Rules of Professional Conduct. Practitioners must accept that the federal courts have embraced the ERISA reimbursement claim as a true "lien" — an "equitable lien by agreement" — and speak of recoveries that "in good conscience, belong" to the plan.[9] At the moment there has been an actual or constructive delivery of a recovery to a plan participant or beneficiary, or their attorney, an ERISA health plan's valid claim for "reimbursement claim" transforms into a "lien" that is recognized and protected under federal law.

An appropriate starting point is the Preamble to North Carolina's Rules of Professional Conduct, a reminder of an attorney's important obligations in addition to those owed to their clients.

0.1 Preamble: A Lawyer's Responsibilities

[1] A lawyer, as a member of the legal profession, is a representative of clients, an officer of the legal system, and a public citizen having

Personal injury attorneys are required to represent zealously and diligently the interests of their clients, but they must do so as officers of the court and in accordance with the Rules of Professional Conduct.

8. But See, *Montanile v. Bd. Of Trs. Of the Nat'l Elevator Indus. Health Ben. Plan*, 136 S.Ct. 651 (2016) (where the funds were dissipated).

9. *Knudson*, 534 U.S. at 214, 122 S. Ct. at 715, 151 L. Ed. 2d at 645.

special responsibility for the quality of justice.

[2] As a representative of clients, a lawyer performs various functions.

As advisor, a lawyer provides a client with an informed understanding of the client's legal rights and obligations and explains their practical implications.

As advocate, a lawyer zealously asserts the client's position under the rules of the adversary system.

As negotiator, a lawyer seeks a result advantageous to the client but consistent with requirements of honest dealing with others.

As evaluator, a lawyer acts by examining a client's legal affairs and reporting about them to the client or to others.

[5] A lawyer's conduct should conform to the requirements of the law, both in professional service to clients and in the lawyer's business and personal affairs.

A lawyer should use the law's procedures only for legitimate purposes. A lawyer should demonstrate respect for the legal system.

While it is a lawyer's duty, when necessary, to challenge the rectitude of official action, it is also a lawyer's duty to uphold the legal process.

[12] In the nature of law practice, however, conflicting responsibilities are encountered.

Virtually all difficult ethical problems arise from conflict between a lawyer's responsibilities to clients, to the legal system, and to the lawyer's own interest in remaining an ethical person while earning a satisfactory living.

The Rules of Professional Conduct often prescribe terms for resolving such conflicts.

Within the framework of these Rules, however, many difficult issues of professional discretion can arise.

Such issues must be resolved through the exercise of sensitive professional and moral judgment guided by the basic principles underlying the Rules.

These principles include the lawyer's obligation *zealously to protect and pursue a client's legitimate interests, within the bounds of the law*, while maintaining a professional, courteous and civil attitude toward all persons involved in the legal system.[10]

A practicing attorney's ethical and professional obligations have long included obligations imposed by the existence of valid, judicially recognized liens. In undertaking representation for a personal injury or wrongful death claim, an attorney needs to educate the client about these additional duties for officers of the court and practicing attorneys.

If through due diligence an attorney determines that a self-funded ERISA plan has a valid claim for reimbursement — and therefore a legally recognized ability to enforce an equitable lien by agreement upon one with actual or constructive possession of a recovery from a third-party — the attorney has an ethical duty to address the plan's reimbursement interest.[11]

Once a settlement or judgment recovery is in hand, the federal courts dictate the legal consequences, and the Rules of Professional Conduct dictate the ethical consequences. The ERISA equitable lien by agreement

10. N.C. Rules of Prof 'l Conduct, 0.1 Preamble: A Lawyer's Responsibilities (2006) (emphasis supplied; reformatted for clarity).

11. What due diligence requires goes well beyond the scope of this article.

Attorneys are required to follow certain rules regarding the holding of property, including settlement and judgment recoveries, entrusted to them for safekeeping.

is, under federal law, created automatically and as soon as a settlement or judgment recovery is in the attorney's actual or constructive possession. Logically, therefore, the attorney's obligation to represent the client with zeal and diligence demands that the attorney to deal with the ERISA lien long before it is ever created.

Attorneys are required to follow certain rules regarding the holding of property, including settlement and judgment recoveries, entrusted to them for safekeeping. RPC Rule 1.15-1(e) states:

(e) "Entrusted property" denotes trust funds, fiduciary funds and other property belonging to someone other than the lawyer which is in the lawyer's possession or control in connection with the performance of legal services or professional fiduciary services. [12]

RPC Rule 1.15-2(a) then states general rules for such entrusted property:

(a) Entrusted Property. All entrusted property shall be identified, held, and maintained separate from the property of the lawyer, and shall be deposited, disbursed, and distributed only in accordance with this Rule 1.15. [13]

RPC Rule 1-15, Comment 15 sets forth what the attorney must do with respect to a valid ERISA lien—hold the disputed funds in trust until the claim for reimbursement is resolved:

Third parties may have lawful claims against specific funds or other property in the lawyer's custody, …

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 claim is 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 receive the funds, the lawyer may file an action to have a court resolve the dispute.[14]

In addition to the above ethical requirements, settlement funds are almost invariably paid under a settlement agreement that includes *the express precondition* that all valid liens are to be satisfied or resolved. When a settlement is paid with such a precondition to disbursement, a practitioner handling a settlement recovery is *obligated* to deal with an ERISA equitable lien by agreement. The failure to do so amounts to a dishonest and unethical breach of a precondition of the settlement's payment. [15]

Given the above discussion regarding the ethical

12. N.C. Rules of Prof 'l Conduct, Rule 1.15-1 Definitions (2012) (reformatted for clarity).

13. N.C. Rules of Professional Conduct, Rule 1.15-2 General Rules (2012) (emphasis supplied; reformatted for clarity).

14 N.C. Rules of Prof 'l Conduct, Rule 1-15, Safekeeping Property, Comment 15 (2008) (emphasis supplied; reformatted for clarity).

15 N.C. State Bar Formal Op. 127, Conditional Delivery of Settlement Proceeds (1992) ("Opinion rules that deliberate release of settlement proceeds without satisfying conditions precedent is dishonest and unethical.").

obligation of personal injury attorneys, it is inappropriate and unacceptable to disburse a settlement recovery in accordance with a client's direction or instruction to ignore an ERISA plan's valid lien. Wholly inapplicable are old ethics opinions dealing with a client's instruction to ignore payment of unpaid medical bills in the absence of a valid medical lien. [16]

ERISA Reimbursement Litigation

The plan provisions must authorize the claim for reimbursement, and indeed, the reimbursement claim will fail if not *properly* authorized by the plan provisions. If the plan's reimbursement provisions [17] are proper in content, however, they will be honored by a federal court. [18]

Plan participants and beneficiaries cannot evade ERISA reimbursement claims by creatively manipulating a settlement or its proceeds. If the plan provisions call for reimbursement from a settlement or judgment, the provisions will be honored even if the settling parties attempt to designate the recovery as being for something other than reimbursement of medical expenses. [19]

Under *McCutchen*, the courts will not require a plan to be "fair" or "equitable," and therefore courts will not require ERISA self-funded plans to follow equitable principles developed under the common law for health insurance. [20] Equitable principles developed by the states for insurance companies do not apply to ERISA plans, although these principles may inform interpretation and construction of plan terms and provisions.

For a self-funded plan, if the plan provisions clearly state a *priority of payment*, these provisions will be followed.[21] Before plans became so emboldened by the free hand given to them by the federal courts, plan provisions regularly included provisions for sharing the

16 See N.C. State Bar Formal Op. 69, Payment of Client Funds To Medical Providers (1989) ("Opinion rules that a lawyer must obey the client's instruction not to pay medical providers from the proceeds of settlement in the absence of a valid physician's lien); N.C. State Bar Formal Op. 125, Disbursement of Settlement Proceeds (1992) ("Opinion rules that a lawyer may not pay a medical care provider the proceeds of the settlement negotiated prior to the filing of suit over his client's objection unless the funds are subject to a valid lien.").

17 *Reinhart Cos. Employee Benefit Plan v. Vial*, 2011 U.S. Dist. LEXIS 27703, pp. 15-19 (W.D. Mich. 2011) (plan provisions authorized reimbursement claims against parties found to be "responsible or liable," so that reimbursement claim failed against settling party who had not been judicially determined to be responsible or liable).

18 Shank, 500 F.3d at 838 ("The Supreme Court has directed that when courts consider the meaning of 'appropriate' equitable relief, they should 'keep in mind the special nature and purpose of employee benefit plans.' Among the primary purposes of ERISA is to ensure the integrity of written plans and to protect the expectations of participants and beneficiaries. Ordinarily, courts are to enforce the plain language of an ERISA plan 'in accordance with its literal and natural meaning.'"); See *Findlay Indus., Inc. v. Bohanon*, 2007 U.S. Dist. LEXIS 85154 (N.D. Ohio 2007) (plan provisions were explicit regarding priority of payment, and so plan provisions honored).

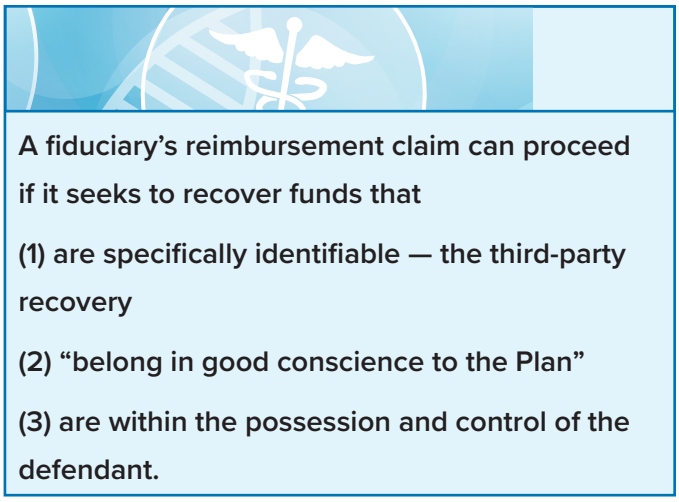
19 See Shank, 500 F.3d at 839 (rejecting argument successfully made for Medicaid reimbursement in Arkansas Department of Health & Human Services v. Ahlborn, 547 U.S. 268, 126 S. Ct. 1752, 164 L. Ed. 2d 459 (2006) that part of settlement was for items other than medical benefits); *Wright v. Aetna Life Ins. Co*., 110 F.3d 762, 765, n.3 (11th Cir. 1997) ("Since Aetna was not a party to the settlement agreement, that agreement's purported allocation of damages does not govern the district court's determination. To hold otherwise would allow [the covered individual] and the [tortfeasor] to control Aetna's reimbursement rights."); *Moore v. Blue Cross and Blue Shield of the Nat'l Capital Area and CapitalCare*, 70 F. Supp. 2d 9,30 (D.D.C. 1999) ("An ERISA plan participant cannot unilaterally allocate settlement proceeds to something other than medical expenses in order to evade subrogation."); *Bd. of Trustees for the Laborers Health & Welfare Trust Fund v. Hill*, 2008 U.S. Dist. LEXIS 9193, pp. 3, 17 (N.D. Cal. 2008) (participant characterizes settlement compensation exclusively for her pain and suffering and lost wages, but court allows claim for constructive trust as an equitable remedy to keep the plan participant from "unjust enrichment."); *Diamond Crystal Brands, Inc. v. Wallace*, 2010 U.S. Dist. LEXIS 48684, pp. 19-21 (N.D. Ga. 2010) ("The Estate's actions in structuring the settlement to maximize its reimbursement to the plan for the medical expenses of Deborah Hayes while maximizing the recovery to Defendant Tamara Hayes violates the express terms of [the plan]."); but see *Administrative Comm. of the Wal-Mart Stores, Inc. Associates' Health and Welfare Plan v. Gamboa*, 2007 U.S. Dist. LEXIS 50644 (W.D. Ark. 2007) (Gamboa II) (plan had no right to settlement funds against plan participant who received nothing personally, but released liable third-party in consideration for the participant's family receiving $1MM.).

20 McCutchen,U.S., 133 S. Ct. 1537, 185 L. Ed. 2d 654; see *Shank*, 500 F.3d at 837-38 ("[T]he make-whole doctrine originated in the law of insurance, where the overriding purpose of an insurance policy is to fully compensate the insured in case of loss, but … many ERISA-regulated benefit plans do not share that purpose. We thus concluded that the make-whole doctrine does not carry over from the insurance context to ERISA."); see *Elec. Energy, Inc. v. Lambert*, 757 F. Supp. 2d 765, 770-71 (W.D. Tenn. 2010).

