FOCUS

(Updated) Q&A on the (Not So) New State Employee Health Plan "Super Lien" on Settlement Proceeds

by Christopher R. Nichols

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On July 20, 2004, the North Carolina Legislature created a lien (the lien) on proceeds received from third party funds for employees and dependants covered by the North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan (the Health Plan). The lien essentially abrogates the current North Carolina Insurance Commission regulation that forbids subrogation for funds paid when a third party is liable for medical costs that were paid by the Health Plan. This lien applies only to the Health Plan, and does not create a right of subrogation for any other health plans in North Carolina. This article will discuss the specific application of the lien. Any opinions expressed herein are those of the author alone.

While the effective date of the legislation is July 1, 2004, for administrative purposes, the Health Plan is using July 20, 2004 as the date upon which the lien becomes effective.[1] The lien was passed as part of the state budget.

Before the lien was created by the Legislature, the Health Plan had claimed "a right to equitable subrogation" beginning on January 22, 2004. The Health Plan claimed that this right was derived from the decision of *In re Declaratory Ruling by North Carolina Com'r of Ins.,* wherein the court upheld the anti-subrogation position of the North Carolina Commissioner of Insurance, but also held in part that there may be other methods of subrogation that would not be prohibited.[2]

The Health Plan asserted that the right to equitable subrogation was derived from an administrative statute that was designed to coordinate benefits among insurance plans. It is this writer's opinion that the provision in question, N.C.G.S. §135-40.13, was actually intended to coordinate payments among *health* insurers only. The Health Plan interprets this section also to include payments made by "any persons to or for or with respect to whom such payments were made, any insurance companies, or any other organizations," meaning third-party liability insurance companies.

Q. Why was the lien created?
According to the Health Plan, the lien was created for several reasons. First, the State has been in a "budget crisis" for several years, and the Health Plan is completely self-funded by the State, although it is supported by dependant coverage premiums paid by Health Plan members. Second, the Health Plan must pay the ever-increasing costs of medical care for its members. Finally, other "state" benefits, such as Vocational Rehabilitation and Medicaid, have rights of reimbursement, or liens. During 2002-2004, the Health Plan paid approximately $1.9 billion in claims.

Q. Who is a member of the Health Plan?
Currently, the Health Plan has over 560,000 members. It covers all teachers and employees of the state, as well as several classes of employees that normally may not be considered "state employees," such as members of the legislature.

Some of the largest categories of state employees (and their dependants) include: all retired state employees, state university employees, community college employees, state hospital employees, legislators, judges, Administrative Office of the Courts employees, Highway Patrol employees, state boards and commissions, Department of Transportation employees, and other state governmental institutions.

State employees receive the coverage for "free," but must pay for dependant coverage. Currently, the only option for dependant coverage is for the entire family; if a spouse is covered, other dependants are also covered. The newly created lien applies to *all* persons covered under

the Health Plan, *including* spouses and dependants.

Q. What does the lien say?
State Health Plan Subrogation

> § 135-40.13A. Liability of third person; right of subrogation; right of first recovery.
>
> Whenever the Plan pays benefits for hospital, surgical, medical, or prescription drug expenses, with respect to any Plan member, the Plan shall be subrogated, to the extent of any payments under the Plan, to all of the Plan member's rights of recovery against liable third parties, regardless of the entity or individual from whom recovery may be due. The Plan member shall do nothing to prejudice these rights. The Plan has the right to first recovery on any amounts so recovered, whether by the Plan or the Plan member, and whether recovered by litigation, arbitration, mediation, settlement, or otherwise. If the Plan is precluded from exercising its right of subrogation, it may exercise its rights of recovery to the extent allowed by law. If the Plan recovers damages from a third party in excess of the claims paid, any excess will be paid to the member, less a proportionate share of the costs of collection. In the event a Plan member recovers any amounts from a third party to which the Plan is entitled under this section, the Plan may recover the amounts directly from the Plan member. The Plan has a lien, for the value of claims paid related to the liability of the third party, on any damages subsequently recovered against the liable third party. If the Plan member fails to pursue the remedy against a liable third party, the Plan is subrogated to the rights of the Plan member and is entitled to enforce liability in the Plan's own name or in the name of the Plan member for the amount paid by the Plan.

