I. INTRODUCTION

Insurance carriers are faced with situations wherein their employees are given access to confidential information of the carrier's policyholders and claimants in connection with the settlement of a claim. In fact, the handling of claims raises a variety of privacy issue concerns. When defending claims, insurance carriers gather confidential medical and personal information about the claimants and insureds. However, with increasing frequency, claims settlement discussions erode and many parties have resorted to tactics that may call into question the privacy and confidentiality of insured's information. For example, the health insurance "lien", or more accurately, "subrogation interest" has been sold to the Defendant funded by a liability insurer; the liability insurer has notified the hospital that it should file its lien after a settlement was reached; or when attempts are made to ask a medical provider to reduce its bill, it refuses; an insurer requests a claimant's Social Security information for Medicare reporting but the claimant refuses. Is this behavior acceptable under the applicable statutes and regulations? What remedies do you have? This presentation will address confidentiality and privilege concerns involving medical authorizations, fraudulent liens, and settlement in insurance claims and lawsuits and offer techniques for counsel to address these issues. Before addressing these situations, you need to have an understanding of the legal and regulatory landscape that can affect your claims and settlement negotiations.

II. FEDERAL AND STATE LAWS TO CONSIDER REGARDING PRIVACY

There are numerous federal and state statutes and regulations that an insurance carrier must observe when handling claimants' and insureds' personal information. The two main Federal privacy statutes that a carrier handling claims must consider is the Gramm-Leach-Bliley Act ("GLB") and Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

A. Gramm-Leach-Bliley Act ("GLB")

In the 1990's, Congress became concerned over the merger of banks and insurance companies and unlimited access to personal financial data. Therefore, Congress combined the old law with new law and merged previously separated financial institutions and passed 15 U.S.C. § 6801, which is commonly referred to as Title V of the Gramm-Leach-Bliley Act ("GLB"). The GLB regulates, in pertinent part, the collection, transfer and sharing of "financial information" concerning consumers in relation to certain "financial institutions." 15 U.S.C. §6801(b), et. seq. The purpose of the GLB is to protect the security and confidentiality of consumers' nonpublic personal information. 15 U.S.C. § 6801 (a). The GLB applies to activities that are financial in nature as defined by 12 U.S.C. §1843(k), commonly referred to as the Bank Holding Carrier Act of 1956. 15 U.S.C. §6809(3)(A); 12 U.S.C. §1843(k)(4). Activities that are "financial in nature" include, among other things, insuring, guaranteeing or indemnifying against loss, harm damage, illness . . . and acting as principal, agent, or broker for purposes of the foregoing, in any State." 12 U.S.C. §1843(k)(4)(B). The GLB prohibits the disclosure of "nonpublic personal information," which includes any information furnished by a

consumer in order to receive a product or service. 15 U.S.C. § 6809(4)(A)(i), (ii). The GLB allows for states to impose their own legislation.

The definitions set forth above unequivocally establish that: (1) the GLB applies to insurers, such as insurance carriers; and (2) the information provided by policyholders, such as their names, last known addresses and telephone numbers, falls within the GLB definition of nonpublic personal information. Therefore, the GLB precludes the disclosure of a carrier's policyholders' names, last known addresses, and telephone numbers. Moreover, in accordance with the GLB, insurers were under notice obligations that subsequently should have resulted in the adoption of a Privacy Policy wherein each carrier discloses to its policyholders the instances in which it will not disclose nonpublic personally identifiable information to third parties. If such a Privacy Policy is not in place, the carrier should adopt a Privacy Policy that reflects these regulatory requirements, which should also coordinate with any Internet disclosures. Each carrier should also have a privacy officer to help train employees and implement compliance programs.

