



# The Role of Health Care Liens in Litigation and Recovery

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## Preface

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Third-party liens have increasingly become an issue in resolving mass litigation events. Traditionally, liens in the civil justice system represent a claim by a creditor against a plaintiff's (the debtor's) cause of action. This lien could be for back taxes, child support, or other financial obligations. In recent years, Medicare and increasingly other forms of health insurance have been given far more extensive lien rights, particularly with regard to the obligations they are owed by defendants' insurers. Because these rights extend beyond the plaintiff to the plaintiff's lawyer and the defendant, these rights have made resolving these liens a requirement of settlement. Not surprisingly, anecdotal evidence suggests that liens are becoming more frequent. This is potentially problematic if liens become sufficiently burdensome or costly that potential litigants do not pursue cases. In this paper we examine the different types of health care liens and trends in prevalence, as well as how liens have changed the landscape of claim resolution. We use a unique dataset on the resolution of a number of mass compensation events, as well as smaller claims. We find that health care liens are relatively common in our dataset of mass compensation events. Moreover, we find some evidence that smaller-value liens are more prevalent among Medicare liens, which is consistent with the hypothesis that Medicare liens' more extensive rights relative to other lien types lead CMS to pursue more and smaller liens than private lien holders.

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# Contents

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<b>Preface</b> .....	iii
<b>Figures</b> .....	ix
<b>Tables</b> .....	xi
<b>Summary</b> .....	xiii
<b>Acknowledgments</b> .....	xvii
<b>Abbreviations</b> .....	xix
<b>CHAPTER ONE</b>	
<b>Introduction</b> .....	1
<b>CHAPTER TWO</b>	
<b>Background on Lien Rights for Health Care Providers</b> .....	7
Medicare: The 800-Pound Gorilla.....	7
Medicaid: The Importance of the State-Federal Partnership for Liens .....	11
Medicare Part C.....	14
Private Insurance.....	15
Other Issues in Lien Resolution .....	18
Summary.....	19
<b>CHAPTER THREE</b>	
<b>Research Questions</b> .....	21
The Data .....	21

**CHAPTER FOUR**

**Results** ..... 29

The Frequency of Liens..... 29

Recovery Relative to Medicare Liens ..... 31

Liens by Event Type ..... 34

Trends in Liens ..... 38

**CHAPTER FIVE**

**Conclusion and Implications** ..... 41

**APPENDIX** ..... 43

**References** ..... 49

**About the Author** ..... 53



# Figures

---

2.1. States in Which Plaintiff Cannot Release Defendant from Lien Liability If Defendant Has Full Knowledge of Subrogation Claim.....	17
3.1. The Distribution of Events and Medicare Liens per Case over the Sample Period (96 compensation events) .....	24
3.2. Average Number of Law Firms Involved per Event.....	26
3.3. Average Total Payment by Law Firm (U.S. dollars).....	26
4.1. Average Resolved Value of Liens by Lien Type (U.S. dollars)....	30
4.2. Average Number of Liens per Claimant by Claim Type .....	31
4.3. Lien Value as a Percentage of Total Claim Value.....	32
4.4. The Distribution of Resolved Liens.....	33
4.5. Medicare Versus Medicaid Liens.....	34
4.6. Average Proportion of Lien Type per Event by Event Type .....	35
4.7. Average Lien Payment as a Percentage of Total Payment .....	36
4.8. Average Lien Payment Proportion by Type .....	37
4.9. Trend in Number of Liens.....	38



# Tables

---

3.1. Breakdown of Claimants and Cases over 100 Compensation Events.....	23
3.2. Number of Events by Category and Average Total Payment by Event (2008–2017).....	25
A.1. Summary of Statutory Requirements by Lien Type .....	44
A.2. Data on Proportion of Lien Type by Event and Average Lien Payment as a Percentage of Total Payment.....	46
A.3. Regression Results for Figure 4.9 .....	48



## Summary

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Increasingly, third-party health care liens are alleged to impede settlement in mass litigation events. Traditionally, liens in the civil justice system represent a claim by a creditor against a plaintiff's (the debtor's) cause of action. The lien has two effects. The first is that it potentially reduces the payment the plaintiff receives in settlement or at trial dollar for dollar, up to the amount of the lien. Second, without resolving the lien, it is often difficult to settle a claim only because the plaintiff may have liens larger than a settlement offer, thus making the plaintiff indifferent when faced with the choice between taking the settlement and "rolling the dice" at trial, since the money would have been paid to the lienholder in any event.