21 See *Copeland Oaks v. Haupt*, 209 F.3d 811, 814 (6th Cir. 2000) ("for plan language to conclusively disavow the default rule, it must be specific and clear and establishing both a priority to the funds recovered and a right to any full or partial recovery"); Popowski, 461 F.3d at 1370; Bohanon, 2007 U.S. Dist. LEXIS 85154; Hill, 2008 U.S. Dist. LEXIS 9193; Wallace, 2010 U.S. Dist. LEXIS 48684; Farie v. Jeld-Wen, Inc., 2008 U.S. Dist. LEXIS 88893, p. 7 (N.D. Ohio 2008)(Farie I).

procurement costs — the attorney fees and litigation expenses.[22] A court will enforce, however, plan provisions that disavow payment of attorney fees and expenses.[23] If the plan provisions decline to pay fees or expenses except in the plan administrator's discretion, those plan provisions will be followed.[24] If the plan states a valid claim for reimbursement, but fails to disavow any obligation to share pro rata the procurement cost of attorney fees and claim expenses, then the courts will enforce the Common Fund Doctrine.[25]

ERISA plans have no obligation to file or serve any document in order to perfect an equitable lien by agreement. The "notice" is found in the very existence of the plan contract. As the "familiar rule" from the 1914 case cited in *Sereboff* states, "a contract to convey a specific object even before it is acquired will make the contractor a trustee as soon as he gets title to the thing."[26] For example, EOBs[27] provide notice that third-party recovery may be subject to a reimbursement claim, for they indicate who is paying the medical bills.[28] A plan may bring a reimbursement claim even if the participant or beneficiary has settled the case before the plan sends out notice of its reimbursement claim.[29]



A fiduciary's reimbursement claim can proceed if it seeks to recover funds that

(1) are specifically identifiable — the third-party recovery

(2) "belong in good conscience to the Plan"

(3) are within the possession and control of the defendant.

A fiduciary's reimbursement claim can proceed as long as it seeks to recover funds that (1) are specifically identifiable — the third-party recovery, (2) "belong in good conscience to the Plan," and (3) are within the possession and control of the defendant.[30] The fund over which a lien is asserted was not, but need not be, in existence at the time of the execution of the contract

22 See *Beveridge v. Benefit Recovery*, 2006 U.S. Dist. LEXIS 50942 (D. Az. 2006).

23 *McCutchen*, 133 S. Ct. at 1543, 185 L. Ed. 2d at 661 (common fund doctrine cannot "override the clear terms of plan"); *Quest Diagnostics v. Bomani*, 2013 U.S. Dist. LEXIS 85747, pp. 3-4 (D. Conn. 2013) ("Unlike the plan in McCutchen, the plain language in this case is unambiguous, leaving no room for equitable defenses to operate."); see *Johnson Controls, Inc. v. Flaherty*, 408 Fed. Appx. 312 (11th Cir. 2011) (no reduction of lien for attorney's fees and expenses when the plan language clearly and unambiguously denies such a reduction); *Aetna Life Ins. Co. v. Kohler*, 2011 U.S. Dist. LEXIS 126841 (N.D. Cal. 2011) (rejects application of the common fund doctrine because the plan terms provide that if a party accepts benefit that party agrees that the plan is not required to pay court costs or attorney fees); *Sheet Metal Workers Local 27 Health & Welfare Fund v. Estate of Beenick*, 2008 U.S. Dist. LEXIS 99345, pp. 32-33 (D.N.J. 2008); O'Hara, 604 F.3d at 1237, n. 4 (11th Cir. Ga. 2010); Cutting v. Jerome Foods, Inc., 993 F.2d 1293, 1298-99 (7th Cir. 1993) (the make-whole rule can be overridden by clear plan language).

23 *Brown v. Associates Health and Welfare Plan*, 2007 U.S. Dist. LEXIS 60307 (W.D. Ark. 2007) ("Plaintiffs had a pre-existing contractual obligation to the Plan to reimburse it for the full amount of any benefits paid on their behalf without a reduction for attorney's fees. That obligation precludes Plaintiffs from entering into an agreement with their lawyer to pay him from a fund they were not entitled to."); Shank, 2006 U.S. Dist. LEXIS 62280, pp. 12-13 (E.D. Mo. August 31, 2006), aff 'd, 500 F.3d 834 (8th Cir. Mo. 2007), cert. denied, 552 U.S. 1275, 128 S. Ct. 1651, 170 L. Ed. 2d 386 (2008) (provisions called for plan to get first dollar until fully reimbursed and made attorney fees and litigation costs the responsibility of the participant).

24 *Brown v. Associates Health and Welfare Plan*, 2007 U.S. Dist. LEXIS 60307 (W.D. Ark. 2007) ("Plaintiffs had a pre-existing contractual obligation to the Plan to reimburse it for the full amount of any benefits paid on their behalf without a reduction for attorney's fees. That obligation precludes Plaintiffs from entering into an agreement with their lawyer to pay him from a fund they were not entitled to."); Shank, 2006 U.S. Dist. LEXIS 62280, pp. 12-13 (E.D. Mo. August 31, 2006), aff 'd, 500 F.3d 834 (8th Cir. Mo. 2007), cert. denied, 552 U.S. 1275, 128 S. Ct. 1651, 170 L. Ed. 2d 386 (2008) (provisions called for plan to get first dollar until fully reimbursed and made attorney fees and litigation costs the responsibility of the participant).

25 McCutchen, 133 S. Ct. at 1543, 185 L. Ed. 2d at 661 (2013) (common fund doctrine informs interpretation of plan provisions when they are silent about allocating costs of recovery); see Iron Workers Locals 40, 361 & 417 *Health Fund. v. Dinnigan*, 911 F. Supp. 2d 243, 261 (S.D.N.Y. 2012).

26 Sereboff, 547 U.S. at 363, 126 S. Ct. at 1877, 164 L. Ed. 2d at 612 (quoting *Barnes v. Alexander*, 232 U.S. 117, 121, 34 S. Ct. 276, 58 L. Ed. 530 (1914)).

27 "Explanation of Benefits."

28 See *Schwade v. Total Plastics*, Inc., 837 F. Supp. 2d 1255, 1271 (M.D. Fla. 2012) (Schwade II) (EOB makes claim for reimbursement).

29 Brown, 2007 U.S. Dist. LEXIS 60307 (settlement date is not relevant because participant "had prior notice they would be required to reimburse the Plan if they recovered funds from a third party as reimbursement for injuries for which the Plan paid out benefits").

30 Popowski, 461 F.3d at 1372; Sereboff, 547 U.S. at 366, 126 S. Ct. at 1876; Bombardier Aerospace Employee Welfare Benefits Plan v. Ferrer, Poirot & Wansbrough, 354 F.3d 348, 356 (5th Cir. 2003); Brown, 2007 U.S. Dist. LEXIS 60307; Beveridge, 2006 U.S. Dist. LEXIS 50942, pp. 10-12.

containing the lien provision.[31]

Litigation over a reimbursement claim can possibly result in more than a mere loss of part or all of a recovery by settlement or judgment. If plan provisions called for the payment of reasonable attorney's fees and if the plan is required to seek equitable relief in order to enforce reimbursement provisions, these attorney-fees provisions may be enforced.[32] Indeed, a plan participant or beneficiary may be ordered to pay to a prevailing plan attorney's fees for fighting a valid claim for reimbursement.[33]

Jurisdiction and Revenue

Federal courts have original, exclusive jurisdiction for reimbursement claims brought by plans.[34] Furthermore, 29 U.S.C. § 1132(d)(2) authorizes nationwide service of process in ERISA actions.[35]

Under 29 U.S.C. § 1132(e)(2), proper venue is where the plan is administered, where the breach took place, or where the defendant resides or may be found.[36] A plan can bring an action for reimbursement in the district court where the plan is administered, even if the participant or beneficiary lacks minimum contacts with that state in which the district is found.[37] Thus, if a plan is administered in Illinois and the injured beneficiary resides in North Carolina, the plan has the choice of filing a lawsuit in Illinois or in North Carolina.

Forum selection clauses in plan provisions are enforceable, potentially requiring the participant or beneficiary to carry out what is essentially a document-centric litigation in an inconvenient jurisdiction.[38]

Who Can and Cannot be Sued for Reimbursement?

No conscious wrongdoing on the part of the participant/beneficiary is required for enforcement of a plan's reimbursement claim.[39] Plan reimbursement may be had from any recovery based on a liability of another for the injuries necessitating payment of health plan benefits, even if the recovery comes from UM or UIM coverage.[40] If a workers compensation claim is initially denied, so that an employee's ERISA health plan pays the medical bills from a workplace accident, and if the workers compensation claim is later honored or enforced, the employee will have to reimburse the health plan, if the plan provisions so require.[41]

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31 See Sereboff, 547 U.S. at 366, 126 S. Ct. at 1876; see Beveridge, 2006 U.S. Dist. LEXIS 50942, pp. 11-12. But See, Montanile v. Bd. Of Trs. Of the Nat'l Elevator Indus. Health Ben. Plan, 136 S.Ct. 651 (2016) (where the funds were dissipated).

32 See Farie II, 2010 U.S. Dist. LEXIS 24864, p. 31 ("[T]he Court finds that the unambiguous language of [the master plan document] entitles the Plan to an award of reasonable attorneys fees under the circumstances of this case.… [T]he express terms of the contract … are controlling and clearly establishment and entitlement to this relief."); Ritter, 2011 U.S. Dist. LEXIS 66686, pp. 18-19 (court to consider application for attorney's fees when plan documents allow for reimbursement of costs and attorney's fees if the plan is forced to file suit in order to recover reimbursement).

33 *K-VA-T Food Stores, Inc. v. Hutchins*, 2012 U.S. Dist. LEXIS 26575, p. 11 (W.D. Va. 2012) (attorney's fees awarded to prevailing plan against participant who far reimbursement without a reasonable basis).

34 29 U.S.C. § 1132(e)(1); see *Cavanagh v. Providence Health Plan*, 699 F. Supp. 2d 1209 (D. Or. 2010) (removal from state court to federal court of underlying tort action in the process of obtaining judicial approval of a personal injury settlement).

35 *Pioneer Title Co. Employee Welfare Benefit Trust v. Tague*, 2009 U.S. Dist. LEXIS 51022, p. 2 (D. Idaho June 17, 2009).

36 2009 U.S. Dist. LEXIS 51022, p. 3.

37 See *United Health Group Inc. v. Mesa*, 2007 U.S. Dist. LEXIS 71692 (D. Minn. 2007); 29 U.S.C. § 1132(e)(2).

38 *Smith v. Aegon USA, LLC*, 2010 U.S. Dist. LEXIS 17243 (W.D. Va. 2011) (enforced forum selection clause); Price v. PBG Hourly Pension Plan, 2013 U.S. Dist. LEXIS 26348 (E.D. Mich. 2013); Marin v. Xerox Corp., 2013 U.S. Dist. LEXIS 33400 (N.D. Cal 2013); but see Coleman v. Supervalu, Inc. Short Term Disability Program, 2013 U.S. Dist. LEXIS 13372 (N.D. Ill. 2013) (forum selection clause violates ERISA public policy).

39 *Humana Health Plan, Inc. v. Powell*, 2009 U.S. Dist. LEXIS 102887, pp. 3-4 (W.D. Ky. 2009).

40 Simnitt, 2009 U.S. Dist. LEXIS 20876, pp. 17-19 (D. Or. 2009) (though plan documents focused upon reimbursement from recovery for "third-party" liability, UIM coverage is treated as payments made on behalf of the tortfeasor, and therefore plan could seek reimbursement from UIM recovery; "to hold otherwise would provide a windfall to plan members who are injured by uninsured or underinsured tortfeasors"); Rhodes, 937 F. Supp. 1202 (ERISA plan seeks reimbursement from UIM recovery).

41 DeGryse, 579 F. Supp. 2d 1063 (N.D. Ill. 2008) (plan must be reimbursed from workers compensation proceeds; plan provisions excluded benefits for medical expenses covered under workers compensation).

Unlike the traditional, "equitable lien for restitution," which is limited to the res itself, traceability is not required for "equitable liens by agreement or assignment." [42] As long as the plan sues the proper person with the money or assets from the recovery, it does not matter that the person was neither a participant nor a beneficiary of the plan. A reimbursement claim will be permitted to go forward against a third-party so long as an action is filed while the funds or assets from the funds are in the possession of a defendant. [43]

Almost every type of arrangement has been attempted to avoid ERISA reimbursement, but they can almost all be trumped by enforcement of truly valid reimbursement claims by self-funded plans. ERISA self-funded plans can go after commingled funds, settlement trusts, special needs trusts, conservatorships, and even annuity payments.[44] Examples of unsuccessful efforts to thwart reimbursement claims include:

- A plan successfully sought reimbursement from annuity payments used to fund a special needs trust, even when the settlement provided for no recovery payment to the plan participant or beneficiary.[45]
- A federal court ordered reimbursement after a guardianship proceeding in state court established a special needs trust with spendthrift protection.[46]
- When the recovery was obtained for a bad faith insurance claim, as opposed to a recovery from a tortfeasor, the plan was permitted to pursue reimbursement for benefits paid.[47]
- Faced with the claim that settlement proceeds have been dissipated, the court may well order discovery to determine how the settlement proceeds were spent.[48]
- If the money from a settlement recovery can be followed to newly purchased property, a lien will be imposed on the new property.[49]
- After the participant's attorney transferred his fees from his IOLTA account to his operating account, the court ordered him to replace the money into the IOLTA account and then awarded it to the plan.[50]

At the time this chapter is being written, there appears to be a split between the circuits as to whether the attorney of a participant or beneficiary can be a valid defendant for reimbursement claim. In the Fifth, Sixth, Seventh, Ninth and Eleventh Circuits, at least, attorneys

At the time this chapter is being written, there appears to be a split between the circuits as to whether the attorney of a participant or beneficiary can be a valid defendant for reimbursement claim.

