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Liens in Civil Cases with a Special Emphasis on the Newly Passed SMART Medicare Act

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Generally, subrogation and claims for reimbursement are limited in personal injury cases by 75 Pa.C.S.A. §1720 of the Pennsylvania Motor Vehicle Financial Responsibility Law (hereinafter ñMVFRLò), and Section 508 of the MCARE Act. However, in the MVFRL and MCARE Act, and over the last several years, many exceptions to the general rule have developed where it is almost the exception, rather than the rule, for there not to be valid claims for subrogation or a right to reimbursement when a person in injured and recovers damages from a third party.

The seminal case on this issue was FMC v. Holliday, 498 U.S. 52 (1990), where the Supreme Court of the United States held that sections 1720 and 1722 of the MVFRL are preempted by a self-funded ERISA plan. The United States Supreme Court held in FMC that federal ERISA laws preempt state law. Other exceptions under federal and state law have developed including federal workerôs compensation, HMO, DPW, bankruptcy, child support and Medicare. Thus, there are many exceptions which must be considered under federal and state law.

BLUE CROSS/BLUE SHIELD PLANS

Typically, Pennsylvania Blue Cross/Blue Shield plans are contractual by nature. Although contractual, in the health insurance context, principles of equity apply. These usually provide for subrogation and reimbursement for expenses paid for injuries arising out of third party negligence. These plans are generally state plans and subject to being precluded from subrogation by section 1720 of the Pennsylvania Motor Vehicle Financial Responsibility Law in auto accident cases. However, there are times when Blue Cross/Blue Shield is administering an ERISA self-insured plan and the subrogation prohibition does not apply.

The insurer still must assert its subrogation claim before benefits are paid or at least notify the insured or insuredôs attorney before a final settlement is reached. Unless there is proof of notice of the subrogation claim before a final settlement is reached, equity will not permit recovery. Blue Cross of Northeastern Penn. V. Platt, 576 A.2d 1128 (Pa. Super. 1990) (affirming trial court opinion located at 3 Pa. D&C 4th 561 (1989)).

Although uncommon, there are still some plans which do not seek subrogation for injuries caused by a third party. Since they are contractual claims the importance or reading and re-reading the plan document cannot be emphasized more than enough.

MEDICARE (Recent SMART Act)

Beginning with 42 C.F.R. § 411.21, the beneficiary has an obligation to cooperate with Medicare (through its agent, the Health Care Financing Agency or ñHCFAò) to recover the subrogation lien. If HCFAôs recovery action is unsuccessful because the beneficiary does not cooperate, HCFA may recover from the beneficiary. (Id. At § 411.23). HCFA also has a right of action to recover its payments from any entity that has received a third party payment, including the beneficiary and his or her attorney. Id. at § 411.24(g).

This has been interpreted to mean that if an attorney receives a settlement and passes it through the attorneyôs escrow account and does not recognize Medicareôs lien, the attorney may be personally liable for the amount. However, the regulation is not clear. If a third party payer (for example, a liability insurance company) learns that HCFA has made a Medicare primary payment for services which the third-party payer has made or should have made, it must give notice to that effect to Medicare. Id. at § 411.25(a).

Importantly, the Medicare Operations Manual in Section 50.4.4 states that ñthe only situation in which Medicare recognizes allocation of liability payments to nonmedical losses is when payment is based on a court order on the merits of the caseé .Medicare does not seek recovery from portions of court awards that are designated as payment for losses other than medical services.ò Thus, in some cases the court may be asked and needed to enter an actual award for the amount of medical losses recovered as opposed to non-medical losses.

HCFA may join or intervene in any action related to the events that gave rise to the need for services for which Medicare paid. Id. at § 411.26(b). If HCFA incurs procurement costs because of opposition to its recovery, HCFAôs recovery is the lower of either the Medicare payment or the total judgment or settlement amount minus the parties total procurement costs. It is obvious that under these circumstances, Medicare could take the entire amount of the settlement. Id. at § 411.37(e). However, there does not seem to be any specific requirement for the beneficiaryôs attorney to notify Medicare.

In U.S. v. Sosnowski, 822 F.Supp. 570 (W.D.Wisc. 1993), the court entered judgment against a personal injury plaintiff and his attorney. The plaintiff had settled his personal

injury case, but he did not reimburse HCFA for Medicare from the settlement process. The District Court rejected their estoppel arguments and held that the plaintiff was required to reimburse HCFA. See also Roberts v. Total Health Care, Inc., 349 Md. 499, 709 A.2d 142 (1998) which cites Sosnowski with approval and discusses the ethical obligations of attorneys to protect subrogation liens.

WAIVER

The attorney can request Medicare to waive right to reimbursement:

a. If probability of recovery does not warrant pursuit of claim. 42 C.F.R. § 411.28.

b. Claim is under $20,000 and would be difficult or costly to collect. 42 C.F.R. 405.374.

c. Client not at fault and recovery would defeat the purpose of Medicare or be against equity and good conscience. 42 C.F.R. §§405.355(a), 404.508, and 404.509.

Settlements made on this basis can consider ñfairnessò when determining what constitutes an acceptable offer. Medicare will consider - - the ongoing physical conditions of the beneficiary including permanent disability or disfigurement caused by the accident; the extent to which the beneficiary has been compensated for the intangible effects of the accident such as the loss of a spouse or close relative; and documented out-of-pocket medical expenses that would have been covered had Medicare been primary payer.

The future financial condition of the beneficiary may be taken into consideration. This includes lost wages or otherwise unreimbursed expense that the beneficiary is forced to incur as a result of the accident. It is not intended that the beneficiary should suffer financially, simply because Medicare is the secondary payer.

SMART ACT

Despite all of the problems with agreeing on legislation in the last Congress, it was able to pass important legislation just before the New Year and its recess. With only three ñnoò votes in the House and unanimous passage in the Senate, Congress passed H.R. 1845, including legislation known as the ñStrengthening Medicare and Repaying Taxpayers Actò (SMART Act). The Act is designed to improve the efficiency of the Medicare Secondary Payer (MSP) system and process, by requiring the Centers for Medicare and Medicaid Services (CMS) to streamline its process, eliminating the uncertainty and costly delays in settling claims and providing funds to the beneficiaries sooner. The bill was signed into law on January 10, 2013.

Overview

The Act creates a new enforcement tool for CMS to pursue MSP claims through a new reporting requirement and a shift in compliance responsibilities upon the regulated community of group health plans, workersô compensation plans and insurers, liability insurers, self-insureds, and others. The SMART Act is intended squarely at speeding up Medicare liens and the potential liability to CMS which lingered when litigation, third-party actions or workersôcompensation claims were settled.

One of the biggest obstacles for carriers and insurers was the overriding question as to whether an injured plaintiff or claimant was Medicare eligible ï the lynchpin for all of the administrative nightmares previously associated with the MSP law.

The SMART Act creates a ñsafe harboròwhere the primary payer is unable to obtain the plaintiffsô SSNs after a good faith effort. This change was necessitated by plaintiffsô refusal to provide their Medicare numbers or SSNs due to privacy concerns. Medicare numbers are often just as ñprivateò as SSNs because they are generally the SSN followed by a letter.