What has changed within the last 15 years is that Medicare and, increasingly, other forms of government-provided insurance have been given far more extensive lien rights, particularly concerning the obligations, such as reporting requirements, that defendants' insurers have to Medicare. Because these rights extend beyond the plaintiff to the plaintiff's lawyer and the defendant, they have made resolving these liens a requirement of settlement. The expansion of statutory rights by the Medicare Secondary Payer Act, under which Medicare has a superior right of recovery over all other liens, has led to Medicare liens being described as "super liens," since they are taken directly out of the plaintiff's settlement regardless of other claims or state law.

Medicaid, the joint state and federal insurance program for low-income Americans, and Medicare Part C plans are two examples of expanding lien rights. Medicaid liens are more complicated than those for Medicare because Medicaid is a means-tested program and people

can go on and off the program over time, making checking whether someone is eligible for Medicaid inherently more difficult than it is for Medicare. Nevertheless, the Bipartisan Budget Act (2013) increased federal efforts to harmonize state Medicaid lien resolution with that of Medicare, giving Medicaid similar super lien rights to Medicare's. Similarly, legal rulings regarding Medicare Part C plans have provided essentially the same rights as the Center for Medicare Services with regard to settling parties. Thus, Medicare, Medicaid, and Medicare Part C plans now all have super lien rights.

This study examines how frequently health care liens appear in large litigation events. We provide the results of a study using a unique data source on the frequency and value of health care liens in mass compensation events ranging from pharmaceutical litigation, including multidistrict litigation, to consumer products claims and hospital malpractice. The data come from the Garretson Resolution Group and contains anonymized data on 96 compensation events resolved between 2008 and 2017.

There is one important limitation of our data that we cannot avoid. To be included in our data, the plaintiffs or defendants must have contracted with the Garretson Group to resolve their claims. As such, the sample is not representative of the prevalence of liens in the civil justice system, as we would expect compensation events going to the Garretson Group to be significantly larger, to be more expensive, and perhaps to involve more plaintiffs and therefore more liens than other cases in the civil justice system. Moreover, because the data are wholly anonymized, we are also unable to examine issues in lien resolution related to the participants in the litigation (attorney, insurers, etc.) or the specific facts of the mass litigation event. Finally, our data do not include information on other lien types beyond health care liens. Although health care liens are anecdotally the most common types of liens in the civil justice system, the results must be caveated by this omission. Nonetheless, Garretson employees have indicated that they do not feel the events and claims they handle differ systematically in terms of lien exposure from other, large compensation events dealing with similar issues.

We find that the average lien value is \$11,349, or about 11.65 percent of the total value of the claim. Each claim in the data has an aver-

age of one lien, although there is significant variation in the number of liens per claim across compensation events. We also examine the breakdown of health care liens by the types of lien holders (i.e., Medicare, Medicaid, etc.).

We find that Medicare liens are, on average, more frequent and recover less money than private liens, which is consistent with Medicare's expanded lien rights. Medicaid liens, while similar in frequency, recover less than Medicare liens. We suggest that this may be because, during our sample period, the *Ahlborn* and *Wos* cases had restricted Medicaid's lien rights relative to Medicare, something Congress reversed in 2013. The amount paid out to resolve liens in our dataset is on average about 10–20 percent of the total claim value, depending on lien type, and no particular lien type dominates the recovery.

Although lien rights for Medicare Part C and Medicaid are expanding, there is no evidence of a trend in the number of health care liens. However, our data cover only 2008–2017, so some care must be taken in interpreting these results. It is likely that a longer time series would show an uptick in liens around the introduction of reporting requirements.

