

**FACT SHEET:
STATE AND PROVIDER LIENS ASSERTED AGAINST THE RECOVERIES OF
MEDICAID AND MEDICARE BENEFICIARIES¹**

Prepared by:
Manjusha P. Kulkarni
National Health Law Program
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I. Introduction

This fact sheet will discuss the Medicaid Act's third party liability and balance billing provisions as they relate to liens imposed on tort recoveries of Medicaid beneficiaries and how the courts have interpreted those provisions. It will also describe similar provisions in the Medicare program, including recent changes to Medicare regulations that involve liens on tort recoveries and how those changes impact relevant case law. Finally, this fact sheet will explain the significance of these liens and provide tips for advocates whose clients may face state and provider liens.

II. Medicaid Provisions

A. Third Party Liability

1. Medicaid Statutes and Regulations

A basic principle of the Medicaid program is that Medicaid is the payer of last resort.² This means that other third party resources must be used before Medicaid pays for medical services provided to an individual enrolled in the Medicaid program.³ Further, states are required to take "all reasonable measures" to determine third party liability for the medical costs

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² 42 U.S.C. §§ 1396a(a)(25), b(o).

³ 55 *Fed. Reg.* 1423 (January 16, 1990).

of injury, disease or disability of a Medicaid beneficiary.⁴ A third party, for purposes of this discussion, is any individual, entity of program that is or may be liable to pay all or part of the expenditures for medical assistance furnished under a state plan; examples include commercial insurance, casualty insurance, unions and state workers' compensation commissions.⁵ The State Medicaid Manual mandates that each state participating in the Medicaid program maintain laws allowing it to acquire the right of the Medicaid beneficiary to payment by any other party for health care items or services for which that third party is responsible.⁶ Medicaid will pay benefits only to the extent that the medical costs of the beneficiary's injury or illness exceed the amount of third party liability.⁷ As a condition of eligibility, Medicaid beneficiaries must assign their right to payment from any liable third party to the state Medicaid agency.⁸ Additionally, states must have subrogation laws in effect so that the state Medicaid agency can acquire the rights of the beneficiary to payment by other payers of health care services.⁹ Collected funds are used to reimburse the state for medical assistance payments made on behalf of the beneficiary, but the remainder, if there is any, must be paid to the individual.¹⁰

2. Case Law Analysis

Several state and federal cases have examined the issue of state liens against the tort recoveries of Medicaid beneficiaries. Evaluating the third party liability provisions of the federal Medicaid Act and regulations, the courts have consistently upheld state liens, though there has been significant variation regarding the extent to which those liens can be imposed on beneficiary recovery. In *Wilson v. Washington*,¹¹ the Court examined the issue of whether Washington state law allowing Medicaid recovery of amounts beyond those specifically allocated to medical expenses was preempted by federal law. The Supreme Court found that the state law was not preempted because there was no federal statute or regulation limiting recovery

⁴ 42 U.S.C. § 1396a(a)(25). See 42 C.F.R. §§ 433.137 - 433.140.

⁵ 55 *Fed. Reg.* 1423 (January 16, 1990).

⁶ CMS, STATE MEDICAID MANUAL §3900.

⁷ 42 U.S.C. §§ 1396a(a)(25)(C); 42 C.F.R. § 433.139; CMS, STATE MEDICAID MANUAL §3904.

⁸ 42 U.S.C. § 1396a(a)(45); 42 U.S.C. § 1396k(a); 42 C.F.R. §§ 433.145 - 433.148; CMS, STATE MEDICAID MANUAL § 3905.

⁹ 42 U.S.C. § 1396a(a)(25)(H).

¹⁰ 42 C.F.R. § 1396k(b); 42 C.F.R § 433.154.

