

**SETTLEMENT STRATEGIES IN COMPLEX  
MEDICAL MALPRACTICE CASES  
Plaintiff's Perspective**

William F. Horsley  
Greensboro, NC 27405

As a rule, plaintiff lawyers prefer to focus on slaying the dragons of malpractice. After the battle, however, we have to continue the fight or we may discover the war has been lost.

**A. RELEASE PITFALLS**

**1. *Dealing with Medicare, Medicaid, ERISA claims:***

There is more detailed discussion of liens and subrogation claims below. For purposes of this section, dealing with releases, plaintiff's counsel should keep the following in mind:

1. The defense is entitled to protect itself, as best it can, by including language in the release to the effect that satisfaction of all liens and subrogation claims are the responsibility of the plaintiff. Remember that, ethically, plaintiff's lawyer cannot execute an agreement to indemnify the tortfeasor's liability insurance carrier against any unpaid liens. Rule 5.1(b), Rules of Professional Conduct; RPC 228 (July 26, 1996).
2. If the settlement agreement provides that money will be held back to assure payment of liens, make sure the carrier does not immediately pay Medicare directly. The current practice is to get the Medicare lien information after the fact of the settlement. Remember, Medicare's reimbursement right is not absolute and there may be defenses. There may also be grounds to justify a compromise based on need, especially where the plaintiff is not receiving full value for his or her injury. If funds are to be held back, payment to Medicare should not be made

until the Medicare claim is fully determined.

3. As will be demonstrated later in this manuscript, it is pointless to try to use settlement language to the effect that settlement is for “pain and suffering only.” The language of the settlement agreement cannot circumvent the obligation to reimburse Medicare.
4. Despite the foregoing paragraph, the settlement agreement should not attempt to break the settlement down into specific amounts for specific elements of damage.
5. In the case of a reimbursement claim by an ERISA health benefit plan, the lawyer should avoid language obligating the client to make the reimbursement. The ERISA plan has no right to independently pursue the paying tortfeasor for reimbursement so there is no risk to his or her liability carrier in the event plaintiff opts not to reimburse the plan. If the client signs a release with language obligating him or her to pay the plan, the client will then become exposed to the risk of a state action for reimbursement.

If the settlement is with one of several defendants, take care that the release does not contain language effectively releasing “all persons, firms or entities” or similar language.<sup>1</sup> Generally, a release of one of several defendants does not operate as a release of all of them, unless the language of the release is to that effect.<sup>2</sup>

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<sup>1</sup> *Kendrick v. Cain*, 272 N.C. 719, 159 S.E.2d 33 (1968); *Allen v. NCDOT*, 120 N.C. App. 627, 463 S.E.2d 275 (1995)

<sup>2</sup> N.C.G.S. § 1B-4(1)

A release from liability for injuries resulting from negligence does not bar a claim against a physician for malpractice in treating the injured person, unless the release specifically says so. The malpractice is regarded as a separate tort.<sup>3</sup> The statute appears to be an exception to North Carolina's common law regarding a general release in a settlement with one of several tortfeasors. Note, however, that this statute does not apply to wrongful death actions.<sup>4</sup>

If the client is receiving or is expected to receive Medicaid, Social Security, SSI or certain veteran's benefits, a "special needs trust" should be considered to protect the client against loss of those benefits. Otherwise, the settlement may be consumed by the payment of future expenses leaving the client with no compensation for other elements of damages. The trust becomes the payee of settlement proceeds so that plaintiff's benefits will be preserved. This is especially important if the settlement is for less than full value of the claim and would have to be consumed before the plaintiff would again qualify for benefits. Of course, the disadvantage is that plaintiff does not have unrestrained use of the money. The funds are earmarked to pay for expenses other than basic support but there is still some flexibility in the use of the money. The trust must be irrevocable. Medicaid will have a lien against the remainder of the trust at the death of the beneficiary to the extent it has made payments for his or her benefit. If anything is left after that, it will pass to the heirs of the beneficiary.

If a case is settled at mediation make sure all the terms and conditions of the settlement are established before the mediation is adjourned. Agreement at mediation to sign a "mutually agreeable" release may not be an agreement at all. See, *Chappell v. Roth*, 353 N.C. 690, 548 S.E.2d 499 (2001), in which the parties agreed at mediation to settle for \$20,000 in exchange for

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<sup>3</sup> N.C.G.S. §1-540.1

<sup>4</sup> *Simmons v. Wilder*, 6 N.C. App. 179, 169 S.E.2d 480 (1969)

a release “mutually agreeable to both parties.” Defendant submitted a release which plaintiff found objectionable and would not sign. Defendant refused to pay the settlement amount and plaintiff moved to enforce the settlement. The Supreme Court held that since there was no agreement on all the terms, and no agreed way by which to settle the dispute, there was no enforceable settlement.

## **B. PARTIAL SETTLEMENTS**

It is not unusual, in medical malpractice cases, for a claim to involve several defendants. These could include a surgeon, anesthesiologist, nurses, hospitals, or other providers. Typically, one or more of the named defendants will at some point want to discuss “settling out,” while others may adamantly refuse to settle.

The decision whether to settle with less than all the defendants is mostly one of strategy. In reaching the decision, counsel must consider a number of things.

- **What is the culpability of the settling defendant?** If the party that wants to settle is one whose negligence played a minor role in producing the injury, or if that party has a strong defense, the benefit of settling with that party, and continuing to pursue claims against other parties, may outweigh the potential pitfall of doing so.
- **What role does insurance coverage play?** If the party desiring to settle is willing to pay all, or nearly all, of its coverage, so that continuing to pursue that party would result in little or no additional benefit, there may be some advantage to the client in an early, partial, settlement.
- **How will settling with one of several defendants affect the defenses of the remaining ones?** Generally, defendants in medical malpractice cases do not

aggressively defend by pointing to other defendants as being responsible. That will change if one or two defendants are out of the case at trial. Counsel can be assured that at trial remaining defense counsel will point to the “empty chair” and argue that the settling defendant was at fault.

- **Are there jurisdictional problems?** This can get tricky if there is a product liability component to the case, as where a defendant has brought in a product manufacturer with an allegation that it was a product failure, not medical negligence, that caused plaintiff’s injury. The chances are that the product manufacturer is a corporate citizen of another state and, if that is the last remaining defendant, it may look to remove the case to federal court - not a friendly environment for a personal injury plaintiff. Federal courts present hurdles not encountered in state courts.

Of course, there may be advantages to settling with fewer than all defendants.

- **Is the client in desperate need of immediate cash?** Ultimately, this is the client’s decision and his or her financial condition may make settlement with fewer than all defendants attractive and worth the risk.
- **Will some of the money be available to defray expenses?** Anyone handling medical malpractice cases knows how expensive they are to prepare and prosecute. Proceeds from settlement with one defendant may finance the remainder of the case.
- **To what degree is the client being compensated?** Sometimes, one defendant will offer an amount that would come close to fully compensating the plaintiff. In that case, there is little to lose by settling. Any subsequent recovery from the non-

settling defendants becomes “gravy.”

