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Lies, Liens & Loopholes

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This paper is a brief review of a few of the issues we will cover during our presentation.

I. FEDERAL SUPER LIENS

There are federal statutes that may allow the government to seek reimbursement from tortfeasors and their insurers in contested liability cases — the Medicare Secondary Payer Statute (“MSPS”) and the Medical Care Recovery Act (“MCRA”).

A. The controlling language in the Statutes

1. MSPS

The applicable MSPS language states, in pertinent part, as follows:

(A) In general

Payment under [the Medicare program] may not be made, except as provided in subparagraph B, with respect to any item or service to the extent that —

- (i) payment has been made, or can be reasonably be expected to be made, with respect to the item or service, as required under [a group health plan or large group health plan], or
- (ii) payment has been made or can reasonably be expected to be made under a workmen’s compensation law or plan of the United States or a State or under an automobile or liability insurance policy or plan (including a self-insured plan) or no fault insurance.

In this subsection, the term "primary plan" means a group health plan, to the extent that clause (i) applies, and a workmen’s compensation law or plan an automobile or liability insurance policy or plan (including a self-insured plan) or no fault insurance, to the extent that clause (ii) applies.

(B) Repayment required

(ii) Primary plans

A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this subchapter with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan’s responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient’s compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan’s insured, or by other means. If

reimbursement is not made to the appropriate Trust Fund before the expiration of the 60-day period that begins on the date notice of, or information related to, a primary plan's responsibility for such payment or other information is received, the Secretary may charge interest (beginning with the date on which the notice or other information is received) on the amount of the reimbursement until reimbursement is made (at a rate determined by the Secretary in accordance with regulations of the Secretary of the Treasury applicable to charges for late payments).

(iii) Action by United States

In order to recover payment under this subchapter for such an item or service, the United States may bring an action against any entity which is required or responsible . . . to make payment with respect to such item or service . . . under a primary plan (and may, in accordance with paragraph (3)(A) collect double damages against that entity) . . . ¹

2. MCRA

The MCRA states, in relevant part, that where the government provides medical care to a person who is injured "under circumstances creating a tort liability upon some third person," the government has the right to recover from the third person, or that person's insurer, the reasonable value of the care and treatment furnished.²

B. The Fifth Circuit's original interpretation of the MSPS

In *Thompson v. Goetzmann*,³ the Fifth Circuit denied the government's attempt to seek reimbursement against a defendant tortfeasor, a manufacturer of a hip replacement prosthesis, after Medicare paid for two hip replacement surgeries on behalf of a Medicare recipient. There, the Medicare recipient sued the manufacturer for personal injuries caused by a hip replacement prosthesis. The manufacturer settled the Medicare recipient's claim, but did not reimburse Medicare. Thereafter, the government sued the manufacturer under the MSPS, claiming that it was entitled to reimbursement for the medical care it had paid on behalf of the recipient. The manufacturer moved to dismiss the government's action, arguing that it was not a "primary plan" as that term is used in the MSPS. The trial court agreed with the manufacturer and dismissed the government's action for reimbursement. The government appealed.

The central issue on appeal was whether the manufacturer met the definition of a "primary plan" under the MSPS.⁴ According to the Fifth Circuit, the definition of a "primary plan" essentially has two elements. First, the Medicare recipient must have a source of insurance under which they are entitled to payment for medical expenses, such as a group health insurance

¹ 42 U.S.C. § 1395y(b)(2)(A)(ii), and (b)(2)(B)(ii)-(iii). Section (3)(A) of the MSPS provides a private cause of action to the United States to seek double the amount of its lien against a primary plan.

² 42 U.S.C. § 2651(a).

³ 315 F.3d 457 (5th Cir. 2002).

⁴ *Id.* at 462

plan, a worker's compensation, liability insurance, or a self-insurance plan.⁵ Second, that source of insurance must reasonably be expected to pay for a recipient's medical services "promptly".⁶ "Promptly" is defined in the regulations as payment being made within 120 days after the earlier of: (1) the date the claim is filed; (2) the date the service was provided; or (3) the patient was discharged from the hospital.⁷

The Fifth Circuit opined that the MSPS did not apply to the manufacturer because, among other reasons, the manufacturer (tortfeasor) could not satisfy the second element of the definition of a "primary plan".⁸ Interpreting the prior version of the MSPS in place in 2003, which still included the term "promptly," the Fifth Circuit reasoned that a defendant tortfeasor, like the manufacturer, could not be expected to promptly pay for the Medicare recipient's medical expenses — especially in a contested liability suit.⁹ Accordingly, the Fifth Circuit upheld the district court's holding that the prompt payment requirement in the MSPS was a valid basis for precluding *per se* liability for an alleged tortfeasor.¹⁰

But, the Fifth Circuit later amended the *Thompson* opinion and deleted the discussion of the prompt payment requirement in the MSPS.¹¹ On petition for rehearing, the government argued that the Fifth Circuit's interpretation of "primary plan" in the MSPS would produce an absurd result.¹² The government reasoned that, although the MSPS seeks to protect Medicare's right to reimbursement in virtually all situations where there is other insurance, the Fifth Circuit's prompt payment requirement that it read into the definition of "primary plan" would preclude Medicare's right to reimbursement in cases where liability is disputed, a result not contemplated by the MSPS. The Fifth Circuit conceded that its interpretation was inconsistent with the statute's purpose.¹³ But the Fifth Circuit remained convinced that the plain terms of the MSPS require an expectation of prompt payment before Medicare is entitled to reimbursement from a primary plan under the MSPS.¹⁴

C. The District Court for the Eastern District of Virginia and the Road to the Statutory Change regarding Prompt Payment Requirement

A case out of the Eastern District of Virginia — *Brown v. Thompson*¹⁵ — correctly construed the terms of the MSPS in favor of allowing reimbursement in disputed liability situations. There, a Medicare recipient received a medical malpractice settlement from a self-insured health care provider. The settlement came well after Medicare paid for the recipient's medical expenses. Medicare sought reimbursement from the settlement, but the recipient disputed Medicare's right to reimbursement.

⁵ *Id.* at 462.

⁶ *Id.*

⁷ *Id.*

⁸ *Id.* at 467-468.

⁹ *Id.*

¹⁰ *Id.*

¹¹ *Thompson v. Goetzmann*, 337 F.3d 489 (5th Cir. 2003).

¹² *Id.* at *3.

¹³ *Id.*

¹⁴ *Id.* at *3.

¹⁵ 252 F. Supp. 2d 312 (E.D. Va. 2003).

The recipient filed a declaratory judgment, seeking a declaration that Medicare did not have a right to reimbursement. One of the issues in the declaratory judgment was identical to the issue in *Thompson* — does the definition of "primary plan" in the MSPS require a prompt payment before Medicare is entitled to reimbursement? The recipient argued that it did, and Medicare argued that it did not.