¹¹ 10 P.3d 1061 (Washington 2000).

to the portion earmarked for medical expenses.¹² Rather, the federal Medicaid statute permitted recovery “to the extent that payment has been made” under the State plan.¹³ Several other courts came to the same conclusion: that a lien may be imposed on the entire settlement.¹⁴

Another issue that is frequently raised in state lien cases involves the timing of satisfaction of the lien. In *Norwest Bank of North Dakota v. Doth*,¹⁵ the Eighth Circuit held that the Minnesota Department of Health Services could require that the Medicaid lien imposed on the proceeds of the personal injury award be satisfied before remaining funds were placed in a special needs trust. The Court found that the state had a right to enforce its lien, stating that the Medicaid beneficiaries in this case should not be able to avoid reimbursing the state by simply placing the third party recovery in a special need trust.¹⁶ Similarly, in *Wallace v. Estate of Jackson*,¹⁷ the Utah Supreme Court found that third party payments did not become the property of the Medicaid beneficiary until after settlement “because third party settlement proceeds have been specified by the recipient as belonging to the State Medicaid Agency as a precondition of the recipient’s eligibility.”

B. Balance Billing

1. Medicaid Statutes and Regulations

Another basic tenet of the Medicaid program is that Medicaid participating providers

¹² *Id.*

¹³ *Id.* (referring to 42 U.S.C. § 1396a(a)(25)(H)).

¹⁴ *See Wallace v. Estate of Jackson*, 972 P.2d 446 (Utah 1998); *Calvanese v. Calvanese*, 710 N.E.2d 1079 (N.Y. 1999); *Ahlborn v. Arkansas Department of Human Services*, 280 F. Supp. 2d 881 (E.D. Ark. 2003). *But see Martin v. City of Rochester*, 642 N.W.2d 1 (Minn. 2002)(finding that Minnesota’s state Medicaid subrogation provision was preempted by the federal anti-lien provision to the extent that it permitted the state to obtain anything more from a Medicaid beneficiary than the beneficiary’s right to payment for medical services from third parties who were liable for injuries that necessitated medical assistance). For additional cases, refer to the National Health Law Program, *An Advocate’s Guide to the Medicaid Program*, 2.15 (fn. 250) (2001).

¹⁵ 159 F.3d 328 (8th Cir. 1998).

¹⁶ *Id.*

¹⁷ 972 P.2d 446 (Utah 1998).

accept the Medicaid payment as “payment in full.”¹⁸ That is, by accepting Medicaid reimbursement, they waive their right to bill Medicaid beneficiaries for any amount over the Medicaid payment, other than copayments, co-insurance and deductibles.¹⁹ Specifically, the balance billing provision of the Medicaid statute prohibits providers who have rendered a service from seeking to collect

payment of an amount for that service (i) if the total of the amount of the liabilities of third parties for that service is at least equal to the amount payable for that service under the plan ... or (ii) in an amount which exceeds the lesser of (I) the [nominal copayment] amount which may be collected under section 1936o of this title, or (II) the amount by which the amount payable for that service under the plan ... exceeds the total of the amount of the liabilities of third parties for that service.²⁰

This prohibition on balance billing was enacted by Congress and promulgated as regulations by the Secretary of Health, Education and Welfare in recognition of the fact that any amount charged to a Medicaid beneficiary for health care services would interfere with or impede the beneficiary’s access to medically necessary care.²¹ To ensure that Medicaid beneficiaries would not be charged amounts exceeding the Medicaid reimbursement, the regulations required states to limit providers to only those who accepted Medicaid payment as “payment in full.” Congress went a step further and provided that, in addition to any other sanction available to a state, the state may provide for a reduction in payment equal to up to three times the amount of any

¹⁸ See 42 U.S.C. §1396a(a)(25)(C); 42 C.F.R. § 447.15. See also 42 U.S.C. § 1320a-7b(d).

¹⁹ 42 C.F.R. § 447.20. Also, Medicaid participating providers cannot refuse to furnish services to a beneficiary because of the potential third party liability. 42 U.S.C. §1396a(a)(25)(D).

²⁰ 42 U.S.C. §1396a(a)(25)(C)

²¹ See *Yanez v. Jones*, 361 F.Supp. 701, 706 (D.Utah 1973).