B. Health Insurance Portability and Accountability Act of 1996 ("HIPAA")

HIPAA went into effect on April 14, 2001, and its enforcement began on April 14, 2003. HIPAA was intended to encourage covered entities to rely upon de-identified information. However, HIPAA does not apply to all insurance carriers---insurers that provide automobile liability insurance that includes coverage for medical payments are exempt from HIPAA. Still, the medical providers from which the adjusters have to retain claimants' and insureds' medical information are not exempt and must comply with HIPAA. HIPAA requires that covered entities must obtain patient consent in advance in order to use and/or disclose Protected Health Information ("PHI"), which is information created or received by a covered entity relating to an individual's mental or physical health, health care or payment for health care services. PHI can include all personal medical records, in whatever form, created or held by covered entities, regardless of whether the information was ever in electronic form.[1] This even includes oral communications. To obtain guidance on whether an entity is a covered entity under the Administrative Simplification provisions of HIPAA, see the Covered Entity Charts at www.cms.gov/HIPAAGenInfo/. Once there, under General Information click on the tab for "are you a covered entity" link. The HIPAA Administrative Simplification regulations exclude from the definition of "health plan" any policy, plan or program to the extent it provides, or pays for the cost of, excepted benefits, which includes automobile liability insurance and automobile

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[1] a. Protected Health Information ("PHI")

(1) PHI means individually identifiable health information that is "(1) transmitted be electronic media; (ii) maintained in electronic media; or (iii) transmitted or maintained in any other form or medium." 45 CFR 160.103.

(2) "Individually identifiable health information" is information that is a subset of health information, including demographic information collected from an individual, and:

a. Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and

b. Relates to the past, present, or future physical or mental health or condition or an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and

i. That identifies the individual; or

ii. With respect to which there is a reasonable basis to believe the information can be used to identify the individual.

45 CFR 160.103.

medical payments coverage. *See* 42 U.S.C. §300gg-91(c)(1). Still, an attorney involved in cases involving PHI needs to understand what forms will allow the medical providers to produce the necessary records in order to evaluate and handle a claim. *See* below examples of the forms needed for the covered entities to disclose information.

C. Each State's comparable statutes and regulations

Different states have implemented statutes and regulations to comply with the GLB and HIPAA. In addition, many states have detailed what type of authorization is needed for the disclosure of medical information; for example, see Texas Occupations Code at Section 159.005.

III. ERISA or "Federal Super Lien"

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."[2] 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.[3] 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.[4]

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

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

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

[4] *Id.*

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.[5]

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.[6] 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;[7]
- 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;[8]
- funds held in a beneficiary's lawyer's trust account meet all prongs of the *Knudson* test;[9]
- 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;[10]

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[5] 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.

[6] 534 U.S. at 215.

[7] *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).

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

[9] *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).

[10] *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).

- an insurer's offer to tender policy limits that has not yet been accepted by the beneficiary does not meet the *Knudson* test.[11]

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.[12] 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.[13] The fundamental element necessary to create an equitable lien is the existence of an express or implied contract.[14] It is not necessary that a lien is created by express contract or by operation of statute.[15] 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.[16] 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 – banks[17] and lawyers.[18] 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.

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

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

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

[14] *Id.*

[15] *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.).

[16] *Id.; Bray*, 544 S.W.2d at 819.

[17] *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).

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

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.[19] The funds, however, had been placed in a Special Needs Trust for the beneficiary to provide for her medical care pursuant to California law.[20] 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."[21] 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).[22]

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 settlement funds received for the benefit of a minor meet all prongs of the Knudson test.[23] 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

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[19] *Knudson*, 534 U.S. at 208.
[20] *Id.* at 207-08.
[21] *Id.* at 214.
[22] *Id.*
[23] *Id.*

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 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.[24]

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.

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.

V. 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.

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

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 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.[25] 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.[26]

A hospital lien also does not attach to wrongful death actions.[27] A hospital lien does attach to proceeds recovered under a survival action which is based on damages sustained by the deceased.[28]

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.[29] 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.[30]

VI. OTHER HEALTH CARE PROVIDERS AND LIENS

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

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[25] *Id.*
[26] *Members Mut. Ins. Co. v. Hermann Hosp.*, 664 S.W.2d 325 (Tex. 1984).
[27] *Tarrant Hosp. Dist. v. Jones,* 664 S.W. 191 (Tex. App.—Ft. Worth 1984, no writ).
[28] TEX. CIV. PRAC. & REM. CODE § 71.021.
[29] TEX. PROP. CODE § 55.005.
[30] *University Med. Cntr. v. Borders*, 581 S.W.2d 731 (Tex. App.—Dallas 1979, writ ref'd n.r.e.).

assignment of the patient's vested rights to receive insurance benefits.[31] 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 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.[32]

VII. EXCEPTIONS AND/OR CARVE-OUTS

Just as stated in the Privacy Policies provided to policyholders, there are exceptions when the carrier will have to share the confidential information.