In addition to eliminating the use of SSNs and Medicare numbers, the SMART Act creates a three-year statute of limitation for all MSP claims. The new three-year statute of limitations for MSP recovery actions accrues from the date of receipt of the Section 111 report, which makes that date our new best friend.

A key provision in the SMART Act is a new ability to ñlock inò Conditional Payment amounts prior to settlement. If the Medicare Secondary Payer Recovery Contractor (MSPRC) is provided with enough time to calculate the Conditional Payments prior to settlement, and, if they are informed of the settlement less than three months after its determination of Conditional Payments, the MSPRC cannot increase that amount thereafter

Under the new Act, CMS has 65 days from the receipt of a request to provide the Medicare reimbursement amount, which can be extended 30 days after additional notice is provided to CMS with respect to a failure to respond to the initial request. After this period, the parties can rely on the reimbursement amount available on the CMS website.

Effective January 1, 2014, certain liability claims will now be exempt from reporting and reimbursement if the claim falls below the annual threshold as calculated by the Secretary of Health and Human Services (HHS). Civil penalties for non-compliance with mandatory insurance reporting requirements will now be discretionary and ñup toò $1,000 for each day of non-compliance with respect to each claimant. CMS is also now mandated to implement a reporting process so that responsible reporting entities do not have to access or report SSNs or Health Identification Claim Numbers (HICN).

On its website (justice.org) and in publications, The American Association of Justice (AAJ) has provided summaries of some of the changes made by the SMART Act.

Here are a few highlights:

Portal: CMS is required to maintain a secure web portal with access to claims and reimbursement information. The web portal must meet the following requirements:

ÅPayments for care made by CMS must be loaded into the portal within 15 days of the payment being made.

ÅThe portal must provide supplier or provider names, diagnosis codes, dates of service, and Conditional Payment amounts.

ÅThe portal must accurately identify that a claim or payment is related to a potential settlement, judgment, or award.

ÅThe portal must provide a method for receipt of secure electronic communications from the beneficiary, counsel, or the applicable plan.

Å Information transmitted from the portal must include an official time and date of transmission.

ÅThe portal must allow parties to download a statement of reimbursement amounts.

Reimbursement Process: The SMART Act requires parties to notify CMS when they reasonably anticipate settling a claim (any time beginning 120 days before the settlement date). CMS then has 65 days to ensure the portal is up to date with all of the appropriate claims data. CMS can have an additional 30 days on top of the 65 days to update the portal if necessary. At the expiration of the 65 and potentially the 30-day periods, the parties may download a final Conditional Payment amount from the website. The final Conditional Payment amount is reliable as long as the claim settles within three days of the download.

Discrepancies: CMS is required to provide a timely process to resolve any discrepancies regarding the amount to be reimbursed. An individual can provide the Agency with documentation to establish that the web portal is not reflecting an accurate reimbursement amount. CMS is required to respond to this documentation within 11 business days. If CMS does not make a determination within 11 days, the reimbursement amount as calculated by the beneficiary becomes the final Conditional Payment amount.

Appeals: CMS must draft regulations that give applicable insurance plans limited appeal rights to challenge final Conditional Payment amounts. These appeal rights are only applicable in the event CMS attempts to collect reimbursement from the plan. Beneficiaries must be given notice of any appeal undertaken by an insurance plan. Existing appeal rights for beneficiaries remain the same.

Threshold (Section 202): CMS, with input from the Government Accountability Office (GAO), is required to calculate and implement a threshold amount for liability claims

(excluding ingestion, implantation, and exposure claims) only. The threshold amount will be based on the costs to CMS for collecting an average claim. If an amount owed is under that threshold amount, CMS is barred from seeking repayment. The threshold will be calculated and adjusted annually.

Reporting (Section 203): CMS has discretion in applying reporting penalties on insurance companies. Previously, any reporting error by an insurer was subject to a $1,000 a day penalty. The SMART Act amends the statute to allow for discretion in the amount of the penalty based on the severity of the violation.

Social Security numbers (Section 204): CMS is required to modify plan reporting requirements within 18 months so that plans do not have to use SSNs or Health Identification Claim Numbers (HICN). CMS may have an additional 12 months if it affirms to Congress it needs more time. This provision addresses several policy concerns related to privacy and reporting.

Statute of Limitations (Section 205): CMS only has three years from the time they are notified of a settlement to seek payment for medical services provided. This provision will eliminate a CMS push for a six-year statute of limitations that had recently been argued in the 11th Circuit.

Comparative Fault

The Medicare Secondary Payer Manual establishes that ñthe only situation in which Medicare recognizes allocations of liability payments to non-medical losses when payment is based on a court order on the merits of the case. If the court or other adjudicator of the merits specifically designates amounts that are for payment of pain and suffering or other amounts not related to medical services, Medicare will accept the courtôs designation. Medicare does not recover from portions of court awards that are designated as payment for losses other than medical services.ò (Section 50.4.4: Designation in Settlements.) Medicare will not make any reduction for comparative fault. If a beneficiary has considerable comparative fault for an injury causing liability accident, Medicare has a waiver process whereby Medicare could potentially reduce the amount it is seeking in reimbursement. More information about the waiver process can be found on the MSPRC website at www.msprc.info.

The New "Self-Calculated Final Conditional Payment Amount" Option

CMS will be ñimplementing an option that will allow certain Medicare beneficiaries to obtain Medicareôs final conditional payment amount prior to settlement.ò This will only apply to certain settlements of $25,000 or less where the beneficiary is done treating. Under this option, the beneficiary will be able to calculate and submit the amount of Medicareôs conditional payments, which the MSPRC will review and respond within 60-days with a final conditional payment amount.

MEDICAL ASSISTANCE (MEDICAID)/DPW

Under Pennsylvania State Law, Medical Assistance/Medicaid gives the Department of Public Welfare a right to make claims against third parties. Specifically, the law provides that in any action brought by or on behalf of a beneficiary, any settlement, judgment or award obtained is subject to the Department of Public Welfare's claim for reimbursement. Further, the law obliges and requires the attorney to notify the Department of Public Welfare of any potential claims and in the event of a judgment or award the court can reduce litigation expenses and allow the first lien to the Department. 62 P.S. §1409 et seq.; O'Neal v. Henry's Riverside Market, 566 A.2d 307 (Pa. Super. 1989).

In Bowmaster v. Clair, 933 A.2d 86 (Pa. Super. 2007) the Pennsylvania Superior Court held that monies owed by a Plaintiff were only those apportioned to the minor after reaching the age of majority, unless a claim for the medical bills was filed prior to the injured plaintiff reaching 18. However, the Pennsylvania Supreme Court accepted DPW's petition for allowance of appeal and reversed in 2009. See, Bowmaster v. Clair, 987 A.2d 681 (Pa. 2009).

Two holdings which can be considered to come out of the case are:

1. In a DPW case, the minor can plead, prove and recover medical expenses incurred during the age of minority and which are paid by DPW but cannot recover them if paid by another source. The Supreme Court did not consider whether or not a minor has a common law right to bring a cause of action for medical bills.

2. The parents of the minor retain the right to plead, prove and recover medical expenses incurred while their child is a minor assuming they are not otherwise precluded from doing so by statute or applicable case law.