42 *Sereboff*, 547 U.S. at 364-65, 126 S. Ct. at 1875, 164 L. Ed. 2d at 621; see *Gutta v. Standard Select Trust Ins*., 2006 U.S. Dist. LEXIS 65530 (N.D. Ill. 2006).

43 See *Popowski* I, 461 F.3d at 1373.

44 *Horton*, 513 F.3d 1223 (conservatorship) ("[T]he important consideration is not the identity of the defendant, but rather the settlement proceeds are still intact, and thus constitute an identifiable res that can be restored to its rightful recipient."); Shank, 500 F.3d 834 (settlement trust and special needs trust); *ACS Recoveries v. Griffin*, 2013 U.S. App. LEXIS 9324 (5th Cir. 2013) (special needs trust); Arachikavitz, 2007 U.S. Dist. LEXIS 71172 (special needs trust); Ralcorp Holdings, Inc. v. Fricke, 290 F. Supp. 2d 759 (W.D.Ky. 2003)(annuity payments); *Popowski v. Parrott*, 2008 U.S. Dist. LEXIS 71615 (N.D. Ga. 2008)(Popowski II) (annuity payments); Dinnigan, 911 F. Supp. 2d 243, 258 (supplemental needs trust).

45 *Griffin*, 2013 U.S. App. LEXIS 9324, pp. 24-25 (release exchanged for obligation of annuity company to make payments into a special needs trust; plan entitled to reimbursement from special needs trust and the periodic annuity payments).

46 *Bush*, 2006 U.S. Dist. LEXIS 81912.

47 *AirTran Airways, Inc. v. Elem*, 771 F. Supp. 2d 1344 (N.D. Ga. 2011) (bad faith insurance settlement).

48 *Bd. of Trustees for the Laborers Health & Welfare Trust Fund v. Hill*, 2008 U.S. Dist. LEXIS 96239 (N.D. Cal. 2008) (Hill II). But See, *Montanile v. Bd. Of Trs. Of the Nat'l Elevator Indus. Health Ben. Plan*, 136 S.Ct. 651 (2016) (where the funds were dissipated).

49 *Board of Trustees for the Laborers Health & Welfare Trust Fund for N. Cal. v. Hill*, 2009 U.S. Dist. LEXIS 27116 (N.D. Cal. 2009) (Hill III) (equitable lien imposed on purchased auto and condominium); Popowski v. Parrott, 2008 U.S. Dist. LEXIS 71615, pp. 19-20 (N.D. Ga. 2008) (Popowski II) (discovery and briefing ordered to determine whether a constructive trust would be imposed on tangible assets purchased by settlement funds that should have been reimbursed to plan); contrast, *UNUM Life Ins. Co. v. Wolf*, 2008 U.S. Dist. LEXIS 43735 (D. Colo. 2008); *Security Mutual Life Ins. Co. v. Joseph*, 2007 U.S. Dist. LEXIS 47664 (E.D. Pa. 2007); *UnitedHealth Group, Inc. v. Dowdy*, 2007 U.S. Dist. LEXIS 80090 (M.D. Fla. 2007).

50 Brown, 2007 U.S. Dist. LEXIS 60307.

Without the availability of legal or equitable defenses, plan participants and beneficiaries, and their counsel, are left with little or no litigation tools for negotiating with self-funded ERISA health plans.

are legitimate defendants in suits for enforcement of an equitable lien by agreement.[51] The Fourth and Eighth Circuit might not allow recovery against attorneys,[52] but the decisions from these Circuits disallowing such claims are highly suspect in light of more recent decisions and the reasoning behind those decisions. Attorneys should simply avoid allowing themselves to be in a position to become a defendant to an ERISA claim, for litigation reasons and for ethical reasons, as discussed *supra*.

Plan administrators and their collection designees have no legal or equitable leverage as a tortfeasor or a liability insurer. Plan administrators must get their reimbursement through an actual recovery by a plan participant or beneficiary. A plan cannot sue a third-party liability insurer to pay a claim. Liability insurance policies that pay settlements to participants and beneficiaries cannot be sued for conversion regarding benefits that "should" go to reimburse a plan.[53] Plans can only *enforce* their right to a recovery share after the participant or beneficiary has actual or constructive possession.

Negotiating the Plan's Claim for Reimbursement

Without the availability of legal or equitable defenses, plan participants and beneficiaries, and their counsel, are left with little or no litigation tools for negotiating with self-funded ERISA health plans. The only leverage available for negotiations on behalf of participants and beneficiaries are practical ones: the plan desires cooperation for voluntary reimbursement, and the best way to get that cooperation is through concession. While it is true that plans can enforce reimbursement provisions through litigation, doing so consumes time, energy, and expense.

If a plan requires a participant or beneficiary to sign an agreement to honor the plan's claim for reimbursement, a plan may refuse to pay medical bills until that signing occurs.[54] A plan cannot require a participant, beneficiary, or attorney to sign a document acknowledging the lien or creating a greater obligation, unless the plan provisions so provide,[55] or unless a

51 Bombardier, 354 F.3d at 353 (ERISA permits reimbursement claim against non-fiduciary attorney who holds disputed settlement funds on the half of a plan participant); Longaberger, 586 F.3d 459; Wells, 213 F.3d 398 at 403 (7th Cir. 2000); *CGI Techs. & Solutions, Inc. v. Rose*, 683 F.3d 1113, 117-18 (9th Cir. 2012); *Central States v. Lewis*, 871 F. Supp. 2d 771, 778 and 780 (N.D. Ill. 2012) (relief available against attorney who commingled or dissipated funds; ordering attorney to restore settlement funds paid as attorney fees); Elem, 771 F. Supp. 2d 1344; *Board. of Trustees of the Health & Welfare Dep't of the Construction and General Laborers' District Council of Chicago and Vicinity v. Filichia*., 2013 U.S. Dist. LEXIS 11517, p. 8 (N.D. Ill. 2013); *Greenwood Mills, Inc. v. Burris*, 130 F. Supp. 2d 949, 960 (M.D. Tenn. 2001).

52 *T.A. Loving Co. v. Denton*, 723 F. Supp. 2d 837, 840-41 (E.D.N.C. 2010) (declining to follow Sixth Circuit and Longaberger and instead following Bullock); Great-West Life & Annuity Ins. Co. v. Bullock, 202 F. Supp. 2d 461, 465 (E.D.N.C. 2002) (allowing claim under § 502(a)(3) only where there are allegations of attorney wrongdoing or an intentional effort to enable participant to avoid plan reimbursement provisions.); *Treasurer v. Goding*, 692 F.3d 888, 895-96 (8th Cir. Mo. 2012) (attorney who properly disposed of settlement recovery could not be sued for equitable relief).

53 See *Central States, Southeast & Southwest Areas Health and Welfare Fund v. Bollinger, Inc*., 2013 U.S. Dist. LEXIS 119295, p. 13 (D.N.J. 2013) (plan provisions did not create a lien on the property of insurance companies, for they are not in possession of specific, identifiable assets belonging to the plan); *Hartford Hosp'l Medical Plan v. State Farm Mut. Ins. Co*., 2010 Conn. Super. LEXIS 1137, pp. 21-22 (Conn. Sup. Ct. 2010) (conversion action against auto liability insurer did not seek specifically identifiable funds, and action dismissed for seeking legal, rather than equitable, relief).

54 See *Cagle v. Bruner*, 112 F.3d 1510, 1519-20 (11th Cir. 1997)(plan requiring participant, in the exercise of the plan's discretion, to sign reimbursement agreement before obtaining benefits); *Cossey v. Associates' Health and Welfare Plan*, 2008 U.S. Dist. LEXIS 7185 (E.D. Ark. 2008) (plan permitted to refuse to pay medical benefits until participant and attorney signed agreement to reimburse); *Schwade v. Total Plastics, Inc*., 837 F. Supp. 2d 1255, 1265 (M.D. Fla. 2011) (Schwade I) (benefits denied for failing to sign documents); but see *Martinez*, 695 F. Supp. 2d at 1105 (improper to require execution of a document purporting to create greater lien obligations than the plan provisions provide).

55 *Martinez*, 695 F. Supp. 2d at 1105.

requirement to sign documents is a proper exercise of the discretion granted the plan administrator.[56]

Plans enjoy the greatest negotiating leverage when the participant or beneficiary is in need of future medical care that will be covered under the plan. Depending upon plan language, plans may have the authority, perhaps even the discretionary authority, to deny payment of future benefits to an uncooperative participant or beneficiary.[57] Plans can also answer a participant's or beneficiary's breach of the plan contract by denying future benefits.

Given the above realities, participants and beneficiaries are best served by initiating negotiations early, probably while obtaining the necessary documents from the plan administrator for review. Ideally, an arrangement should be reached by which the plan agrees to accept a specific percentage, or graduated percentage, of whatever recovery may be obtained, and this agreement should take into account attorney's fees and other procurement costs. Most importantly, a negotiated arrangement should be reached before a claim is pursued, and certainly before litigation is initiated.

The following list of suggestions may be helpful to attorneys in negotiating with plan administrators or their collection designees.

- The plan administrator has a fiduciary obligation not only to the plan, but also to plan participants and beneficiaries.
- The plan administrator desires reimbursement in the most efficient and least costly manner.
- Plan administrators have neither the attorneys nor the resources to pursue personal injury and wrongful death claims for plan participants and beneficiaries.
- Plan administrators, and the collection companies they designate, have economic incentives to reach an agreement with participants and beneficiaries.[58]
- During the oral arguments for *U.S. Airways v. McCutchen*, the plan's counsel and BCBS, as amicus curiae, promised the court that the current, normal practice for dealing with ERISA reimbursement claims is to reach a negotiated arrangement before litigation is initiated.[59]
- Under ERISA, the plan has no authority to seek reimbursement directly from a third-party, an indemnitor, or a liability insurer, and reimbursement must come to the plan, if at all, through a recovery by a participant or beneficiary.

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56 *Zarringhalam v. UFCW Local 1500 Welfare Fund*, 2012 U.S. Dist. LEXIS 170560, pp. 32-33 (E.D.N.Y. 2012).

57 See *Bird v. NECA-IBEW Local 176 Health & Welfare Plan of Benefits*, 2003 U.S. Dist. LEXIS 22866 (N.D. Ill. 2003) (plan provisions call for denial of benefits if beneficiary or participant refused to sign reimbursement agreement).

58 Collection representatives face added pressure to reach reimbursement agreements at the end of fiscal or accounting periods.

59 During oral argument, Justice Alito inquired about the lack of incentive for participants and beneficiaries and their counsel to pursue claims when the money would go only to reimburse the plan, and the Court was informed that arrangements are "usually" negotiated prior to the commencement of litigation.

> JUSTICE ALITO: … If [Mr. McCutchen and his attorneys] understood that things would work out the way you think they should work out and they saw that the limits of the insurance policies against which they could collect were $110,000, wouldn't they have realized that this was a suit that wasn't worth pursuing? There would be no point in doing it because nothing would be — nothing would be gained for Mr. McCutchen or for his attorneys.
>
> MR. KATYAL: Not at all, Justice Alito. Two things. One, the rule on ERISA – and this rule has been the rule in the Third Circuit since Federal Express v. Ryan in 1996. This is a long-establish rule — if an attorney comes and takes a case knowing that there is an ERISA plan at stake, seems to me there at least on inquiry notice that there must be some sort of —
>
> JUSTICE ALITO: Well, perhaps they should have realized it; but, if they realized it, they have no incentive to pursue this litigation or to pursue the tort decision
>
> MR. KATYAL: Not so. This is both in our brief, as well as the Blue Cross amicus brief.
>
> What usually happens in these situations is that an agreement is struck in advance, before the lawsuit is filed, between the plan and the plaintiff 's attorney to reach some accommodation.
>
> After all, the plan has an incentive in some sort of action being brought —

U.S. Airways v. McCutchen, Oral Argument before the U.S. Supreme Court, pp. 19-21, November 27, 2012 (emphasis supplied).