The recipient hinged her argument on the reference in subparagraph B to subparagraph A where the "prompt" payment language is found.¹⁶ Specifically, subparagraph B states that Medicare payments subject to reimbursement are those "with respect to any item or service to which subparagraph A applies."¹⁷ The recipient argued that Medicare is entitled to reimbursement for only those payments under subparagraph A that are reasonably expected to be made promptly — within 120 days.¹⁸ Because payment of her settlement was not made promptly, the recipient argued that the MSPS reimbursement provisions in subparagraph B did not apply.¹⁹

The court disagreed with the recipient's interpretation of the MSPS. The court explained that the reference in subparagraph B to subparagraph A was meant to define the universe of reimbursable payments to consist of those where a primary plan exists.²⁰ "Any other construction of this phrase in subparagraph B results in effectively and nonsensically shrinking the universe of reimbursable payments to a nearly null set, a result clearly contrary to the statute's purpose."²¹ The court explained that the recipient's construction of the MSPS would impermissibly eliminate Medicare's right to reimbursement under the MSPS in cases where liability is disputed and there is insurance available to cover the recipient's damages. The court explained that prompt payment is typically never expected from the defendant tortfeasor in those situations.²² The court then concluded that the phrase "reasonable expected to be made promptly" in subparagraph A of the MSPS is to ensure that needed Medicare payments are not delayed to the detriment of a Medicare beneficiary — nothing more and nothing less — and that it was not meant to place a condition on Medicare's right to reimbursement under subparagraph B.²³

In coming to its conclusion, the court criticized the Fifth Circuit's analysis utilized in *Thompson* and another case that construed the "prompt" payment provision in subparagraph A as a condition to Medicare's right of reimbursement. The court opined that the Fifth Circuit mistakenly focused too narrowly on the prompt payment requirement, "thereby failing adequately to consider both the practical effect of [its] interpretation of the MSPS and the fact [its] interpretation is flatly contrary to the statute's purpose of making Medicare a secondary payer when there is a primary plan responsible for payment."²⁴ The court reasoned that, if the

¹⁶ *Id.* at 318.

¹⁷ *Id.*

¹⁸ *Id.*

¹⁹ *Id.*

²⁰ *Id.*

²¹ *Id.*

²² *Id.*

²³ *Id.* at 319.

²⁴ *Id.*

subparagraphs are to be read together and as complementary provisions, then the prompt payment requirement should be limited to its appropriate role of ensuring that Medicare payments are not delayed.²⁵ The Court accordingly held that a prompt payment from a primary plan was not a condition on Medicare's right to reimbursement, and that Medicare was entitled to reimbursement when other insurance was responsible for a Medicare recipient's medical expenses.²⁶

Thereafter as noted in *Brown v. Thompson*,²⁷ on December 8, 2003, the President signed into law amendments to MSPS designed to resolve this dispute. See Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub.L. No. 108-173, § 301, 117 Stat.2066, 2221 (2003). The amendment to MSPS removed the two elements that had resulted in these conflicting interpretations, i.e., the word "promptly" in subparagraph (A)(ii) and the cross-reference to subparagraph (A) in paragraph (B)(i). So the MSPS now clearly provides that the reasonable expectation of a prompt payment is not a requirement for reimbursement. MSPS now states unequivocally that "[a] primary plan, and an entity that receives payment from a primary plan, shall reimburse" Medicare for any payment made by Medicare "with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service." § 1395y(b)(2)(B)(ii). It further states that "[a] primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means."

D. MCRA's Impact Coupled with MSPS

The MCRA gives the government a right to seek reimbursement from a tortfeasor and the insurer when it provided or paid for medical expenses.²⁸ Thus, despite the application of the MSPS, an insurer could potentially be liable under the MCRA if it does not protect Medicare's right to reimbursement. Second, the MSPS allows the government to seek double damages and interest damages against an insurer who fails to reimburse the government. In fact, the U.S. Department of Justice recently filed a suit on this precise issue in the United States District Court for the Northern District of Alabama. In *U.S. v. Stricker*, Civil Action No. 1:09-cv-02423-KOB, several attorneys, corporations and insurers settled a large class action involving 907 Medicare beneficiaries, but the payments were not reimbursed. The class action was settled for approximately \$300 million and the DOJ is now seeking double damages against all parties as a result of the failure to reimburse Medicare.

E. What does an insurer do in a *Stowers* situation?

There are at least three viable options available to an insurer in a *Stowers* situation when a Medicare lien is involved. First, an insurer can require that plaintiff's counsel provide a release of an insurer by Medicare and its insured from liability for reimbursement under the MSPS prior

²⁵ *Id.* at 319-320.

²⁶ *Id.* at 320.

²⁷ 374 F. 3d 253 (4th Cir. 2004).

²⁸ *Id.* at 3(a).

to issuing the settlement check. Second, it can have defense counsel obtain a release from Medicare in exchange for placing the settlement funds into the registry of the court in an interpleader action. Third, the MCRA allows the government to intervene in a lawsuit to protect its lien.²⁹ In accordance with the statute, an insurer can ask the government to intervene and protect its interest.

These three options will probably facilitate settlement of both the third party's liability claim and the government's right to reimbursement. Traditionally, insurers have accepted a hold harmless/indemnity provision in a settlement with a plaintiff. But, this traditional arrangement could expose the insurer to liability under the MSPS. There is no exception in the MSPS that allows an insurer to make a payment and rely on an indemnity provision in a settlement agreement to avoid liability under the MSPS. Given the stiff penalties for violating the MSPS, insurers should not rely merely on a hold harmless/indemnity provision in a settlement with a plaintiff without taking additional steps to ensure compliance with the MSPS.

There are four requirements that a plaintiff must meet to trigger an insurer's duty under the *Stowers* doctrine: (1) the policy covers the claim; (2) the insured's liability is reasonably clear; (3) the claimant has made a proper settlement demand within policy limits; and (4) the demand's terms are such that an ordinarily prudent insurer would accept it.³⁰ A proper settlement demand under the *Stowers* doctrine generally must propose to release the insured fully in exchange for an offer within policy limits.³¹

The third and fourth elements of the *Stowers* doctrine arguably have not been met if there is a Medicare lien and no full release is offered. The claimant has to allow Medicare's lien to be satisfied in order to trigger *Stowers*.

Next, an ordinarily reasonable prudent insurer arguably would not issue payment in accordance with the terms of a *Stowers* demand if the offer carried the risk of further liability because the offer did not fully release the insured under the MSPS. And under the MSPS, the insured and the carrier run the risk of incurring damages twice the amount of Medicare's lien if it fails to reimburse Medicare. Moreover, the MCRA still imposes liability on the tortfeasor and the insurer when the government pays for a person's medical expenses. And the plaintiff cannot release the government's claim. Accordingly, an insurer can argue that an ordinarily prudent insurer would not accept a *Stowers* demand if it would still leave the insured and the carrier with potential exposure.

We can anticipate that the MSPS reimbursement scheme and *Stowers* will come into conflict. This conflict will raise a host of issues including possible preemption of the *Stowers* doctrine by the MSPS or the fleshing out of the *Stowers* elements to address the MSPS issue. It will, in all likelihood, be an issue to watch once the MSPS goes on-line.

²⁹ 42 U.S.C.A. § 2651 (d).

³⁰ *American Physicians Ins. Exch. v. Garcia*, 876 S.W.2d 842 (Tex. 1994).

³¹ *Texas Farmers Ins. Co. v. Soriano*, 881 S.W.2d 312, 314-15 (Tex. 1994); *Trinity Universal Ins. Co. v. Bleeker*, 966 S.W.2d 489 (Tex. 1998). (See also concerning the requirements of a valid release of a hospital lien.)