Also important is that in 2006 the United States Supreme Court in Arkansas v. Ahlborn, 547 U.S. 268 (2006) held that only monies recovered as part of a settlement that are attributable to medical benefits paid by Medicaid are subject to reimbursement. In response the Pennsylvania Department of Public Welfare has announced policy guidelines as to how it interprets the Ahlborn decision. These guidelines were published in the September 8, 2007 Pennsylvania Bulletin and are now located in Title 55 of the Pennsylvania Code at Section 259.2.

When addressing a possible Medical Assistance/Medicaid lien, the attorney should first check with the Department of Public Welfare to make sure other expenses are not included. The reimbursement lien is specifically limited to medical expenses related to the injury. 62 P.S. §1409 (b) (1).

As of August 15, 1994, the attorney has a responsibility to contact the Department of Public Welfare of a claim. Prior to that date Pennsylvania Supreme Court decisions held that the attorney had no obligation to notify the Department of Public Welfare. There is now a clear notification requirement in section 1409 (b) (12). However, this may present an ethical violation.

On August 15, 1994, a provision enacted on attorney liability at 62 P.S. §1409 (b) (9) provides:

> ñA court, administrative agency, insurer, attorney or other person shall not pay or distribute to the beneficiary or his or her designee the proceeds of an action, claim or settlement where the Department has an interest without first satisfying or assuring satisfaction of the interests of the Commonwealth. Any insurer, attorney or other person who fails to comply with the obligations established under this section shall be liable to the Department for conversion and the Department may sue the insurer, attorney or other person to recover.ò

Except as otherwise provided, the entire amount is subject to the Departmentôs claim for reimbursement. However, in no event shall the claim exceed one-half of the recovery after reducing for attorneyôs fees, costs and medical expenses paid by the beneficiary. 62 P.S. §1409 (b) (11).

Therefore, an attorney should always be careful when faced with Medical Assistance/Medicaid claims. It is probably best to always inquire with the Department about a potential lien. Failure to notify the Department may make the attorney liable for conversion.

Further, on September 5, 2008 Act 44 of 2008 became law. This is an important change to Section 1409 and provides for new procedures to notify the Department of a lien and provide it with a chance to assert its reimbursement claim if the beneficiary will not pursue it. There are now specific obligations and procedures to be followed when deciding whether to protect the DPW lien or not and how to provide notice.

Recently the United States Supreme Court announced an extremely important decision in WOS, Secretary, North Carolina Department of Health And Human Services v. E.M.A., a minor, by and through her guardian ad litem, Johnson, et al., No. 12-98, 568 U. S. ____ (2013).

By way of background, the federal Medicaid law provides that all U.S. States must require Medicaid beneficiaries ñto assign the State any rights . . . to support (specified as support for the purpose of medical care by a court or administrative order) and to payment for medical care from any third party.ò 42 U. S. C. §1396k (a) (1) (A). U.S. States receiving Medicaid funds must also ñha[ve] in effect laws under which, to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished to an individual, the State is considered to have acquired

the rights of such individual to payment by any other party for such health care items or services.ò §1396a (a)(25)(H).

However, a separate provision of the federal Medicaid law, known as the anti-lien provision, provides that ò[n]o lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan.ò §1396p (a) (1).

Thus, the federal Medicaid law requires an assignment to the State of ñthe right to recover that portion of a settlement that represents payments for medical careò but it also ñprecludes attachment or encumbrance of the remainder of the settlementò because the beneficiary has a property right in the proceeds of the settlement, bringing it within the ambit of the anti-lien provision, and that property right is subject to the specific statutory ñexceptionò requiring a State to seek reimbursement for medical expenses paid on the beneficiaryôs behalf (the anti-lien provision protects the beneficiaryôs interest in the remainder of the settlement).

In this case arising out of North Carolina, the Supreme Court decided whether a North Carolina statute that required that up to one-third of any damages recovered by a beneficiary for a tortious injury be paid to the State to reimburse it for payments it made for medical treatment on account of the injury was compatible with the federal anti-lien provision.

The North Carolina statute requires that ñé Any attorney retained by the beneficiary of the assistance shall, out of the proceeds obtained on behalf of the beneficiary by settlement with, judgment against, or otherwise from a third party by reason of injury or death, distribute to the Department the amount of assistance paid by the Department on behalf of or to the beneficiary, as prorated with the claims of all others having medical subrogation rights or medical liens against the amount received or recovered, but the amount paid to the Department shall not exceed one-third of the gross amount obtained or recovered.ò N. C. Gen. Stat. Ann. §108Aï 57(a).

The North Carolina Supreme Court had held that the statute ñdefines óthe portion of the settlement that represents payment for medical expensesô as the lesser of the Stateôs past medical expenditures or one-third of the plaintiffôs total recovery.ò In other words, when North Carolinaôs Medicaid expenditures on behalf of a beneficiary exceed one-third of the beneficiaryôs tort recovery, the statute establishes a conclusive presumption that one-third of the recovery represents compensation for medical expenses, even if the settlement or a jury verdict expressly allocates a lower percentage of the judgment to medical expenses.

The U.S. Supreme Court holds that the federal Medicaid anti-lien provision prohibits a State from making a claim to any part of a Medicaid beneficiaryôs tort recovery not ñdesignated as payments for medical careò and further stated that North Carolinaôs statute, therefore, is pre-empted if, and insofar as, it would operate that way.

The Supreme Court holds that the North Carolina statute is pre-empted by the federal anti-lien provision for that reason: ñthe defect in §108Aï 57 is that it sets forth no process for determining what portion of a beneficiaryôs tort recovery is attributable to medical expenses. Instead, North Carolina has picked an arbitrary numberð one-thirdð and by statutory command labeled that portion of a beneficiaryôs tort recovery as representing payment for medical care. Pre-emption is not a matter of semantics. A State may not evade the pre-emptive force of federal law by resorting to creative statutory interpretation or description at odds with the statuteôs intended operation and effect.ò

The Supreme Court concluded, ñThe law here at issue, N. C. Gen. Stat. Ann. §108Aï 57, reflects North Carolinaôs effort to comply with federal law and secure reimbursement from third-party tortfeasors for medical expenses paid on behalf of the Stateôs Medicaid beneficiaries. In some circumstances, however, the statute would permit the State to take a portion of a Medicaid beneficiaryôs tort judgment or settlement not ñdesignated as payments for medical careò é The Medicaid anti-lien provision, 42 U. S. C. §1396p (a) (1), bars that result.ò

CASH ASSISTANCE/PUBLIC ASSISTANCE (WELFARE)

A person who has received these benefits has an obligation to pay back cash assistance from the date of the accident causing the injury to the time of the settlement. 62 P.S. § 1974. The Department of Public Welfareôs right to recovery is the same as other creditors. In Re: Reiverôs Estate, 343 Pa. 137, 22 A.2d 655 (1941).

Normally, the Department will ask the claimant to sign a reimbursement agreement under a PA 176-K form. However, the language of the form exceeds the rights given in the statute, and the reimbursement agreement has been held not to constitute an assignment of rights under Tunnicliff v. Department of Public Welfare, 483 Pa. 275, 396 A.2d 1168 (1978). The form only acts as an acknowledgment of the obligation.