As evidenced by this legislative history, the Secretary clearly intended to bar a health care provider from recovering from a Medicaid beneficiary any amount exceeding the cost-sharing charged allowed under the state plan. The Secretary found it necessary to impose this limitation on provider recovery in order to effectuate Congress’ intent and to insure medical care for the needy.

Olszewski v. Scrippshealth, 135 Cal.Rptr.2d 1, 19 (Cal. 2003)(referring to *Yanez v. Jones*, 361 F.Supp. at 706).

payment sought to be collected by a provider in violation of the statute.²²

2. Case Law Analysis

In the past several years, however, states have allowed providers to assert liens against Medicaid beneficiaries in circumstances in which there is clear third party liability and the Medicaid beneficiary has obtained a significant tort recovery or settlement. Advocates and attorneys for these Medicaid beneficiaries have argued that such liens violate the balance billing provision of the Medicaid Act. A number of state and federal courts have examined this issue and, in most cases, they have invalidated the liens and the statutes that allow them.

In *Evanston Hospital v. Hauck*,²³ the hospital brought an action against the Illinois state Medicaid agency to allow it to refund the Medicaid reimbursement so that it could sue the Medicaid beneficiary who had obtained a substantial tort judgment. In finding that there was no conflict between federal law and Illinois law requiring that hospitals accept Medicaid payment as payment in full, the Seventh Circuit held that the hospital could not refund the Medicaid payment to the state Medicaid agency and instead sue the Medicaid beneficiary.²⁴ Further, the court determined that the “Medicaid as payer of last resort” provision implied that the state, and not private providers, could seek reimbursement from third parties who had legal responsibility for the beneficiary’s medical bills.²⁵ According to the Court, the statute said nothing about turning over the right of reimbursement to providers who had already been compensated for their services.²⁶ The Court noted:

[N]o one coerced the hospital into cashing a \$113,424 check from the taxpayers as partial reimbursement for Hauck’s medical bills By opting for reimbursement from Medicaid, Evanston Hospital bought certainty. It purchased a guarantee of partial payment in lieu of possibly full payment or possibly no payment at all.²⁷

²² See 42 U.S.C. § 1396a(g)(establishes a sanction for violation of 42 U.S.C. § 1396a(a)(25)(C)).

²³ 1 F.3d 540 (7th Cir. 1993).

²⁴ *Id.*

²⁵ *Id.* at 543.

²⁶ *Id.*

²⁷ *Id.* At 542.

Similarly, in *Mallo v. Public Health Trust of Dade County*,²⁸ the hospital which treated the Medicaid beneficiary asserted a lien against the beneficiary for costs exceeding the amount paid by Medicaid. The Court found that the Medicaid recipient was as a third party beneficiary of a contract between the state and the provider, in which “the State will disburse Medicaid funds at the amount it sets, in exchange for which the health care provider will not charge the patient more than the amount of Medicaid funds that the provider receives from the State.”²⁹ Like the *Evanston Hospital* case, the plaintiff in *Mallo* suffered severe injuries for which he was treated by the hospital. When he obtained a tort recovery, the hospital placed a lien on his settlement award. The Court held that when a Medicaid patient obtains a tort recovery in excess of the medical expenditures paid by Medicaid, that recovery is meant to go to the injured party, not the provider.³⁰

In *Public Health Trust of Dade County v. Dade County School Board*,³¹ the Florida Court of Appeal invalidated a state regulation that allowed providers to seek recovery of third party benefits on behalf of the state Medicaid agency. Under the Florida regulation, “any excess third-party benefits collected by the provider are permitted to be applied to provider charges that exceed Medicaid payment” once the Medicaid program has been made whole.³² Here too, the hospital sought and received Medicaid reimbursement. Only after it realized that the Medicaid beneficiary’s family would be receiving a significant monetary settlement did it promise to return the Medicaid reimbursement and assert a lien on the family’s recovery. The Court found that the administrative regulation clearly conflicted with federal Medicaid law and a state statute providing that Medicaid payment is “payment in full.”³³

More recently, the California Supreme Court invalidated two state statutes authorizing provider liens against Medicaid beneficiaries in *Olszewski v. Scrippshealth*.³⁴ The statutes in question allowed providers who rendered services for which a third party was liable to file a lien on any third party recovery obtained by the beneficiary even after obtaining Medicaid

²⁸ 88 F. Supp.2d 1376 (S.D. Fla. 2000).