The Fifth Circuit has concluded that the government's right to reimbursement under the MCRA is not one for subrogation but, rather, an independent right to recovery.³²

The Seventh Circuit has concluded that the Medical Care Recovery Act confers on the United States an independent right of recovery that is not impaired by the limitations of state family immunity laws.³³ The Seventh Circuit did not, however, conclude that the Act requires an insurer to pay the government more than it is contractually obligated to pay. For example, whether the government is also attempting to seek reimbursement under the policy's personal injury protection ("PIP") coverage, there may be no available PIP coverage because the PIP limits were paid to the insured prior to the government's request for reimbursement. Similarly, under 10 U.S.C. § 1095 the government is only entitled to reimbursement "to the extent that the [beneficiary] would be eligible for reimbursement . . . if the person were to incur such charges on the person's own behalf."³⁴ Indeed, as the Seventh Circuit has noted, "the government's recovery is limited by co-insurance, deductibles, and policy limits which would limit the insured's recovery."³⁵

E. Miscellaneous Medical Issues

1. Medicare Allowed on settlement check

In *Texas Farmers Ins. Co. v. Fruge*³⁶, the court did find that the insurer breached its contract with the insured by including Medicare's name on settlement checks for over \$1000 in PIP benefits when there was evidence to show that Medicare had only made payment of \$168 for the insured. But, the court reformed the judgment in that case to permit the insurer to make one payment to Medicare and the insured for \$168, and thus permit the insurer to pay the remainder of the PIP benefits only to the insured. In *Lewis v. Allstate Ins. Co.*,³⁷ the court made the statement that there is "no requirement pursuant to the law for an insurance company to independently obtain the amount of Medicare's lien prior to issuing a draft for policy benefits," and upheld Allstate's payment of the UM settlement check to the insured, the insured's attorney, and Medicare as co-payees to be proper – even when the amount of the Medicare claim was unknown.

2. Reimbursement for related medical claims only

The carrier is only required to reimburse Medicare for related Medicare claims. *Denekas v. Shalala*³⁸, provides that settlement proceeds for parental loss of consortium claims were free from Medicare's right of reimbursement. The court in that case found that Medicare does not have the right to obtain such reimbursement from claimants who are not Medicare beneficiaries and whose claims are not for medical services to the beneficiary. In that case, the court determined that there was no dispute concerning the reasonableness of the loss of consortium

³² *United States v. Haynes*, 445 F.2d 907, 909-10 (5th Cir. 1971).

³³ *United States v. Moore*, 469 F.2d 788, 790 (7th Cir. 1972).

³⁴ See also 32 C.F.R. § 220.4(a).

³⁵ *United States v. United Servs. Auto. Ass'n*, 5 F.3d 204, 206 n.2 (7th Cir. 1993) (emphasis added).

³⁶ 13 S.W.3d 509 (Tex.App. — Beaumont 2000, pet. denied).

³⁷ 2006 WL 665790 (Tex.App. — Beaumont March 16, 2006, no pet.)

³⁸ 943 F. Supp. 1073 (S.D. Iowa 1996).

claims. The *Denekas* case also references a Fifth Circuit case, *Waters v. Farmers Texas County Mut. Ins.*³⁹, which, though not as detailed as *Denekas*, seems to further support the position that Medicare's right to reimbursement would not attach to claims not related to the medical expenses it paid.

II. OTHER FEDERAL LIENS

A. IRS Liens

In the United States, a federal tax lien may arise in connection with any kind of federal tax, including but not limited to income tax, gift tax, or estate tax.

1. Federal tax lien basics

Internal Revenue Code section 6321 provides:

Sec. 6321. LIEN FOR TAXES.

If any person liable to pay any tax neglects or refuses to pay the same after demand, the amount (including any interest, additional amount, addition to tax, or assessable penalty, together with any costs that may accrue in addition thereto) shall be a lien in favor of the United States upon all property and rights to property, whether real or personal, belong to such person.

Internal Revenue Code section 6322 provides:

Sec. 6322. PERIOD OF LIEN.

Unless another date is specifically fixed by law, the lien imposed by section 6321 shall arise at the time the assessment is made and shall continue until the liability for the amount so assessed (or a judgment against the taxpayer arising out of such liability) is satisfied or becomes unenforceable by reason of lapse of time.

The term "assessment" refers to the statutory assessment made by the Internal Revenue Service (IRS) under 26 U.S.C. § 6201 (that is, the formal recording of the tax in the official books and records at the office of the Secretary of the U.S. Department of the Treasury). Generally, the "person liable to pay any tax" described in section 6321 must pay the tax within ten days of the written *notice and demand*.⁴⁰ If the taxpayer fails to pay the tax within the ten day period, the tax lien arises automatically (i.e., by operation of law), and is *effective retroactively to (i.e., arises at) the date of the assessment*, even though the ten day period necessarily expires after the assessment date.

Under the doctrine of *Glass City Bank v. United States*,⁴¹ the tax lien applies not only to property and rights to property owned by the taxpayer at the time of the assessment, but also to after-acquired property (i.e., to any property owned by the taxpayer during the life of the lien).

The statute of limitations under which a federal tax lien may become "unenforceable by reason of lapse of time" is found at 26 U.S.C. § 6502. For taxes assessed on or after November 6, 1990, the lien generally becomes unenforceable ten years after the date of assessment. For taxes

³⁹ 9 F.3d 397 (5th Cir. 1993).

⁴⁰ See 26 C.F.R. section 601.103(a).

⁴¹ 326 U.S. 265 (1945).

assessed on or before November 5, 1990, a prior version of section 6502 provides for a limitations period of six years after the date of assessment. Various exceptions may extend the time periods.

2. Perfection of federal tax liens against third parties (the Notice of Federal Tax Lien)

A federal tax lien arising by law as described above is valid against the taxpayer without any further action by the government.

The general rule is that where two or more creditors have competing liens against the same property, the creditor whose lien was perfected at the earlier time takes priority over the creditor whose lien was perfected at a later time (there are exceptions to this rule). Thus, if the government (which is treated as a "creditor" with respect to unpaid taxes) properly files a Notice of Federal Tax Lien (NFTL) before another creditor can perfect its own lien, the tax lien will often take priority over the other lien.

To "perfect" the tax lien (to create a priority right) against persons other than the taxpayer (such as competing creditors), the government generally must file the NFTL in the records of the county or state where the property is located, with the rules varying from state to state. At the time the notice is filed, public notice is deemed to have been given to the third parties (especially the taxpayer's other creditors, etc.) that the Internal Revenue Service has a claim against all property owned by the taxpayer as of the assessment date (which is generally prior to the date the NFTL is filed), and to all property acquired by the taxpayer after the assessment date. (As noted above, the lien attaches to all of a taxpayer's property such as homes, land and vehicles and to all of a taxpayer's rights to property such as promissory notes or accounts receivable.) Although the federal tax lien is effective against the taxpayer on the assessment date, the *priority* right against third party creditors arises at a later time: the date the NFTL is filed. The form and content of the notice of federal tax lien is governed only by federal law, regardless of any requirements of state or local law.⁴²

3. Subsequent liens taking priority over previously filed federal tax liens

In certain cases, the lien of another creditor (or the interest of an owner) may take priority over a federal tax lien even if the NFTL was filed before the other creditor's lien was perfected (or before the owner's interest was acquired). Some examples include the liens of certain purchasers of securities, liens on certain motor vehicles, and the interest held by a retail purchaser of certain personal property.