The cash assistance statutes do not obligate the attorney to notify the Department or protect the Departmentôs interests in a settlement. This is different than the statutory obligation now imposed on an attorney representing a Medicaid recipient. The Department of Public Welfare uses a lump sum income rule and regulatory resource limitation of $2,000 to be eligible for food stamps to withhold benefits.

It is important for the practitioner to be aware of the ñlump sum income ruleò which is found at 55 Pa. Code 183.37. Under the rule, a welfare recipient who receives a large sum of money is automatically disqualified for a period of time. The period of time is used by dividing the lump sum by the ñstandard of needò. 55 Pa. Code 183.105. This disqualification will apply to the entire family. The United States Supreme Court has ruled that the lump sum income rule is valid and applies to personal injury awards. Gardebring v. Jenkins, 485 U.S. 415 (1988). However, a lien may not be applied against the real property comprising the primary residence of the person assisted. 62 P.S. §1974(c).

ERISA Reimbursement/Subrogation

A self-funded or partially funded ERISA plan under 29 U.S.C. §514 preempts Pennsylvania law. Traditional health plans do not preempt Pennsylvania law. This is probably one of the most important areas of personal injury insurance reimbursement in motor vehicle accident cases in the last several years.

As previously noted, in FMC v. Holliday, 498 U.S. 52 (1990), the Supreme Court of the United States held that sections 1720 and 1722 of the PaMVFRL are preempted by a self-funded ERISA plan. The Supreme Court ruled that section 1720 of the PaMVFRL relates to an employee benefit plan and any law that ñrelatesò to a plan is subject to ERISA. Since the ERISA plan preempts state law, the provisions of the plan are followed. If they provide for subrogation then subrogation applies. The precise terms of the Plan dictate how the subrogation claim is applied. In fact, certain plans may take away their subrogation right if they include a provision which states that the provision does not apply if not allowed by local or state law.

Traditional state law concerning reimbursement and reductions for attorneyôs fees and costs are different for ERISA plans. The amount of the ERISA planôs subrogation interest may not be subject to any reduction for a proportionate share of attorneyôs fees and costs. The issue has given rise to significant litigation and emerging conflict around the United States in its various circuit courts.

Under Pennsylvania law, in Bollman Hat Co. v. Root, 112 F.3d 113 (3d Cir. 1997), the Court of Appeals for the Third Circuit specifically held that unjust enrichment does not apply, and that a planôs requirements to be reimbursed for ñany paymentsò and subrogation of ñall rights of recoveryò unambiguously precluded reduction for a proportionate share of attorneyôs fees. Bollman Hat, 112 F.3d at 117. Bollman Hat basically affirms the Third Circuit decision in Ryan v. Federal Express, 78 F.3d 123 (3rd Cir. 1996), where the Third Circuit held that the language of the subrogation provision unambiguously required that the plaintiffs pay back all of the money they received. In Silcot v. Walmart, 1998 WL 422032 (E.D. Pa. July 24, 1998) (mem.), the District Court of Pennsylvania concluded it was bound by Ryan and Bollman, although it led to an unfair result.

The courts have also noted that the fact that a claimant cannot recover medical expenses from a tortfeasor is irrelevant to subrogation by an ERISA plan, or even whether or not liability is contested. Travitz v. Northeast Department ILGWU Health and Welfare Fund, 13 F.3d 704 (3d Cir. 1994). In Travitz, the plaintiff argued that there was no subrogation interest because under section 1722, she cannot recover medical expenses for which reimbursement was sought. Travitzôs case with the tortfeasor had been settled for $125,000 cash, plus a structured settlement. The fund expended $55,000 after the first $10,000 was paid by automobile insurance. She attempted to argue that the entire settlement was for pain and suffering. The Court ruled that section 1722 was preempted; therefore she could not have recovered medical expenses from the tortfeasor. The Court also noted in Austin v. Dionne, 909 F. Supp. 271 (E.D. Pa. 1995) that ERISA does not

require that the terms of the plan contain a subrogation clause. The parties never argued that the benefit plan was entitled to subrogation, and the defendant asserted section 1722. The Court granted the defendantôs motion in limine on introducing medical expenses.

The Supreme Court of the United States in Great-West Life v. Knudson, 534 U.S. 204 (2002) held that an ERISA plan or its administrator cannot file a lawsuit to enforce the planôs subrogation provisions where the plan or its assignee seeks to impose personal liability on a participant or beneficiary for a contractual obligation to pay money. In Great-West, the plan sought to enforce its subrogation provision under ERISAôs civil enforcement provisions. Knudson argued that there was no remedy for the plan pursuant to equitable restitution under the ERISA statute, Section 502 (a) (3).

Knudson was insured by an ERISA plan. The plan had a subrogation/reimbursement provision which allowed the plan to recover medical expenses it paid on behalf of Knudson or dependents for injuries sustained as a result of a third party. Knudsonôs spouse was seriously injured in a car accident. Great-West paid medical expenses in excess of $400,000. The plan contained a reimbursement provision and the plan assigned its right of reimbursement to Great-West, the insurance company which provided stop-loss coverage for the plan.

The personal injury lawsuit was filed and settled in state court. Great-West had no notice of the lawsuit and sued the employee in federal court under the ERISA statute to enforce its reimbursement rights under the plan. The carrier sought an injunction and order requiring the participant of the trust fund to receive the settlement proceeds to pay Great-West the amount of the medical expenses the plan had paid.

The Supreme Court held that although ERISA authorizes suits ñto enjoin any act or practice which violates the terms of a plan or to obtain other appropriate equitable reliefò to enforce any provisions of the terms of a plan, the suit was improper. Justice Scalia reasoned that the insurance company was seeking the repayment of money and was not really seeking non-money or ñequitable reliefò permitted by ERISA. The Court said the suit was really for money damages and suggested that if the insurance carrier or plan wanted to enforce its rights, it should have intervened in the employeeôs state court personal injury lawsuit or should have sued for money damages in state court for reimbursement under the contract.

Self-funded plans have started to implement procedures and place provisions in contracts which help monitor litigation filed by plan participants. Also, plans may start to intervene in cases to preserve their ability to be reimbursed for medical expenses. A key to Knudson is that the plan participant was not in possession of the proceeds recovered from a third party tortfeasor. In Wal-Mart v. Varco, 2002 WL 47159 (Northern District of Illinois, January 14, 2002), a court ruled that an equitable trust can be imposed if the monies have not been recovered and distributed.

In Sereboff v. Mid-Atlantic Medical Services Inc., 547 U.S. 1015 (2006), the United States Supreme Court determined that monies placed in a special needs trust are still

subject to the ERISA claim. The claim is not equitable and seems to have defeated a lot of the Knudson argument.

Another issue which has been addressed by a trial court is whether a Plaintiff can present evidence of medical bills that will be paid by an ERISA plan. In Roberts v. Brytczuk, 65 Pa. D. & C. 4th 510 (Centre Co. March 16, 2004) the trial court held that because ERISA pre-empts Section 1797 of the MVFRL the Plaintiff is permitted to present evidence that a part of any damage award received will have to be repaid to the self-funded ERISA plan that paid medical expenses.

One important issue resolved in favor of the ERISA plans is stop loss coverage. In Bill Gray v. Gourley, 248 F.3d 206 (3rd. Cir. 2001) the Court of Appeals for the Third Circuit held that the purchase of stop loss coverage does not relinquish the ERISA plan claim for subrogation or reimbursement. Also, the court held that the third party insurance carrier is not liable is the claim is unpaid.