UPDATE: *Senate Bill 893 (S. 893) was introduced this last year to amend the lien statute to provide a less burdensome lien in situations where insurance coverage was not sufficient to satisfy the lien and leave the client with funds. The bill limits the Plan to reimbursement of up to half of a gross recovery, exclusive of the reasonable cost of collection. The proposed bill did not define "reasonable cost of collection," nor did it provide a remedy to challenge the determination of the Plan as to what is "reasonable." Thus, the plan would never take more than half of the total settlement and would further reduce the lien by the "cost of collection," which arguably could include attorneys' fees and costs incurred by the client. Language similar to S. 893 passed each chamber of the legislature, but in different bills, so it was not codified.*

The Academy has worked with the Plan to operate under the intent of this language until the Short Session in May 2006.

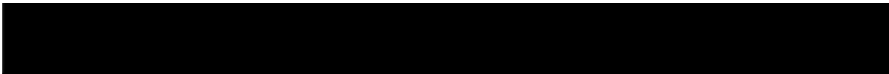
Q. Is the Health Plan required to give notice of the lien to attorneys?
No. The lien created on July 20, 2004 does *not* require the Health Plan specifically to notify you or your client of the claimed lien. The enactment of the statute is considered notice to all involved. Many attorneys received a generalized announcement from the Health Plan that was mailed on November 22, 2004, that places attorneys on notice that the plan is claiming equitable subrogation beginning January 22, 2004.

Q. What is the effective date of the lien?
The lien was created on July 20, 2004. It applies to all medical claims *paid* by the Health plan after July 20, 2004.

If you suspect a lien exists, you should audit the statements of the Health Plan and compare them to the Explanation Of Benefit (EOB) forms your client receives from the Health Plan through the Health Plan's administrator, Blue Cross/Blue Shield.

Because of the language of the lien statute, the "triggering" date is the day the Health Plan *paid* the medical bill—*not* the actual date of medical service.

Q. What about medical claims paid by the Health Plan before July 20, 2004?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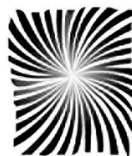
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As stated earlier, there is a two-tiered approach to medical costs paid before July 20, 2004. From January 22, 2004 until July 20, 2004, the Health Plan claims a right to equitable subrogation but has no actual statutory "lien." Practically speaking, the Health Plan would like for attorneys to treat this equitable subrogation as the same as the lien created in July.

From this writer's perspective, the equitable subrogation claim is not the same as the lien. In fact, because the equitable subrogation claim has not been tested in our courts, this writer believes that you should advise your client that the Health Plan may or may not have a viable claim for repayment of bills paid during the relevant time period.

Anecdotal reports from lawyers across the state suggest that the Health Plan has been willing to negotiate on their subrogation interest for claims paid by the Health Plan during the period of January 22, 2004 through July 20, 2004. The best comparison of this type of claim against recovery might be to ERISA rights of reimbursement that arise from the health provider contract between the insured and the insurer. While ERISA governs the contract, suit over failure to pay an ERISA claim is based in contract. A lawyer failing to honor the claims of the Health Plan for the period of January to July 2004 *might* have some personal liability, but in this writer's opinion, the liability would be based upon a failure to properly advise the client of the law regarding the equitable subrogation claim.

The next tier of subrogation claims by the Health Plan is for any medical claims paid *before* January 22, 2004. The plan claims it "may exercise its right to recovery on all claims" for these payments. Again, this claim is based upon the Health Plan's interpretation of N.C.G.S. §135-40.13.

Anecdotal reports again suggest that the Health Plan has not been aggressive in attempting to subrogate on claims paid before January 22, 2004. In fact, if a lawyer has settled a claim where all of the medical bills were paid before January 22, 2004, it is this writer's opinion that the lawyer has a duty to his client to advise him that the Health Plan may *not* have any enforceable rights to recovery for payments made before January 22, 2004.