- A third-party paying a recovery will invariably require the execution of a release in order to protect the releasees and to reach finality regarding resolution of a claim and future exposure.
- Unless the plan provisions require the participant or beneficiary to execute a release in consideration for healthcare benefits, and so long as the participant or beneficiary otherwise cooperates, the plan cannot obtain reimbursement without the execution of a release of the third party.
- The fairness, equity, and practicality called for by the McCutchen decision demand an equitable arrangement by which the plan, the participant or beneficiary, and her attorney share the settlement or judgment recovery and share the cost of procurement.
- The plan benefits from having its reimbursement claim acknowledged and integrated early in the prosecution of the personal injury or wrongful death claim.
- The plan benefits from the surety of having an agreement and arrangement about reimbursement.
- The plan and its participant/beneficiary both benefit by mutual cooperation and through a negotiated agreement, and this is best done, for many reasons, in the beginning of a claim.
- Plan administrators abrogate their fiduciary obligations towards the plan and towards participants and beneficiaries if discretionary decisions about plan reimbursement are not being made upon appropriate considerations but are instead being driven by a collection company's profit motive.

Creative lawyering will certainly add to the above list.[60] The key will be to find practical incentives for the plan to negotiate and reach an arrangement early in the process, while the participant or beneficiary still enjoys some negotiating leverage. If the claim is pursued without negotiating an arrangement early, the claimant and attorney can expect the plan will seek a full reimbursement, and the longer and further the claimant and attorney are committed to pursuing a claim in the absence of an agreement, the stronger will be the negotiating position of the plan.

McCutchen teaches attorneys, plan administrators and their collection designees that they cannot look to judicial solutions for the resolution of the many thousands of reimbursement claims by ERISA plans. *McCutchen* teaches that attorneys, plan administrators and their collection designees ought to share in procurement costs, and that these parties need to find practical solutions — *for sharing of procurement and recovery* — in pursuing personal injury and wrongful death claims on behalf of a plan participants and beneficiaries. The best advice for the practitioner may be to decline the representation unless an agreement with the ERISA plan on reimbursement can be negotiated. *Montanile v. Board of Trustees*, 136 S.Ct. 651 (2016) may present the practitioner with a third way forward. All practitioners should read that opinion in the context of his or her client's circumstances.

McCutchen teaches attorneys, plan administrators and their collection designees that they cannot look to judicial solutions for the resolution of the many thousands of reimbursement claims by ERISA plans.

60 See, e.g., the strategy employed by the lawyer in Montanile v. Bd. Of Trs. Of the Nat'l Elevator Indus. Health Ben. Plan, 136 S.Ct. 651 (2016).

MEDICAID

Medicaid is a "welfare" program administered by the State of North Carolina. Eligibility depends on such factors as income level, available financial resources, and other criteria. Generally, health care providers are not required to accept Medicaid patients. However, if they accept Medicaid patients, they must accept Medicaid payments in full, except for certain specific services for which a co-payment may be charged. If a provider itemized the charges for a particular course of treatment and submitted only some of these charges to Medicaid, the provider may legitimately seek payment from the patient for the non-submitted items. The lien is created by N.C. Gen. Stat. § 108A-57 and is not limited to the $4,500 cap on recovery from wrongful death settlements set forth in N.C.G.S. §28A-18.[61] Medicaid has a lien on payments made by or from any of the following sources: (1) Uninsured and Underinsured Motorist Coverage; (2) Medical Payments Coverage; (3) Liability Insurance; and (4) Workers' Compensation Insurance.

Creation & Characteristics of a Medicaid Lien

Medicaid has a lien on any settlement or recovery that is related to services for which Medicaid has paid. Medicaid is not required to share in attorneys' fees or recovery costs. Medicaid's lien is perfected upon the Medicaid recipient's acceptance of benefits and his or her assignment of rights to Medicaid. Actual notice of a Medicaid lien is not required; constructive notice is sufficient.[62] "Constructive notice" includes, but is not limited to, an attorney's receipt of a medical bill that references Medicaid filing or payment. This requires an attorney to be on high alert for any potential Medicaid liens to avoid potential malpractice claims from Medicaid. In most cases, you will have to determine lien priority amongst multiple liens. Here is how Medicaid interacts with other liens:

Medicare vs. Medicaid: Medicare liens have priority over Medicaid liens in tort settlements and Medicare will not pro-rate with Medicaid. So if the Medicare lien is greater than the portion of the settlement allotted for medical expenses, Medicaid cannot make any recovery. If the Medicare lien is less than the total allotted for medical expenses, Medicaid can recover the difference.

Medicaid v. Medical Provider Liens (N.C.G.S. §§44- 49, 44-50): Pursuant to the Bipartisan Budget Act of 2013 (effective October 1, 2017) and revisions to N.C.G.S. §108-57 (effective July 1, 2017), Medicaid now gets 100% of their lien up to 1/3 of the gross settlement, NOT prorated with other liens, with the exception of Medicare, which still takes priority over Medicaid.

If you suspect that Medicaid has paid any medical or hospital bill for your client, review all medical and hospital billings and charge statements to determine if a Medicaid submission was made or Medicaid benefits were received. Write to the North Carolina Department of Human Resources, Third-Party Recovery Section, to determine if there is a lien. The Third-Party Recovery Section will send you a written statement of its payments. Do not automatically assume this statement is correct. Like Medicare, Medicaid's statement shows all charges they paid from the date of the accident until the date of the request, using best efforts to determine related charges. You need to compare Medicaid's claim against the accident-related bills and advise Medicaid of any unrelated payments. Simply review Medicaid's statement and flag or otherwise indicate the payments that are unrelated to the accident. Mail your "audited copy" of the statement back to the Third-Party Recovery Section. Medicaid is very understanding of contested payments. Keep in mind that if a provider itemized charges for a particular course of treatment and only submitted some of these charges to Medicaid, the provider may legitimately seek payment from the patient for the non-submitted items.

61 See, *Cox v. Shalala*, 112 F.3d 151 (4th Cir. 1997).

62 *Johnston County v. McCormick*, 65 N.C. App. 63, 308 S.E.2d 872 (1983).

MEDICARE

Medicare is a federal program available to those who are in four basic groups: (1) persons who have reached age 65 and are entitled to receive either Social Security, widows or Railroad Retirement benefits; (2) disabled persons of any age who have received Social Security, widows or Railroad disability benefits for 25 months; (3) persons with end-stage renal disease ("ESRD") who require dialysis treatment or a kidney transplant; and (4) persons over age 65 who are not eligible for either Social Security or Railroad Retirement benefits who purchase Medicare coverage by payment of a monthly premium. There are four types of Medicare plans available: Parts A, B, C, and D. Parts A and B are administered by Medicare directly, through the Centers for Medicare and Medicaid Services (CMS). These plans are certain to have an enforceable lien. Parts C and D allow private insurance companies to provide health insurance (Part C) and prescription drug (Part D) plans through contracts with the government. These plans are commonly referred to as "Medical Advantage Plans" (MAP) and they are not administered through the government. Accordingly, it is important to clarify what type of Medicare plan the client carries, so that the claims procedure can be properly directed at the Medical Advantage Organization (MAO) if the client carries Part C or D. While it is still somewhat unsettled as to whether an MAO has the right to assert a claim, the trend appears to be that they do.[63] As a result, a case involving a Medical Advantage Plan should be treated as if it has a valid lien claim. The same procedures should be followed as if the coverage were provided under a Part A or Part B plan.

Creation of a Medicare Lien

Medicare is a "secondary payer" with respect to medical expenses incurred due to an injury that was caused by the negligence of another. Medicare's payments are "conditional payments," and Medicare makes these payments on the condition that they will be repaid once payment is received from the "primary payer." Such primary payers include liability insurance, self-insurance, medical payments, uninsured motorist coverage, and underinsured motorist's coverage. Being a secondary payer, Medicare is entitled to assert its rights to reimbursement for those payments in the form of a lien authorized by the Medicare Secondary Payer Act.[64] Federal regulation requires payment to be sent to Medicare within 60 days of a personal injury settlement.[65] Notice is not required for Medicare to assert a lien,[66] its lien is typically in first position,[67] and the lien can be asserted against the attorney's earned fees.[68] This provides the ultimate incentive for an attorney to determine whether a client is a Medicare beneficiary in their intake form.

Procedure for Handling a Medicare Lien

If the client is determined to be a Medicare beneficiary, the claim should immediately be set up with Medicare. Doing this early in the process will provide the

63 In *re Avandia Mktg.*, 685 F.3d 353 (2012).

64 42 USC § 1395y(b)(2)(B)(ii).

65 42 C.F.R. 411.25(h).

66 42 C.F.R. 411.21.

67 42 U.S.C. § 1395y(b) (Supp. 1998).

68 42 U.S.C. § 1395y(b)(2)(B)(ii) and 42 C.F.R. 24(2)(g).

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In a “contributory negligence” state like North Carolina, the chances of Medicare foregoing recovery are real and use of this approach is encouraged.

necessary time before settlement to work out any disagreements with Medicare over the correct amount of their reimbursement claim. Waiting until settlement is imminent will only complicate and delay settlement of the case.

Plaintiffs' lawyers are all too familiar with dealing with Medicare liens. Perhaps the only positive is that Medicare shares in the costs of recovery and attorney fees.[69] That is, unless the source is medical payments coverage under an automobile or home insurance policy, in which case they do not share in the costs or fees. The process is usually an arduous one that requires a deeper level of familiarity with the CMS and MAO administration systems than this manuscript attempts to address. The basic process involves: (1) setting up the client's claim; (2) receipt of and response to the rights and responsibilities letter from Medicare which outlines what they will need to complete the recovery process; (3) sending Medicare a proof of representation letter; (4)receipt, review, and disputing of the conditional payment letter (CPL), which itemizes all the payments Medicare believes they made in connection with the injury settlement; (5) notifying Medicare of a final settlement; (6) obtaining a Final Payment Letter from Medicare; (7) disbursing the funds appropriately; and (8) obtaining the clearance letter.

Alternative Resolution Methods

In addition to those steps, which assume a fairly routine process, alternative resolution methods may be favorable for your client. This is particularly true if the Medicare lien threatens to absorb all of the client's settlement proceeds, which it legally has the right to do.[70]

A party can seek a reduction in the lien by a **Pre-Settlement Compromise**, which is allowed by the Federal Claims Collection Act (FCCA) of 1966 in the event that: (1) the cost of collection does not justify enforcement of collection of the full claim; (2) there is an inability to pay within a reasonable time by the individual against whom the claim is made; or (3) the chances of successful litigation are questionable, making a settlement compromise advisable.[71] In a “contributory negligence” state like North Carolina, the chances of Medicare foregoing recovery are real and use of this approach is encouraged.

When the settlement is $25,000 or less, another option is the **Self-Calculated Conditional Payment Option** if the following conditions are met: (1) the claim was originally submitted to the Coordination of Benefits Contractor (COBC); (2) the liability insurance (including self-insurance) settlement will be for a physical trauma based injury; (3) the total settlement does not exceed $25,000; and (4) the date of the accident must have occurred at least six months prior to the request for conditional payment information.[72]

For even smaller settlements, $5,000 or less, another option is the **Fixed Percentage Option** if: (1) the settlement total is less than $5,000; and

69 C.F.R. § 411.37(a).

70 C.F.R. § 411.37(d).

71 31 U.S.C. § 3711.

72 Medicare Secondary Payer Recovery Contractor, Option to Self-Calculate Your Final Conditional Payment Amount Prior to Settlement, at 2, www.msprc.info/forms/SelfCalculatedFinalCP.pdf (last visited June 26, 2013).

(2) the settlement involves physical, trauma-based liability insurance (including self-insurance). Under this option, Medicare will accept 25% of the gross settlement (no reduction for attorney fees) as payment in full, regardless of the amount paid in by Medicare on the beneficiary's behalf.[73]

A complete Waiver may also be sought if a beneficiary is without fault and adjustment or recovery would either: (1) defeat the purpose of Title II or Title XVII of the Act; or (2) be against equity or good conscience. Waivers usually only occur post-settlement.[74] After a waiver denial, a beneficiary can submit a written request for redetermination within 120 days from the date of the initial notice. This redetermination appeal will be reviewed and decided by someone not involved in the initial determination. If the appeal is denied, the next level of appeal is Reconsideration by a Qualified Independent Contractor. Beneficiaries have 180 days from the date of the Redetermination notice to submit the request for Reconsideration directly to the Qualified Independent Contractor. If the Reconsideration is denied and the amount remaining in question is $100 or more, the beneficiary has 60 days to request a hearing before an administrative law judge.