**How will the settlement affect the way other defendants view the case?** In North Carolina, once one defendant settles with plaintiff, the provisions of the Uniform Contribution Among Tortfeasors Act<sup>5</sup> may not apply to allow the non-settling defendants to seek contribution from the settling defendant. If the non-settlers have significant concerns about the possibility of paying more than their respective “fair share,” that fear may motivate them to enter settlement discussions in order to protect themselves. On the other hand, once joint and several liability has been established by a verdict, settlement with one tortfeasor will not avoid the requirements of proportionality required by the Act.<sup>6</sup>

If the decision is made to settle with one of several defendants, counsel should be careful to make sure the client does not sign a release containing language effectively releasing all tortfeasors (see above section). The better practice is for the release to clearly preserve the right to pursue the claim against the non-settling defendants.

### **C. MULTIPLE PARTY SETTLEMENTS**

Particular problems arise when there are multiple parties involved in the resolution of a case. This can be either multiple plaintiffs or multiple defendants.

In the medical malpractice arena, the most likely scenario involves an injury to a minor

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<sup>5</sup> N.C.G.S. §1B-1, *et seq.*

<sup>6</sup> See, *Medical Mut. Ins. Co. v. Mauldin, et al.*, 137 N.C. App. 690, 529 S.E.2d 697 (2000), in which one defendant paid \$225,000 to settle pending the appeal of a \$750,000 judgment. The appellate court found no error, leaving the non-settling defendant liable for the remainder of the judgment. Medical Mutual sought contribution from the settling defendants. The Court of Appeals held that the joint and several liability of the defendants was established by the judgement below and the non-settling defendants were entitled to contribution to offset the disproportionate share of the joint and several liability established by the trial.

with a resulting claim on behalf of the parents in addition to the minor's claim. Also, with increasing frequency, we see multiple claims against a single provider arising out of a particular surgical technique or some other negligent activity on the part of the provider. Sometimes one lawyer may find him- or herself handling a number of similar claims against a single defendant.

In the case of a minor's claim, along with that of the parents, conflicts may arise if there is a limited recovery. The parents will be most anxious to recover their outlay of medical expenses, the court will be most anxious to maximize the recovery for the child. It is never a good idea for a parent to serve as guardian ad litem in such a case and, when it becomes apparent that there may be a conflict, the prudent lawyer should withdraw from representing the parents and allow them to retain independent counsel. No allocation of settlement proceeds should be made until the court has approved the settlement, and resolved the issues between the parents and child.

Another scenario involving multiple plaintiffs occurs when the lawyer finds himself or herself representing a number of plaintiffs in similar claims, all against the same defendants. There will be pressure from the defense for a global settlement and, in cases where coverage may be limited, such a settlement may be advisable. There are risks involved, however. The lawyer for plaintiffs should not be compelled to devise the formula by which the global settlement would be divided among claimants. This places the lawyer in a conflict of interest. On the other hand, if all of the claimants consent to that procedure, the lawyer may proceed. It is advisable to seek court approval of any proposed global settlement.

In cases in which there are multiple defendants, settlement can become complicated and difficult. North Carolina does not have comparative fault, so there is no common law or statutory scheme for apportioning damages among multiple defendants. There may be pressure

from defendants for plaintiff counsel to do just that, but that pressure should be avoided. You can be assured that each defendant would argue that its respective share of any settlement is too large and, once you compromise with that defendant, you have lowered the settlement total, because no other defendant will willingly accept a larger share of responsibility than that already suggested. Unfortunately, even in situations in which everyone agrees on a settlement value, settlement can be stymied by a defendant who disagrees with its projected share of responsibility.

For these reasons, the better practice is probably to refrain from attempting to allocate responsibility. Leave that to the defendants. In some cases, it might be appropriate to suggest that the matter of allocation of responsibility, if that is the sole remaining obstacle to completing a settlement, be submitted to a mutually agreeable arbitrator.

#### **D. LIENS**

##### **1. Liens in favor of health care providers**

Two statutes in North Carolina create potential liens in favor of health care providers.

N.C.G.S. §44-49(a) creates a lien “upon any sums recovered as damages for personal injury in any civil action in this State.” Subsection (b) of the statute provides that no lien is valid unless the health care provider “furnishes, without charge to the attorney as a condition precedent to the creation of the lien” such things as an itemized bill, medical or hospital records, or a medical report. The provider claiming the lien must also give a written notice to the attorney of the lien claimed.

N.C.G.S. §44-50 provides that if a plaintiff is not represented by an attorney, the lien created under §44-49 nevertheless applies. It also provides that “[t]he lien provided for shall in no case, exclusive of attorney’s fees, exceed fifty percent (50%) of the amount of damages

recovered.” The lien attaches even before any money is paid to the plaintiff in satisfaction of the underlying personal injury claim.<sup>7</sup>

A health care provider claiming a lien must do two things if the plaintiff is represented by counsel: the records, bills, or report must be provided *without charge*<sup>8</sup>, AND the attorney must be given written notice of the claim of lien. Once that is done, the lien is perfected. If either of those conditions are not met, there is no enforceable lien.

The lien attaches only to any recovery in the claim, and not to the general assets of the patient/plaintiff.<sup>9</sup>

If there are insufficient funds to satisfy all of the perfected liens, there is no requirement that there be a pro-rata distribution,<sup>10</sup> although that is a practical means of resolving such a situation.

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<sup>7</sup> *Charlotte-Mecklenburg Hosp. Auth. v. First of Georgia Ins. Co., et al.*, 340 N.C. 88, 455 S.E.2d 655 (1995)

<sup>8</sup> N.C.G.S. §90-411 allows health care providers to charge a reasonable fee to cover costs in handling and copying records.

<sup>9</sup> *Gordon v. Forsyth County Hosp. Authority*, 409 F. Supp. 708 (M.D.N.C. 1975), *aff'd in part, vacated in part*, 544 F.2d 748 (4<sup>th</sup> Cir. 1976)

<sup>10</sup> *N.C. Baptist Hosps., Inc. v. Crowson*, 155 N.C. App. 746, 573 S.E.2d 922 (2003), *aff'd* 357 N.C. 499, 586 S.E.2d 90 (2003)

In *N.C. Baptist Hospitals, Inc. v. Mitchell*, 323 N.C. 528, 374 S.E.2d 844 (1988) plaintiff's counsel settled the claim for \$25,000, deducted her fee, and then paid the hospital \$5,812.50 and paid other medical expenses in the amount of \$3,562.50. Her disbursement was in accord with N.C.G.S. §44-50. However, the client had previously executed an "assignment" of any compensation he might receive as a result of the wreck. The hospital obtained a default judgment against the injured plaintiff for the balance of its bill, but then sued the lawyer who, it appears, was well aware of the "assignment" when she disbursed the settlement proceeds. The Court of Appeals had ruled that the "assignment" was invalid as contrary to public policy which prohibits the assignment of claims.<sup>11</sup> The Court affirmed the result reached by the Court of Appeals, but for "different reasons," and held that the lawyer could not be held liable for failing to honor the "assignment."