In Mills v. London Grove Township, 2007 U.S. Dist. LEXIS 52536 (E.D. Pa July 19, 2007) the adult plaintiffs and their minor child suffered severe and permanent injuries in an automobile accident. The accident allegedly occurred because a stop-sign for which the Defendant Township was responsible was obscured by shrubbery.

Plaintiffs sued the Township, the owner of the property in question, and the other driver, all of whom asserted claims against the wife-plaintiff. The wife-plaintiff was seven months pregnant at the time of the accident, and her injuries caused the premature birth of the plaintiff-minor (now aged 2 1/2 years). The minor-plaintiff sustained serious head injuries which have resulted in cerebral palsy, a permanent condition for which the minor will require constant medical attention. Although each of the potentially liable parties could properly assert that they were not at fault, all concerned--or, more accurately, their liability insurance carriers-have agreed to settle the case, by payments substantially equal to the total of available liability insurance. Plaintiffs have now petitioned for approval of the compromise settlement, insofar as the minor is concerned. It is proposed that the minor's portion of the settlement be placed in a "self-funded special needs trust" (under Maryland law, and approved by the Attorney General of Maryland, where the plaintiffs now reside). Under the terms of the settlement, the minor's share would be $ 500,000, her father's share would be $ 125,000, and her mother's share would be $ 275,000. After deduction of attorneys' fees (reduced to 25%) and the compromised amount of certain liens, the net settlement payable to the special needs trust for the minor would be $ 357,170.21.

All parties agree that the proposed settlement of the minor's claim is reasonable under the circumstances--doubtful liability and limited insurance coverage. There is, however, opposition to the proposed distribution of the settlement proceeds. It appears that the plaintiffs were beneficiaries under an ERISA health and welfare plan as a result of the father's employment. The Plan has made significant payments on account of the minor's medical expenses. The insurance company which made those payments now asserts that

the petitioners should first reimburse it (ACS Recovery Services) in the amount of $ 123,690.12 because of the benefits it paid on account of the minor's injuries.

> The pertinent language of the Plan was as follows:
>
> "If you or a dependent are injured because of the negligence or wrongdoing of someone else, the Plan Administrator has the right, subject to any applicable law, to recover benefits paid by the third-party medical plan from any amount you receive from the other person or his or her insurance company, whether by lawsuit, settlement or otherwise and without regard to attorney fees you may have incurred to collect such amounts. *In this situation, you must sign a* ***reimbursement*** *agreement before benefits will be paid under the Wyeth health care plans*. You also are responsible for taking any necessary actions to protect the Wyeth health care plans' right of recovery." (emphasis added)

At the hearing on the pending petition, counsel for plaintiffs asserted, without contradiction, that the plaintiffs have never been asked to sign any such **reimbursement** agreement, and have not done so. Thus, it may be that ACS Recovery Services should be deemed to have waived its right to assert a lien. Stated otherwise, it may be that, by paying the medical benefits without first obtaining plaintiffs' agreement to recognize the lien now claimed, ACS Recovery Services may have impaired its right to assert such a lien. The Court held that the claim for reimbursement was no valid under the facts of the case.

In order to confirm the status of a self-insured plan the Form 5500, Summary Plan Description, and a letter from the plan itself seeking the reimbursement pursuant to its self-insured status is recommended to be obtained. Under Section 29 U.S.C. Section 1132 the Plan only has 30 days to provide the documents or a fine of $110 a day can be imposed, absent good cause being shown for not complying.

However, as the attorney you need to be careful. The Sixth Circuit, in Longaberger Co. v. Kolt, 586 F.3d 459 (6th Cir 2009), holds that ERISA lien holder can recover that portion of a recovery in tort that was the attorneys net fee from the attorney for the plaintiff, despite the fact that the money in his IOLTA account had already been disbursed.

An extremely important opinion was announced by the united States Supreme Court on April 16, 2013. US Airways v. McCutcheon, --- U.S. --- (April 16, 2013).

Originally, in this case the ERISA participant was ñgrievously injured and survived only emergency surgery.ò The ERISA plan, seeking reimbursement of $66,864 paid in medical bills sued for 100% of the net tort recovery of ñless than $66,000ò secured by the participant. The trial court granted summary judgment for the ERISA plan, awarding it $41,400 held in a trust account and further ordered the participant to pay $25,366 personally. This panel decision by the 3rd Circuit was unanimous and it held that the

lower courtôs ruling was ñinappropriate and inequitableò as those words are found in ERISA § 503(a)(3) because the recovery ñexceeds the net amount of McCutcheonôs third-party recovery, thus undermining the entire purpose of the Plan.ò

The panel decision further states that the courtôs ruling ñamounts to a windfall for US Airways.ò This decision abrogates the 3rd Circuitôs prior three cases on this issue and also squarely rejects the holdings and logic of decisions found in other circuits, including the 8th Circuitôs *Shank* decision and the 11th Circuitôs *O'hara* decision. A rather notable line from this opinion is, ñUS Airways cannot plausibly claim that it charged lower premiums because it anticipated a windfall.ò Another notable line is that the lower courtôs ruling is inequitable because ñEquity abhors a windfall.ò

The United States Supreme Court essentially reverses the reasoning. The Court holds that neither unjust enrichment principles nor specific equitable doctrines reflecting those principles can override the ERISA plan contract. Thus, the plan contract determines the entire process.

HEALTH MAINTENANCE ORGANIZATIONS

In 2006 the Pennsylvania Supreme rendered its decision in Wirth v. Aetna, 904 A.2d 858 (Pa. 2006). This opinion greatly changed the way all motor vehicle accidents cases are handled and evaluated in Pennsylvania where an HMO pays any portion of the accident related medical expenses. Subrogation claims were supposed to be precluded by Section 1720 of the Pennsylvania Motor Vehicle Financial Responsibility Law (hereinafter ñPaMVFRLò). In the future an argument could be made that the same reasoning and holding would apply to Section 508 of the MCARE Act of 2003.

In Wirth, the Pennsylvania Supreme Court answered the unresolved issue as to whether or not in Pennsylvania a Health Maintenance Organization (ñHMOò) is entitled to subrogation in a case arising out of the maintenance and use of a motor vehicle. The Pennsylvania Supreme Court held in Wirth that Section 1560 of the Pennsylvania Health Maintenance Organization Act prevents Section 1720 of the MVFRL from applying to a motor vehicle accident case. The Court observed that the plain language of Section 1560 of the HMO Act states that any law enacted after the implementation of Section 1560 must say that it applies to an HMO in ñexplicit and exact termsò in order for the later enacted law to apply to the HMO.

Thus, under the decision, an HMO is allowed to subrogate. In reality this can also be expanded to the MCARE Act since there is no specific mention of HMO in the law. However, bear in mind that and HMO is not a PPO so PPOs which attempt to use Wirth should not be allowed to subrogate.