²⁹ *Id.* at 1385.

³⁰ *Id.* at 1385-86.

³¹ 693 So.2d 562 (Fla. Dist. Ct. App. 1996).

³² *See* FLA. ADMIN. CODE ANN. R. 59G-7.055(6)(2004).

³³ *Public Health Trust of Dade County*, 693 So.2d at 566(referring to federal Medicaid statute and regulations and 1990 Fla. Stat. Ann. § 409.2665(5)).

³⁴ 135 Cal.Rptr.2d 1 (Cal. 2003)

reimbursement.³⁵ The statutes did require, however, that the provider fully reimburse Medicaid before recovering upon the lien.³⁶ While the California statutes authorized the provider liens, the federal statutes and regulations regarding provider payment are, according to the Court, “unambiguous and limit provider collections from a Medicaid beneficiary to, at most, the cost-sharing charges allowed under the state plan, even when a third party tortfeasor is later found liable for the injuries suffered by that beneficiary.”³⁷ Because of this conflict, the Court found that the state statutes were preempted by federal statutes and regulations and were, therefore, invalid.

III. Medicare Provisions

A. Secondary Payer Provision

Medicare law, unlike the Medicaid statute, forbids Medicare payment where a third party can reasonably be expected to make prompt payment.³⁸ Specifically, the Medicare Secondary Payer Provision states

“[p]ayment under this title may not be made, except as provided . . . with respect to any item or service to the extent that (i) payment has been made, or can *reasonably be expected* to be made, with respect to the item or service as required under paragraph (1), or (ii) payment has been made or can *reasonably be expected* to be made under a workmen’s compensation law or plan of the United States or a State or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no-fault insurance.”³⁹
(italics added)

Where third party payments, including those of insurance companies, are not “prompt,” Medicare can pay the medical expenses of an injured Medicare beneficiary; these payments are described as “conditional.”⁴⁰ Hospitals and other providers accepting conditional payment must

³⁵ See CAL. WELF. & INST. CODE §§ 14124.74, 14124.791 (West 2004).

³⁶ *Id.*

³⁷ 135 Cal.Rptr.2d at 19.

³⁸ 42 U.S.C. § 1395y(b)(2).

³⁹ 42 U.S.C. § 1395y(b)(2)(A). See also 42 C.F.R. § 402.322(c).

⁴⁰ Center for Medicare Advocacy, Medicare Handbook § 9.07 (explaining 42 U.S.C. § 1395y(b)(2)(A)(ii) and (b)(2)(B)).

do so at the Medicare rate and cannot seek additional amounts from the third party recovery.⁴¹ Furthermore, Medicare expects to recover these amounts when payment by the private insurance carrier “has been or could be made.”⁴²

Similar to the Medicaid Program, Medicare provides Centers for Medicare and Medicaid (CMS) Services the power to collect conditional payment through subrogation of the beneficiary’s claim.⁴³ Additionally, CMS has the right to bring a separate action to recover conditional payments it made to providers.⁴⁴ In seeking Medicare repayment, CMS can recover the amount equal to the Medicare payment or the amount payable by the third party, whichever is less.⁴⁵ The exact amount is determined in part by the time of the award or settlement, the point at which the recovery ceases to accrue.⁴⁶