In *Charlotte-Mecklenburg Hosp. Auth. v. First of Georgia Ins. Co., et al.*, 340 N.C. 88, 455 S.E.2d 655 (1995), the personal injury claimants were not represented by counsel. In such a case, there is no requirement that the health care provider perfect its lien as provided in §44-50. The insurance company was apparently made aware, before settlement, of the hospital's claim of lien, but nevertheless paid a settlement directly to the injured parties, without honoring the hospital's lien. The hospital also argued that the injured parties had executed "assignments," similar to the assignment at issue in *N.C. Baptist Hospitals, Inc. v. Mitchell, supra*, and that these assignments should be enforceable. The Court disagreed with the Court of Appeals holding in *Mitchell* that there was no real distinction between an assignment of a claim and an assignment of proceeds of resolution of the claim, but based its decision in favor of the hospital on the

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<sup>11</sup> 88 N.C. App. 263, 362 S.E.2d 841 (1987). The Court of Appeals determined that there was no distinction to be made between an assignment of a claim and an assignment of the proceeds of the claim. This part of its decision was later rejected by the N. C. Supreme Court in

failure of the insurance company to follow §44-50. In neither of these cases did the Court base a decision on the enforceability of the assignment to the hospital.

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the *First of Georgia* case, fn. 1.

Wrongful death cases present different problems. The Wrongful Death Act<sup>12</sup> provides that the recovery in a wrongful death case is not an asset of the estate, except for reasonable funeral expenses and \$4,500 in medical expenses incurred incident to the fatal injury. A creditor of the decedent, such as a hospital, cannot reach the settlement proceeds to satisfy its claim, except to that extent.<sup>13</sup> A wrongful death action is not a claim on behalf of the decedent, but is a claim on behalf of the heirs of the decedent. There is a clear anomaly here. The statute clearly allows the recovery, as an element of damages for the wrongful death, all medical expenses of the decedent incident to the injury giving rise to the death.<sup>14</sup>

## **2. Medicare and Medicaid**

### ***a. Medicaid liens***

Medicaid is a government program set up to provide medical care to persons eligible due to financial need. It is administered by the state under applicable provisions of federal law.<sup>15</sup> In North Carolina, the program is administered by the Department of Health and Human Services, Division of Medical Assistance (DMA).

Recently, the General Assembly enacted legislation clarifying and expanding DMA's

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<sup>12</sup> N.C.G.S. §28A-18-2(a)

<sup>13</sup> *Forsyth County v. Barneycastle*, 18 N.C. App. 513, 197 S.E.2d 576 (1973)

<sup>14</sup> N.C.G.S. §28A-18-2(b). This is only one of several such inconsistencies in the Wrongful Death Act. Another is that evidence of each of the survivor's relationship with the decedent is admissible to allow the jury to assess damages, but the award is in a lump sum, to be distributed to each class of beneficiaries equally, regardless of his or her relationship to the decedent. Thus, the estranged son gets the same amount as the loyal and loving daughter, whose share is more than likely reduced by the jury taking into account the lack of love and affection between decedent and the estranged son.

<sup>15</sup> 42 U.S.C. §§ 301, *et seq.*; 41 U.S.C. § 1396a(a)25(A) and (B) requires each state Medicaid program to ascertain the legal liability of third parties to reimburse for medical assistance provided by the state and recover from third parties the cost of the medical assistance provided.

“subrogation” rights. Prior to this legislation, it was sometimes possible to negotiate a compromise of a Medicaid lien, but now the state is unwilling to take a reduced amount to satisfy the lien. While the legislative intent may have been to aid in full Medicaid recovery, it may actually hinder some claimants from pursuing claims against responsible tortfeasors if the Medicaid lien appears likely to gobble up a significant portion of any potential recovery. It remains to be seen if this new legislation will actually increase recovery of benefits by the state.

The new law absolves the DMA of any responsibility for its pro-rata share of the cost of recovery, and provides for the abrogation of common law principles of equity declaring that the State “shall be subrogated to all rights of recovery . . . notwithstanding any other provisions of the law.”<sup>16</sup> In *Ezell v. Grace Hospital*, 623 S.E.2d 79 (N.C. App. 2006), plaintiff filed a medical malpractice suit against the hospital and other health care providers, alleging that the minor plaintiff’s cerebral palsy was the result of negligence in her delivery, some eleven years earlier. Plaintiff and the hospital settled early in the case for \$100,000 and later, discovery having created significant doubts about causation, plaintiff settled with remaining defendants for another \$100,000. DMA intervened, claiming a lien in the amount of \$86,840.92. This represented all Medicaid payments made on behalf of the minor plaintiff.

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<sup>16</sup> N.C.G.S. §108A-57(a) (2003)

At the hearing, the trial court approved the settlement, and limited DMA's recovery to \$8,054.01, which the Court determined to be the amount of medical expenses causally related to the negligence of defendants. DMA appealed, alleging error by the application of equitable principles. The majority of the Court of Appeals felt that the legislature "surely did not intend that DMA could recoup for medical treatment unrelated to the injury" and concluded that N.C.G.S. §108A-57(a) limits DMA's subrogation rights to the injury for which the beneficiary received third-party recovery. The Court also thought the trial court's findings on causation were not supported by competent evidence. Judge Steelman dissented, in part, relying on *Cates v. Wilson*, 321 N.C. 1, 6, 361 S.E.2d 734, 738 (1987) in which the Court said "North Carolina law entitles the state to full reimbursement for any Medicaid payments made on a plaintiff's behalf in the event the plaintiff recovers an award for damages." Judge Steelman would have held that DMA was subrogated to the entire amount of the settlement (only the second \$100,000 was at issue) and was entitled to receive one-third of that amount as partial payment of its lien.<sup>17</sup> The State Supreme Court reversed in a Per Curiam opinion, "for the reasons stated in the dissent."<sup>18</sup>

*Ezell* was argued in the North Carolina Supreme Court April 18, 2006, and its Per Curiam opinion was filed June 30, 2006. Subsequently, On May 1, 2006, the U.S. Supreme Court handed down its opinion in *Arkansas Dept. of Health and Human Services, et al. v. Ahlborn*, 126 S.Ct. 1752 (2006).

Heidi Ahlborn was seriously and permanently injured in a car wreck. Because of her financial condition, she qualified for Medicaid and the Arkansas Department of Health Services

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<sup>17</sup> The statute provides that DMA can recover up to one-third of the plaintiff's recovery .

<sup>18</sup> 631 S.E.2d 131.

(ADHS) paid \$215,645.30 in medical expenses on her behalf. ADHS and Ahlborn's attorney were in frequent contact during the pendency of her claim, and ADHS gave notice to the attorney that it claimed reimbursement from any recovery from any third party and that no settlement should be finalized without ADHS having an opportunity to "establish its interest." Ahlborn's lawsuit sought damages past and future medical expenses and other allowable damages. ADHS intervened in the lawsuit to assert a lien on the proceeds of any third party recovery Ahlborn might obtain. The case was settled for \$550,000. The settlement was in a lump sum, with no allocation of damages. ADHS did not participate, nor did it seek to participate, in any of the settlement negotiations. It did, however, assert its lien for \$215,645.30.

Ahlborn then filed a declaratory judgement action in U.S. District Court seeking a declaration that the lien violated the federal Medicaid laws insofar as its satisfaction would deplete her compensation for injuries other than her past medical expenses. There was a stipulation that the value of Ahlborn's personal injury claim was in excess of \$3,000,000 and that the settlement amounted to about one-sixth of that and that, if Ahlborn's interpretation of federal law was correct, ADHS would only be entitled to \$35,581.47, the portion of the settlement that constituted reimbursement of past medical expenses.