WORKER'S COMPENSATION

The Pennsylvania Workerôs Compensation Act provides:

> Where the compensable injury is caused in whole or in part by the act or omission of the third party, the employer shall be subrogated to the right of the employeeé against such third party to the extent of the compensation payable under this article by the employer; reasonable attorneyôs fees and other property disbursement occurred in obtaining a recovery or in effecting a compromised settlement shall be prorated between the employer and the employeeé the employer shall pay that portion of the attorneyôs fees and the other proper disbursements that the amount of compensation paid or payable at the time of recovery or settlement bears to the total recovery or settlement.
>
> 77 P.S. §671.

The workerôs compensation laws do not appear to place an affirmative duty upon the plaintiffôs attorney to notify a compensation carrier of the potential subrogation claim, or an obligation to protect the subrogation lien. However, the compensation carrier has a right of action against the plaintiff who received the benefits for repayment of the lien.

As noted above, the workerôs compensation lien always applies in non-motor vehicle accident cases. However, depending on the date of the accident, it may not apply where the employee is injured/killed in an accident arising out of the maintenance or use of a motor vehicle. In the motor vehicle case there are also issues concerning whether or not the workers compensation carrier is entitled to subrogation from underinsured motorist coverage/uninsured motorist coverage (hereinafter ñUM/UIMò).

The courts have held that this right is automatic. However, subrogation is prohibited in tort cases involving the Commonwealth, its political subdivisions, agencies, officials and employees. Frazier v. WCAB, --- A.3d --- (Pa. Sept. 28, 2012).

Some of the more important cases dealing with workers compensation subrogation issues are:

DISCLAIMING RIGHTS TO SETTLEMENT PROCEEDS:

Gillette v. Wurst, 937 A.2d 430 (Pa. 2007).

The Pennsylvania Supreme Court recently held that the wife of the decedent could not disclaim her share of settlement proceeds once offered, which would effectively negate the subrogation rights of the workersô compensation insurer. The Court held that the wife could not disclaim the rights to the wrongful death proceeds since the right was not held by her, but by the workers compensation insurer which was supposed to be subrogated to the share that the wife had to receive under Section 8301 of the Wrongful Death Act.

HEART AND LUNG BENEFITS:

City of Wilkes-Barre v. Sheils, 2008 U.S. Dist. LEXIS 5550 (M.D. Pa. Jan. 25 2008).

The Federal Court in the Middle District of Pennsylvania held that the City has no right to subrogation from the funds out of a tort settlement obtained by a city employee injured as a result of a motor vehicle accident. The Court relies mainly upon Fulmer v. Pa. State Police, 647 A.2d 616 (Pa. Commw. 1994) where the Commonwealth Court held that the State Police did not have a right to subrogation after a state trooper received a tort settlement. Also, the Court notes that under Section 1722 the employee cannot plead, prove or recover the benefits as well so there is no double recovery.

This case was reversed recently by the United States Court of Appeals for the Third Circuit. On April 23, 2009 (Not Precedential) in City of Wilkes-Barre v. Sheils the Third Circuit Court of Appeals holds that Heart and Lung Benefits can be plead, proven and recovered under Section 1722 of the Pennsylvania Motor Vehicle Financial Responsibility Law (MVFRL) and also are subrogable under Section 1720 of the MVFRL. The Court relies mainly upon 2 Commonwealth Court decisions in Hannigan v. WCAB, 860 A.2d 632 (Pa. Commw. Ct. 2004) and Brown v. Rosenberger, 723 A.2d 745 (Pa. Commw. Ct. 1999).

LOSS OF CONSORTIUM CLAIMS:

Darr Construction Co. v. W.C.A.B. (Walker), 552 Pa. 400, 715 A.2d 1075 (1998).

The Supreme Court of Pennsylvania held that an employer has no subrogation interest in a spouseôs recovery for loss of consortium. In Darr, there was a third party recovery and the amount of the consortium claim was entered into before a workerôs compensation referee. The Supreme Court wrote that a loss of consortium claim is a separate and distinct cause of action and the mere fact ñthat such a claim is joined in the same civil action as a claim for bodily injuries does not alter its basic character as a separate and distinct claim.ò Darr Construction, 715 A.2d at 1080. The Court analyzes the statutory language in section 319 of the Workerôs Compensation Act and notes that a spouse does not fall within the statutory category subject to subrogation. A spouse is not an employee, estate or personal representative and not a dependent within the meaning of section 319. Therefore, it holds that a wife is not a ñperson entitled to compensation under the Actò.

There is also no subrogation for any monies awarded to dependent children under the Pennsylvania Wrongful Death Act. Anderson v. Borough of Greenville, 442 Pa. 11, 273 A.2d 512 (1971).

LEGAL MALPRACTICE CLAIMS:

Poole v. W.C.A.B. (Warehouse Club, Inc.), 810 A.2d 1182 (Pa. 2002).

As a matter of first impression, the proceeds from a legal malpractice claim are subject to subrogation. The Supreme Court reverses the Commonwealth Court decision which held they were not.

PERSONAL MOTOR VEHICLE UNINSURED MOTORIST COVERAGE:

Standish v. American Manufacturers Mut. Ins. Co., 698 A.2d 599 (Pa. Super. 1997).

The Superior Court of Pennsylvania focused upon whether or not a workerôs compensation carrierôs subrogation lien applies against the proceeds of a UM/UIM claim on an injured workerôs personal automobile insurance policy. The plaintiff in Standish was involved in a car accident on April 29, 1994. Since the accident occurred after the amendment to Section 1720 subrogation could be involved.

The Court reviews section 671 of the workers compensation law which provides that an employer and the insurance carrier have a right to assert a subrogation lien for the amount of workerôs compensation it paid against compensation recovered by an insured from a ñthird partyò. The Court concludes that the provisions of section 671 do not apply to damages received pursuant to contract, but only in tort. The Court notes that the plaintiff did not receive damages in tort, but rather UM/UIM motorist coverage under an insurance policy for which he paid premiums. Therefore, the Court held that UM/UIM motorist coverage was accident insurance for the benefit of the claimant, not the tortfeasor, and any claim that the plaintiff had with his uninsured motorist carrier was not a claim against the third party tortfeasor. Subrogation by a compensation carrier was not permitted.

EMPLOYERôS UNDERINSURED MOTORIST BENEFITS:

Warner v. Continental/INA Ins. Co., 688 A.2d 177 (Pa. Super. 1996), Petition for Allowance of Appeal Denied, 548 Pa. 660, 698 A.2d 68 (1997).

Warner was involved in a motor vehicle accident after the Act 44 amendments. He settled for the third party liability limits, and then made a claim for underinsured motorist benefits on his employerôs motor vehicle insurance policy since it was the first level of UIM coverage under the PaMVFRL. His employerôs insurance, Continental, denied coverage based upon its determination that Warner was precluded from recovery of benefits by virtue of exclusivity provisions of the Pennsylvania Workerôs Compensation Act, 77 P.S. §481.

The Court determined that an employee injured in the course and scope of his employment while operating a motor vehicle owned by his employer and insured under a policy which specifically provides optional UM/UIM motorist benefits is not precluded from recovering benefits available to him or her under the insurance policy as a result of the Pennsylvania Workerôs Compensation Act, 77 P.S. §481 (a). The Court notes that ñallowing the injured employee to recovery underinsured or uninsured motorist benefits

from his or her employerôs motor vehicle insurance will create a fund against which the employerôs workmanôs compensation carrier can exert its subrogation lien.ò Warner, 688 A.2d at 185.