A. Special Investigation Unit Fraud Investigations

One long-recognized exception to the disclosure of confidential policyholder and claimant information is in the context of fraud investigations. Claims adjusters and special investigative unit ("SIU") investigators initially become aware of fraudulent activity through the handling of individual claim files. Many times the carrier will have to pay the suspicious medical bill due to the risk of the severe penalties for failure to meet the state deadlines for prompt payment of claims. A carrier may have to sue the medical provider for fraud in order to recover the monies paid. The use of policyholder and/or claimant confidential information may be necessary to prosecute the fraud. Therefore, there are civil immunity laws governing anti-fraud activities so that insurers have protections that are designed to encourage them to aggressively fight fraud. Still, there has been an impact on SIU Fraud investigations in light of the new privacy laws. The SIU investigators should have knowledge of the proper boundaries of investigations, which will allow investigators to do their job appropriately, effectively and in sync with carrier attorneys. The following are recommended Internet resource material:

- Coalition Against Insurance Fraud ("CAIF") http://www.insurancefraud.org/ The CAIF site contains various resources including legislation, regulations and state fraud laws at a glance. The legislation research site also lists a chart with a link to the state immunity laws that are specifically designed to allow insurers and others to share information related to insurance fraud investigations.

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

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

- International Association of Special Investigation Units, Inc. ("IASIU") https://www.iasiu.org This site has a list of research links to various agencies and other helpful websites.

- National Insurance Crime Bureau ("NICB") www.NICB.org

- National Association of Insurance Commissioners, Inc. State Insurance Web Site Map http://www.naic.org/state_web_map.htm

- Cornell Law http://www.law.cornell.edu/

- State and Local Governments On-line http://www.statelocalgov. net/

B. Court Order and/or Subpoena

An exception to the disclosure of confidential policyholder and claimant information is when the court orders the production of the documents. Even so, the party producing the documents can request a protective order from the court to protect the public dissemination of such material. There are also third party subpoenas that require the production of documents. However, many times these third party subpoenas are not valid. The attorney should analyze the subpoena and determine the following: 1) Whether the subpoena was properly served, 2) Whether the subpoena is valid, and then call the requesting party and discuss specifics to narrow the request. Once the attorney analyzes the subpoena then he can explore the options with the client, such as 1) compiling the documents to produce, 2) filing a motion to quash the subpoena, and/or 3) having a protective order entered executed by the requestor.

C. Request By Governmental Agency Such As State Attorney General Or Department Of Insurance

Another exception to the disclosure of confidential information is when a governmental agency, such as the state Attorney General or Department of Insurance, serves a civil investigative demand or a subpoena to review documents. Any request of this nature should immediately be sent to the carrier legal department who may refer the matter to outside defense counsel. These requests sometimes ask for confidential policyholder and/or claimant information that should be handled under a confidentiality provision usually contained in the state statutes relating to requests by the Attorney General's office and/or state statues relevant to the state's insurance laws.

D. Freedom of Information Act ("FOIA") Requests

Many people are now requesting carrier information or information the carrier may have related to a specific person through FOIA requests. Usually, there is a ten-business-day time period to respond to these requests in which the carrier can also object to the requests. .

E. Medicare Reporting

The Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA) requires Responsible Reporting Entities (RRE's), which include employers, insurance companies, Third Party Administrator's and group health plans, to electronically report to Centers for Medicare & Medicaid Services (CMS) any settlement, judgment, award, or other payment made to a Medicare beneficiary, as well as any assumption of or termination of a responsibility to pay for a Medicare beneficiary's medical expenses.