B. Balance Billing

Like Medicaid, the Medicare program has a prohibition against billing Medicare beneficiaries. Participation has been limited to providers who agree not to charge beneficiaries for items or services for which an individual is entitled to have payment made under Medicare.⁴⁷ Recently, however, changes that dramatically alter the prohibition on balance billing were made to two Medicare regulations.⁴⁸ In 2003, the Bush Administration removed 42 CFR § 411.54(c)(2); it stated “the provider or supplier may not bill the liability insurer nor place a lien against the beneficiary’s liability insurance settlement for Medicare covered services.” The Administration also modified 42 CFR § 489.20(g) to read “the provider agrees to . . . bill other primary payers before Medicare.” The new version omits a significant phrase: “except when the primary payer is a liability insurer.” These changes indicate that billing a Medicare beneficiary or asserting a lien against the beneficiary’s recovery, obtained from the tortfeasor’s liability

⁴¹ *Id.*

⁴² *Id.*

⁴³ *Id.*

⁴⁴ *See* 42 U.S.C. § 1395y(b)(2)(B)(ii).

⁴⁵ Center for Medicare Advocacy, Medicare Handbook § 9.07 (citing 42 C.F.R. § 411.24(c)).

⁴⁶ *Id.*

⁴⁷ 42 U.S.C. § 1395cc(a); 42 C.F.R. § 489.21.

⁴⁸ *See* 68 *Fed. Reg.* 43940 (July 25, 2003)(explaining that Court’s decision in *American Hospital Association (AHA) v. Sullivan*, 1990 WL 274639 (D.D.C. May 24, 1990) prevented the implementation of 42 C.F.R. §§ 411.54(c)(2), 489.20(g) and resulted in modification of rules).

insurance, is no longer prohibited.⁴⁹

C. Case law Analysis

In the seminal case involving Medicare and provider liens, *Rybicki v. Hartley*,⁵⁰ a hospital sought to recover from a Medicare patient more than it received from the Medicare program for treating injuries that the patient sustained in an automobile accident. The First Circuit, however, held that the fact that the Medicare patient recovered more from the tortfeasor than the hospital charged the patient under Medicare and that the patient reimbursed Medicare from the settlement as required did not entitle the hospital to charge the patient the difference between its full fee and Medicare's lower flat fee.⁵¹ The Court found that the underlying assumption in this agreement was that Medicare's "guaranteeing payment to the hospital [was] ... the quid for which the hospital's 'no additional payment' promise was in part the quo."⁵²

Timing of the claim was critical in *Rybicki*. It was the key to determining 1) whether the Medicare patient was entitled to have Medicare pay for services and 2) whether the provider could collect from the beneficiary more than the amount that Medicare would pay for services. In *Rybicki*, Medicare paid for the medical services first; had the liability insurer settled the patient's claim before Medicare made payment, the patient would not have been entitled to Medicare payment and the hospital would have sought its customary charges from the patient's third party recovery. The changes to the regulations will now allow providers to first seek payment by billing the liability insurer or placing a lien on the Medicare beneficiary's recovery and obtain their usual and customary charges, eliminating the possibility of a future *Rybicki*-like scenario. More importantly, the regulations will likely lead to very few Medicare payments where there is a tort settlement or award and many more provider liens.

Medicare rules regarding state and provider liens on third party recoveries are extremely complicated. A brief description of the important provisions is outlined above. For more information, please refer to the following resources:

Resources on Provider Liens Against Medicare Beneficiaries

⁴⁹ *See id.* (stating "we are allowing them [providers and suppliers] to bill liability insurers or assert or maintain liens on a beneficiary's liability insurance settlement rather than billing Medicare).

⁵⁰ 792 F.2d 260 (1st Cir. 1986).

⁵¹ *Id.* *See also Evanston Hospital v. Hauck*, 1 F.3d 540 (7th Cir. 1993), in which the Seventh Circuit came to a similar conclusion.

⁵² *Id.* at 262.