A very important distinction is displayed when comparing the Standish and Warner cases. It is important to look at whether or not the UM/UIM benefits are paid from the employerôs policy or employeeôs personal policy.

UNINSURED BENEFITS FROM CO-EMPLOYEEôS POLICY:

Gardner v. Erie Insurance Co., 555 Pa. 59, 722 A.2d 1041 (1999).

The Pennsylvania Supreme Court holds that an employee receiving workerôs compensation benefits for injuries sustained in an automobile accident involving a co-employeeôs vehicle and arising out of wrongful third party conduct is not precluded from seeking uninsured motorist benefits from the co-employeeôs insurance carrier.

DATE OF ACCIDENT/MAINTENANCE OR USE OF MOTOR VEHICLE:

DePaul Concrete v. W.C.A.B. (White), 734 A.2d 481 (Pa. Cmwlth. 1999), Petition for Allowance of Appeal Denied, 562 Pa. 675, 753 A.2d 481 (2000). The employerôs right of subrogation accrues on the date of the injury, not the date of the third party recovery. The pre-August 1993 version of section 1720 of PaMVFRL precludes the carrier from asserting the right of subrogation or reimbursement from the claimantôs recovery provided that it arises out of the maintenance or use of a motor vehicle. See also Updike v. W.C.A.B. (Yeager Supply, Inc.), 740 A.2d 1193 (Pa. Cmwlth. 1999) where the Pennsylvania Commonwealth Court held that the employer was entitled to subrogation from the third party action based upon the plaintiffôs product liability claim for operation of a forklift which did not arise from the operation and use of a motor vehicle.

SETTLEMENT OF ALL CLAIMS MUST BE IN WRITING:

Rissmiller v. W.C.A.B. (Warminster Township), 768 A.2d 1212 (Pa. Cmwlth. 2001). In Rissmiller, the Commonwealth held that an oral agreement to settle a workerôs compensation subrogation claim is not enforceable. The Plaintiffôs attorney argued that an oral agreement with the workers compensation carrier was enforceable. The Commonwealth Court noted that in 1996 the Workerôs Compensation Act established a rule for allowing settlements between parties in workerôs compensation cases. Specifically, sections 449 (b) and (c) of the Act now require that settlements be reduced to a writing and executed to be enforceable. Therefore, an oral agreement between a workerôs compensation insurer and claimantôs attorney is not enforceable.

DISABILITY DISCRIMINATION:

Brubacher Excavating, Inc. v. W.C.A.B. (Bridges), 835 A.2d 1273 (Pa. 2003).

The Supreme Court affirms the Commonwealth Court decision which held that a claimantôs recovery in a lawsuit for disability discrimination against a subsequent employer was not subject to subrogation by the first employer.

IMMUNITY CASES:

Halderman v. PennDot, 66 Pa. D. & C. 4th 52 (Centre Co. March 3, 2004).

The trial court held that subrogation is allowed in a case where the plaintiff was involved in a work related motor vehicle accident. The court held that sovereign immunity did not bar the plaintiff from seeking to recover from the Commonwealth the amount of the workerôs compensation lien that was asserted by the employerôs insurer.

In addition to the above, there are some other important compensation cases to remember.

OTHER IMPORTANT ISSUES:

An employerôs subrogation interest cannot be reduced by an employeeôs comparative negligence. Goldberg v. W.C.A.B. (Girard Provision Co.), 620 A.2d 550 (Pa. Cmwlth. 1993). Also, a third party tortfeasor may not mold a verdict in favor of the Plaintiff to allow the tortfeasor to take credit for compensation benefits paid in order to defeat the claim. Beary v. Container General Corp., 568 A.2d 190 (Pa. Super. 1989).

In Dillow v. Myers, 916 A.2d 698 (Pa. Super. 2007), Petition for Allowance of Appeal denied, 937 A.2d 445 (Pa. 2007) the trial court decision in Dillow v. Myers, 65 Pa. D. & C. 4th 78 (Carbon Co. Oct. 23, 2003) was affirmed where it had held that because the settlement of the subrogation claim between the plaintiffôs self-insured employer and the defendantsô liability insurance carrier did not extinguish the subrogation claim, the plaintiff was entitled to introduce evidence of lost wages and medical expenses.

FEDERAL EMPLOYEE WORKER'S COMPENSATION ACT (FECA)

The basic premise of this statute (5 U.S.C. § 8101) is:

A. The United States has an absolute right of reimbursement under 5 U.S.C. § 8132 even if the employee cannot recover benefits from the tortfeasor.
B. Attorneys may not distribute funds to the federal employees pursuant to a judgment or settlement without first satisfying the government reimbursement claim. The Attorney is jointly and

severally liable with employee for reimbursement. Green v. U.S. Dept. of Labor, 775 F.2d 964 (8th Cir. 1975).

C. Similar laws Railroad Unemployment Insurance Act, 45 U.S.C. § 351. See US v. Rogers, 658 F.2d 246 (5th Cir. 1981). Long Shore and Harbor Workers Compensation Act, 33 U.S.C. § 933. See Haynes v. Rederi A/S Aladdin, 362 F.2d 345 (5th Cir. 1966).

D. The employee must receive a minimum of 1/5 of the total net recovery. 5 U.S.C. § 8132.

E. Consider getting a court order on apportionment in cases involving consortium claims.

F. May deduct cost and reasonable attorneysô fees.

In United States of America v. Epstein, 2007 WL 2617174 (W.D. Pa. Sept. 6, 2007) the Court addressed the case where an attorney made a distribution from a third-party settlement on behalf of the beneficiary without first satisfying or assuring the satisfaction of the interest of the United States. There were monies placed in a structured settlement and the argument made was that the monies did not need be reimbursed.

The Court grants the Governmentôs Motion for Summary Judgment to enforce the claim against the lawyer and writes:

> the government's ability to stop making worker's compensation payments to the beneficiary and/or its ability to "attack" the future structured payments to the beneficiary do not reflect undertakings by defendant to "assure" the satisfaction of the government's interest; they reflect methods of self-help that remained potentially available to the government in spite of defendant's failure to fulfill the affirmative duty of action that the phrase "without first satisfying or assuring satisfaction of the interest of the United States" placed on him.
>
> Second, defendant did make a distribution of the settlement proceeds to the beneficiary. Payment of attorneyôs fees from any contingent-fee litigation recovery is the satisfaction of the beneficiary's legal obligation to the attorney from a prior assignment. Comm'r v. Banks, 543 U.S. 426, 437, 125 S. Ct. 826, 160 L. Ed. 2d 859 (2005). A recovery from litigation is the realization of economic gain by the agent on behalf of the principal "and the gain realized by the agentôs efforts is income to the principal." Id. "The contingent-fee lawyer is not a joint owner of his client's claim in the legal sense any more than the commission salesman is a joint owner of his accounts receivable." Id. (citation omitted). Thus, the payment to defendant off the top did reflect a distribution of the proceeds to the beneficiary's designee and this distribution was made "without first satisfying or assuring satisfaction of the interest of the United States," in direct contravention of the FECA. See 5 U.S.C. § 8132 *("No* court, insurer, *attorney,* or other person *shall* pay or *distribute to* the beneficiary or *his designee* the proceeds of such suit or settlement without first

satisfying or assuring satisfaction of the interest of the United States.") (emphasis added).