This reporting requirement involves the electronic submission of information regarding the claimant such as Social Security Number (SSN) or Health Insurance Claim Number (HICN), date of birth, ICD-9 codes for the alleged cause of injury and diagnosis as well as the payment amounts. In order to protect data confidentiality CMS requires RREs to sign a Section 111 Data Use Agreement (DUA). The DUA requires RREs to implement safeguards against unauthorized use, access, and disclosure of the reported information. The DUA also requires RREs to ensure that any vendors hired to assist with reporting duties also implement these responsibilities. Pursuant to this agreement, RRE's agree to give CMS access to the premises where the Medicare data is kept to inspect arrangements regarding compliance with the DUA security requirements. RRE's must advise personnel who have access to the data of the civil and criminal penalties for noncompliance with "applicable federal law".

Per CMS regulation an individual's SSN or HICN is required for reporting. Because of concerns regarding the exchange of private information CMS has issued guidance advising participants to cooperate with RRE requests for information. CMS issued a revised model collection form that RRE's may use to obtain information to enable them to comply with the reporting requirements. The model form can be found at www.cms.gov/MandatoryInsRep. The form requires claimants to provide information regarding their Medicare status and gives the claimant the opportunity to refuse to provide the requested information.

The MMSEA also mandates the disclosure of the settlement amount regardless of any confidentiality agreement between the parties. Section 111 mandates disclosure of the amount, identity of the claimant, and circumstances of the claim (among other factors). CMS asserts that it is entitled to this information because Section 111 serves a coordination of benefits purpose. 42 C.F.R. §411.24(a); CMS MMSEA Section 111 Teleconference Tran. at 34 (Jan. 22, 2009). Accordingly, RRE's should be aware that Section 111 information will be maintained in a government database and will be used by CMS to identify secondary payor circumstances and facilitate recovery efforts.

VIII. SCENARIOS TO CONSIDER WITH PRIVACY IN INSURANCE CASES

A. So They Sold The Subrogation Interest To The Liability Insurer

While more prevalent in larger damage cases, liability insurers have been known to purchase a health insurer's or ERISA plan's subrogation interest. It goes something like this: Plan or health insurer claims a subrogation interest in a personal injury lawsuit brought by an insured; the Plan or health insurer has paid about $325,000 in medical bills and expenses for a very seriously injured Plaintiff; the liability insurer armed with its one sided view of paid versus incurred decides that it can minimize or eliminate its exposure by removing or owning Plaintiff's

past medical expenses; the liability insurer contacts the Plan or health insurer and offers thirty-three cents ($.33) on the dollar for the subrogation interest. The two parties discuss resolution and the liability insurer agrees to pay the Plan the sum of $109,000. The Plan accepts and defense counsel prepares the necessary paperwork assigning the interest to the Defendant who can then, at the least, claim a credit on any judgment. The Plaintiff has *not* provided any HIPAA release to the Defendant to permit discussions between the liability insurer and the Plan representatives. You learn of this sale about sixty (60) days before trial. Your response cannot be reprinted. Are you up the creek?

The answer is "no." This situation was the subject of a lawsuit styled *Quintana v. Lightener*, originally filed in state court. The state court trial court granted a temporary restraining order prohibiting the use of this arrangement. *See* copy of TRO and lawsuit papers at *Quintana v. Ingenix*, Case No. DC-10-03069 in the 193rd District Court, Dallas County, Texas.

While the Plan may have a subrogation interest, it cannot simply ignore basic tort law, including violating HIPAA regulations and privacy laws in order to satisfy its interest. Without a HIPAA release, a Plan or health insurer may not discuss a party's private health care information regardless of the existence of a lien or subrogation interest.

With a Plan that satisfies ERISA, preemption and removal become an almost certainty. *Quintana* deals with that dilemma finding that claims such as invasion of privacy, intentional infliction of emotional distress ("IIED"), and conspiracy are not preempted by ERISA and jurisdiction is not exclusive in federal court. In *Quintana*, Ingenix, not the Plan administrator, removed Quintana's case, relying on complete ERISA preemption. Judge Fish rejected Ingenix's preemption argument and remanded the suit to state court. *See* Quintana v. Ingenix, 2011 WL 976773.

The short version is that the remand to state court forced a settlement with consideration of the full range of damages, including all medical bills.