- Medicare Intermediary Manual
Guide to the administration of the Medicare program
- *Medicare Handbook*
Chapter 9: Medicare's Relationship with Private Insurance
Center for Medicare Advocacy
www.medicareadvocacy.org
- "Medicare Secondary Payer and You" Page
Center for Medicare and Medicaid Services
http://www.cms.hhs.gov/medicare/cob/msp/msp_home.asp
- Q&A: Coordination of Benefits/Primary vs. Secondary Payer
Medicare Rights Center
www.medicarerights.org

IV. Significance for Advocates and Advocacy Tips

It is important for advocates to understand state and provider liens which can be asserted against the third party recoveries of their Medicaid and Medicare beneficiaries. As advocates are well aware, these individuals, who are mostly low-income, rely upon their Medicaid and Medicare coverage to obtain health care services. When they experience an injury or accident, they use Medicaid and Medicare benefits, to which they are entitled, to cover what can be enormous hospital and provider charges. In the event that they receive an award or settlement from the tortfeasor, Medicaid and Medicare beneficiaries should be able to keep the funds as compensation for their injury or as payment for their past or future medical expenses, which may not always be covered by Medicaid or Medicare. Instead, they are increasingly being sued by their states and their providers who see beneficiaries reaping sizable recoveries, but ignore the monetary as well as physical and mental costs of the accident. Defending clients against such liens and helping them keep as much of the award or settlement as possible is critical to their overall recovery.

When representing clients who have obtained tort recoveries and are facing state Medicaid liens, there is little that can be done to avoid the lien altogether.⁵³ However, advocates

⁵³ *But see Iowa Dep't of Human Servs. v. Brooks*, 412 N.W.2d 613 (Iowa 1987)(state subrogation claim was denied where state law only allowed subrogation in tort actions where recovery was intended to cover medical expenses and Medicaid beneficiary's personal injury award did not involve medical expenses).

can try to limit the amount of the recovery. While a number of state and federal courts have determined that a state lien can be asserted against the entire settlement, the issue is not completely settled. Depending on the circumstances, advocates can argue that the lien should be limited to medical benefits portion of the settlement, or to simply the past medical expenses, leaving some potential funds for future medical bills. Advocates can also argue that some portion of the award is earmarked for rehabilitation, physical or occupational therapy or a special needs trust for the client. For those clients who have not yet sought a tort recovery, advocates may want to evaluate the wisdom of a tort claim, especially if it means that, ultimately, the client receives little compensation and may even lose her Medicaid eligibility.

It will likely be easier for advocates to challenge provider liens asserted against their client's tort recoveries. Unlike state Medicaid liens which flow from the assignment rights of Medicaid beneficiaries, provider liens have no such assignment rights and, therefore, must attach to the Medicaid beneficiary as her property. This results in an explicit additional charge by the provider, which is prohibited by the balance billing provision. Advocates residing in states that allow provider liens can sue the Medicaid state agency for breaching its obligation under the balance billing provision and request that the court enforce your client's asserted interest in recovering his money. In addition to the legal arguments outlined above, advocates can give public policy reasons for avoiding provider liens. Advocates should argue that when a Medicaid beneficiary obtains a tort recovery in excess of the medical expenditures paid by Medicaid, that recovery is meant to go to the injured party, not the provider.⁵⁴ Advocates can point out that in enacting the balance billing provision, Congress intended Medicaid beneficiaries to benefit from such a windfall."⁵⁵

Challenging federal liens and provider liens against tort recoveries of Medicare beneficiaries is much more difficult than fighting Medicaid liens. As in the Medicaid context, advocates can seek to limit the amount of the lien by arguing that certain portions of the recovery are reserved for future medical expenses, rehabilitation and other costs associated with the injury. Because of recent modifications to the Medicare regulations, advocates can no longer claim that provider liens are prohibited. However, they can still make public policy arguments against the liens. In cases where providers have already received payment from Medicare, the advocate can assert that the provider is having it both ways in accepting lower Medicare payment first and obtaining higher third party recovery later; even where the provider has not received Medicare payment initially, the advocate can claim that beneficiary is essentially being denied his Medicare benefits in being charged for health care services. In addition to allowing providers to reap huge windfalls, these liens violate the fundamental principles of fairness in appropriating the beneficiary's rightful compensation.

⁵⁴ See *Mallo v. Public Health Trust of Dade County*, 88 F. Supp.2d at 1385-86.

⁵⁵ See *id.*