There were cross motion for summary judgement and the District Court held that under Arkansas law, Ahlborn had assigned to ADHS her right to any recovery from the negligent third party. ADHS was entitled to the entire amount claimed.

The Eighth Circuit reversed, holding that ADHS was entitled only to that portion of the settlement that represented payments for medical care. The Supreme Court affirmed.

The Arkansas Supreme Court, like North Carolina's, had interpreted that state's statute,

refusing to endorse an equitable interpretation of the statute.<sup>19</sup> The Arkansas Court rejected a Medicaid recipient's argument that he ought to retain some of his recovery, which was insufficient to cover both his and Medicaid's expenses.

Given the clear, unambiguous language of the statute, it is apparent that the legislature intended that ADHS's ability to recoup Medicaid payments from third parties or recipients not be restricted by equitable subrogation principles such as the "made whole" rule . . . . By creating an automatic legal assignment which expressly becomes a statutory lien, [the statute] makes an unequivocal statement that the ADHS's ability to recover Medicaid payments from insurance settlements, if it so chooses, is superior to that of the recipient even when the settlement does not pay all the recipient's medical costs.

336 Ark. 297 at 308.

The Supreme Court felt the Arkansas statute went too far and held that it was in conflict with the anti-lien provisions of the federal Medicaid laws. The tortfeasor, in its settlement, accepted only one-sixth of Ahlborn's overall damages and ADHS was bound by its stipulation that only \$35,581.47 represented compensation for medical expenses. The relevant "liability" extended no further than that amount.

*Ahlborn* seems to be highly consistent with the reasoning of the majority in the N. C. Court of Appeals decision in *Ezell*, and contrary to the dissent in that case that was adopted, Per Curiam, by the North Carolina Supreme Court. Since federal Medicaid law will preempt state law, it would appear that *Ezell* may be old news. That remains to be seen.

It is noteworthy that the Supreme Court allowed *Ahlborn* to file her declaratory judgement action rather than requiring her to file under 42 U.S.C. § 1983. The Medicaid Act does not expressly confer a right of action. Thus, it would appear that it may now be easier for litigants to proceed in federal court. *Ahlborn* implicitly supports the conclusion that where a

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<sup>19</sup> *Arkansas Dept. Of Human Servs v. Estate of Ferrel*, 336 Ark. 297, 984 SW.2d 807 (1999)

state statute conflicts with or is preempted by federal law, the right of action is conferred by the Supremacy Clause of the U.S. Constitution.

Presumably, there will be a petition for rehearing in *Ezell* following *Ahlborn*, but until the state courts clarify the issue the careful practitioner should at least use the *Ahlborn* decision as a negotiating tool to reduce the amount claimed by DMA in cases where the claimed Medicaid lien would deplete the plaintiff's recovery unduly.

***b. Medicare liens***

About every election cycle there is a great deal of political attention paid to the condition of the Medicare Trust Fund. There is great pressure to preserve the Fund, while at the same time holding taxes used to support it to a minimum. At the same time, the population for whom Medicare is intended to provide coverage (the elderly and the disabled) is growing. As of this writing, there are about 54 million disabled Americans<sup>20</sup> and over 41 million receive Medicare.<sup>21</sup>

In an effort to control Medicare costs, Congress enacted the Medicare Secondary Payer, or MSP, statutes, primarily in recognition that Workers' Compensation insurance carriers should be the primary source of medical insurance coverage for people injured at work.<sup>22</sup> This law provides that Medicare serves as secondary insurance provider when another source of primary coverage exists.

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<sup>20</sup> See, Cornell University, *Disability Statistics, Frequently Asked Questions*, at [www.ilr.cornell.edu/ped/disabilitystatistics/faq.cfm?n=7#Q7](http://www.ilr.cornell.edu/ped/disabilitystatistics/faq.cfm?n=7#Q7) (as of March 21, 2006), based on data from the U.S. Census Bureau, Survey of Income and Program Participation.

<sup>21</sup> Centers for Medicare & Medicaid Services, *Medicare Coverage Center*, at [www.cms.hhs.gov/center/coverage.asp](http://www.cms.hhs.gov/center/coverage.asp) (as of March 21, 2006).

<sup>22</sup> 42 U.S.C. §§ 1302, 139w-101 to -152 (2000 & Supp. 2004).

The Medicare Prescription Drug Improvement and Modernization Act<sup>23</sup> became law in 2003, further defining Medicare's recovery rights and clarifying its enforcement powers. Now,

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<sup>23</sup> Medicare Modernization Act, Pub. L. No. 108-173, 117 Stat. 2066 (2003) (codified as amended in scattered sections of 42 U.S.C. § 1395). Section 103 further clarified the government's right to reimbursement that it had been seeking in *Thompson v. Goetzmann*, 337 F.3d 489 (5<sup>th</sup> Cir. 2003) and *U.S. v. Baxter Int'l, Inc.*, 345 F.3d 866 (11<sup>th</sup> Cir. 2003).

no matter how a settlement agreement is worded, and no matter whether the tortfeasor is covered by liability or other insurance, or is paying out of a self-funded plan, any payments made by Medicare are considered conditional. The Centers for Medicare and Medicaid Services (CMS) has a right to seek recovery “against any entity, including a beneficiary, provider, supplier, physician, *attorney*, state agency, or private insurer that has received any portion of a third party payment directly or indirectly [emphasis added]” if those third party funds should have covered injury related medical expenses.<sup>24</sup> Plaintiff’s attorney and the defendant (including defendant’s liability insurance carrier) can be held responsible for twice the amount owed to the agency.

To make matters worse, plaintiff’s lawyer cannot wait for any kind of notice from CMS before taking action. The onus is on the lawyer to proactively ascertain Medicare’s interests before distributing any settlement proceeds. Medicare’s right to reimbursement is superior to almost all other claims, including those of the injured plaintiff.<sup>25</sup>

Accordingly, all settlements of cases in which plaintiff has received Medicare benefits for payment of medical costs caused by the defendant’s negligence must address reimbursement of Medicare’s past conditional payments. The government’s right of reimbursement under the Medicare Secondary Payer Program (MSP) is generally considered to be far more extensive than those of other public or private payers, including Medicaid. Medicare payments are not to be made for any care or treatment in which “payment has been made or can reasonably be expected

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<sup>24</sup> Memorandum from Thomas L. Grissom, Director, CMS Center for Medicare Management, to All Regional Administrators, *Medicare Secondary Payer - Workers’ Compensation (WC) Frequently Asked Questions*, Question & Answer No. 13, April 22, 2003, found at [www.cms.hhs.gov/WorkersCompAgencyServices/Downloads/42203Memo.rtf](http://www.cms.hhs.gov/WorkersCompAgencyServices/Downloads/42203Memo.rtf) as of March 21, 2006.

<sup>25</sup> 42 C.F.R. § 411.26, *amended by* 71 Fed. Reg. 9466-01 (Feb. 24, 2006).

to be made” pursuant to a liability insurance policy.<sup>26</sup> However, payments may be made in the event the recipient will not receive *prompt* payment from a third-party payer or from the proceeds of a recovery.<sup>27</sup> In medical malpractice cases, there is almost never prompt payment by the liability carrier.