A number of other considerations and factors may also be evaluated. For instance, as discussed more fully above in Section III, in the context of ERISA, the Plan administrator owes the participants a fiduciary duty. Since this is true, can the administrator sell out a participant, thereby compromising or defeating a participant's own personal injury claim? While many fear ERISA, the question of a Plan administrator breaching a fiduciary duty in this context is an unanswered question.

Second, while Texas permits assignments with a great deal of latitude, they are not without limits. For example, assignments of legal malpractice and Deceptive Trade Practices Act claims are generally not permitted. *See PPG Industries v. JMB/Houston Centers Partners*, 146 S.W.3d 798, 85-87 (Tex. 2004); *Zuniga v. Groce, Locke, & Hebdon*, 878 S.W.2d 313, 317-318 (Tex. App. – San Antonio 1994, writ ref'd). The reasoning is that such claims are inherently personal. While no Texas court has squarely decided the issue of the assignability of a subrogation interest to a party adversary, a solid argument can be made that such assignment violates public policy – putting such claims in the hands of the adversary. The adversary is not settling or buying its peace, but is actually owning a part of the Plaintiff's claim, which creates a

number of ethical considerations. Indeed, one might argue that such an assignment of Plaintiff's medical bills to an adversary is tantamount to a Mary Carter agreement, whereby a settling party has a financial interest in Plaintiff's lawsuit.

The big picture is that a Plaintiff can be successfully proactive in negating such assignment or, at minimum, create reasonable and persuasive doubt on such an arrangement, thereby putting the "assigned" damages back into play.

One important point must be made in using this strategy. If you represent the Plaintiff provide a HIPAA release to the Defendant, make sure it does not allow oral communications between the medical provider and the HIPAA recipient. If a HIPAA release has been provided by the client or former counsel before you taking over, revoke the HIPAA authorization, and notify the Defendant, the liability, insurer, and any medical provider. With a broad valid HIPAA release, a Defendant or liability insurer will be able to engage in all sorts of communications with medical providers and result in a waiver of privacy. If you represent the Defendant you will want to confirm what HIPAA release, if any, exists before discussions with the health care provider.

B. The Liability Insurer Adjuster Tells The Hospital About The Settlement So A Lien Can Be Filed Before Funding

The Texas Hospital Lien statutes provides in pertinent part (as discussed above in Section V):

> §55.055. Securing Lien
>
> (a) To secure the lien, a hospital or emergency medical services provider must
>
> (1) provide notice to the injured individual in accordance with Subsection (d); and
>
> (2) file written notice of the lien with the county clerk of the county in which the services were provided *before money is paid to an entitled person because of an injury.*

Tex. Prop. Code Ann. §55.005(a) (Vernon Supp. 2011). Emphasis added.

The significance of the adjuster's conduct is notifying the hospital to file its lien before the settlement is funded, thereby insuring the hospital receiving payment. And of course, this now required payment now has to be factored into the ultimate client recovery and conceivability puts Plaintiff into a lesser bargaining position on the outstanding balance which may likely be exaggerated and/or unreasonable.

The same principles discussed in Part A (Selling Subrogation Interests to the Adversary) above applies here. By the adjuster contacting the hospital and a representative of the hospital discussing a client's medical care, including billing without a valid HIPAA authorization, both the adjuster and hospital may have committed torts, such as invasion of privacy and/or IIED. The very notion of the hospital even acknowledging a Plaintiff was a patient, much less having incurred charges, strikes at the heart of HIPAA, which is a privacy statute. And while HIPAA *does not* provide a private cause of action to a Plaintiff, it can provide a basis for a common law tort claim, such as invasion of privacy and/or IIED.

Furthermore, Texas state law also provides protection for a patient's medical records. *See Tex. Occupations Code Ann.* §159.003 (Vernon Supp. 2011) and *Tex. Health & Safety Code Ann.* §241.152 (Vernon 2011). These statutes, likewise, provide a privacy interest by a client regarding their medical treatment, including billings.