Medicare Set-Asides: Worker's Compensation and Liability Claims

It is important to note that in certain worker's compensation cases, where the worker's compensation plan covers future medical payments and the judgment or settlement is partially for those payments, Medicare will require a set-aside of those funds. Since Medicare is a secondary payer, they will not pay for any future medical expenses until the set-aside has been exhausted. For guidance on the proper handling of Medicare set-asides, an attorney should consult the Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) Reference.[75]

There has been much discussion about whether a Medicare Set-Aside (MSA) is required in liability settlements. The Center for Medicare Services (CMS) has hinted that it plans to promulgate guidelines regarding the application of MSAs to liability claims, but it has done so to date. Notwithstanding the absence of specific guidelines, attorneys have always had the obligation in liability settlements to protect Medicare's interests as a secondary payer. If a beneficiary is being compensated for future medical expenses, consideration of Medicare's interests should be considered and a MSA may be advisable.

McCutchen **teaches attorneys, plan administrators and their collection designees that they cannot look to judicial solutions for the resolution of the many thousands of reimbursement claims by ERISA plans.**

73 Medicare Secondary Payer Recovery Contractor, Fixed Percentage Option, www.msprc.info/forms/Fixed%20Percentage%20Option%20Information.pdf (last visited June 26, 2013).

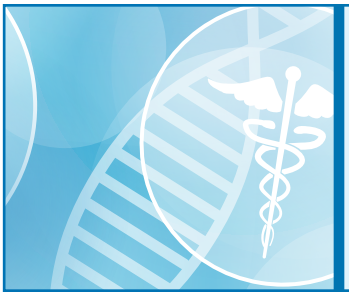
74 42 U.S.C. § 1395gg.

75 Center for Medicare and Medicaid Services, Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) Reference Guide, www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Workers-Compensation-Medicare-Set-Aside-Arrangements/Downloads/March-29-2013-WCMSA-Reference-Guide-Version-13-copy.pdf (last visited June 26, 2013).

TEACHERS' AND STATE EMPLOYEES' HEALTH PLAN, COST PLUS PLANS & NC HEALTH CHOICE PLAN

This lien was revamped by the state legislature in 2012 and is now established by the code in N.C.G.S. § 135- 48.37(c). It was originally created in 2004 by N.C.G.S. § 135-40.13A, which was succeeded by N.C.G.S. § 135-45.15. In no event shall the Plan's lien exceed fifty percent (50%) of the net recovery after deduction of the reasonable costs of collection.[76] There is a presumption that a 33 1/3% attorneys' fee is reasonable. The Plan's lien recovery is not subject to the wrongful death statute's $4,500.00 cap on payment of medical expenses.[77] Similar to workers' compensation carriers, the Plan has the right to pursue recovery directly against a third party in the event the Plan member does not pursue a claim.[78] In determining whether the Plan has a lien against your client's recovery you must first assess the source of the recovery. The deciding factor is whether the proceeds at issue are first party proceeds or third-party proceeds. Only recoveries from "liable third parties" are subject to a lien by the Plan. Examples of third party coverage include: liability proceeds of all types (ex: auto, homeowners', and professional liability). Examples of first party coverage include the following: workers compensation, medical payments, underinsured motorist coverage, and uninsured motorist coverage.

A SEHP lien has been regarded as a "super-lien" because of the authority given to its rights of recovery by the legislature and courts. There is no requirement for the lien to be perfected. No actual notice is required for the lien to exist. Notice of the Plan's lien or right to recovery shall be presumed when a Plan member is represented by an attorney.[79] According to the enacting statute and the first impression case of *The State Health Plan for Teachers and State Employees v. Barnett*, an attorney has an affirmative statutory duty to disburse lien proceeds to SEHP.[80] In *Barnett*, the attorney was held personally liable for the entire SEHP lien that totaled $28,000 because of his failure to disburse to the Plan. This is despite the fact that his earned fee was only $14,000. The attorney disbursed the settlement funds to his client pursuant to a client directive that contained an agreement to release him from future actions. The court held that an attorney cannot ignore a valid SEHP lien when disbursing settlement funds, regardless of his client's wishes.



The deciding factor is whether the proceeds at issue are first party proceeds or third-party proceeds. Only recoveries from "liable third parties" are subject to a lien by the Plan. Examples of third party coverage include: liability proceeds of all types (ex: auto, homeowners', and professional liability).

76 N.C.G.S. § 135-48.37(d).

77 N.C.G.S. § 135-48.37(a).

78 N.C.G.S. § 135-48.37(b).

79 N.C.G.S. § 135-48.37(d).

80 *The State Health Plan for Teachers and State Employees v. Barnett*, NO. COA12-999 (N.C. Ct. App. May 7, 2013).

SEHP Liens Interaction with Other Liens

The Plan claims a first priority right to any funds the Plan member recovers. This is in conflict with federal liens (ex: Medicare, TRICARE, U.S. Workers' Compensation). It is uncertain what the order of lien prioritization should be. The Plan's lien, however, would appear to take priority over healthcare provider liens. An attorney is best advised to notify all parties that hold liens on the settlement and to seek a workout amongst all parties to avoid additional litigation. A best practice would be to get all lienholders to agree to full satisfaction in the settlement agreement. In Barnett, SEHP was awarded 50% of the client's proceeds ($14,000), even though only $9,386 was allocated to medical expenses.[81]The holding appears to indicate that SEHP's lien may operate both separately from and in addition to other valid liens. This makes it of the utmost importance to try to settle with SEHP and other lienholders to limit the possibility of 100% absorption of the client's fees.

Cost Plus Plans

Cost Plus derive its authority from N.C. Gen. Stat.§58-65-135 and typically cover local or county employees. Cost Plus plans are distinct and separate from all other plans, including the State Employees Health Plan and ERISA. This is an important fact, because practitioners often confuse the Cost Plus plan for either a SEHP or ERISA plan. The enacting statute does not specifically authorize a lien in favor of Cost Plus plans. In addition, there is no case law as of today that addresses the issue of the Plan's reimbursement rights. The enacting statute states that "the administration of any Cost Plus plans as herein provided shall not be subject to regulation or supervision by the Commissioner of Insurance."[82] The result is that the Plan will argue that anti-subrogation rules do not apply to the Plan since its administration is outside of the commissioner's reach. However, your client's argument should be that the word "administration" does not apply to the anything other than the daily administrative activities and that subrogation activity is outside of the normal scope of plan administration. While it is unclear whether Cost Plus Plans have valid subrogation and reimbursement rights, it is virtually certain that an attorney has no duty to protect the Plan's interest if it were to assert a lien on your client's settlement funds.

NC Health Choice for Children Plans

NC Health Choice Plans were instituted by the state legislature to provide free or reduced coverage for children within the state whose parents' income is too high for Medicaid and too low for private insurance. Although it is administered by the same entity as the State Employees Health Plan, the lien is separate and distinct. There was not a statutory lien until April 23, 2009 when the state legislature passed an amendment to N.C. Gen. Stat. § 108A-57(c) to include NC Health Choice plans, which gives NC Health Choice that same reimbursement rights as Medicaid. Accordingly, you should refer to the Medicaid section of this manuscript to determine how to proceed when representing a client whose medical bills were paid by a NC Health Choice plan. While there is not a specific effective date declared, an attorney should presume the statute to apply to payments made by NC Health Choice from April 23, 2009 forward.

81 Id.

82 N.C.G.S. §58-65-135.

HEALTH CARE PROVIDERS

Health Care Provider Liens are statutorily created by N.C. Gen. Stat. §§ 44-49, 44-50. These statues create a lien "in favor of any person, corporation, State entity, municipal corporation, or county to whom the person so recovering, or the person in whose behalf the recovery has been made, may be indebted for any drugs, medical supplies, ambulance services, services rendered by any physician, dentist, nurse, or hospital attention, or hospital attention or services rendered in connection with the injury in compensation for which the damages have been recovered." There are certain services, such as chiropractic services, which the statute does not definitively create a lien in favor of. However, these services may obtain a functional equivalent of a Health Care Provider Lien by obtaining a lien by assignment.[83]

Chiropractor Tactics: A Recent Trend

A new tactic that we have seen with increased frequency at Lawyers Mutual is a chiropractor attempting to insert a "U.C.C. lien" into service contracts to increase their odds of collection in the absence of a perfected lien under N.C.G.S. §§ 44-49, 44-50. We have successfully defended such cases, and the result has been a flat dismissal at the magistrate level without an appeal. We believe that health care provider liens are governed specifically by N.C.G.S. §§ 44-49, 44-50. Our stance is that the specific tailoring of this statute along with its omission of chiropractic services preempts any concessions purportedly provided by the general code included in Chapter 9 of the U.C.C., which provides that the article "does not apply to the extent that … another statute of this State expressly governs the creation, perfection, priority, or enforcement of a security interest created by this State[.]"[84] In addition, the same article states that it does not apply to "an assignment of a right to payment under a contract to an assignee that is also obligated to perform under the contract."[85] Please contact us if you are confronted with a similar assertion by a chiropractor's counsel. We may be able to find a successful resolution of the situation.

Lien Creation: No Attorney Representation

In *Charlotte-Mecklenburg Hospital Authority v. First of Georgia Insurance Company et al.*,[86] the North Carolina Supreme Court recognized, in a case where the patient was not represented by counsel, that a valid lien was created by a healthcare provider against proceeds in the hands of the liability carrier. The lien was "created" because the injured victim signed an assignment of the proceeds of a personal injury action and the liability carrier was put on notice of such an assignment. First of Georgia could also be construed to mean an assignment creates a valid lien against the proceeds in the hands of UM and UIM carriers, in cases where no attorney is involved in distributing the proceeds.

In addition to recognizing the creation of a lien under N.C. Gen. Stat. §§ 44-49, 44-50, the North Carolina Supreme Court distinguished between an assignment of a claim for a personal injury and the assignment of proceeds of such a claim. The Court held that the assignment document at issue rose to the level of an assignment of the proceeds, and not the claim, and

83 *Alaimo Family Chiropractic v. Allstate Ins. Co.*, 155 N.C. App. 194, 574 S.E.2d 496 (N.C. Ct. App. 2002).

84 U.C.C. § 9-109(c)(2).

85 U.C.C. § 9-109(d)(6).

86 *Charlotte-Mecklenburg Hospital Authority v. First of Georgia Insurance Company et al.*, 112 N.C. App. 828, 436 S.E.2d 869, rev'd, 340 N.C. 88, 455 S.E.2d 655 (1995).

that such an assignment did create a lien. A client is prohibited from assigning his or her claim as that would constitute champerty and be against public policy.

Creation & Perfection of a Health Care Provider Lien: With Attorney Representation

First of Georgia seems to suggest that any lien created by an assignment may evaporate once the client hires an attorney. Once an attorney is retained, the lien and disbursement protocol follows N.C. Gen. Stat. §§ 44-49, 44-50. These statutes cover liens claimed by physicians, hospitals, nurses, dentists, ambulance services and seemingly any entity which has provided health care services related to the injury for which your client has recovered. Although chiropractors are not listed, their lien is likely covered.[87] A healthcare provider lien is "perfected" under N.C.G.S. §§ 44-49, 44-50 when:

1. Attorney requests client's medical records or itemized bill from a healthcare provider AND
2. Healthcare provider gives requested medical records or itemized bill free of charge AND
3. Healthcare provider sends the attorney written notice of the lien claimed.

Statute of Limitations

The statute of limitations for a healthcare provider to enforce a lien has not been conclusively determined by the legislature or judiciary. It is likely that a suit for violation of a lien could be brought long after the original statute of limitations has run, because the violation may not be deemed to have occurred until the medical provider was not properly paid from a settlement or judgment.[88] Absent a contract stating the date when payment is due, the statute of limitations for a non-lienholder healthcare provider to collect an unpaid balance is three years from the date of the last treatment, provided the client has received continuous treatment.[89] However, a patient may be equitably estopped from asserting a statute of limitations defense if her attorney represented to the healthcare provider that the bill would be paid out of the settlement proceeds.[90]

Disbursement Requirements & Procedures

After determining which healthcare providers have liens under N.C.G.S. § 44-49(b), you should determine if there will be enough money remaining after disbursement to make the case worthwhile for your client. After all, it is your client who suffered the painful injuries and underwent the medical treatment and may face future complications. Consider that settlement funds will have to provide for: paying your fee and expenses, repaying in full the lienholders and other unpaid bills your client wants paid, and allowing your client to receive a large enough "share" of the proceeds to make the case worthwhile. If you have enough money to go around, you can do the traditional math. If not, you will need to turn to the help provided by N.C.G.S. §§ 44-49, 44-50. These statutes create a cap on the amount healthcare provider lienholders can extract from your client's recovery. Under N.C.G.S. §§ 44-49, 44-50, the total liens may not exceed one-half of the remainder of the client's recovery after deduction for attorney's fees. In other words, after deducting your attorney's fees (sorry, the statute does not allow for the "up front" deduction of your expenses), the client is entitled to receive 50% of the remaining funds. This leaves the remaining 50% to be distributed on a pro-rata basis amongst the lienholders. Only perfected liens are entitled to a share.