Federal law also allows a state—if the state legislature so elects by statute—to enjoy a higher priority than the federal tax lien with respect to certain state tax liens on property where

⁴² U.S. Const., art. VI, cl. 2; And this: "The form and content of the notice referred to in subsection (a) shall be prescribed by the Secretary [of the Treasury or his delegate]. Such notice shall be valid notwithstanding any other provision of law regarding the form or content of a notice of lien" (see 26 U.S.C. § 6323(f)(3)). And, from the U.S. Treasury regulations: "(d) [. . .] (1) In general. —The notice referred to in §301.6323(a)-1 shall be filed on Form 668, 'Notice of Federal Tax Lien under Internal Revenue Laws. Such notice is valid notwithstanding any other provision of law regarding the form or content of a notice of lien. For example, omission from the notice of lien of a description of the property subject to the lien does not affect the validity thereof even though State law may require that the notice contain a description of the property subject to the lien.'" See 26 C.F.R. sec. 301.6323(f)-1(d)(1).

the related tax is based on the *value of that property*. For example, the lien based on the annual real estate property tax in Texas takes priority over the federal tax lien, even where an NFTL for the federal lien was recorded prior to the time the Texas tax lien arose, and even though no notice of the Texas tax lien is required to be filed or recorded at all.

4. Certificate of release of federal tax lien

In order to have the record of a lien released a taxpayer must obtain a Certificate of Release of Federal Tax Lien. Generally, the IRS will not issue a certificate of release of lien until the tax has either been paid in full or the IRS no longer has a legal interest in collecting the tax. The IRS has standardized procedures for lien releases, discharges and subordination. In situations that qualify for the removal of a lien, the IRS will generally remove the lien within 30 days and the taxpayer may receive a copy of the Certificate of Release of Federal Tax Lien. The current form of the Notice of Federal Tax Lien utilized by the IRS contains a provision that provides that the NFTL is released by its own terms at the conclusion of the statute of limitations period described above provided that the NFTL has not been refiled by the date indicated on the form. The effect of this provision is that the NFTL operates as a Certificate of Release of Federal Tax Lien on the day after the date indicated in the form by its own terms.

5. The difference between a federal tax lien and an administrative levy

The creation of a tax lien, and the subsequent issuance of a Notice of Federal Tax Lien, should not be confused with the issuance of a Notice of Intent to Levy under 26 U.S.C. § 6331(d), or with the actual act of levy under 26 U.S.C. § 6331(a). The term "levy" in this narrow technical sense denotes an *administrative action* by the Internal Revenue Service (i.e., without going to court) to seize property to satisfy a tax liability. The levy "includes the power of distraint and seizure *by any means*". The general rule is that no court permission is required for the IRS to execute a section 6331 levy.⁴³

In other words, the federal tax lien is the government's statutory right that encumbers property to secure the ultimate payment of a tax. The notice of levy is an IRS notice that the IRS intends to seize property in the near future. The levy is the actual act of seizure of the property.

In general, a Notice of Intent to Levy must be issued by the IRS at least thirty days prior to the actual levy. Thus, while a Notice of Federal Tax Lien generally is issued *after* the tax lien arises, a Notice of Intent to Levy (sometimes misleadingly called simply a "notice of levy") generally must be issued *before* the actual levy is made.

Also, while the federal tax lien applies to all property and rights to property of the taxpayer, the power to levy is subject to certain restrictions. That is, certain property covered by the lien may be *exempt* from an administrative levy. (Property covered by the lien that is exempt from administrative levy may, however, be taken by the IRS if the IRS obtains a court judgment.)

⁴³ See *United States v. Rodgers*, 461 U.S. 677, 103 S. Ct. 2132, 83-1 U.S. Tax Cas. (CCH) paragr. 9374 (1983) (dicta); see also *Brian v. Gugin*, 853 F. Supp. 358, 94-1 U.S. Tax Cas. (CCH) paragr. 50,278 (D. Idaho 1994), aff'd, 95-1 U.S. Tax Cas. (CCH) paragr. 50,067 (9th Cir. 1995). The IRS may, however, be required to obtain court permission in the case of bankruptcy; see 11 U.S.C. § 362.

A detailed discussion of the administrative levy, and the related Notice, is beyond the scope of this article.

In connection with federal taxes in the United States, the term "levy" also has a separate, more general sense of "imposed." That is, when a tax law is enacted by the Congress, the tax is said to be "imposed" or "levied."

6. The effect of an offer in compromise on the tax lien

A properly submitted offer in compromise does not affect a tax lien, which remains effective until the offer is accepted and the offered amount is fully paid. Once the compromised amount is paid, the taxpayer should request removal of the lien.

B. Veteran's Administration

Courts have recognized the right of the Veterans Administration to seek reimbursement for medical charges in connection with compensable disabilities.⁴⁴ The right to recover medical expenses by the United States Veterans Administration in workers' compensation claims is incorporated in the federal code.⁴⁵

C. Federal Worker's Compensation

Under the Federal Workers Compensation Act, 5 U.S.C. section 8101, et seq., employees of the United States are entitled to payment of medical and hospital expenses. The Act provided for express rights accorded to the United States to pursue repayment of any medical benefits paid to an injured employee from the third-party tortfeasor who caused the injury.⁴⁶

D. Longshoreman and Harbor Workers Act

Under the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. section 901, et seq., the lien of the insurance carrier or self-insured employer is repaid 100%, after the payment of attorney's fees and costs, before the injured worker receives any monies from the third-party recovery. At this point in time the insurance carriers' lien extends to the full recovery including general damages.

⁴⁴ *City of Bridgeport v. Barnes*, 591 S.W.2d 939 (Tex. Civ. App.—Fort Worth 1979, writ ref'd n.r.e.). But see *Pennsylvania Nat. Mut. Cas. Ins. Co. v. Barnett*, 445 F.2d 573 (5th Cir. 1971), (holding that VA lien not applicable where there was no assignment of claim.)

⁴⁵ "The United States has the right to recover or collect reasonable charges for such care or services (as determined by the Secretary) from a third party to the extent that the veteran (or the provider of the care or services) would be eligible to receive payment for such care or services from such third party if the care or services had not been furnished by a department or agency of the United States. . . this subsection applies to a non-service-connected disability. . . that is incurred incident to the veteran's employment and that is covered under a workers' compensation law or plan that provides for payment for the cost of health care and services provided to the veteran by reason of the disability. . ." 38 U.S.C.A. § 1729(a)(2)(A), "No law of any State. . . and no provision of any contract or other agreement. . . shall operate to prevent recovery or collection by the United States. . ." 38 U.S.C.A. § 1729(f).

⁴⁶ 5 U.S.C. § 8131.

III. ERISA

A. ERISA does not create a statutory lien for the benefit of an ERISA plan that has paid for medical care.

The Supreme Court has repeatedly observed that ERISA is a “ ‘comprehensive and reticulated statute,’ the product of a decade of congressional study of the nation’s private employee benefit system.”⁴⁷ The Supreme Court describes itself as “reluctant to tamper with [the] enforcement scheme” embodied in the statute by extending remedies not specifically authorized by its text.⁴⁸ By its own terms, ERISA does not provide for liens in favor of any ERISA plan’s efforts to recover funds expended on behalf of a plan beneficiary from third-party tortfeasors or liability insurers.

B. ERISA provides a framework for the recovery of funds expended on behalf of an ERISA-plan beneficiary that could be used to target insurance proceeds while still in the insurer’s possession.