Texas statutory law also provides a direct remedy for the unauthorized release of confidential health care information:

> §241.156. Patient Remedies
>
> (a) A patient aggrieved by a violation of this subchapter relating to the unauthorized release of confidential health care information may bring an action for:
>
> (1) appropriate injunctive relief; and
>
> (2) damages resulting from the release.
>
> (b) An action under Subsection (a) shall be brought in:
>
> (1) the district court of the county in which the patient resides or in the case of a deceased patient the district court of the county in which the patient's legally authorized representative resides; or
>
> (2) if the patient or the patient's legally authorized representative in the case of a deceased patient is not a resident of this state, the district court of Travis County.

Tex. Health & Safety Code Ann. §241.156 (Vernon 2001).

This statute provides direct authorization to pursue claims against the adjuster and hospital.

In using Section 241.156, be aware of an exception or defense to this statute which provides disclosure "to facilitate reimbursement to a hospital, other health care provider, or the patient for medical services or supplies." *Tex. Health & Safety Code Ann.* §241.153 (16). Nonetheless, this exception may not be read broadly in light of HIPAA and other privacy

statutes. Such exception would likely apply only to communications between health insurers and medical providers.

When dealing with the Hospital Lien Statute, caution must be taken, as an exception to privacy has been carved out:

> §55.008. Records
>
> (a) *On request by an attorney for a party by, for, or against whom a claim is asserted* for damages arising from an injury, a hospital or emergency medical services provider shall as promptly as possible make available for the attorney's examination its records concerning the services provided to the injured individual.

Tex. Prop. Code Ann. §55.008(a) (Vernon Supp. 2011). Emphasis added.

Section 55.008(a) appears to suggest an attorney representing the Defendant may obtain the Plaintiff's medical records for "examination." The statute, though, does not permit the attorney to have discussions with the hospital about the records or services. Furthermore, a question arises whether Section 55.008(a) violates HIPAA and whether a HIPAA authorization is required before defense counsel is able to examine the records and/or billings. Nevertheless, be aware of this limited exception to privacy.

When representing the Plaintiff and the adjuster decides to discuss your client's outstanding balance with a hospital, inducing the hospital to file a lien before funding, your client does not have to just take it. As to the adjuster, your client has a cause of action to pursue. For the hospital and its employee who communicated with the adjuster and where a hospital lien has now been filed, your client, at worst, has an offset to damages and leverage to negotiate the lien substantially down.

C. The Hospital Or Third Party Collector Refuses To Negotiate Its "Lien"

1. Introduction

Before you attempt to settle your client's case, you must deal with a pesky hospital lien. Note: Even if you represent the insurance carrier, many times you cannot finalize a settlement due to these types of liens. The Hospital Lien Statute does not provide much wiggle room, so how do you get the lien reduced or even extinguished? The answer may well be found in the Fraudulent Lien Statute, *Tex. Civ. Pract. & Rem. Code Ann.* §12.001, et. seq. (Vernon 2011).

2. The Statute

CPRC §12.001. DEFINITIONS

In this Chapter:

(1) "Court record" has the meaning assigned by Section 37.01, Penal Code.

(2) "Exemplary damages" has the meaning assigned by Section 41.001.

(2-a) "Filing office" has the meaning assigned by Section 9.102, Business & Commerce Code.

(2-b) "Financing statement" has the meaning assigned by Section 9.102, Business & Commerce Code.

(2-c) "Inmate" means a person housed in a secure correctional facility.

(2) "Lien" means a claim in property for the payment of a debt and includes a security interest.

(4) "Public servant" has the meaning assigned by Section 1.07, Penal Code, and includes officers and employees of the United States.

CPRC §12.002. LIABILITY

(a) A person may not make, present, or use a document or other record with:

(1) knowledge that the document or other record is a fraudulent court record or a fraudulent lien or claim against real or personal property or an interest in real or personal property;

(2) intent that the document or other record be given the same legal effect as a court record or document of a court created by or established under the constitution or laws of this state or the United States or another entity listed in Section 37.01, Penal code, evidencing a valid lien or claim against real or personal property or an interest in real or personal property; and

(3) intent to cause another person to suffer:

(A) physical injury;

(B) financial injury; or

(C) mental anguish or emotional distress.

. . .

(b) A person who violates Subsection (a) or (a-1) is liable to each injured person for:

(1) the greater of:

(A) $10,000; or

(B) the actual damages caused by the violation;

(2) court costs;
(3) reasonable attorney's fees; and
(4) exemplary damages in an amount determined by the court.

