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Obtaining Formal Waivers and Reductions of Liens for Medical Care

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As insurance companies, ERISA plans and hospitals become more aggressive about asserting lien claims against our clients' personal injury recoveries, it is more important than ever to understand the variety of defenses to such claims. This article examines the principal defenses to such lien claims that are available. Those which serve as complete defenses, and thereby justify a demand for a formal waiver, are covered first.

COMPLETE DEFENSES

(1) The Make Whole Rule

The most common complete defense to a lien claim is the make whole rule which developed as an equitable defense to subrogation claims. Under the rule, an insurance carrier seeking subrogation is denied any recovery until and unless the insured is made whole. The rule has been expanded to apply with equal force to reimbursement provisions. The case law is in accord that the rule can be waived by clear and concise language in the policy, contract or ERISA plan. Oddly enough, it is still very common to see insurance policies that do not properly waive the make whole rule. The effect of this is to totally defeat the claim if the amount of under-compensation to the injured victim is in excess of the reimbursement or subrogation claim. The leading cases on point in California are *Progressive West Insurance Co. v. Yolo County Superior Ct.* (2005) 135 Cal.App.4th 263 and *Sapiano v. Williamsburg National Insurance Co.* (1994) 28 Cal.App.4th 533. The Ninth Circuit has adopted the same rule in ERISA cases in *Barnes v. Independent Auto Assn. of CA H&B Plan* (9th Cir. 1995) 64 F.3d 1389. In *Chong v. State Farm Mutual Auto. Ins. Co.* (S.D. CA 2006) 428 F.Supp.2d 1136, the district court, applying California law under diversity jurisdiction, held that attorney's fees could be considered in making the make whole calculation. In *Allstate v. Superior Court* (2007) 151 Cal.App.4th 1512, the Fourth Appellate District rejected the *Chong* holding and held that, under the American rule requiring each party to bear his own attorney's fees, such fees could not be included in the calculation. However, the Supreme Court recently granted review in *Allstate* so it is not currently good law.

It appears that the make whole rule has survived the U.S. Supreme Court's decision in *Sereboff, infra*, allowing ERISA reimbursement liens to proceed in equity. *See, Providence Health System v. Bush* (2006) 428 F.Supp.2d 1226 (2006). [Author's Note: for a more in-depth discussion of this issue, see "Using the Make Whole Doctrine to Defeat Insurance Reimbursement Claims," CASD ***Trial Bar News***, Vol. 30, Issue 6, June/July 2007 at p. 5.]

(2) When Medical Expenses Are Not Recovered

In *Fitch v. Select Products* (2005) 36 Cal.4th 812, the California Supreme Court held that a Medi-Cal lien could not be asserted against the Medi-Cal recipient's heirs' recovery for wrongful death. Rather, a survival action, which was not pursued, would have been necessary to recover the decedent's final medical bills. Because the medical expenses were not, and could not, be recovered in the wrongful death action, the Medi-Cal lien for decedent's medical expenses could not attach to the heirs' wrongful death recoveries. This case could be argued in support of any situation in which the claims asserted by plaintiff did not legally allow for recovery of the damages sought by the lien claimant. In a wrongful death case, plaintiffs' attorneys should carefully evaluate likely recoveries, policy limits and other relevant factors before ever submitting any claim for damages that includes survival damages, such as medical expenses.

(3) Government Code §23004.1 Liens

Government Code §23004.1(a) allows a county authorized or required to provide medical care to patients "under circumstances creating a tort liability upon some third person to pay damages therefore" to "have the right to recover from said third person the reasonable value of the care... or be subrogated to any right ...that the injured...person...has against such third person...." Subsection (b) allows the county to enforce such rights in its own name or in the name of the injured person. In *City and County of San Francisco v. Sweet* (1995) 12 Cal.4th 105, the Supreme Court held that both plaintiff and defendant, along with their respective attorneys, were liable for not protecting the county's interest. The *Sweet* Court also held that there was no right to any common fund reduction because the county was to be considered a creditor. However, in a later case, *Mares v. Baughman* (2001) 92 Cal.App.4th 672, the court held that by its unambiguous terms, Gov't. Code §23004.1 provides a county with a **lien only on judgments and not settlements**. Therefore, a lien asserted under this section can be expunged on a motion when the case is resolved by settlement short of judgment. Obviously, this is a significant limitation since the vast majority of cases settle. The *Mares* rule would appear to be inapplicable where the county brings its own action under the statute.