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<sup>26</sup> 42 U.S.C. § 1395y(b)(2)(A) (Supp. 1998); 42 C.F.R. § 411.20(2) (1997)

<sup>27</sup> *Id.*

If payment is made, it is conditioned on reimbursement to Medicare if and when payment for these same services is received from the liability carrier.<sup>28</sup> Hence, Medicare is considered a “secondary” payer, and other sources bear primary responsibility for payment for medical services.

Medicare’s right of reimbursement is sometimes called a “lien,” and is sometimes referred to as a “subrogation” right. Despite the way these terms are sometimes used in appellate decisions, they have technical meanings. “Lien” has been defined as “[a] claim or charge imposed upon specific property to a debt or claim for its satisfaction.” Black’s Law Dictionary, 922 (6<sup>th</sup> ed. 1990). In North Carolina, “[a] lien is simply the right to have a demand satisfied out of the property of another.” *Thigpen v. Leigh*, 93 N.C. 47 (1885). It is a claim imposed upon specific property. Generally, *liens* are created only by statute. “Subrogation,” on the other hand, is an equitable remedy. It is defined as “[t]he substitution of one person in the place of another with reference to a lawful claim, demand or right, so that he who is substituted succeeds to the rights of the other in relation to the debt or claim, and its rights, remedies, or securities.” Black’s Law Dictionary 119 (6<sup>th</sup> ed. 1990). In North Carolina, older cases distinguish between *legal* subrogation, in which a party who is secondarily liable pays the debt of the party who is primarily liable and thereby succeeds to the rights and remedies available to the primary debtor by operation of law, and *conventional* subrogation, in which the parties agree that if the secondarily liable party pays the debt, it succeeds to the rights and remedies of the primary debtor. See, *Everett v. Staton*, 192 N.C. 221 (1926).

Liens, then, attach to property, while subrogation attaches to a claim or right. In a personal injury settlement, a lien must be paid off directly by the lawyer before funds may be

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<sup>28</sup> 42 U.S.C. § 1395y(b)(2)(B)(i)

disbursed to the plaintiff. If that isn't done, the lawyer may incur a personal liability to the lienholder for the funds.

Medicare has frequently referred to its right to recovery as a lien. However, in *Zinman v. Shalala*, 835 F.Supp. 1163 (N.D. Cal. 1993), *aff'd*, 67 F.3d 841 (1995), the court held that Medicare does not have a lien:

The MSP statute does not state that Medicare has a lien, it articulates Medicare's right as a claim to recover from entities who, pursuant to the statute, are required to pay primary . . . [T]he MSP statute does not give the government a claim against property. The statute states that the government may bring an action against any entity which is responsible to pay primary . . . [T]he Court concludes that Medicare does not have a lien interest in the settlement awards.

835 F.Supp. 1163 at 1171.

Notwithstanding the lack of lien status, the statutes and regulations clearly give Medicare a right of action to recover conditional payments from an attorney who has settlement or judgment proceeds in his or her possession.<sup>29</sup> The regulations have a special rule for liability insurance carriers:

In the case of liability insurance settlements . . . the following rule applies: If Medicare is not reimbursed as required by paragraph (h) of this section, the third party payer [liability insurance carrier] must reimburse Medicare even though it has already reimbursed the beneficiary or other party.<sup>30</sup>

Given this, no liability carrier will consent to a settlement without somehow protecting itself against the possibility having to pay Medicare after having paid the settlement amount to plaintiff.

How much can Medicare recover? The general proposition is that CMS may recover an amount equal to the Medicare payment for treatment of injuries covered by the liability

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<sup>29</sup> 42 C.F.R. § 411.24(2)(g) (1997) Also, see the discussion below related to "set aside" issues.

<sup>30</sup> 42 C.F.R. § 411.24(2)(I)(1) (1997)

insurance, up to the full amount of insurance coverage available to pay the claim. However, there is currently no MSP recovery for future Medicare payments after the date of the settlement. Significantly, Medicare, unlike North Carolina Medicaid, reduces its recovery to take into account the cost of recovery (i.e., attorney fees).

Medicare payments may have been made for health care unrelated to the subject injury. For that reason, before accepting the Medicare claim counsel should carefully examine the itemized health services for which reimbursement is claimed to exclude payments of unrelated conditions. If Medicare does not agree, the beneficiary has the right to appeal.

A beneficiary can ask Medicare for a further compromise or even waiver on the ground of hardship.<sup>31</sup> The MSP Manual<sup>32</sup> sets out factors to be considered in granting waivers. These may include out-of-pocket expenses incurred by the beneficiary, his or her age, assets, income and expenses, as well as his or her impairments. All factors claimed to apply must be supported by specific information or documentation. Medicare's decision about whether to waive reimbursement is not appealable.<sup>33</sup>

*c. Medicare "Set Aside" issue*

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<sup>31</sup> 42 U.S.C. § 1395y(b)(2)(B)(v); 42 C.F.R. § 411.29(a)

<sup>32</sup> Found on line at [www.cms.hhs.gov/manuals/105\\_msp/msp105.index.asp](http://www.cms.hhs.gov/manuals/105_msp/msp105.index.asp)

<sup>33</sup> 42 C.F.R. § 405.926(h)

To date, these statutes and regulations requiring a “set aside” as part of a settlement agreement have been applied almost exclusively in the Workers’ Compensation arena. For some time now, Workers’ Compensation settlements involving claims of permanent and total disability have been subject to the necessity of including certain “set aside” provisions in settlement agreements.<sup>34</sup> This “set aside” language must allocate a portion of the settlement to cover the future medical expenses.<sup>35</sup> Before the settlement proceeds can be distributed, CMS approval is required. Medicare does not pay for medical care, either before or after settlement, until the plaintiff/claimant has exhausted his or her remedies under Workers’ Compensation.<sup>36</sup> If the settlement does not specifically account for the past and future injury related medical expenses, CMS will deem the balance remaining after addressing reimbursement for *past* payments to be *entirely* for future medical expenses. If no allocation is made for these future expenses, Medicare will not pay for any future expenses until the *entire* settlement is exhausted. With the set-aside, this is avoided. The claimant is not required to spend the whole settlement before Medicare resumes payment. The set-aside acts as primary coverage for post-settlement medicare care and is the amount the claimant must spend for injury related expenses before Medicare again begins to pay.

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<sup>34</sup> In Workers’ Compensation cases, a set aside allocation must be made if the claimant is a Medicare recipient, regardless of the amount of the settlement. If the claimant is not a Medicare recipient, but it is reasonably expected that he or she will become a Medicare recipient within 30 months of the settlement, the set aside allocation is required *only* if the total amount of the settlement (indemnity plus medical less attorney fees) is over \$250,000.

<sup>35</sup> 42 C.F.R. § 411.46 (2005)

<sup>36</sup> Section 411.45 specifies two exceptions.