(c) A person claiming a lien under Chapter 53, Property Code, is not liable under this section for the making, presentation, or use of a document or other record in connection with the assertion of the claim unless the person acts with intent to defraud.

CPRC §12.003. CAUSE OF ACTION

(a) the following persons may bring an action to enjoin violation of this chapter or to recover damages under this chapter:

(1) the attorney general;

(2) a district attorney;

(3) a criminal district attorney;

(4) a county attorney with felony responsibilities;

(5) a country attorney;

(6) a municipal attorney;

(7) in the case of a fraudulent judgment lien, the person against whom the judgment is rendered; and

(8) in the case of a fraudulent lien or claim against real or personal property or an interest in real or personal property or an

interest in real or personal property, the obligor or debtor, or a person who owns an interest in the real or personal property.

(b) Notwithstanding any other law, a person or a person licensed or regulated by Title 11, Insurance Code (the Texas Title Insurance Act), does not have a duty to disclose a fraudulent, as described by Section 51.901(c), Government Code, court record, document, or instrument purporting to create a lien or purporting to assert a claim on real property or an interest in real property in connection with a sale, conveyance, mortgage, or other transfer of the real property or interest in real property.

(c) Notwithstanding any other law, a purported judgment lien or document establishing or purporting to establish a judgment lien against property in this state, that is issued or purportedly issued by a court or a purported court other than a court established under the laws of this state or the United States, is void and has no effect in the determination of any title or right to the property.

CPRC §12.004. VENUE

An action under this chapter may be brought in any district court in the county in which the recorded document is recorded or in which the real property is located.

CPRC §12.005. FILING FEES

(a) The fee for filing an action under this chapter is $15. The plaintiff must pay the fee to the clerk of the court in which the action is filed. Except as provided by Subsection (b), the plaintiff may not be assessed any other fee, cost, charge, or expense by the clerk of the court or other public official in connection with the action.

(b) The fee for service of notice of an action under this section charged to the plaintiff may not exceed:

(1) $20 if the notice is delivered in person; or

(c) the cost of postage if the service is by registered or certified mail.

(d) A plaintiff who is unable to pay the filing fee and fee for service of notice may file with the court an affidavit of inability to pay under the Texas Rules of Civil Procedure.

(e) If the fee imposed under Subsection (a) is less than the filing fee the court imposes for filing other similar actions and the plaintiff prevails in the action, the court may order a defendant to pay to the court the differences between the fee paid under Subsection (a) and the filing fee the court imposes for filing other similar actions.

CPRC §12.006. PLAINTIFF'S COSTS

(a) The court shall award the plaintiff the costs of bringing the action if:

(1) the plaintiff prevails; and

(2) the court finds that the defendant, at the time the defendant caused the recorded document to be recorded or filed, knew or should have known that the recorded document is fraudulent, as described by Section 51.901(c), Government Code.

(b) For purposes of this section, the costs of bringing the action include all court costs, attorney's fees, and related expenses of bringing the action, including investigative expenses.

3. Some Commentary

As an overview, the term "fraudulent" in section 12.002 is not defined. *See Centurion Planning Corp. v. Seabrook Venture II*, 176 S.W.3d 498, 507 (Tex. App. – Houston [1st Dist.] 2004, no pet.). While the party asserting a §12.002 claim has the burden of proof, that does not differ from other claims. *Aland v. Martin*, 271 S.W.3d 424, 430 (Tex. App. – Dallas 2008, no pet.) (dealing with family law lawyer who filed a lien to secure her fees). The Plaintiff *does need to show* an intent to cause injury which is *not presumed or self evident* but may be proven by circumstantial evidence. *Preston Gate L.P. v. Bukaty*, 248 S.W.3d 892, 897 (Tex. App. – Dallas 2008, no pet). Because it is often a clerk or third party who actually files the lien with virtually no knowledge of the lien's validity, these types of facts become fertile ground to be demonstrate intent to injure. Moreover, if this is the lien holder's typical practice of routinely filing liens without due regard to the lien's validity, accuracy, and legality, an intent to injure can be shown by circumstantial evidence.