1. Appropriate Equitable Relief

Under § 502(a)(3) of ERISA, an ERISA plan may seek “equitable relief.” The United States Supreme Court suggested in dicta in *Great-West Life & Annuity Insurance Company v. Knudson*, 534 U.S. 204, 213 (2002), that this might be accomplished through a constructive trust or an equitable lien. The difference being that a constructive trust entitles the ERISA plan to title to the property, but an equitable lien merely entitles the ERISA plan to a security interest.⁴⁹

Not surprisingly, ERISA plans moved to take advantage of the *Knudson* dicta and won recognition of a cause of action for equitable relief predicated upon a constructive trust in the Fifth Circuit in *Bombardier Aerospace Employee Welfare Benefits Plan v. Ferrer, Poirot, and Wansbrough*, 354 F.3d 348, 358 (5th Cir. 2003) (applying Texas law) *reh'g en banc denied, cert. denied*, 541 U.S. 1072 (2004). The Fifth Circuit upheld Bombardier Aerospace’s cause of action for a constructive trust over: (1) specifically identifiable funds; (2) in the constructive possession and legal control of the plan beneficiary; and (3) that belonged in good conscience to Bombardier Aerospace’s plan. The specifically identifiable funds had been obtained in a settlement agreement of the plan beneficiary’s personal injury action. The funds were placed in the plan beneficiary’s law firm’s trust account. Bombardier Aerospace filed suit against the law firm and the plan beneficiary before the funds were distributed, alleging a constructive trust under Texas law.⁵⁰

⁴⁷ *Mertens v. Hewitt Assoc.*, 508 U.S. 248, 251 (1993) (quoting *Nachman Corp. v. Pension Ben. Guar. Corp.*, 446 U.S. 359, 361 (1980)).

⁴⁸ *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 147 (1985).

⁴⁹ *Id.*

⁵⁰ While not necessary for this analysis, it should be noted that there is a split in the circuits regarding the availability of this type of equitable relief to an ERISA plan. For example, the Ninth Circuit in *Westaff (USA), Inc. v. Arce*, 298 F.3d 1164 (9th Cir. 2002) held that an ERISA plan was not entitled to recover from an injured beneficiary’s tort recovery because the action was legal in nature. *Id.* at 1167. The Ninth Circuit’s opinion appears to be completely at odds with the Supreme Court’s reasoning, although in dicta, in *Knudson*. The Fifth Circuit’s application of the constructive trust doctrine appears much more consistent with *Knudson*.

With the Supreme Court's suggestion of the appropriate test in *Knudson*, litigation in the lower courts has focused almost entirely on the second prong of the test – i.e., whether the funds are in the constructive possession and legal control of the plan beneficiary. While the ERISA plan in *Knudson* sought specific performance of its contractual-reimbursement provision, the court suggested that even if the ERISA plan had pled for proper equitable relief, the ERISA plan could not have shown that the beneficiary had constructive possession and legal control of the funds because the funds were placed in a medical needs trust over which the beneficiary had no control.⁵¹ Following this rationale, the Fifth Circuit has determined that:

- a settlement offer of policy limits, which was rejected by the beneficiary, were not funds in the beneficiary's constructive possession and legal control;⁵²
- an insurer's tender of policy limits to the registry of the court did not place the funds in the beneficiary's constructive possession and legal control;⁵³
- funds held in a beneficiary's lawyer's trust account meet all prongs of the *Knudson* test;⁵⁴
- funds held in a trust by a financial institution subject to Texas statutes controlling settlement funds received for the benefit of a minor meet all prongs of the *Knudson* test;⁵⁵
- an insurer's offer to tender policy limits that has not yet been accepted by the beneficiary does not meet the *Knudson* test.⁵⁶

The *Knudson* court also suggested that equitable liens might be available to an ERISA plan seeking to be reimbursed from its plan beneficiary's settlement proceeds.

Texas law recognizes a party's right to an equitable lien with regard to real property. An equitable lien is not an estate in the thing to which it attaches, but merely an encumbrance against the property to satisfy a debt.⁵⁷ An equitable lien arises when the surrounding circumstances indicate the parties to the transaction intended that certain property would secure the payment of a debt.⁵⁸ The fundamental element necessary to create an equitable lien is the

⁵¹ 534 U.S. at 215.

⁵² *Pan-American Life Ins. Co. v. Bergeron*, 82 Fed. Appx. 388, 392 (5th Cir. 2003) (focusing on the beneficiary's rejection of the settlement offer) (applying Louisiana law).

⁵³ *Bauhaus USA, Inc. v. Copeland*, 292 F.3d 439, 444 (5th Cir. 2002) (applying Mississippi law).

⁵⁴ *Bombardier*, 354 F.3d at 358; *IBEW-NECA Southwestern Health and Benefit Fund v. Gurule*, 337 F.Supp.2d 845, 849 (N.D.Tex. 2004) (applying New Mexico law); *IBEW-NECA Southwestern Health and Benefit Fund v. Douthitt*, 211 F.Supp.2d 812, 816 (N.D.Tex. 2002) (applying to UIM settlement).

⁵⁵ *Administrative Committee of Wal-Mart Stores, Inc. Associates' Health v. Degraffenried*, No. Civ.A.W-01-CA-236, 2004 WL 1987238 *3 (W.D.Tex. June 3, 2004) (applying Texas law).

⁵⁶ *Extendicare v. Crow*, No. Civ.A. 1:02-CV-109-C., 2002 WL 32079263 *4 (N.D.Tex. Oct 23, 2002) (applying Texas law).

⁵⁷ *Day v. Day*, 610 S.W.2d 195, 199 (Tex.Civ.App.—Tyler 1980, writ ref'd n.r.e.).

⁵⁸ *Bray v. Curtis*, 544 S.W.2d 816, 819 (Tex.Civ.App.—Corpus Christi 1976, writ ref'd n.r.e.).

existence of an express or implied contract.⁵⁹ It is not necessary that a lien is created by express contract or by operation of statute.⁶⁰ Courts of equity will apply the relations of the parties and the circumstances of their dealings in establishing a lien based on right and justice.⁶¹ Given Texas court's treatment of an equitable lien as an encumbrance against real property, it is unlikely that an ERISA plan could successfully pursue an equitable lien in light of *Knudson's* requirement that the funds be "specifically identifiable."

2. Applying the *Knudson* Test to an Insurance Claim

As the above cases illustrate, an insurer would need to do more than offer its policy limits or payment to subject itself to an equitable action by an ERISA plan for recovery of the insurance proceeds. While the courts have not held that an insurer can never meet the *Knudson* test, we have not found a case where a court has held an insurer subject to a constructive trust or equitable lien.

The only third parties that the courts have subjected to *Knudson* are those that owe a fiduciary obligation to the plan beneficiary – banks⁶² and lawyers.⁶³ In both instances, the courts have recognized that the fiduciary is actually an agent of the beneficiary and subject to the beneficiary's control. This "fiduciary" relationship, however, is not present in the insurer/insured, insurer/claimant context.