Thus, when dealing with any governmental agency it is very important to not make a distribution until you are reasonable certain that there is no issue with reimbursement.

PENNSYLVANIA EMPLOYEE BENEFIT TRUST FUND

Many practitioners do not realize that at one time the Pennsylvania Employee Benefit Trust Fund was an ERISA Plan. The Plan relinquished its ERISA status in January 1, 1998. Thus, any accidents which occur after that date should not be subject to any argument that the Plan has a subrogation interest arising out of a motor vehicle accident. However, the date of change and date of payments may be important in determining the extent of any claim, if any. Scalice v. Pennsylvania Employee Benefit Trust Fund, 883 A.2d 429 (Pa. 2005).

The Pennsylvania Supreme Court held that the Fund is subject to equitable principles and that there may be issues of Equity in some cases where the Plan fails to notify counsel of a subrogation claim. Valora v. Pennsylvania Employee Benefit Trust Fund, 939 A.2d. 312 (Pa. 2007). The Court holds the Trust Fund waived its right to subrogation in a medical malpractice lawsuit by failing to act with reasonable diligence before raising its subrogation claim. The Court writes that it is possible for a party asserting a right of subrogation to waive its rights.

The Pennsylvania Supreme Court in Wimer v. Pennsylvania Employee Benefit Trust Fund, 939 A.2d 843 (Pa. 2007) held that since the Funds payments in a motor vehicle accident occurred after the Fund relinquished its ERISAôs status that the Plan was not allowed to subrogate from the proceeds in a motor vehicle accident. Also, of note, the Court held that a plan participant did not need to exhaust internal procedures within the plan before filing a declaratory judgment action. However, even if the Fund made payments and it is after it relinquished its self-insured status, the Fund still may be able to recover the benefits if it was made by an HMO plan.

BANKRUPTCY (11 U.S.C. Sections 522, 541(a))

In some circumstances your client may declare Bankruptcy under Chapter 7 or Chapter 13 of the federal bankruptcy law. Most of the time the client will not notify the attorney of a petition filing since the federal claim is usually handled by a different lawyer. However, this is a lien that is automatic under federal law and could create major difficulties if the client does not notify both lawyers of the bankruptcy proceeding and the personal injury claim.

Under federal law the personal injury claim should be included in any claim where the ñlegal right exists on the day the petition is filed or within 6 months thereafter.ò Thus, if the bankruptcy petition is filed and the accident occurs the next day, it must be included.

Under Chapter 7 liquidation proceeding you must send a letter to the Trustee. This will notify the Trustee of the claim and also lay the groundwork for your fees to be approved and the proper listing of the claim to be noted on the petition.

Under a Chapter 13 family payment arrangement you should send a letter to attorney for the debtor (usually your client) who sets out the background of the claim and the nature of the injuries, etc. The attorney will most likely also need to approve your fees as well.

Your client is allowed an exemption of $17,000. This is after fees and costs. However, the claim MUST be listed on the bankruptcy petition or your client risks the chance of the Trustee or Defendant seeking to have the third party case dismissed as a matter of law because it was not listed.

The notification process to the Trustee and/or attorney is not discretionary. You have a duty to notify if you know or have reason to know of the bankruptcy or risk being held personally responsible to the Bankruptcy Court. For instance in In re: Donna Marie Engelbrecht, 368 B.R. 898; 2007 Bankr. LEXIS 1486 (April 16, 2007) the debtor petitioned for bankruptcy relief, the debtor was injured in a car accident with a truck owned by the company. The debtor filed for bankruptcy relief because of the outstanding medical bills related to the accident. The debtor did not list her potential claim against the company on her schedules. The debtor filed a post-petition personal injury action against the company in state court. Thereafter, the trustee, upon learning of the personal injury action, reopened the bankruptcy proceeding and the debtor amended her schedules to reflect her pre-petition claim. The court held that the trustee was the only person who had standing to pursue the personal injury lawsuit and the trustee was the real party in interest. The trustee was entitled to be substituted as the real party in interest in the debtor's personal injury lawsuit. The claim was not time barred because substitution of the trustee as the party plaintiff related back to the original proceeding.

CHILD SUPPORT

Senate Bill 1205 was first introduced in the Pennsylvania Senate on April 27, 2006. After an entire rewriting it was passed in the Senate on June 22, 2006 by a 50-0 unanimous vote and the House by a 198-0 unanimous vote on June 30, 2006 in its current form and is now located in Title 23 of the Domestic Relations Code in a new Section 4308.1. Governor Rendell signed Senate Bill 1205 on July 7, 2006 and it became Act No. 109 of 2006.

Pursuant to Pennsylvania law the Department of Public Welfare (ñDepartmentò) collects past due child support. When a parent owes past due child support there is a lien created and the arrears are the property of the Department of Public Welfare. The Department has authority under 23 Pa.C.S.A. Section 4302 to seek reimbursement of the arrears from any form of income, including personal injury/tort awards. Under Section 4305(b) (10), the Domestic Relations Section of the Family Court has the authority to intercept and seize judgments and settlements. If the Department pursues the reimbursement claim in

court it is represented by the District Attorneyôs office. The claim is then pursued on behalf of both the Department of Public Welfare and the family member owed the support.

Senate Bill 1205 permits the Department of Public Welfare to intercept overdue child support from lump sum monetary awards or settlements paid by insurers and workersô compensation. The overdue child support now becomes a lien by operation of law against the net proceeds of any monetary award. However, the proceeds must be a net exceeding $5,000 for the law to apply. The award must now be stayed in the amount equal to the child support lien pending by payment of the lien. This also applies to monetary awards for workersôcompensation.

If there is a dispute over the amount of support owed, the amount in dispute is placed in escrow with Pennsylvania State Disbursement Unit. There is a dispute resolution system which is implemented.

The attorney, insurer, or other paying agents have immunity from any civil, criminal or administrative remedies for making an erroneous distribution. Any party under the age of 12 is exempt from this law.

In order for an employer to be required to submit the payments electronically to DPW the employer must have 15 employees. Under the law, an employer who fails to comply with the provisions of the law can face a civil penalty of up to $1,000 per violation.

Before distributing any monies, the attorney must be provided by the client with a statement including his or her name, address, date of birth and social security number with the amount of arrearages. If there are no arrearages then the attorney must confirm that no arrearages exist.

There are two (2) ways for an attorney or insurance company to determine if the recipient of the award owes overdue child support. Also, if there is lien search is must be dated within twenty (20) days of the delivery of the release.

They are:

1. A search can be conducted on the Child Support Section of the DPW website. This search is free and can be done 24 hours a day, 7 days a week. The web link is: www.humanservices.state.pa.us/csws

2. Hiring a private judgment company for a nominal fee.

Also, an insurance company may utilize a DPW-approved clearinghouse which matches child support obligors against possible award or settlement recipients.

The law was signed by the Governor on July 7, 2006. Under its provisions it is effective sixty (60) days after being signed. Thus, the law became effective on September 5, 2006.

VETERANS ADMINISTRATION

Statutory basis for the lien is under 42 U.S.C Section 2651 et seq. Generally more easier to deal with than Tri-care.