(4) Third Party Liability Provision Misapplied to First Party Coverage

Notably, most insurance companies use "third party" liability language in their reimbursement provisions rather than using more comprehensive language that would reach first party benefits like UM/UIM. It appears that the reason for this may be California Insurance Code §10270.98 which prohibits a group plan from coordinating benefits with an individual insurance plan. Attempts by an insurance company to reach first party coverage with a third party reimbursement provision would likely be doomed to failure. Any such attempt would, at most, merely create an ambiguity that must be construed against the insurer. However, plaintiffs' attorneys should be aware that many ERISA plans have given themselves the power to interpret their plans, which power includes the power to construe any ambiguities in their own favor. Such plan provisions have been upheld by the federal courts in ERISA cases.

(5) Balance Billing Prohibitions

(a) Statutory

Federal law prevents balance billing in the Medicare, Medicaid (Medi-Cal), Social Security and Champus programs. Following is the authority for each: Medicare – 42 U.S.C. §1395cc(a)(1)(A); 42 Code of Federal Regulations §489.21(a); *Rybicki v. Hartley* (1st Cir. 1986) 792 F.2d. 260. Social Security – Same as Medicare plus *Holle v. Moline Public Hospital* (1984) 598 F.Supp.1017. Medi-Cal — *Olszewski v. Scripps Health* (2003) 30 Cal.4th 798, striking California

Welf. & Instit. Code §14124.791 under federal preemption doctrine; 42 Code of Fed. Regs. §447.15; 42 U.S.C. §1396a(a)(25)(C); Welf. & Instit. Code §14019.4. Additionally, prepaid health plans funded by Medi-Cal are barred from balance billing by virtue of Code of Regulations §53222(b). Champus — 32 Code of Fed. Regs. §199.6(a)(8).

State law also bars a medical provider contracting with a health care service plan (HMO, PPO) from billing the patient insured thereunder for any amounts owed, but not paid, by the plan. Calif. Health & Safety Code §1379.

(b) Contractual

In *Parnell v. Adventist Health Systems* (2005) 35 Cal.4th 595, the Supreme Court held that balance billing by a provider was prohibited when the underlying contract between the health insurance plan and the provider causes the patient's debt to be extinguished. This is the usual arrangement between plans and providers because plans do not want their insureds to be sued by the plan providers. However, the Supreme Court also offered dicta explaining that the balance billing would be permitted if the underlying contracts allowed it. Many health plans now purport to allow their providers to balance bill their insureds. However, it is believed that these same health plans likely retain the power to prevent their providers from suing their insureds.

(6) ERISA Liens

A potential complete defense is available in ERISA claims that was not resolved by the Supreme Court's decision in *Sereboff, infra*: whether any fraud or wrongdoing on the part of the plan participant was necessary to impose a constructive trust or equitable lien. This issue was resolved in the participant's favor by the Ninth Circuit in *Carpenter's Health & Welfare Trust v. Vonderharr* (2004) 384 F.3d 667, 672, cert. denied (2005) 126 S. Ct. 729 as follows: "The remedies of restitution and the imposition of a constructive trust are available under §1132(a)(3), but only as true equitable remedies and provided the traditional requirements of fraud or wrong-doing are satisfied." The issue of whether the Ninth Circuit's ruling survives the *Sereboff* decision is unsettled, but the argument has been used to good effect in negotiating ERISA liens. Another potential complete defense exists when the plan does not sue the person or entity holding the funds or the funds have been dissipated so that there is no res remaining against which a constructive trust or equitable lien could attach. See, *Great West Life & Annuity Ins. Co. v. Knudson* (2002) 534 U.S. 204.