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87 See *Triangle Park Chiropractic v. Battaglia*, 139 N.C. App. 201, review denied, 352 N.C. 683 (2000).

88 See NORTH CAROLINA PERSONAL INJURY LIENS MANUAL 11 (2nd ed. 2011).

89 *Johnson Neurological Clinic v. Kirkman*, 121 N.C. App. 326, 465 S.E.2d 32 (1996).

90 *Duke University v. Stainback*, 320 N.C. 337, 357 S.E.2d 690 (1987).

If a lien is perfected and the attorney fails to honor the lien, the lienholder has an enforceable claim against the attorney.

N.C.G.S. § 44-50.1 creates an affirmative obligation of the attorney to provide "less than paid in full" lienholders with documentation of: (1) the total settlement proceeds, (2) all lien amounts, (3) distribution amounts to respective lienholders, (4) for each lienholder, the percentage of its lien amount that is represented by the distribution amount, and (5) the total amount of attorney's fees. A pro-rata or other payment to a lienholder that is less than the lien amount does not absolve the client from the obligation to pay the unpaid balance on the lien. Additionally, failure of a healthcare provider to perfect a lien does not absolve the client from the obligation to pay the unpaid charges.

If a lien is perfected and the attorney fails to honor the lien, the lienholder has an enforceable claim against the attorney. This claim is in addition to the claim the health care provider has against the client/patient.[90] Where the lien amount is in dispute, no payment is required "... until the claim is fully established and determined."[91]

It is recommended that practitioners encourage payment of all medical bills when there are sufficient recovery proceeds. The employment contract should facilitate this approach. However, if the client instructs his attorney not to pay non-lienholder healthcare providers, then the attorney must follow those instructions, even if the original employment contract provides otherwise.[93] As for healthcare providers that hold a perfected lien, if the claim is liquidated (i.e. clear and certain), the lawyer may pay the provider over the client's objection. If the client disagrees, the attorney may consider filing an interpleader action, paying the disputed funds into the court, and allowing the court to reach a resolution separately. While clearly available, the interpleader remedy should be utilized only as a last resort. Try to iron out the dispute between your client and the lienholder so that you, the client, and the lienholder can close the chapter and move on with your respective lives.

INTERACTION WITH OTHER LIENS

ERISA "liens" and Medicare liens are governed by federal law and thus pre-empt state law. Therefore, they do not come under the purview of the state lien statutes. Medicaid liens being governed by state law, do pro-rate with state health care provider liens. The State Employee Health Plan lien is by statute granted superiority to state health care provider liens.

LIEN VS. ASSIGNMENT OF BENEFITS

The attorney should treat an assignment of benefits just like a lien. Charlotte-Mecklenburg Hosp. Auth,, 340 N.C. at 92, 455 S.E.2d at 658.

SPECIAL NOTE: Entities Not Entitled to Payment Under N.C. Gen. Stat. §§ 44-49 and 44-50

1. Healthcare providers who have received payments from Medicaid. Be on the lookout for

90 See *Triangle Park Chiropractic v. Battaglia*, supra.

91 N.C.G.S. § 44-51.

92 See 2017 FEO 4.

any of your client's medical bills that have the language "MEDICAID RECIPIENT; BENEFITS ASSIGNED" or something similar. This language means the healthcare provider has filed a claim with Medicaid for payment of certain treatment or services provided. A healthcare provider who has received payment from Medicaid for a specific service or treatment cannot assert a lien against your client's recovery for the unpaid balance of the same service or treatment except for certain specific services for which a co-payment may be charged. You need not honor the lien claimed by the healthcare provider and be sure to inform your client that he does not owe the "balance" either. Any balance is essentially waived or erased by the healthcare provider's acceptance of Medicaid benefits. Balance billing is strictly prohibited as affirmed by a Sixth Circuit opinion in the case of *Spectrum Health v. Anne Marie Bowling*.[93] Though not binding on a North Carolina Court, the Spectrum decision and the fact that no United States Court has ever allowed a provider to recover on "balance billing" should squash the provider's claim in your case.

2. Healthcare providers who have filed with a workers' compensation carrier or employer. A health care provider cannot seek recovery from the client for services provided due to a work-related injury "unless the employee's claim or the treatment is finally adjudicated not to be compensable or the employee fails to request a hearing after denial of liability by the employer."[94] A health care provider that seeks to recover payment on a bill incurred by an employee due to treatment for work-related injury could face conviction of a Class 1 misdemeanor.[95]

NOTE : LIEN LAWS OF OTHER STATES

If your client receives medical treatment in a state other than North Carolina, how do you determine what lien rights, if any, the out-of-state medical care provider has? Most would agree that the law of the venue in which the claim may be brought would control. Therefore, the lawyer should first look to our lien law and compare that to the law of the state in which the client received medical treatment to see which law is more favorable to the client.

93 *Spectrum Health Continuing Care Group v. Anne Marie Bowling Irrevocable Trust*, 410 F.3d 304 (6th Cir. 2005).

94 N.C.G.S. § 97-90(e).

95 N.C.G.S. § 97-88.3(c).

N.C. WORKERS' COMPENSATION

N.C. Gen. Stat. § 97-10.2(h) establishes a lien in favor of any employer who has provided workers' compensation benefits upon any award in a third-party liability case for the reimbursement of monetary and medical benefits conferred upon the employee. As a result, the receipt of any workers' compensation benefits by your client creates a lien against any recovery your client receives from a third-party tortfeasor for the on-the-job injury.[96] However, negligence by the employer negates the ability to recover for benefits paid by lien.[97] In addition, uninsured or underinsured motorist monies are subject to a workers' compensation lien.[98]

Jurisdiction over Reduction of a Workers' Compensation Lien

Jurisdiction over the reduction or elimination of a workers' compensation lien is limited to the superior court judge of the county in which the cause of action arose or where the injured employee resides (or presiding judge of either district).[99] The superior court judge may reduce or eliminate the workers' compensation lien without the employer's consent even if the result is a double recovery for the plaintiff, so long as a settlement agreement has not been submitted to and approved by the Industrial Commission.[100] The superior court judge's order binds the Industrial Commission concerning disbursement of the settlement funds. The judge has the power to reduce the employer's lien amount in any manner he believes to be equitable, considering the factual findings of the following five factors: (1) the compensation the employer will likely pay the employee in the future; (2) the net recovery to the plaintiff; (3) the likelihood of the plaintiff prevailing at trial or appeal; (4) the need for finality in the litigation; and (5) any other factors the court deems just and reasonable.[101]

However, before the case can be heard by the superior court, there has to be a "final settlement" between the third party and the employee.[102] Settlements that are conditioned upon the reduction or elimination of a workers' compensation lien are not considered "final." If all parties agree to have the funds that are subject to a potential lien placed in escrow, the settlement or award may be considered "final."[103] The superior court may reduce a workers' compensation lien even if the industrial commission has yet to declare a final order, if there has been a final award.[104] In addition, the superior court retains jurisdiction to reduce or eliminate a workers' compensation lien even after the third party funds assigned to the lien have been distributed. Also, workers' compensation liens attach to any payments by a third-party tortfeasor to any person receiving the funds.[105]

96 N.C.G.S. § 97-10.2.

97 N.C.G.S. § 97-10.2(3).

98 See *Creed v. R.G. Swaim & Son,* 123 N.C. App. 124 (1996); Bailey v. Nationwide, 112 N.C. App. 47, aff'd, 334 N.C. 1, 430 S.E.2d 895 (1993).

99 N.C.G.S. § 97-10.2(j).

100 *Holden v. Boone*, 153 N.C. App. 254, 569 S.E.2d 711 (2002).

101 N.C.G.S. § 97-10.2(j).

102 *Ales v. T. A. Loving Co*., 163 N.C. App. 350, 353 (2004) (interpreting N.C. Gen. Stat. § 97-10.2(j) as permitting the superior court to adjust the amount of a subrogation lien if the agreement between the parties has been finalized so that only performance of the agreement is necessary to bind the parties.)

103 Id.

104 *Wood v. Weldon*, 160 N.C. App. 697 (2003).

105 *Childress v. Flour Daniel, Inc*., 172 N.C. App. 166 (2005).

106 In *Re Estate of Bullock v. C.C. Mangum Co*., 188 N.C. App. 518, 525 (2008).

Attorneys' Fees

An employer is required to share in attorney's fees related to the case before the Industrial Commission in direct proportion to his interest in the settlement.[107] However, N.C. Gen Stat. § 97-10.2(j) does not allow for a deduction of attorney's fees incurred during the lien reduction hearing before the superior court. An employer is only required to pay its fair share of costs and expenses incurred by the plaintiff in obtaining the judgment.[108] An employer's insurance carrier steps into the shoes of the employer and is given the same rights and obligations.[109]

SPECIAL NOTE: UNINSURED & UNDERINSURED MOTORIST COVERAGE

N.C. Gen Stat. § 20-279.21(e) requires all UM/UIM policies to insure against the plaintiff 's damages that are uncompensated by any workers' compensation payments and the amount of a workers' compensation lien. The effect of this statute is that a UM/UIM policy is required to compensate the plaintiff, up to its policy coverage limit, if a reduction or elimination of a workers' compensation lien is granted by the superior court. Courts have interpreted this statute quite favorably to plaintiffs, and the opportunity should be exploited by a plaintiff 's attorney.[110]

Procedures for Handling Workers' Compensation Liens

If a "final settlement" has been reached with the third party and attempts to settle the lien have been unsuccessful, a suit may be commenced in superior court for the purpose of reducing or eliminating the lien in two ways. First, an attorney may file a written complaint against the third-party tortfeasor. This has the advantage of not requiring the employer or insurance carrier to be initially named as defendants, but the carrier's claims adjuster and attorney should still be notified of the suit.[111] Second, an attorney may file a petition without a complaint against the employer and third-party liability insurance carrier. This will require more procedural work than the previous option but is still sufficient to invoke jurisdiction for the suit.

State law restricts the period in which an employee has the exclusive ability to enforce his rights against a third-party tortfeasor in a workers' compensation case. The employee has the exclusive right to seek enforcement against the third party tortfeasor during the first 12 months following the injury.[112] If an employee does not act on his rights during that time, the employee and employer will share a joint right to sue until the exclusivity period is reactivated (if neither party has filed a suit) during the 60 days immediately preceding

State law restricts the period in which an employee has the exclusive ability to enforce his rights against a third-party tortfeasor in a workers' compensation case.

107 N.C. Gen Stat. § 97-10.2(f)(2).

108 *Alston v. Fed. Express Corp.*, 200 N.C. App. 420 (2009).

109 Id.

110 N.C.G.S. § 97-10.2(g).

111 *Austin v. Midgette*, 159 N.C. App. 416 (2003)(Austin I); *Austin v. Midgette*, 166 N.C. App. 740 (2004)(Austin II); *Walker v. Penn National Security Insurance Company*, 168 N.C. App. 555 (2005).

112 N.C.G.S. 97-10.2(d).

It is also very important for the attorney to note that N.C.G.S. § 97-10.2(f)(1) requires the attorney to get final approval of the distribution from the Industrial Commission before distributing.

the expiration of the statute of limitations applicable to the claim against the third party.[113]

It is also very important for the attorney to note that N.C.G.S. § 97-10.2(f)(1) requires the attorney to get final approval of the distribution from the Industrial Commission before distributing. An attorney must also distribute in the following priority: (1) to the employee for court costs and expenses incurred in litigation; (2) to the attorneys for fees; (3) to the employer for his award; and (4) to the employee for his award.

STEP 1 You should request that the employer or its carrier/third party administrator provide you with a fully itemized listing of all benefits paid that compose their claimed lien amount. Review and scrutinize the lien listing to eliminate any unrecoverable items.

STEP 2 After determining the amount of recoverable charges that will compose the lien, contact the carrier regarding a reduction of the lien amount. You should seek to negotiate a reduction of repayment on virtually all workers' compensation liens. [NOTE: If you seek to reduce the lien repayment amount, you must do this before you have your client sign a compromise settlement agreement that is approved by the Industrial Commission. Once the Commission approves the settlement agreement, it is too late.[114]

If the carrier is unwilling to negotiate favorably yet has some unclean hands due to the handling of the workers' compensation case, it is time to use the pen (or computer) as your sword. Send the carrier a letter requesting a reduction of the lien amount and also take care to list any and all "bad faith" acts by the employer or carrier over the course of the case. Examples of such are unjustified delays in the payment of weekly indemnity benefits, unreasonable delay in authorizing medical treatment or procedures prescribed by your client's primary treating physician, and the provision of unsuitable employment.