A careful reading of the statute reveals that the lien does not have to be filed. The language in *Tex. Civ. Pract. & Rem. Code Ann* §12.002(a) uses the terms "make", "present", or "use a document or other record". For example, it can be argued that an entity like Cardon, Rawlings, or Ingenix who are attempting to collect or assert a lien that is fraudulent is just as liable as the person or entity who filed it or created it. Blind acceptance or generic assertions of a lien on a personal injury recovery (personal property) likewise falls under section 12.002.

To the extent a question exists as whether a valid lien has been asserted by a hospital, ERISA Plan, or other entity, it is worthwhile to research the lien alleged. Often the term lien is used when none exists at all. See "Lies, Liens, and Loopholes", Cooper and Perry, 15th Annual Insurance Law Institute, October 14th and 15th, 2010. This paper can be found on the website www.Ticerlawfirm.com under articles.

The consequences to the violator are severe: the greater of $10,000 or actual damages, court costs, reasonable attorney's fees, and exemplary damages. Significantly, only mechanic's and material man's liens are treated differently under Chapter 12. Hospital liens and other medically related claims are not exempted from the statute. Section 12.003(8) permits the person who has a lien asserted against them to file the lawsuit. Court costs are also available which includes attorney's fees and *related expenses including investigative expenses. Tex. Civ. Pract. & Rem. Code* § 12.006 (b). Emphasis added.

In addition to the foregoing, *Tex. Gov't Code Ann.* §51.903 provides an inexpensive and expedited method for removing a fraudulent lien and/or judgment. This remedy can be useful if time is of the essence. The use of a Section 51.903 does not preclude a Chapter 12 claim.

4. Application and Checklist

To repeat, the use of Chapter 12 remedies is *not* a one size fits all remedy for every hospital lien. However, you will find many hospitals, their representatives, their bill collectors, and most counsel completely unprepared to deal with Chapter 12. It is a complete turning of the tables with no presuit notice required.

In evaluating a Chapter 12 claim, please consider the following:

1. Is it a lien at all?

2. Where were the services rendered and what is the history of the facility with regard to billing?

3. Is it a hospital lien or what purports to be a hospital lien?

4. How many liens did the hospital file and does it only cover services that regularly fall under the hospital lien statute?

5. If there is more than one lien, are any of the services included in each lien duplicated in another lien?

6. Who filed the lien on behalf of the hospital or health care provider?

7. If it is a governmental hospital that is asserting the lien (which may be immune from Chapter 12), did a third party file the lien on behalf of the hospital removing sovereign immunity concerns?

8. Are the charges asserted in the lien reasonable and necessary?

9. What venue will be available?

10. Is removal to federal court likely?

11. Have some charges been paid by a health insurer or other third party payer?

12. Is Cardon Healthcare or other major health services bill collector involved?

13. Who has attempted to collect the lien(s)?

14. Did the liability insurer encourage the filing of the lien (conspiracy to violate Chapter 12)?

15. Have payments been made towards the lien(s) which reduces the amount owed but the lien(s) has remained the same?

16. What attempts and by whom have been made to collect on the "lien"? and

All of these considerations are important and certainly not exclusive factors. The information you obtain will dictate if you file at all, where you file, the additional claims that you can make such as conspiracy to violate Chapter 12 and injunctive relief, what are your range of damages, etc.

In order to take control of this litigation from the outset, discovery should be attached to your petition. This most certainly includes requests for production and deposition notices(s) with an effective duces tecum. For example, in order to determine whether the charges that compose the hospital lien are proper, it is necessary to seek the facility's catalogue of charges for the services it offers. The catalogue prices can be compared to the prices actually charged. Another item to obtain is the facility's procedures manual for filing hospital liens. A deposition of the organizational representative dealing with hospital liens should be noticed with appropriate areas of inquiry.

XI. CONCLUSION

If your client whether the Plaintiff or Defendant finds himself in one of these unwanted and unwelcome issues in settlement discussions, consider the alternatives offered in this paper. These remedies should be used surgically, strategically, and aggressively as the circumstances warrant. Do not fear the unknown. Be bold.

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