Attorneys may want to write a letter to the client advising him or her about the current state of the law, then have the client sign an election form directing the lawyer to either make inquiries with the Health Plan or distribute the settlement without contacting the Health Plan. The client should be advised that the Health Plan could have a cause of action against the client, but that the lawyer is unaware of any such action being taken in the past by the Health Plan.

Obviously, there are no perfect rules for all situations, and the lawyer always should consider the amount of money in question when assessing the risk of disbursement. The Health Plan seems to recognize that claims for subrogation for medical costs paid before January 22, 2004, are the weakest legal claims it has against its members.

UPDATE: *Attorneys from across the state have reported that the Plan has been willing to negotiate on any claims made on the basis of equitable subrogation. Further, the Plan does not seem to be sending out notices of claims for reimbursement for claims that were paid before July 2004.*

Q. How does the lien work?

As the lien is currently written, the Health Plan has a 100 percent lien on proceeds paid to your client. Quite literally, this means that if the lien amount exceeds the settlement amount, the Health Plan recovers *all* of the settlement—with no provisions to pay attorneys' fees, costs, other medical providers, or the client/plan member.

This "super lien" claims to trump all other liens and has the right of first payment from any sums recovered. This would appear to include medical payments coverage, as well.

Unlike Medicaid and Medicare liens, this "super lien" has no written limitations on recovery and no specific equity provisions to reduce the lien. It is suggested that the equity provisions used to reduce a Medicare lien are an excellent guideline for arguing reduction of the Health Plan lien.

Q. Are attorneys' fees and costs paid by the plan?

No. The plan is not required to reduce its lien for attorneys' fees or costs.

UPDATE: *Senate Bill 893 (S. 893) does provide for the Plan to reduce its lien by the cost of collection, and the Plan has been considering such costs until the Legislature is back in session.*

Q. Does this lien prorate with Medicare, Medicaid and physician liens?

No, but if you have other liens that apply and you are negotiating with the Health Plan, you should argue that the other liens should be prorated with the Health Plan's lien.

Q. Does this lien apply in denied workers' compensation cases?

Yes. In the case of a denied workers' compensation case, where the state employee's medical bills have been paid by the Health Plan rather than through the state's workers' compensation carrier, the Plan has a right to subrogation if the claim is later accepted or compromised.

Q. Does this lien apply in medical malpractice cases?

Yes, based upon the language of the lien.

Q. Will the Health Plan compromise a lien?

Yes. The Health Plan has indicated its willingness to compromise the lien in situations where, under equitable principles, it would be unfair for the plan to recover the full amount of the lien.

Currently, there are no specific guidelines for reduction of the lien. The Health Plan has indicated that they are willing to consider reduction of the lien and are using a loose guideline that would compromise their lien to 50 percent of the *gross* recovery if the settlement is not sufficient to cover the entire lien and pay the attorneys' fees and the client. With this approach, if the attorneys' fees and costs equal 35 percent of the settlement, the Health Plan would receive 50 percent of the settlement, and the client would receive 15 percent of the settlement.

When negotiating with the Health Plan, you should cite all factors affecting the client and the claim. Include the value of the settlement compared to the liens and costs. Also include the strength of the liability case, the extent of physical damages to your client, emotional damages, and future costs and medical treatment.

UPDATE: *The Plan has continued to negotiate the lien based upon the terms set out in the answer above.*

Q. How does the Health Plan claim a right of repayment before January 22, 2004?

The North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan intends to exercise its right of recovery as set out in N.C.G.S. §135-40.13 (g) and pursue all subrogation rights allowed by North Carolina law.

> N.C.G.S. §135-40.13 Coordination of Benefits provides:
>
> (g) Right of Recovery. - Whenever payments have been made by the Claims Processor with respect to covered services in a total amount which is, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, irrespective of to whom paid, the Claims Processor shall have the right to recover such payments, to the extent of such excess, from among one or more of the following, as the Claims Processor shall determine: any persons to or for or with respect to whom such payments were made, any insurance companies, or any other organizations.