STEP 3a If you reach a written agreement with the carrier regarding a lien reduction, your work is not quite done. Any disbursement to the client must be preceded by an application and an order from the North Carolina Industrial Commission approving such disbursement. Have the comp carrier join in and sign your application. It may also be helpful to have you sign either the

113 N.C.G.S. § 97-10.2(c).

114 *Holden v. Boone*, 153 N.C. App. 254 (2002).

application or a Settlement Statement that evidences the agreed upon lien reduction amount as well as the employer/carrier's intention not to appeal. You will need to receive the signed order from the Industrial Commission before you disburse any recovered funds.

STEP 3b If you are unable to reach an agreement with the workers' compensation carrier regarding a reduced lien repayment amount, do not despair. N.C.G.S. § 97-10.2(j) allows the employee to petition a Resident or Presiding Superior Court Judge to reduce or eliminate the subrogation amount to be paid to the employer or insurance carrier after proper notice to the employer. The statute states that the judge has the right to determine the amount of reimbursement in his/her "discretion." If the third party case is pending in Federal Court, your petition must be made therein. The Industrial Commission cannot order the carrier to accept less than the statutory lien amount. Only a judge has this authority. After a judicial decision on your petition, you must still prepare an application and proposed order to the Industrial Commission approving disbursement. It would still be helpful to have a letter showing the carrier/employer's lack of intent to appeal the decision. In the event of an appeal, the total amount of the lien should be kept in the trust account until all appeals are exhausted.

PROCEDURES FOR HANDLING WORKERS' COMPENSATION LIENS

1. Request that the employer or its carrier/third party administrator provide you with a fully itemized listing of all benefits paid that compose their claimed lien amount
2. After determining the amount of recoverable charges that will compose the lien, contact the carrier regarding a reduction of the lien amount. You should seek to negotiate a reduction of repayment on virtually all workers' compensation liens
3. If you reach a written agreement with the carrier regarding a lien reduction, your work is not quite done. Any disbursement to the client must be preceded by an application and an order from the North Carolina Industrial Commission approving such disbursement

   If you are unable to reach an agreement with the workers' compensation carrier regarding a reduced lien repayment amount, petition a Resident or Presiding Superior Court Judge to reduce or eliminate the subrogation amount to be paid to the employer or insurance carrier after proper notice to the employer.

TRICARE (FORMERLY KNOWN AS CHAMPUS)

The Federal Medical Recovery Act (42 U.S.C. §§ 2651- 2653) allows the federal government to be reimbursed for its costs of treating a TRICARE beneficiary. TRICARE's recovery measures and methods are stated in 10 U.S.C. § 1095, et seq. TRICARE is a program of medical assistance for veterans (often referred to as "sponsors" in government correspondence), their spouses and their children.

The government has a lien on the proceeds of recovery for any sums paid for or incurred by the services rendered by Veterans' Administration hospitals or private health care providers. This lien attaches to the source of funding, as well as the proceeds of settlement. This lien is not limited or controlled by state law which means the government can (and sometimes does) pursue a claim of its own directly against the tortfeasor and his insurance company. Once a qualified beneficiary reaches Medicare age, TRICARE benefits become secondary coverage. If the qualified beneficiary has other coverage available, it will become secondary above TRICARE.

Once you determine that your client has received TRICARE benefits you need to ascertain the name, social security number, and branch of service of the veteran who is the conduit through which your client is entitled to receive TRICARE benefits. If your client is a veteran, this information will be one and the same. Next, you will need to forward the above-described contact information along with the date and place of incident to the nearest military base of the branch of service to which the veteran belongs(ed). Your letter should be directed to the Affirmative Claims Recoveries Branch of the Federal Medical Case Recovery Section in the Office of the Staff Judge Advocate for that service. You or the client may be required to complete a DD Form 2527, "Statement of Personal Injury - Possible Third-Party Liability" to assist the government in preparing its itemized lien statement.

Each branch of service has its own jurisdictional boundaries. Jurisdiction is usually assigned to the base closest to the site of the incident giving rise to the injury. However, if the injury occurs in one jurisdiction with minimal treatment in that jurisdiction, and follow-up treatment is extensive in another jurisdiction, the treating jurisdiction will probably handle the case. Further, each branch has a unique procedure regarding handling and recovery of liens.

The TRICARE lien is subject to adjustment and can be reduced or waived by the Claims Recovery Office when justice requires. There is no deduction permitted for attorney's fees, and there is no cap on the amount of the lien. By law, a Claims Recovery Officer has limited initial authority to compromise or waive the lien. Whether a TRICARE lien will be compromised will ultimately depend on how much the beneficiary will receive. For instance, if the proposed compromise would reap few benefits to the beneficiary but more to the attorney, chances of compromise will be slim. On the other hand, if there is a recovery for less than the full value of the claim and other lienholders or claimants (including

The Federal Medical Recovery Act (42 U.S.C. §§ 2651- 2653) allows the federal government to be reimbursed for its costs of treating a TRICARE beneficiary.

attorneys) are willing to adjust their claims, chances of a compromise with the Claims Recovery Office improve. The plaintiff 's attorney should keep in close contact with the Recovery Office and plead the case for compromise armed with sufficient facts and arguments to justify an adjustment.

The limit on the dollar amount of the local Claims Recovery Officer's authority to compromise a claim are subject to adjustment. Further, each service has its own methodology which it follows, and some services require more supporting documents than others, especially when compromising a large claim. KEYNOTE: Federal law prohibits payment of an attorney fee for assertion or collection of a claim by the government.[115]

VOCATIONAL REHABILITATION

This lien is created by N.C. Gen. Stat. § 143-547. Vocational Rehabilitation claims a lien against any source, including payments made under the claimant's own medical payments coverage, uninsured motorist coverage, underinsured motorist coverage, personal insurance, workers' compensation, or any other source. A Vocational Rehabilitation lien only applies in those cases where a financial needs test was administered in order to receive benefits. If no financial needs test was required, then no lien attaches.[116] Vocational Rehabilitation takes the position that it has a statutory right of subrogation and can make a claim and sue the tortfeasor directly. Accordingly, an attorney should review all medical, hospital, and rehabilitation facility records as well as billing and charge statements to determine if Vocational Rehabilitation is involved.

The formula for payment of a Vocational Rehabilitation lien is set forth in N.C. Gen. Stat. § 143- 547(a). The statutory formula allows deductions for attorney's fees and costs but not to exceed one-third of the amount recovered. The amount of the lien is likewise capped at one-third of the amount recovered.

Additionally, if there are other liens to be paid out of the recovery, the statute allows you to pro-rate the Vocational Rehabilitation lien with such liens.
Should there be insufficient funds available to repay the lien, N.C. Gen. Stat. § 143-547 permits the Division of Vocational Rehabilitation Services to totally or partially waive subrogation rights. This may be done when the Division finds that enforcement would tend to defeat the client's process of rehabilitation, or when the client's assets can be used to offset additional Division costs.

The TRICARE lien is subject to adjustment and can be reduced or waived by the Claims Recovery Office when justice requires. There is no deduction permitted for attorney's fees, and there is no cap on the amount of the lien.

115 5 U.S.C. § 3106.

116 N.C.G.S. § 143-547(c).

AMBULANCE SERVICE LIENS

N.C. Gen. Stat. § 44-51.1 et seq. contains the provisions relating to ambulance service liens. N.C. Gen. Stat. § 44-51.8 contains a long list of the counties to which the ambulance service lien applies. Although the list seems to include virtually every county, you should still consult the statute to see if the county relevant to your case is covered. There is no statutory allowance for an attorney's fee or costs reduction of ambulance service liens.

Ambulance service liens must be filed with the Clerk of Superior Court in order to be perfected. Ambulance service liens can be asserted versus real property only if the lien was filed with the Clerk of Superior Court within 90 days after the date service was furnished.[117]

The county can utilize garnishment or attachment proceedings to recover the lien amount from your client if the lien was filed with the Clerk of Superior Court within 91 to 180 days after the date service was furnished.[118] This means that your client's wages, bank deposits, personal property, etc., are potential recovery sources for the county. A county's failure to file their outstanding bill with the Clerk of Superior Court within the requisite time period means only that the county cannot undertake the aforementioned procedures to recoup its money. The county would retain a lien under N.C. Gen. Stat. §§ 44-49 and 44-50. The lien exists for 10 years from the date the service was furnished or 3 years from the date of the recipient's death.[119]

CHILD SUPPORT LIENS

N. C. Gen. Stat. §58-3-185 creates a lien for past-due child support on the personal injury recovery on a non-custodial parent. If perfected, this lien is subordinate to most other health care provider liens, including Chapter 44 health care provider liens, ERISA liens (federal law), SEHP liens, Medicaid liens and Medicare liens (federal law). In practice, the perfected child support lien is paid after the attorney's fees and costs are deducted and medical provider liens and health benefit plan claims are satisfied.

There are four requirements for a child support lien to be "perfected" under G.S. §58-3-185:

1. The notification must be in writing to the obligor, the insurance carrier, or the attorney; and
2. The notification must include a certified copy of the court order ordering the support; and
3. The notification must include proof that the claimant or beneficiary is past-due in meeting this obligation; and
4. The recovery must be a lump-sum amount equal to or in excess of $3,000 or periodic payments with an aggregate amount that equals or exceeds $3,000.

OUT-OF-STATE CHILD SUPPORT LIENS

Orders for child support adjudicated in other states are given "full faith and credit" in North Carolina under federal as well as state law. However, if the injury occurred in North Carolina and North Carolina is the proper venue for the injury claim to be brought, then G.S. §58-3-185 should apply and the out-of-state child support enforcement agencies should have to comply with the requirements of our statute in order to have a perfected child support lien.

117 N.C.G.S. § 44-51.2.

118 N.C.G.S. § 44-51.6.

119 N.C.G.S. § 44.51.1.

SAMPLE REQUEST FOR PLAN DOCUMENTS

Date

(Name of Plan Administrator – should be set forth in SPD)
Plan Administrator for _____ Medical Plan
Street Address
City, State, Zip Code

CERTIFIED MAIL: Return Receipt Requested

Dear Mr./Ms.:

My name is _____. Pursuant to my right as a participant and beneficiary of _____ Plan, I respectfully request copies of the following materials:

Copies of the Summary Plan Description (SPD) and other Plan Documents relating to my health insurance coverage for the years, _____, _____, _____, and _____. (year preceding date of injury through current year); and

Administrative Services Contract between _____ (Employer/Plan) and _____ (Plan Insurer(s)/Claim Administrator) for the years _____, _____, _____, and _____. (year preceding date of injury through current year); and

Copies of all contracts including, but not limited to: Insurance contracts, Stop Loss Contracts, Health Insurance Contracts, Insurance Intermediary Services Contracts, and Administrative Services Contracts related to _____ Medical Plan serving (insert name of state or region encompassing client) participants for the years _____, _____, _____, and _____. (year preceding date of injury through current year); and

Amendments to the Plan Documents for _____ Medical Plan (including, but not limited to the Summary Plan Description) for the years _____, _____, _____, and _____. (year preceding date of injury through current year); and

Copies of the SMM (Summary of Material Modifications) statements for the years _____, _____, _____, and _____. (year preceding date of injury through current year); and

Copies of form 5500, including all attached schedules, filed with the U.S. Department of Labor for the years _____, _____, _____, and _____. (year preceding date of injury through current year.

Please forward these materials to my attorney, Mr./Ms. _____, (street address), (city), (state), (zip code).

Thank you.

_____ (signature)
(Name of Participant/Beneficiary – PRINTED)
Plan Participant
Plan Beneficiary

SAMPLE FORM 5500:
ANNUAL RETURN REPORT OF EMPLOYEE BENEFIT PLAN

ATTACHMENT 3 -SAMPLE FORM 55OO

freeERISA.com

Form 5500

Department of the Treasury
Internal Revenue Service
Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

OMB Nos. 1210 - 0110
1210 - 0089

2010

This Form is Open to Public Inspection

Complete all entries in accordance with the instructions to the Form 5500.

Part I Annual Report Identification Information

For calendar plan year 2010 or fiscal plan year beginning January 01, 2010 , and ending December 31, 2010

A This return/report is for: ☐ a multiemployer plan; ☐ a multiple-employer plan;
☒ a single-employer plan; ☐ a DFE (specify)

B This return/report is: ☐ the first return/report; ☐ the final return/report;
☐ an amended return/report; ☐ a short plan year return/report (less than 12 months).

C If the plan is a collectively-bargained plan, check here ☐

D Check box if filing under: ☒ Form 5558; ☐ automatic extension; ☐ the DFVC program;
☐ special extension (enter description)

Part II Basic Plan Information – enter all requested information.

1a Name of plan
TENENBAUM & SAAS, P.C. 401(K) PLAN

1b Three-digit plan number (PN) 001

1c Effective date of plan March 01, 2005

2a Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.)