Moreover, the *Knudson* opinion can even be read to suggest that funds held by an insurance company are never within the beneficiary's constructive possession and legal control. In *Knudson*, the plan administrator sought to recover benefits paid to a beneficiary following the latter's receipt of settlement funds from a third-party tortfeasor.⁶⁴ The funds, however, had been placed in a Special Needs Trust for the beneficiary to provide for her medical care pursuant to California law.⁶⁵ The Supreme Court rejected the plan administrator's argument that it sought equitable relief under § 502(a)(3), stating that "the funds to which [the plan] claims an entitlement under the Plan's reimbursement provision ... are not in the [beneficiary's] possession."⁶⁶ As the plan essentially sought "the imposition of personal liability [upon the beneficiary] for the benefits" it had conferred, the Court held that its claim was legal, rather than equitable, in nature and thus fell outside the scope of relief authorized by § 502(a)(3).⁶⁷

This limitation on *Knudson* was completely ignored by the court in *Administrative Committee of Wal-Mart Stores, Inc. Associates' Health v. Degraffenried*, No. Civ.A.W-01-CA-236, 2004 WL 1987238 *3 (W.D.Tex. June 3, 2004) (applying Texas law). In that case, the funds were held in a trust by a financial institution subject to Texas statutes controlling

⁵⁹ *Id.*

⁶⁰ *First Nat'l Bank in Big Spring v. Conner*, 320 S.W.2d 391, 394 (Tex.Civ.App.—Amarillo 1959, writ ref'd n.r.e.).

⁶¹ *Id.*; *Bray*, 544 S.W.2d at 819.

⁶² *See, e.g., Administrative Committee of Wal-Mart Stores, Inc. Associates' Health v. Degraffenried*, No. Civ.A.W-01-CA-236, 2004 WL 1987238 *3 (W.D.Tex. June 3, 2004).

⁶³ *See, e.g., Bombardier*, 354 F.3d at 358; *Gurule*, 337 F.Supp.2d at 849; *Douthitt*, 211 F.Supp.2d at 816.

⁶⁴ *Knudson*, 534 U.S. at 208.

⁶⁵ *Id.* at 207-08.

⁶⁶ *Id.* at 214.

⁶⁷ *Id.*

settlement funds received for the benefit of a minor meet all prongs of the Knudson test.⁶⁸ The court did not give the same deference to the Texas statute controlling the disposition of recoveries benefiting a minor as the Supreme Court did the California statute providing for special needs trust for future medical costs. While the *Degraffenried* opinion is outside the well-reasoned approach presented in *Knudson*, it is the type of decision that can be expected in the judicially conservative Fifth Circuit.

Given the Fifth Circuit's willingness to go beyond *Knudson*, an insurer who is prepared to fund a settlement should avoid placing itself in a situation where the *Knudson* factors might be applicable. This could happen where an insurer and an ERISA-plan beneficiary have agreed that the funds need to be paid. If under those circumstances, the ERISA plan attempted to recover from the insurer, it might be able to successfully assert that all three prongs of the *Knudson* test have been met.

C. ERISA does not provide a remedy for an ERISA plan to pursue an insurer for funds paid subject to a claimant's first or third-party claim without taking into account the ERISA plan's claim.

ERISA § 502(a)(3) authorizes a civil action “by a ... fiduciary (A) to enjoin any act or practice which violates ... the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of ... the terms of the plan.” In *Mertens v. Hewitt Associates*, 508 U.S. 248, 256 (1993), the Supreme Court made clear that the term “equitable relief” in § 502(a)(3) referred only to “those categories of relief that were typically available in equity.” The court was forced to address what it meant by “equitable relief” in *Knudson*.

In *Knudson*, Janette Knudson, a beneficiary of an ERISA-governed employee welfare benefit plan, was injured in a car accident. The plan included a reimbursement provision. In particular, the Plan had “ ‘a first lien upon any recovery, whether by settlement, judgment or otherwise,’ that the beneficiary receives from the third party, not to exceed ‘the amount of benefits paid [by the Plan] ... [or] the amount received by the [beneficiary] for such medical treatment...’ ” According to this provision, the plan covered \$411,157.11 of Janette's medical expenses, of which all except \$75,000 was paid by Great-West.

Janette and her then-husband sued the Hyundai Motor Company (“Hyundai”), the manufacturer of the car in which they were riding when they were injured, and other tortfeasors. The parties negotiated a \$650,000 settlement which allocated \$256,745.30 to a Special Needs Trust to provide for Janette's medical care; \$373,426 to attorney's fees and costs; and \$13,828.70 to satisfy Great-West's claim under the plan's reimbursement provision. Accordingly, the tortfeasors paid the settlement money to the Special Needs Trust and gave the remainder to the Knudsons' attorney, who tendered a check in the amount of \$13,828.70 to Great-West. Instead of cashing its check, however, Great-West filed suit in the federal district court seeking declaratory and injunctive relief under ERISA § 502(a)(3) to enforce the

⁶⁸ *Id.*

reimbursement provision of the plan and recover from the settlement proceeds the \$411,157.11 it had advanced to Janette.

The Supreme Court held that ERISA did not authorize Great-West's suit. The Court found that Great West was not seeking "to enjoin any act or practice which violate [d] ... the terms of the plan" or "to obtain other appropriate equitable relief" under § 502(a)(3). The Court reasoned that Great-West essentially sought "to impose personal liability on [the Knudsons] for a contractual obligation to pay money-relief that was not typically available in equity."

The Court refused to accept Great-West's argument that the relief it sought met the *Mertens* standard. First, the Court rejected Great-West's contention that Great-West sought an injunction or specific performance to compel the Knudsons to repay the contested funds. The Court also held that the relief that Great-West sought did not constitute restitution *in equity*. Distinguishing restitution in equity from restitution at law, the Court defined restitution in equity as a "form of constructive trust or equitable lien, where money or property identified as belonging in good conscience to the plaintiff could clearly be traced to particular funds or property *in the defendant's possession*."

Based on the Court's reasoning in *Knudson*, a court should reject any attempt by an ERISA plan to impose personal liability upon an insurer for paying insurance proceeds to the plan beneficiary without accounting for the ERISA plan's alleged interest in the proceeds. This type of action would not be equitable in nature, meaning it would not meet ERISA's requirements as interpreted by the *Knudson* court.

There are several pending actions challenging this portion of *Knudson*. This is being actively litigated by ERISA-plan recovery agents across the country.

IV. ASSIGNMENTS

A. **The Simple Solution: An Insurer must recognize a valid assignment by its insured.**

It is black-letter insurance law that an insurer must comply with a valid and enforceable assignment. To fail to do so can subject an insurer to extra-contractual claims.⁶⁹

1. **Basic Terms**

Subrogation: The right of a party secondarily obligated to recover a debt it has paid from a party primarily obligated to pay the debt. The right of subrogation itself can arise by contract, statute or under common law principals.

Assignment: The transfer for value of a right to recover or a cause of action. In the insurance context, this usually occurs where the insurance company makes a payment to an insured and at the same time takes an assignment of their cause of action. A true assignment transfers the cause of action to the insurance company, and it may thereafter only be pursued in the name of the insurance company.

⁶⁹ See, e.g., *Texas Farmers Ins. Co. v. Fruge*, 13 S.W.3d 509, 511 (Tex. App.—Beaumont 2000, pet. denied).

Lien: The right to enforce a claim against specific property to be applied to the discharge of a specific debt. In the insurance context, this usually involves the question of when a third-party can obtain part of a settlement or judgment before it is released to the claimant or the insured. Liens can be created by law (statutory lien), contract (consensual lien) or by court made rule (common law lien). In most cases that we would deal with, the party who made the payment already has the right to enforce a subrogation interest against the party to whom they made the payment. The issue to be discussed is whether a lien in aid of that subrogation interest is enforceable against others (the insurance company) who might temporarily hold the money to be paid to the injured party.