(7) Hospital Liens Subject to a Complete Substantive Defense

Notably, Civil Code §3045.4 limits a hospital to enforcing liens to amounts "which the hospital was **entitled to receive as payment** for the medical care and services rendered to the injured person." [Emphasis supplied.] Consequently, any substantive defense to the hospital's underlying claim is equally a complete defense to the hospital lien. Thus, for example, when a hospital serves a lien after taking Medicare or Medi-Cal or Champus, or the balance billing is prohibited by virtue of Health & Safety Code §1379 or by contract with a health plan, a complete defense to the hospital lien exists.

(8) Improperly Perfected Hospital Liens

The Hospital Lien Act ("HLA") at Civil Code §3045.1 *et seq*. provides that hospital liens shall not be effective unless they are properly served on the appropriate parties with the information required by the statute **before** the plaintiff or his attorney receives any funds from the case. When the lien is served late or improperly, or does not contain the requisite information, the lien is invalid. Unless there is substantial compliance with the HLA, these failures should constitute a complete defense to the hospital lien. However, the fact that the lien is invalid does not affect the hospital's rights as a creditor. Pursuant to dicta in *Mercy Hospital and Medical Center v. Farmers Ins. Grp.* (1997) 15 Cal.4th 213, the hospital can enforce its hospital lien for the maximum amount due under the HLA and then file suit for the balance as a creditor (unless the hospital has surrendered its rights by law or

contract). Consequently, attorneys negotiating to pay a hospital lien should attempt to get a full release on behalf of the client to avoid this problem.

USING THE CALIFORNIA CONSUMER LEGAL REMEDIES ACT TO OBTAIN FORMAL WAIVERS

When a complete defense exists to an asserted claim of lien and federal preemption does not apply, the Consumer Legal Remedies Act ("CLRA", Civil Code §§1750, *et seq.*) can be very useful in seeking a formal waiver of the lien claim. [Author's Note: Even in a federal ERISA plan, if it is an insured plan, California law applicable to insurers will apply by virtue of the "savings clause" in the ERISA preemption provision, 29 U.S.C. §1144.] Section 1770(a)(14) of the CLRA defines as an "unfair or deceptive act" conduct "Representing that a transaction confers ... rights, remedies...which it does not have... ." Thus, when a legal defense exists under state law, but the plan is still asserting reimbursement to which it knows it is not entitled, a violation of CLRA may exist.

Among the various benefits available under CLRA are mandatory attorney's fees to a prevailing plaintiff [§1780(d)], availability of punitive damages [§1780(a)(4)], and simplified class action procedures [§1781]. No action may be brought under the CLRA unless a demand to cease and desist is served by certified or registered mail and the offending party has not agreed to do so within a 30 day "safe harbor" period under Section §1782. This provision likely accounts for the scarcity of cases properly filed under the CLRA. However, if plaintiff's attorney is seeking to obtain a formal waiver of an improper lien, the statute is ideally suited for that purpose. The attorney should be sure to comply with all procedural aspects of the demand in order to preserve the right to proceed under the statute when no formal waiver is forthcoming.

PARTIAL DEFENSES

There are also a large number of significant partial defenses with which attorneys should be conversant in the event that a total defense does not exist. Following are the most significant.

(1) *Ahlborn* Reduction

In *Arkansas DHHS v. Ahlborn* (2006)126 S. Ct. 1752, the Supreme Court held that a state Medicaid lien asserted under federal law (virtually identical to Medi-Cal) extended only to the amount of the recipient's recovery for medical care, holding that "the statute does not sanction an assignment of rights to payment for anything other than medical expenses—not lost wages, not pain and suffering..." In *Ahlborn*, there was a stipulation that the Medicaid recipient was 5/6 at fault. As a result, the Court held that DHHS could recover only 1/6 of its statutory lien. In California, the *Ahlborn* decision has been codified at Welf. & Instit. Code §14124.76(a)-(d). Although the actual holding applies only to Medicaid cases, the rationale of the Court is useful in any case in which a full recovery was not obtained.