TENEBAUM & SAAS, P.C.
4504 WALSH STREET
SUITE 200
CHEVY CHASE MD 20815

2b Employer Identification Number (EIN) 52-1964824

2c Sponsor's telephone number

2d Business code (see instructions) 541110

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established. Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

Signature of plan administrator	08/12/2011 Date	CAROL JOHNSON Enter name of individual signing as plan administrator
Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
Signature of DFE	Date	Enter name of individual signing as DFE

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. **Form 5500 (2010) v.092308.1**

3a 3b

Plan administrator's name and address (if same as plan sponsor, enter"Same")

TENEBAUM & SAAS, P.C.
4504 WALSH STREET
SUITE 200
CHEVY CHASE MD 20815

Administrator's EIN
52-1964824

3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:

a Sponsor's name

4b EIN

4c PN

5	Total number of participants at the beginning of the plan year	5	25
6	Number of participants as of the end of the plan year (welfare plans complete only lines **6a, 6b, 6c,** and **6d**)		
a	Active participants	6a	17
b	Retired or separated participants receiving benefits	6b	
c	Other retired or separated participants entitled to future benefits	6c	4
d	Subtotal. Add lines **6a, 6b,** and **6c**	6d	21
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	6e	
f	Total. Add lines **6d** and **6e**	6f	21
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	6g	19
h	Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	6h	1
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7	0

8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:

2E 2F 2G 2J 2K 2T 3D

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:

9a Plan funding arrangement (check all that apply)

(1) ☐ Insurance
(2) ☐ Section 412(e)(3) insurance contracts
(3) ☒ Trust
(4) ☐ General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

(1) ☐ Insurance
(2) ☐ Section 412(e)(3) insurance contracts
(3) ☒ Trust
(4) ☐ General assets of the sponsor

10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached,and, where indicated, enter the number attached (See instructions)

a **Pension Schedules**

(1) ☒ **R** (Retirement Plan Information)
(2) ☐ **MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information)- signed by the plan actuary
(3) ☐ **SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary

b **General Schedules**

(1) ☐ **H** (Financial Information)
(2) ☒ **I** (Financial Information – Small Plan)
(3) ☐ **A** (Insurance Information)
(4) ☐ **C** (Service Provider Information)
(5) ☐ **D** (DFE/Participating Plan Information)
(6) ☐ **G** (Financial Transaction Schedules)

RPC 69

October 20, 1989

PAYMENT OF CLIENT FUNDS TO MEDICAL PROVIDERS

Opinion rules that a lawyer must obey the client's instruction not to pay medical providers from the proceeds of settlement in the absence of a valid physician's lien.

Inquiry:

Attorney A represents Client C in a personal injury action. Client C directs Attorney A to seek the cooperation of various medical providers and to inform them that their fees will be paid from the proceeds of any settlement.

Attorney A writes the medical care providers and requests the medical records of Client C. He also requests a statement of charges from the medical providers. Subsequently, the medical providers send copies of Client C's account to Attorney A.

After settlement of the personal injury claim, Client C instructs Attorney A not to pay the medical providers, but to pay those sums directly to her. Client C claims she has a dispute with the medical providers as to the amount owed.

May Attorney A ethically refuse to pay the subject funds directly to Client C?

Would there be a different response to this question if Client C had never directed Attorney A to inform the medical providers that their fees would be paid following Client C's recovery in the personal injury action?

Opinion:

Rule 10.2(E) of the North Carolina Rules of Professional Conduct provides that, "[A] lawyer shall promptly pay or deliver to the client or to third persons as directed by the client the funds, securities, or properties belonging to the client to which the client is entitled in the possession of the lawyer." A lawyer is generally obliged by this rule to disburse settlement proceeds in accordance with his client's instructions. The only exception to this rule arises when the medical provider has managed to perfect a valid physician's lien. In such a situation the lawyer is relieved of any obligation to pay the subject funds to his or her client, and may pay the physician directly if the claim is liquidated, or retain in his or her trust account any amounts in dispute pending resolution of the controversy.

In those cases where the client has authorized the lawyer to represent to the medical provider that the provider's fees will be paid from the proceeds of settlement and thereafter forbids the lawyer to pay the physician, the lawyer is, as the client's agent and trustee of the client's funds, under an obligation to comply with the client's instructions. If the lawyer is of the opinion that he might thereby be facilitating his client's fraud, it would not be inappropriate for the lawyer to advise the medical provider of the client's change of heart in sufficient time for the medical provider to pursue any remedies it might have in anticipation of the disbursement of the settlement proceeds. See Rule 4(c)(4). Should no action be taken by the medical provider within a short specified time, the lawyer would then be obligated to comply with his or her client's instructions. See also *N.C. Baptist Hospitals v. Mitchell*, 323 N.C. 528 (1989).

RPC 75

October 20, 1989

DISBURSEMENT OF CLIENT FUNDS

Opinion rules that a lawyer may not pay his or her fee or the fee of a physician from funds held in trust for a client without the client's authority.

Inquiry:

Last year Lawyer L began representation of Ms. B for injuries she received in an automobile accident. Since that time Ms. B has failed to cooperate in the processing of her claim, has not given any response to numerous letters, has not returned telephone messages, and has not accepted a certified letter. Lawyer L feels that he is no longer in a position to provide representation to Ms. B based on her lack of cooperation.

The question which has arisen deals with a $353.00 balance which is maintained in the trust account on behalf of Ms. B. This represents a portion of the medical payments coverage which was received on behalf of Ms. B. Lawyer L generally obtains medical payments coverage for his clients as a courtesy with no deduction of legal fees. However, Lawyer L has spent a great deal of time on this case and feels that he should be entitled to some fee. Additionally, Ms. B has signed a doctor's lien in favor of Dr. K.

Lawyer L has on several occasions written Ms. B asking her to authorize him to disburse this amount to Dr. K for his outstanding expenses and to himself in payment for legal services performed. There has been no response. May Lawyer L ethically take a reasonable legal fee from this balance and forward the remainder to Ms. B's physician for his services?

Opinion:

No. Rule 10.2(E) of the Rules of Professional Conduct [Rule 1.15-2 of the Revised Rules] requires a lawyer holding client funds in trust to pay or deliver those funds only as directed by the client. In this case the client has evidently not offered any direction regarding the disbursement of the funds in question and Lawyer L should therefore continue to hold this money in trust. Although there would appear to be a valid physician's lien against some portion of the trust funds, Lawyer L should refrain from disbursing any money to Doctor K until he obtains his client's consent to pay some or all of the amount billed or is required to pay some liquidated amount by a valid court order. Any funds which are the subject of an ongoing dispute should be retained in trust.

RPC 125

January 17, 1992

DISBURSEMENT OF SETTLEMENT PROCEEDS

Opinion rules that a lawyer may not pay a medical care provider from the proceeds of a settlement negotiated prior to the filing of suit over his client's objection unless the funds are subject to a valid lien.

Inquiry:

Lawyer A represents a plaintiff in a personal injury action. During the course of settling the case, the attorney receives medical bills from medical care providers which treated the client for the personal injuries. Settlement is reached without the filing of a lawsuit. There is no dispute over the medical bills. The client instructs Lawyer A to pay all proceeds of the settlement over to her and to not pay the medical bills. The medical care providers have not taken the steps set forth in G.S. §44-49 to perfect the lien provided in that statute, but Lawyer A has actual notice of the bills (see G.S. §44-50). Does RPC 69 mandate that the attorney pay the settlement proceeds to the client rather than following the distribution scheme set forth in G.S. §44-50?

Opinion:

RPC 69 ruled that an attorney has an ethical obligation to disburse funds belonging to the client as instructed by the client in the absence of a valid lien in favor of a health care provider. Rule 10.2(e) [Rule 1.15-2 of the Revised Rules]. From the standpoint of the Rules of Professional Conduct, the situation is the same regardless of whether the case is settled before or after the initiation of litigation. The interpretation of G.S. §44-50 is beyond the purview of the ethics committee. Suffice it to say that if that statute has the effect of imposing a lien upon settlement proceeds in the hands of an attorney when the attorney has received actual notice of the medical care provider's claim and suit has not been filed, then the attorney may pay the medical care provider's undisputed claim in spite of his client's objection. If, on the other hand, a lien is not perfected by the attorney's acquisition of actual notice under such circumstances, the attorney would have to abide by the instructions of the client in regard to the disbursement of the proceeds of settlement.

RPC 228

July 26, 1996

Editor's Note: This opinion was originally published as RPC 228 (Revised).

INDEMNIFYING THE TORTFEASOR'S LIABILITY INSURANCE CARRIER FOR UNPAID LIENS OF MEDICAL PROVIDERS AS A CONDITION OF SETTLEMENT

Opinion rules that a lawyer for a personal injury victim may not execute an agreement to indemnify the tortfeasor's liability insurance carrier against the unpaid liens of medical providers.

Inquiry:

Attorney A represents Client A who was injured in an automobile collision caused by the negligence of Mr. X. Mr. X has liability insurance with Insurance Carrier. Attorney A negotiated a settlement of Client A's claim with Insurance Carrier for a sum certain. However, Insurance Carrier's settlement offer is conditioned upon the execution by Attorney A and Client A of an indemnity agreement in addition to the traditional general release. In the indemnity agreement, Attorney A would agree to indemnify Insurance Carrier against all claims Insurance Carrier might sustain as a result of any outstanding medical lien incurred by Client A as a result of the accident. The agreement requires Insurance Carrier to notify Attorney A of all medical provider claims or liens of which Insurance Carrier has actual or constructive knowledge. Is it ethical for Attorney A to sign the indemnity agreement as a part of the settlement of Client A's claim?

Opinion:

No. Rule 5.1(b) of the Rules of Professional Conduct . [Rule 1.7 of the Revised Rules]

RPC 231

October 18, 1996

Editor's Note: This opinion was originally adopted as RPC 231 (Revised).

COLLECTING A CONTINGENT FEE ON THE GROSS RECOVERY AND ON THE MEDICAL INSURANCE PROVIDER'S CLAIM

Opinion rules that a lawyer may not collect a contingent fee on the reimbursement paid to the client's medical insurance provider in addition to a contingent fee on the gross recovery if the total fee received by the lawyer is clearly excessive.

Inquiry #1:

Attorney A's contingent fee agreement with Client for representation in a personal injury case will pay Attorney A a fee of one-third of the gross recovery from the defendant plus whatever contingent legal fee may be provided by law for recovering and paying the claim for reimbursement of an insurance carrier or medical insurance program that paid some or all of the client's medical expenses. Is it ethical for a lawyer to collect a contingent fee on the gross recovery and an additional contingent fee for recovering and paying the claim of the medical insurance carrier or program?

Opinion #1:

No opinion is expressed as to whether a legal fee for collecting a medical insurance provider's claim for reimbursement is permitted by law. If such a fee is permitted by law, the collection of this fee in addition to the collection of a contingent fee on the gross recovery may render the lawyer's total fee for the representation of the client "clearly excessive" in violation of Rule 2.6(a) of the Rules of Professional Conduct [Rule 1.5 of the Revised Rules]. Whether the total fee is "clearly excessive" depends upon the facts and circumstances of the particular representation. "Contingent fees, like all legal fees, must be reasonable." RPC 35. Further, a lawyer may not charge a clearly excessive fee even though the fee may be recovered from an opposing party. RPC 196

Rule 2.6(b) [Rule 1.5 of the Revised Rules] provides that "[a] fee is clearly excessive when, after a review of the facts, a lawyer of ordinary prudence experienced in the area of law involved would be left with a definite and firm conviction that the fee is in excess of a reasonable fee." The rule then lists a number of factors to be taken into consideration in determining the reasonableness of a fee including the following:

(1) the time and labor required, the novelty and difficulty of the questions involved, and the skill requisite to perform the legal service properly;
…
(4) the amount involved and the results obtained;
(5) the time limitations imposed by the client or by the circumstances;
…

(7) the experience, reputation, and ability of the lawyer or lawyers performing the services; and
(8) whether the fee is fixed or contingent.

A lawyer may not know at the beginning of the representation whether collecting the additional fee will render the lawyer's total fee clearly excessive in violation of the rule. However, at the conclusion of the representation, the lawyer should examine the factors listed in Rule 2.6(b) to determine the reasonableness of the total fee. If the collection of the additional fee renders the total fee paid to the lawyer clearly excessive in light of these factors, the lawyer should reduce the fee paid by the client in an amount equivalent to the fee permitted by law for collecting and paying the claim of the medical insurance provider.

Inquiry #2:

At the beginning of the representation, should the lawyer disclose to the client the lawyer's intention to seek the fee from the medical insurance provider in addition to the contingent fee payable by the client on the gross amount of the recovery?

Opinion #2:

Yes, the fee arrangement should be fully explained to the client and the client should agree to the fee arrangement. See Rule 2.6 [Rule 1.5 of the Revised Rules] and comment.