Why, you may ask, have this discussion of Workers' Compensation issues in a seminar about medical malpractice? The short reason is that the statutory scheme requiring protection of Medicare's interest in Comp cases appears to apply to liability settlements as well. The MSP provisions say Medicare is always secondary to Workers' Comp and other insurance, including no-fault and liability insurance. Under the Social Security Act, payment "may not be made under Medicare for covered items or services to the extent that payment has been made, or can reasonably be expected to be made promptly, under a liability insurance policy or plan."<sup>37</sup> Too, Medicare's authority to review liability settlements arises under the same statute as the authority to review Workers' Compensation settlements.<sup>38</sup>

Why hasn't CMS begun to enforce the requirement that Medicare be protected in liability settlements? For starters, the math is much more difficult. Unlike Comp, which covers the injured worker's lifetime injury related care, there are limits to what a liability insurance policy will or can pay (the coverage available), the existence of contributory negligence as a defense, which can cause a settlement to be for less than "full value" of the claim, and liability issues which often force compromise in settlement. So far, CMS has devised calculation methodologies geared only toward the full-value, "no fault" nature of Workers' Compensation claims. Comp damages, such as "indemnity" and "medical" payments, are easily identified, but in personal injury cases there is an array of damages, both general and special, that make application of these calculations impossible.

Given that the MSP has limited resources and, while statistics are not available, it is likely that the agency is currently overwhelmed with Workers' Comp set asides.

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<sup>37</sup> 42 U.S.C. § 1395y(b)(1)

<sup>38</sup> Social Security Act § 1862, *as amended*, 42 U.S.C. § 1395y(b)(2), (b)(5)(d), (b)(6)

Notwithstanding the lack of published CMS requirements for set asides in liability settlements, the statutory language should make plaintiff lawyers nervous. It is probably unnecessary to be so cautious as to attempt an evaluation of the cost of future medical expenses and include “set aside” language in settlement agreements, and to submit those agreements to CMS for approval. It is even possible that the agency may never get around to releasing standards for liability set asides. At present, it does not appear that a lawyer has a duty to the client to include set aside language in a settlement agreement, but don’t be surprised if this doesn’t happen in the future.

In North Carolina, personal injury and wrongful death recoveries are paid in a lump sum, with no allocation to any specific element of allowable damages. If a release is drafted using broad language (as is usually the case), such as reference to “all damages, past and future,” instead of attempting any breakdown, there is arguably no assumption that the settlement covers lifetime medical costs. Ultimately, it may be impossible to avoid some degree of allocation, since life care plans will always include figures for future medical expenses, and even in the absence of a life care plan, there may be evidence of future medical costs disclosed in discovery documents and used in negotiating the settlement. Also, if the claim involves a significant injury with a large settlement, CMS may presume the plaintiff is being compensated for future medical costs.

There are three things to remember about future injury related payments:

9. In 2001 the government hired an outside vendor to help hunt down, largely through the use of trauma related diagnosis codes, future medical payments made by Medicare that a Workers’ Comp carrier or other primary payer should have paid. The radar is working.

10. CMS is entitled to double damages if it resorts to litigation to recover payments that another entity should have made.

11. By their terms, the 2003 amendments are retroactive to 1980.

### 3. ERISA claims<sup>39</sup>

When Congress passed the Employee Retirement Income Security Act (ERISA)<sup>40</sup> in 1974 the legislation was intended to regulate and protect retirement and other benefit plans provided by employers.<sup>41</sup> For our purposes, ERISA relates to employee health care plans that are self-funded by employers and which seek reimbursement, or “subrogation,” out of proceeds recovered by injured plaintiffs. If a plan is not “self-funded” by the employer, but is fully insured, the ERISA preemption of state laws and regulations does not apply, and the regulation of the N.C. Department of Insurance prohibiting “subrogation” in health insurance policies will apply.<sup>42</sup>

These ERISA plans are free from the restraints typically imposed traditional health care insurance plans by the various states, which are preempted by the federal legislation.<sup>43</sup> Congress having thus created the monster, without providing for any kind of national oversight or regulatory agency, it became necessary for the federal courts to become the “national insurance commissioner.” Instead of becoming a great benefit to workers, ERISA has actually nullified

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<sup>39</sup> Special thanks is due to Arthur J. Donaldson, whose research provides the basis for this portion of the manuscript. Art is generally acknowledged as a “guru” on the subject of ERISA matters.

<sup>40</sup> 29 U.S.C. § 1001, *et seq.*

<sup>41</sup> 29 U.S.C. § 1002(1)

<sup>42</sup> 11 N.C.A.C. 12.0319

<sup>43</sup> *Madonia v. BCBS of Virginia*, 11 F.3d 444 (4<sup>th</sup> Cir. 1993); *Pilot Life Ins. Co. V. Dedeaux*, 481 U.S. 41 (1987)

much of the rights previously secured to working people by state regulation of insurance companies. For example, there is no “bad faith” recourse against an ERISA plan that egregiously denies benefits.

ERISA plans often characterize reimbursement provisions as constituting a “lien,” or may describe them as creating “subrogation” rights. However, from our discussion of liens and subrogation elsewhere in this manuscript, we know that neither term applies to these claims. Note, however, as will be discussed below, if the court imposes a constructive trust on identifiable funds in the possession of the plaintiff (which includes constructive possession), a lien is created.

While the rules and regulations governing ERISA are all-encompassing with respect to retirement or pension plans, very little is addressed to health care plans. The idea was that a federal “common law” would develop. Unfortunately, there is now a patchwork of rulings among the circuits with the Supreme Court occasionally stepping in to resolve some differences. This is not an ideal situation. Counsel may be confident, for example, in his or her knowledge of the applicable law in one circuit, only to have a case filed by an ERISA plan transferred from a federal circuit which recognizes the imposition of a constructive trust on identifiable proceeds to one which does not recognize that remedy.<sup>44</sup>

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<sup>44</sup> *Mid Atlantic Medical Services, Inc. v. Sereboff*, 407 F.3d 212, (4<sup>th</sup> Cir. Md. 2005), cert. granted 126 S.Ct. 735, aff’d 126 S.Ct. 1869 (2006)

Once it has been established that a health care plan demanding reimbursement is, indeed, an ERISA plan, what remedy does it have against the plaintiff if reimbursement is not forthcoming out of plaintiff's recovery? In *Great West Life & Annuity Ins. Co. v. Knudson*<sup>45</sup> the plan sought reimbursement out of funds already disbursed. The Supreme Court found that only an equitable remedy is available to the plan, and ERISA plans could not seek reimbursement in an action at law, once the settlement proceeds had already been disbursed. The Court ruled that the ERISA plan's equitable remedy could be enforced only against identifiable funds.

Following *Great West*, ERISA plans attempted to impose a constructive trust (an equitable remedy) against specifically identifiable funds from plaintiff's recovery, whether in a lawyer's trust account, paid into court, or in some other escrow account not commingled with other clients' funds.<sup>46</sup> The Federal Circuits have split on the question whether a constructive trust may be imposed on identifiable funds. The Fourth,<sup>47</sup> Fifth,<sup>48</sup> Seventh,<sup>49</sup> and Tenth<sup>50</sup> Circuits have considered only the remedy sought and ruled that an ERISA plan can seek imposition of a constructive trust on identifiable proceeds, since that is an equitable remedy. The Sixth<sup>51</sup> and

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<sup>45</sup> 534 U.S. 204 (2002)

<sup>46</sup> *Wellmark, Inc. v. Deguara*, 257 F.Supp. 2d 800 (N.D. Ill. 2002)

<sup>47</sup> *Mid Atlantic Medical Services, LLC v. Sereboff*, *op. cit.*

<sup>48</sup> *Bombardier Aerospace Employee Welfare Benefits Plan v. Ferrer*, 354 F.3d 1119 (5<sup>th</sup> Cir. 2003)

<sup>49</sup> *Admin. Comm. Of Wal-Mart Stores, Inc. Assoc.'s Health & Welfare Plan v. Varco*, 338 F.3d 680 (7<sup>th</sup> Cir. 2003)

<sup>50</sup> *Admin. Comm. Of Wal-Mart Stores, Inc. Assoc.'s Health & Welfare Plan v. Willard*, 393 F.3d 1119 (10<sup>th</sup> Cir. 2004).