The Health Plan is claiming a right to recover any payments that may have been made before January 22, 2004, the date upon which the Health Plan began to "officially" assert the right of equitable subrogation.

The Health Plan, to this writer's knowledge, has never litigated the issue of whether N.C.G.S. §135-40.13 is enforceable in a subrogation context against a third-party liability insurer or plan member. In practice, the Health Plan recognizes that the legal basis for this claim is untested, so it may exercise greater discretion in negotiating with attorneys regarding these claims.

An attorney should advise his client that if the Health Plan paid medical bills for the client before January 22, 2004, the plan *might* have a legal basis to sue the client for reimbursement. Further, like ERISA plans, if there is a dispute as to whether the client/member should have paid the Health Plan from a settlement that has already been disbursed, it is possible that the Health Plan could deny future medical benefits or reduce the benefits by the claimed subrogation amount.

UPDATE: *There have been no reported cases where the Plan has been challenged on this subrogation basis in court. Purportedly, the Plan has deeply discounted subrogation when it depends only upon this legal basis.*

Q. How does the Health Plan claim a right of equitable subrogation from January 22, 2004, to July 20, 2004?

January 22, 2004, was the date upon which the Health Plan first began "officially" to claim equitable subrogation rights against recoveries. The Health Plan claims that these rights are derivative of their rights to coordinate coverage among "any insurance" or "any other organizations."[3]

Whether this right of equitable subrogation actually is enforceable under North Carolina law, in this writer's opinion, has not yet been resolved by our courts. Generally speaking, North Carolina does not recognize a "lien" other than those created by statute.

Q. What happens if I ignore a lien?

If you ignore a lien for medical costs paid by the Health Plan after July 20, 2004, you may be held personally liable for the amount of the lien, much like you would if you ignored a Medicare or Medicaid lien.

As discussed earlier in this article, any claims for subrogation claimed by the Health Plan arising out of payments made before July 20, 2004, result in weaker liability against the attorney because there is a good faith basis to assert that the Health Plan does not have a right to equitable subrogation under North Carolina laws.

UPDATE: *As a practical approach, many lawyers across the state report that if they have discovered payments made by the Plan only before July of 2004, they are weighing the amount of the possible subrogation claim against the likelihood*

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and potential legal success of the Plan in collecting. In some instances, the attorneys are placing funds in trust for limited amounts of time and then disbursing to their clients.

Q. Does the lien apply to UM/UIM payments?

In this writer's opinion, the lien statute is vague and ambiguous as to whether it applies or attaches to funds received by a client from Uninsured or Underinsured insurance policies or any first-party insurance. When asked, the Health Plan states that they are approaching this issue on a "case-by-case basis."

UPDATE: *In at least two instances since this article was originally published, the Plan has recognized, in writing, that the lien does not apply to UIM benefits. There are no reported cases regarding UM benefits but, presumably, UM would be treated the same as UIM benefits.*

UPDATE: Q. Does the lien apply to Medical Payments Insurance?

As addressed above for Uninsured or Underinsured coverage, the lien statute is vague and ambiguous as to whether it applies or attaches to funds received by a client from medical payments insurance. The lien specifically states, "the Plan shall be subrogated . . . to all of the Plan member's rights of recovery against liable third parties, regardless of the entity or individual from whom recovery may be due."

This language suggests that the Plan only has a right to subrogation for moneys received as recovery against a liable third party; medical payments coverage has no such requirement and is typically first-party insurance. However, the Lien goes on to say that the Plan may recover regardless of the entity or individual from whom recovery is made, which might act to counterbalance the first part of the statement.

Given that in most cases medical payments coverage is a small portion of any claim, it appears relatively safe to consider medical payments coverage in the same way as Uninsured and Underinsured coverage.

Q. How do I determine if there is a lien and request lien information?

First, you should attempt to determine if your client is insured by the Health Plan. The Health Plan employs North Carolina Blue Cross/Blue Shield (BC/BS) as a third-party administrator for processing medical claims. Thus, many clients may say their insurance is through BC/BS and not be aware that they are actually insured by the Health Plan.