IV. STATE LAW LIENS

A. Workers Compensation

Texas Workers' Compensation carriers have the statutory right to reimbursement out of the first monies paid to an injured worker or his representative by a third-party tortfeasor or the tortfeasor's insurer. It is not necessary for the workers' compensation carrier to intervene to protect its subrogation interests.⁷⁰ The majority of Texas courts to consider the issue have held the workers' compensation lien applies to both liability claims and first-party Uninsured/Underinsured motorist claims. Although the statute does not expressly provide for the existence of automatic liens without notice, the case law interpreting workers' compensation liens has effectively created automatic notice without the need for further notice to the tortfeasor or any insurer.

1. Employee and Third-Party Tortfeasor Are Jointly and Severally Liable for Settlement Amount Wrongfully Withheld From Workers Compensation Carrier

In *Garriga v. Ace American Insurance Company*, 2010 WL 1490022 (Tex.App.—Eastland, April 15, 2010), the Eastland Court of Appeals held that an employee and a third-party tortfeasor were jointly and severally liable for settlement proceeds wrongfully withheld from a workers' compensation carrier, limited to the amount of the settlement. This case arises out of an automobile accident between Ramon Barragan and Troy Hickman in which Hickman was injured. The accident occurred within the scope of Barragan's employment. Ace, the workers' compensation carrier, initially denied Barragan's workers' compensation claim. State Farm provided insurance coverage for Hickman. Barragan retained the services of Jose Garriga to pursue a third-party claim against Hickman, and Garriga negotiated a settlement from Hickman for \$12,600, of which Garriga paid \$6,364.81 for medical expenses and a health subrogation claim, and Garriga received \$2,706.83 in attorneys' fees.

After administrative hearings, Ace accepted Barragan's workers' compensation claim and paid benefits to Barragan. Ace sent correspondence to Garriga reminding him of Ace's notice of subrogation, which was sent before the settlement with Hickman, and notified Garriga that Ace was aware of the settlement with Hickman and would assert a future credit against all medical

⁷⁰ *Travelers Ins. Co. v. Seidel*, 705 S.W.2d 278 (Tex. App.—San Antonio 1986, writ dismissed).

and indemnity benefits pursuant to the Texas Labor Code. Ace subsequently filed suit against Garriga to recover the entire amount of the workers' compensation lien, which was greater than the amount of the settlement. The court explained that a party should not benefit from wrongfully receiving a settlement in contravention of a carrier's subrogation right. But, the court determined that the carrier's recovery was limited to the settlement amount (\$12,600), and that the employee and the third-party tortfeasor were jointly and severally liable for the wrongfully appropriated funds.

2. Workers Compensation Liens do not reach Statutorily-Required Minimum Personal Auto UM/UIM

Many of the workers compensation disputes in this area have focused on the ability of workers compensation carriers to satisfy statutory liens against available UM/UIM benefits. The courts have focused on the statutorily-required minimum UM/UIM coverage under the insured's own policy. The courts have held that the statutorily-required minimum exempts the insured's personal auto policy UM/UIM from the workers compensation lien,⁷¹ but the insured's employer's business auto policy does not enjoy the same exception.⁷²

B. Hospital Liens

The Texas Hospital and Emergency Medical Services Lien Statute can be found at Chapter 55 of the Texas Property Code. The statute was originally enacted in 1933 to provide hospitals an additional method of securing payment for medical services, thus encouraging prompt and adequate treatment of accident victims. The legislature's intent was to provide hospitals with a separate cause of action to satisfy their liens and at the same time ensure that accident victims receive the treatment they need promptly, without the hospital worrying about reimbursement for their cost. In 2003 the legislature revised the Texas Hospital Lien Statute to also include emergency medical services providers that provide services in counties with a population of 575,000 or less. This means that now ambulatory services can also file a lien to recover funds for services rendered when an individual is injured in a motor vehicle accident.

The lien attaches to the patient's right of action against a third party that negligently causes personal injuries for which he or she was treated. The lien also attaches to money paid as a result of a claim or lawsuit for personal injuries sustained by a patient involved in an accident. A hospital with a properly filed lien has a valid cause of action against settling parties and their insurers who ignore the hospital bill when settling claims. The hospital can successfully recover against all parties involved in a settlement for violating the hospital lien statute. Texas case law

⁷¹ *McLennan Community College v. State Farm Mut. Auto. Ins. Co.*, 2004 WL 444648 (Tex. App.—Waco 2004, writ denied); *City of Corpus Christi v. Gomez*, 141 S.W.3d 767 (Tex. App.—Corpus Christi 2004, no writ); *Casualty Reciprocal Exchange v. Demock*, 130 S.W.3d 74 (Tex. App.—El Paso 2002, no writ); *Liberty Mutual v. Kinser*, 82 S.W.3d 71 (Tex. App.—San Antonio 2002, no writ).

⁷² *Eryas v. State Farm Mut. Auto. Ins. Co.*, 141 S.W.3d 671 (Tex. App.—El Paso 2004, no writ); *Texas Workers' Compensation Ins. Facility v. Aetna Cas. & Sur. Co.*, 994 S.W.2d 923, 925 (Tex. App.—Houston [1st Dist.] 1999, no writ); *Employers Cas. Co. v. Dyess*, 957 S.W.2d 884 (Tex. App.—Amarillo 1997, writ denied).

has even ruled in favor of the hospital when insurance companies and attorneys disburse proceeds of a settlement or judgment without satisfying the hospital bill first.

For the automatic lien to apply, the hospitalization must take place within 72 hours of the injury. TEX. PROP. CODE § 55.002(b). Subsequent hospitalizations for the same condition are also protected by the automatic lien. The automatic hospital lien, however, does not attach to the proceeds of an uninsured/underinsured motorist claim or a PIP/Med Pay claim.⁷³ In other words, the automatic lien does not apply to a first-party claim in Texas, but it does apply to a third-party liability claim. Note, however, that the hospital may still possess an assignment that will need be honored if notice is provided to the insurer. So, in a first-party UM/UIM claim, the automatic lien will not apply but an assignment will still need to be honored if the hospital provides notice of the assignment.⁷⁴

A hospital lien also does not attach to wrongful death actions.⁷⁵ A hospital lien does attach to proceeds recovered under a survival action which is based on damages sustained by the deceased.⁷⁶

In order to secure the hospital lien, the hospital must file written notice of the lien with the County Clerk of the county in which the hospital services were provided.⁷⁷ The filing by the hospital must take place prior to payment of any proceeds by the tortfeasor or its insurer to compensate the injured party for the injury. If a properly filed hospital lien is not satisfied, the hospital may bring a direct action against the settling party, their insurer, and the attorneys who ignored the statutory lien.⁷⁸

C. Other Health Care Providers

Physicians, chiropractors, and health care providers (other than hospitals) are not vested with an automatic lien following the rendering of medical care or treatment to a patient. If these health care providers wish to protect their legal interests, they must do so contractually. Most health care providers protect their interests through either a power of attorney or an assignment. In exchange for the rendering of medical services, it is legal for a health care provider to obtain an assignment of the patient's vested rights to receive insurance benefits.⁷⁹ In order to be valid and binding on any insurer, the assignee must give notice to the insurer. *University of Texas Medical Branch of Galveston v. Allan*, 777 S.W.2d 450 (Tex. App.--Houston [14 Dist.] 1989, no writ). If a health care provider fully performs their obligations for which the assignment was given, the assignment becomes irrevocable and the insurer must not prejudice or defeat the health care providers rights under the assignment. *Id.* The health care provider usually stamps or otherwise marks the medical invoice or Explanation of Benefits with a notation that an assignment exists. Although there is no case law on this practice, it is generally considered sufficient if the health care provider sends some notification that an assignment exists thus

⁷³ *Id.*

⁷⁴ *Members Mut. Ins. Co. v. Hermann Hosp.*, 664 S.W.2d 325 (Tex. 1984).