(2) *Sereboff* Title Argument

In *Sereboff v. Mid Atlantic Medical Services* (2006) 126 S. Ct. 1869, the Supreme Court upheld an ERISA plan's action for constructive trust and equitable lien to obtain reimbursement from a plan member's injury case. In doing so, the Court relied heavily on *Barnes v. Alexander* (1914) 232 U.S. 117, as authority for the proposition that Mid Atlantic could impose a constructive trust or equitable lien on the proceeds of the lawsuit as soon as the proceeds reached the Sereboffs' hands. The Court cited Justice Holmes' opinion in *Barnes, supra*, for "'the familiar rule of equity that a contract to convey a specific object even before it is acquired will make the contractor a trustee as soon as he gets a title to the thing.'" *Id*. at 620, 623, quoting from 232 U.S. at 121. This portion of the *Barnes* holding was considered so controlling that it was quoted 2 ½ times in the decision. Thus, when an injured ERISA participant **does not recover title** to most of his medical expenses by virtue of policy limits, causation, comparative negligence, statutory restrictions, or any other limitations, one can

effectively make this argument for a substantial reduction. The argument is identical to one for equitable apportionment under state law, but without the need to show procedural and substantive unconscionability. For a more detailed discussion of *Sereboff* and the title argument, see "Supreme Court Approves Enforcement of Reimbursement Provisions in ERISA Plans" CASD ***Trial Bar News***, Vol. 29, Issue 7, August/September 2006 at p. 5.

(3) Civil Code §3040

Civil Code §3040 applies to claims for reimbursement made by licensees of the Department of Insurance as well as the Department of Managed Care (HMO's, PPO's). It limits the maximum recovery of a lien claimant to 1/3 of the gross recovery when an attorney is retained (50% when there is no attorney). It also applies the common fund reduction to these claims. It further provides for a reduction when there is a final award by a court or arbitrator, apportioning comparative fault to the plaintiff. Note that Civil Code §3040 will apply to insured ERISA plans (but not self-funded plans) by virtue of the insurance savings clause in the ERISA preemption provision. 29 U.S.C. §1144.

(4) Common Fund

Common fund is an equitable doctrine requiring one who benefits from another's efforts in creating a fund to share in the attorney's fees and costs entailed. It is frequently recognized by statute, as in Civil Code §3040 above. Both Medicare and Medi-Cal statutes also authorize common fund reductions, although Medi-Cal is limited by statute to 25%. The common fund defense does not apply to any entity that is a creditor because a creditor's rights are independent of the creation of any fund. The trend among ERISA plans is to attempt to contractually waive the common fund doctrine in the plan. There is virtually no authority addressing whether such a waiver will be effective.

(5) Hospital Liens

Hospital liens are limited by virtue of the statute to 50% of the gross after paying prior liens. See Civil Code §3045.4. In the normal case, when the attorney is retained before the hospital lien is served, the attorney's fee lien is such a prior lien. *See, County of San Bernardino v. Calderon* (2007) 148 Cal.App.4th 1103. In many cases, the fact of the prior attorney's fee lien may seem to operate like the common fund. However, it is important to note that the hospital, as a creditor, can enforce the hospital lien and then sue the client for the balance of its bill. *See, Mercy Hospital & Med. Ctr. v. Famers Ins. Grp.* (1997) 15 Cal.4th 213. For this reason, it is important to attempt to get a full release if paying anything on a hospital lien. Of course, if the hospital has surrendered its rights to balance bill by contract or statute, the debt is extinguished and will not support any further claim. *See, Parnell, supra.*

(6) Health & Safety Code §127400

In 2007, the legislature passed Health & Safety Code §127400, which limits a "self-pay patient" with family income no greater than 350% of the federal poverty level to paying no more in hospital bills than the greater of the applicable Medicare, Medi-Cal or Health Families rate. Obviously, this would substantially discount any hospital's bill. By its terms, the statute does not apply to cases in which there is health insurance from any source or tort liability covered by insurance ("and whose injury is not a compensable injury for purposes of worker's compensation, automobile insurance, or other insurance... .") *See,* Health & Safety Code §127400(f). The statute does not quantify the level of insurance and, therefore, it is undetermined whether the statute could apply to hospital bills above the available insurance policy limits.