<sup>51</sup> *Qualchoice, Inc. v. Rowland*, 367 F.3d 638 (6<sup>th</sup> Cir. 2004)

Ninth<sup>52</sup> Circuits have focused on the basis for the remedy, concluding that because the remedy is contractual in nature there can be no equitable remedy imposing a constructive trust.

An examination of the *Sereboff* case (fn. 43) is in order. Marlene Sereboff and her husband were covered under her employer's ERISA plan, administered by Mid Atlantic Medical Services (MAMSI) when they were injured in a car wreck in California. The plan had the usual "subrogation" language providing for reimbursement out of any recovery obtained from a third party. The plan provided that the reimbursement would not be reduced in the event the beneficiary's recovery was less than full value of the claim, unless MAMSI agreed to the reduction in writing. The Sereboffs settled their claims for \$750,000. MAMSI claimed a "lien" in the amount of \$74,869.37. The Sereboff's lawyer disbursed the money without paying MAMSI anything, whereupon MAMSI sued and sought a temporary restraining order and preliminary injunction requiring the Sereboffs to retain and set aside the amount claimed. The parties actually agreed to preserve the claimed amount until the courts decided who was entitled to what.

Following a Fourth Circuit decision favorable to MAMSI, the Supreme Court granted *certiorari*, addressing the issue of whether an ERISA plan could bring a civil action against a plan participant to obtain equitable relief, where the plan required the beneficiary to reimburse medical expenses advanced by the plan where there is a recovery against a third party and where the recovery (or here part of it) is in an identifiable fund. The Supreme Court held that the relief sought by MAMSI was equitable and therefore in accordance with *Great West* and other cases. Imposition of a constructive trust was appropriate against the identifiable funds in the investment

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<sup>52</sup> *Westaff (USA) Inc. v. Arce*, 298 F.3d 1164 (9<sup>th</sup> Cir. 2002). But see *Honolulu Joint Apprenticeship & Training Committee of United Ass'n Local Union No. 675 v. Foster*, 332 F3d 1234 (9<sup>th</sup> Cir. 2003) where the court held that the distinction between legal and equitable restitution rests on whether there is an identifiable fund.

account. The Court noted that the funds in *Great West* were not an identifiable fund against which the equitable relief sought could be granted, because the funds were in a “special needs trust” and therefore not in plaintiff Knudson’s possession. Thus, the funds must not only be identifiable, they must also be in the beneficiary’s possession in order for equitable relief to be granted.

Because the Sereboffs had agreed to segregate the amount sought by MAMSI into an identifiable account, in their control, an equitable constructive trust could be imposed and the funds could not be disbursed without reimbursing the plan.

The Sereboffs wanted the Court to consider equitable defenses of the “make whole doctrine” and the “common fund doctrine” but the Court, in footnote 2 of the opinion, noted:

The Sereboffs argue that, even if the relief Mid Atlantic sought was “equitable” under §502(a)(3), it was not “appropriate” under that provision in that it contravened principles like the make-whole doctrine. Neither the District Court nor the Court of Appeals considered the argument that Mid Atlantic’s claim was not “appropriate” apart from the contention that it was not “equitable,” and from our examination of the record it does not appear that the Sereboffs raised this distinct assertion below. We decline to consider it for the first time here. [Citation omitted.]

What are the implications of *Sereboff*?

For those of us practicing in the Fourth Circuit, on its face *Sereboff* changes nothing. An ERISA plan can still assert an equitable claim for the imposition of a constructive trust on funds that are (1) identifiable and (2) in the possession of the beneficiary. The only relief available to a self-funded ERISA plan is equitable in nature. The general assets of the beneficiary are not subject to any claim by the plan.

ERISA plans are clearly “allowed,” but not required, to “follow” a portion of a recovery and impose on it a constructive trust by way of court order.

Equitable defenses formerly used to negotiate reductions in claims (such as the make-

whole doctrine) are no longer available.

However, the above footnote in the opinion still gives some negotiating room based on whether the plan's equitable claim is "appropriate," considering the circumstances of the particular case. No case has been found which discusses the "appropriate" portion of the statute.<sup>53</sup> Arguably, it would not be "appropriate" to reimburse the plan in full, if to do so means the injured party gets nothing. Given the amounts involved in *Sereboff*, the "appropriateness" argument would probably fail. But, what if the Sereboffs had recovered only \$75,000, an amount barely sufficient to pay MAMSI's claim, and not even that if attorney fees and costs were paid? Would it be "appropriate" for the court to order full payment to the plan?

There also remains open the question of just what constitutes an "identifiable fund." If the client takes his or her portion of the recovery and places it in an investment account, it might be "identifiable" within the meaning of the law. On the other hand, if that amount is placed in an account with other funds, does it remain "identifiable?" Should the client take his or her share and buy a house, or a car, expending all of the money in the process, is it "identifiable?" What would have been the result of the case had the Sereboffs not agreed to segregate the funds pending judicial resolution of their dispute with MAMSI?

Issues also remain regarding "possession." From *Great West* we know that if a special needs trust is established before the imposition of a constructive trust the corpus of that trust is not in the possession of the defendant and is untouchable. If plaintiff's settlement is in the form of a structure, utilizing an annuity to make future payments, it is probably not in the "possession" of the beneficiary (there are tax laws and revenue rulings already on record to that effect).

We do know that ERISA plans will become more aggressive following *Sereboff*.

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<sup>53</sup> 29 U.S.C. § 1132(a)(2) and (3)(B)

From all this it appears that the best course of action for the prudent lawyer to take is the following:

- Initiate a full and frank discussion of the issues with the client at the earliest opportunity. This is not a situation which should be unanticipated by the client when making decisions about resolving a lawsuit.
- Carefully evaluate the value of the case as it progresses to make sure that, in the event of the worst-case scenario, the case will remain worth taking if the ERISA plan must be fully reimbursed. With the client's consent, contact the plan to determine if a compromise can be negotiated. Remember, the plan has no "subrogation rights, as it cannot succeed to any interest or right of the beneficiary, so the only way it can get any reimbursement at all is if the beneficiary pursues the claim. If the reimbursement is too great, the client may opt not to pursue the claim, in which case the plan will never see a dime.
- On the other hand, there is no obligation on the part of the lawyer to contact the plan at any time. With full and frank discussion with the client of the implications of simply remaining silent, the client may decide to take his or her chances and not make any reimbursement. If the client elects not to make the reimbursement, the lawyer must follow those instructions. It would be prudent in such a case to have the client sign a written directive, including an acknowledgment that the client has been fully advised of the possible consequences of this course of action.<sup>54</sup>
- Recovery funds held in the lawyers trust account, or in the Clerk's office if

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<sup>54</sup> These consequences might include the plan withholding future benefits until it

payment is due to a judgement, are constructively in the possession of the beneficiary. If no compromise has been reached with the plan, or if the client decides not to reimburse the plan, these funds should be disbursed as quickly as possible.