A better method of determining coverage is to ask the client by whom he and his spouse are employed. If either is a state employee or a retired state employee, the Health Plan has likely paid the medical benefits.

The Health Plan has hired Public Consulting Group (PCG) to help administer subrogation claims for the Health Plan. To make a lien inquiry, contact:

Public Consulting Group, Inc.
PO Box 20733
Raleigh, NC 27619
Phone: 1-800-294-2757
Fax: 919-870-9658
www.PublicConsultingGroup.com

You will need to send a lien request form and provide a HIPPA-compliant release before the PCG will disseminate information. The release can be downloaded from the Internet at http://www.statehealthplan.state.nc.us/forms/PDFs/AuthorizationFormSHP.pdf. The lien request form is available at http://www.statehealthplan.state.nc.us/forms/PDFs/NC_SHP_Lien_Request_Form.pdf. General information about the Health Plan can be viewed at www.statehealthplan.state.nc.us.

UPDATE: *Copies of these forms follow this article.*

Q. I've heard the lien language may change. Will there be changes?

The Academy is working with Senator Tony Rand's office and the Health Plan in an effort to introduce some guidelines for reduction of the lien in situations where equity would demand less than a full recovery for the Health Plan. The Academy has recommended several amendments to the lien legislation and, as discussed above, there may be changes in the Legislature's May Short Session.

The Health Plan lien has affected the practice of personal injury law in North Carolina by depriving state employees of limited insurance funds in catastrophic cases. Because the statute does not require the Health Plan to notify the attorney or client/plan member, the attorney will have to make diligent efforts to discern if a lien exists. The date the Health Plan paid for medical services will determine whether a lien or a claimed right of equitable subrogation exists.

Attorneys should ensure that clients are fully advised of the law before making decisions on the manner of disbursement. Attorneys also should protect themselves by having the client sign documents acknowledging the risks involved in disbursement of funds if the client and the attorney decide not to negotiate directly with or contact the Health Plan.

Finally, because there is the possibility of changes in the Health Plan lien, attorneys handling cases where the Health Plan refuses to strike a fair compromise should contact this author at cnichols@hardisonandleone.com, or send an email to Holly Bryan, legal affairs counsel for the Academy, at holly@ncatl.org, with their clients' stories. ■

[1] The Health Plan has decided to use the July 20, 2004, date as the date upon which it will enforce its lien. Based upon the stated effective date of the statute—July 1, 2004—the Health Plan could use July 1, 2004, as the beginning date of the lien. The Health Plan has indicated that, for administrative purposes, it has instructed its third party administrator to use the July 20, 2004, date. The Health Plan still claims a right of equitable subrogation from July 1, 2004, until July 20, 2004, so this administrative accommodation may have little change on the actual subrogation claim amount of the Health Plan. For the purposes of this paper, the date the lien begins will be considered July 20, 2004, to reflect the administrative operation of the lien.

[2] In re Declaratory Ruling by North Carolina Com'r of Ins., 134 N.C. App. 22, 517 S.E.2d 134 (N.C. App, July 06, 1999).

[3] *See* N.C.G.S. §135-40.13 (g).

NC STATE HEALTH PLAN LIEN REQUEST FORM

Today's Date ________________

Caller: ☐ Attorney ☐ Insurance ☐ Recipient ☐ Other Staff Taking Call: ________________

Caller's Name: ____

Case Information:

Recipient (Client) Name: ______________________ Member ID # ______________________

SSN: ______________________ Accident Type ______________________

Policy No: ______________________ ☐ Auto ☐ Malpractice ☐ Industrial

Accident Date: ______________________ ☐ General Liability ☐ Violent Crime ☐ Other

Caller has Plan authorization: ☐ Yes ☐ No

Referral Type: ______________________

Instructions/Activities

☐ Order CD's and segments

☐ Call, Fax, or Mail Information

☐ Settling (Ready to Negotiate)

Lien Amount ______________________

Settlement Amount ______________________

Settle Date ______________________

Notes and other addresses:

Attorney Information

Attorney/Firm: ____

Address: ____

City: ______________________ State: ______________________

Zip Code:______________________ Phone: ______________________

Fax: ______________________ Other family members on Plan in accident? ________________