⁷⁵ *Tarrant Hosp. Dist. v. Jones*, 664 S.W. 191 (Tex. App.—Ft. Worth 1984, no writ).

⁷⁶ TEX. CIV. PRAC. & REM. CODE § 71.021.

⁷⁷ TEX. PROP. CODE § 55.005.

⁷⁸ *University Med. Cntr. v. Borders*, 581 S.W.2d 731 (Tex. App.—Dallas 1979, writ ref'd n.r.e.).

⁷⁹ *Southwestern Clinic vs. Farmers Ins. Group*, 850 S.W.2d 750 (Tex. App.—Corpus Christi 1993, no writ).

allowing the insurer to further investigate the validity of the assignment, if it so desires. Texas law does not impose any obligation upon an insurer to investigate the existence of an assignment unless notice of such of an assignment is given by the assignee. If, however, an insurer is aware of an assignment, it must honor the assignment or risk double exposure to the assignee. Although it is extremely rare, health care providers can also obtain a judgment against a patient for an unpaid bill and then pursue a direct action against any insurer potentially responsible for payment.⁸⁰

D. Texas Risk Pools

The Austin Court of Appeals determined the Texas Risk Pool could not pursue its subrogation rights against a settling tortfeasor in *Texas Health Ins. Risk Pool v. Sigmundik*, 2009 WL 2341837 (Tex.App.—Austin, July 31, 2009). The Risk Pool presented two arguments to the court. As to the first, the court agreed with the Risk Pool that a settlement with a tortfeasor could not destroy an insurer's right to subrogation if the tortfeasor is aware of the subrogation claim. But, the court found the Risk Pool waived the argument by failing to raise it prior to appeal. As to the second, the Risk Pool contended it was entitled to some portion of the settlement monies paid by the tortfeasor. The court found, however, the Risk Pool can only recover against settlement monies paid to its deceased insured's estate. And, the settlement specifically paid only the widow and children. The Risk Pool did not request that the trial court find that settlement monies should have been paid to the estate.

E. Support Liens

Texas Family Code § 157.317 creates a valid lien in favor of child support against insurance benefits. We have found no reported cases discussing the application of this statute with respect to insurance proceeds.

V. Conclusion

Insurers and plaintiffs face a host of new challenges in successfully resolving third-party liability claims. Counsel on both sides of the docket should be prepared to consider what steps they can reasonably take to facilitate settlement of claims with outstanding liens. The days of waiting until the day of mediation to call the lienholder on the phone are long gone. But, with advanced planning and coordination with the lienholders, parties should be able to avoid situations that expose either the insurer, the claimant, or their counsel to reimbursement claims from lienholders.

⁸⁰ *State Farm v. Olis*, 768 S.W.2d 722 (Tex. 1989).

APPENDIX
MEDICARE
RESOURCES

The following resources can help practitioners obtain a better understanding of Section 111 reporting requirements and the effect those requirements have on claims involving Medicare beneficiaries.

- *User Guide*

The Centers of Medicare and Medicaid Services (CMS) has posted a *User Guide* on its website. The *User Guide* provides an in-depth review of the reporting process. It is an evolving document and subject to alteration by CMS at any time. Practitioners should make sure to review the latest version of the *User Guide* and be aware of any ALERTS that may modify the *User Guide*. Currently, the latest version of the *User Guide* is Version 4.0, dated February 22, 2010. CMS plans to make several revisions to this latest version of the *User Guide* by July 1, 2010. The *User Guide* and instructions do not and are not intended to cover all aspects of the MSP program.

The *User Guide* can be accessed at www.cms.hhs.gov/MandatoryInsRep/Downloads/NCHPUserGuide2ndRev082009.pdf.

- Listserv to receive ALERTS

A listserv for notification of ALERTS and other updates and changes CMS implements relating to Section 111 reporting requirements is available. Visit www.cms.hhs.gov/MandatoryIns.Rep and click on the “For e-mail updates and notifications” link to receive CMS ALERTS and updates.

- CMS website

The official CMS website provides relevant information and documents. The website does not provide an organized index for many items and topics. For example, not all of the ALERTS are found under one tab. A thorough review of all links and tabs of the CMS website is necessary.

The CMS website is available at www.cms.hhs.gov/home/medicare.asp.

For Mandatory Insurer Reporting information, go to www.cms.hhs.gov/MandatoryInsRep.

For Medicare Secondary Payer information, go to www.cms.hhs.gov/MedicareSecondPayerandYou.

- Conference Calls

CMS holds bi-monthly conference calls. Each conference call is two hours long. One call is designated to discuss policy-related issues, and the other call is designated to discuss the technical side of the reporting requirements. Information relating to these conference calls including dates of the calls and the telephone number and code to participate in the calls, is available at www.cms.hhs.gov/MandatoryInsRep/Downloads/NGHPRevTeleconfDoc2009.pdf.

- Computer-based training

Computer-based training (CBT) is available on the CMS website. The CBT courses simulate the actual reporting process. There are twenty-two CBT courses offered by CMS and all are free of charge. The courses vary in length, with some courses lasting as little as four minutes and others as long as thirty-three minutes. Instructions about the CBT are available at www.cms.hhs.gov/MandatoryInsRep, under the “MMSEA 111 Computer Based Training (CBT)” tab.

- Internet-only manuals

The Internet-only manuals (IOMs), including CMS Medicare manuals, provide guidance on administering CMS programs and are a good source of Medicare information for the general public. They are available at www.cms.hhs.gov/manuals/IOM.

- *MSP Manual*

The *MSP Manual* is available at www.cms.hhs.gov/manuals/downloads/msp105c02.pdf.

- Medicare Secondary Payer Recovery Contractor (MSPRC) website

The MSPRC website, which provides resources and information regarding MSP and Medicare’s recovery process, is available at msprc.info.

MEDICARE ACRONYMS

CMS:	Centers for Medicare and Medicaid Services	MSA:	Medicare Set Aside
COBC:	Coordination of Benefits Contractor	MSP:	Medicare Secondary Payer
COBSW:	Coordination of Benefits Secure Website	MSPRC:	Medicare Secondary Payer Recovery Contractor
EDI:	Electronic Data Interface	NGHP:	Non-Group Health Plan
GHP:	Group Health Plan	ORM:	Ongoing Responsibility for Medicals
HICN:	(Medicare) Health Insurance Claim Number	RRE:	Responsible Reporting Entity
MMSEA:	Medicare, Medicaid, and SCHIP Extension Act of 2007	TPA:	Third-Party Administrator
		TPOC:	Total Payment Obligation to the Claimant