Generally, once the lawyer has disbursed the recovery to the client, there is no personal liability imposed on him or her.<sup>55</sup> The plan may seek settlement funds that remain in the lawyer's trust account.<sup>56</sup> Note, however, that if the lawyer, at the behest of the client, signs an agreement to repay the plan out of any recovery, failure to honor that agreement may result in personal liability.<sup>57</sup>

#### **4. Workers' Compensation Liens**

Occasionally, a medical malpractice claim will arise out of medical treatment rendered for an injury or illness covered by Workers' Compensation. The malpractice does not relieve the employer from its obligation to continue to pay benefits, but the employer is not liable for payment of damages caused by the malpractice, except to the extent the malpractice causes additional medical bills and lost earnings.<sup>58</sup> In such a case, the malpractice of the physician will be treated as a consequence of the work-related injury, but the liability of the employer is limited to the benefits provided under the Workers' Compensation Act.<sup>59</sup>

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<sup>55</sup> *Chapman v. Klemick*, 3 F.3d 1508 (11<sup>th</sup> Cir. 1993), cert. denied 510 U.S. 1165 (1994).

<sup>56</sup> *Bombardier Aerospace, op. cit.*

<sup>57</sup> *Essex v. Randall*, (D.C. Md. Mar. 15, 2006)

<sup>58</sup> N.C.G.S. § 97-26(h); *Bryant v. Dougherty*, 267 N.C. 545, 148 S.E.2d 548 (1966)

<sup>59</sup> N.C.G.S. §§ 97-1, *et seq.*

The employee in such a case has a claim against the negligent health care provider for all damages arising out of the malpractice. In the event of a recovery, the lien provisions of the Act apply.<sup>60</sup> The statute creates a lien in favor of the employer/carrier,<sup>61</sup> and provides the priority in which third-party recoveries will be disbursed. The employer/carrier is reimbursed after payment of attorney fees and expenses and the employer bears a pro-rata share of the attorney fees.<sup>62</sup> Remember, however, that the employer is reimbursed only if it has filed a written admission of liability or if there is an award, final in nature, in favor of the employee.

Subsection (j) of the statute<sup>63</sup> provides a mechanism whereby, in some cases, an injured plaintiff can obtain some relief from the effects of the lien in favor of the employer/carrier. If the injured employee recovers a judgement against, or reaches a settlement with, the third-party tortfeasor, he or she may apply to the court for an order determining the “subrogation” amount.<sup>64</sup> A hearing must follow notice to all interested parties. The court makes the determination of the amount to be paid in its discretion, based upon appropriate findings of fact.<sup>65</sup>

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<sup>60</sup> N.C.G.S. §97-10.2(f)(1)

<sup>61</sup> N.C.G.S. §97-10.2(h)

<sup>62</sup> N.C.G.S. §97-10.2(f)(2)

<sup>63</sup> N.C.G.S. §97-10.2(j)

<sup>64</sup> The statute says the application is to the resident Superior Court Judge of the county in which either the claim arose or the plaintiff resides, or to a presiding judge in either district (clearly giving the District Court jurisdiction to hear these matters).

<sup>65</sup> See, *In re Biddix*, 138 N.C. App. 500, 530 S.E.2d 70 (2000), cert. denied, 352 N.C. 674, 545 S.E.2d 418 (2000).

As a practical matter, the better practice is to attempt to negotiate a settlement with the Workers' Comp insurance carrier. Failing that, the statute is available for possible relief. Remember that the N. C. Industrial Commission must approve the distribution of settlement proceeds, including the amount to be paid as attorney fees.<sup>66</sup> Except for the provisions of subsection (j) of the statute, the Industrial Commission has the exclusive jurisdiction for determination of any "subrogation" in favor of the employer/carrier.<sup>67</sup> However, the statute does not clothe the Commission with the discretion to reduce a lien and it will strictly follow the priorities set in subsection (f)(2) of the statute. There is some authority that even if the Court has entered an order determining the "subrogation" amount, the Commission nevertheless has exclusive jurisdiction over the distribution of the proceeds, although it cannot issue orders to contravene the orders of the Superior (or District) Court.<sup>68</sup>

Federal Workers' Compensation is covered under 5 U.S.C. § 8131 *et seq.* (Federal Employees Compensation Act - FECA). There are a couple of important aspects of this statute:

- The Secretary of Labor may *require* the injured employee to assign his or her claim to the United States, or to prosecute the claim for the benefit of the United States and, if the employee refuses to do so, compensation can be denied. The Secretary of Labor may prosecute the claim and deduct all expenses of collection and pay over any excess to the employee, who must credit the government against future payments due under the Act for the same injury.<sup>69</sup> However, the employee

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<sup>66</sup> *Hieb v. Lowery*, 134 N.C. App. 1, 516 S.E.2d 621 (1999)

<sup>67</sup> *Cox v. Pitt Co. Transportation Co.*, 259 N.C. 38, 129 S.E.2d 589 (1963)

<sup>68</sup> *Hieb v. Howell's Child Care Center, Inc.*, 123 N.C. App. 61, 472 S.E.2d 208 (1996)

<sup>69</sup> 5 U.S.C. § 8131(c)

is entitled to a minimum guaranteed share of “not less than one-fifth of the net amount of a settlement or recovery remaining after the expenses thereof have been deducted.”<sup>70</sup>

If the employee chooses to pursue the claim, he or she may deduct a “reasonable attorney fee” from the recovery, before reimbursing the government.<sup>71</sup>

## **5. Other Liens**

There are other liens lurking around that cannot be ignored. If the client has had vocational rehabilitation as a result of his or her injuries, N.C.G.S. § 143-547 creates a lien in favor of the State Division of Vocation Rehabilitation. Priorities for payment are the same as those for Workers’ Compensation, *supra*.

The Federal Medical Care Recovery Act<sup>72</sup> entitles the federal government to “subrogation in cases where it is authorized or required to provide medical care to persons injured or killed by a negligent third-party. Under this statute, the Veteran’s Administration or the military services may recover for medical care provided to eligible personnel and their dependents. Veteran’s Administration “subrogation” rights are covered in 38 U.S.C. § 629(a)(1), and are similar.

As with FECA, *supra*, the government may require plaintiff to assign the claim to the government “to the extent of that right or claim.”<sup>73</sup> The government can intervene, or file its claim separately if plaintiff does not file an action within six months.<sup>74</sup>

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<sup>71</sup> 5 U.S.C. § 8132. Fees of up to one-third have been found to be “reasonable.” *Sandoval v. Mitsui Sempaku K.K. Tokyo*, 460 F.2d 1163 (5<sup>th</sup> Cir. Canal Zone 1972)

<sup>72</sup> 42 U.S.C. § 2651

<sup>73</sup> *Id.*, subsection (a)

<sup>74</sup> *Id.*

The Medical Care Recovery Act does not provide for recovery of attorney fees and it can recover the full amount paid.<sup>75</sup> However, the government is authorized to compromise its claim, and may even waive it, if the government first concludes that collection would result in “undue hardship” to the injured person.<sup>76</sup>

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<sup>75</sup> *United States v. Nation*, 299 F. Supp. 266 (N.D. Okla. 1969)

<sup>76</sup> *Hanley v. Condrey*, 467 F.2d 697 (2d Cir. 1972)