Insurance Information

Insurance Co: ____

Policy Holder's Name & Claim #: ____

Adjuster: ______________________ Fax: ______________________

Address: ____

City: ______________________ State: ______________________

Zip Code: ______________________ Phone: ______________________

STATE OF NORTH CAROLINA TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN AND NORTH CAROLINA HEALTH CHOICE FOR CHILDREN PROGRAM

MEMBER/DEPENDENT AUTHORIZATION REQUEST FORM

You may give the State of North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan and NC Health Choice (SHP/ NCHC) written authorization to disclose your Protected Health Information (PHI) to anyone you designate and for any purpose. If you wish to authorize a person or entity to receive your PHI, please complete the information below. **Completion of this form will not change the way that the SHP/NCHC communicates with members or dependents.** ***For example, we will still send Explanation of Benefits (EOB) statements to the member.***

MEMBER/DEPENDENT NAME		MEMBER/DEPENDENT DATE OF BIRTH *(month, day, year)*
MEMBER ID NUMBER	MEMBER/DEPENDENT ADDRESS ON RECORD	

At my request, I authorize the SHP/NCHC and their business associates to disclose my PHI to *(enter name of person/entity who will receive your PHI)*:

NAME ______________________ RELATIONSHIP TO MEMBER/DEPENDENT) ______________________

I authorize the SHP/NCHC and their business associates to disclose the following PHI to the person/entity listed above:

- ☐ Enrollment Information
- ☐ Premium Payment Information
- ☐ All Claims Information
- ☐ Benefit Information
- ☐ Explanation of Benefits (EOB) Information
- ☐ Any Information Requested
- ☐ All services from a specific health care provider *(list provider's name)*: ______________________
- ☐ Other *(please list specific PHI)*: ______________________

I would like this authorization to expire on:

☐☐ / ☐☐ / ☐☐☐☐ (MONTH DAY YEAR) **OR** ☐ **When my coverage expires.**

(If no expiration date is provided, this authorization will expire twelve (12) months from the date of receipt.)

I understand that I may revoke this authorization at any time by giving the SHP/NCHC written notice mailed to the address at the bottom of this form. I also understand that revocation *will not* affect any action the SHP/NCHC and their business associates took in reliance upon this authorization before receiving my written notice of revocation.

I also understand that the SHP/NCHC *will not* condition the provision of health plan benefits on this authorization.

I further understand that if the persons or entities I authorize to receive my PHI are not health plans, covered health care providers or health care clearinghouses subject to the Health Insurance Portability and Accountability Act (HIPAA) or other federal health information privacy laws, they may further disclose the PHI and it may no longer be protected by HIPAA or federal health information privacy laws.

I also release and discharge the State of North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan and North Carolina Health Choice for Children and their business associates, including Blue Cross and Blue Shield of North Carolina, from any and all liability, cost and claims of whatsoever kind and nature arising from the release of this information.

Signature ______________________ **Date** ______________________

If signed by a personal representative:

Print your full name: ______________________

Describe your authority to act for the member (e.g., power of attorney, administrator, parent of minor child, executor of estate, etc.):

____

NOTE: The SHP/NCHC will consider the effective date of this authorization to be the date the Claims Processing Contractor enters this authorization into its system, typically five days following receipt. If you would like this authorization to become effective on a date after the Claims Processing Contractor enters the authorization into its system, please insert the date here: ☐☐ / ☐☐ / ☐☐☐☐ (MONTH DAY YEAR)

RETURN THIS AUTHORIZATION TO: **ATTN: AUTHORIZATION DEPARTMENT**
NC TEACHERS' AND STATE EMPLOYEES'
COMPREHENSIVE MAJOR MEDICAL PLAN AND NC HEALTH CHOICE
PO BOX 30111 • DURHAM, NC 27702-3111

Please provide the following information to the person you have authorized so that we may verify the person's identity and authority to receive your PHI: (1) your name, (2) your member ID number, (3) your date of birth, (4) your address on record, and (5) the type of PHI you have authorized to be released.

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