Although not directly addressed by the research in this report, previous research has associated expanded lien rights with delays in resolving claims, as reporting requirements must be satisfied and liens must now be resolved. The evidence in this report suggests why these delays may be occurring. At least in the Garretson data, liens are already relatively frequent.

The current frequency of liens in mass compensation events suggests a potential implication of the push to expand lien rights in non-Medicare statutory liens. As lien rights grow, liens will almost certainly become more frequent and command a more significant share of recovery funds. Our range of 10–20 percent of total payment comes before attorneys' fees. If the typical attorney's fee is 33.3 percent, this suggests that in some compensation events claimants are receiving less than 50 percent of the claim value. As this number grows, plaintiffs may decide not to pursue some claims. Put differently, the increase in lien rights suggests that the risk of plaintiffs being unwilling to pursue claims is real, even if the data surveyed here do not necessarily indicate

that increased lien rights have reduced potential claimants' willingness to pursue a claim.

There are many important questions left unanswered by this study that are worthy of further research. The first is whether the objective of raising additional funds for Medicare, or Medicaid, warrants the expanded lien rights. This report has documented the extent of liens in a sample of large compensation events, but it has not documented the benefits to Medicaid and other health insurance providers, and the evidence of the costs to participants in the form of delay or unwillingness to pursue a claim is only touched on obliquely here.



## Acknowledgments

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## List of Abbreviations

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CCRMC	RAND Center for Catastrophic Risk Management and Compensation
CMS	Center for Medicare Services
ERISA	Employee Retirement Income Security Act
FEHBA	Federal Employees Health Benefits Act
ICJ	RAND Institute for Civil Justice
MAIS	Medical Assistance Intercept System
MDL	multidistrict litigation
MSP	Medicare Secondary Payer Act
PLRP	Private Lien Resolution Program
SMART	Strengthening Medicare and Repaying Taxpayers Act



## Introduction

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In 2015 almost 40 percent of the pending federal civil docket was part of a multidistrict litigation (MDL).<sup>1</sup> This represents a dramatic increase over the 4 percent of civil cases involved in MDLs in 1992 (Resnik, 2017). Much like the expanded use of the class action procedure, these efforts represent courts' attempts to process a large volume of complex litigation working its way through the court system. In many ways the success of the courts' efforts in dealing with complex litigation on such a large scale hinges on getting the parties to settle the claim without trial. Simply put, the courts could not handle anywhere near the volume of litigation they now oversee unless the vast majority of the cases settled. Efficient consolidation techniques such as federal MDL panels and state mass tort courts follow a common pattern of case management that appears designed to produce a settlement. Thus mass litigation events typically use consolidated discovery and motion rulings across a large number of cases, utilize "bellwether" trials, and often

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<sup>1</sup> For the purposes of this study, a mass compensation event is characterized by a large group of potential plaintiffs who have allegedly been harmed by a common defendant. Moreover, these harms typically have some common cause: for example, a drug taken by the plaintiffs, a release of a toxic substance, or a single accident such as an air crash or a product defect. Because some events do not involve lawsuits filed through the courts, this is potentially a broader definition than that of *mass litigation*, or *mass tort*, in which the lawsuits are consolidated into one action and not treated as individual lawsuits for at least some portion of the litigation process. An MDL is a procedure to aggregate a group of lawsuits against a common defendant resulting from a similar harm but in which the plaintiff still has an individual claim. In a class action, by contrast, a class representative serves as a stand-in for other members of the class.

provide settlement grids in the pursuit of global settlement (see Fallon, Grabill, and Wynne, 2008).<sup>2</sup> Even compensation programs that are run outside the civil justice system, like the 9/11 victims' compensation fund that allowed victims to have their claims resolved through the fund or to sue in court, have dealt with similarly massive numbers of claims and similarly aimed for mass settlement.

There have been numerous discussions of the problems with processing a massive number of claims through a court system that has traditionally been focused on providing individualized justice (see Nagareda, 2008). Increasingly, however, a new issue has been added to the litany of problems in settling mass litigation events: third-party liens. For example, after the Deepwater Horizon oil spill, BP created the Gulf Coast Claims Facility to compensate victims. The voluntary program, which processed 19,000 claims in the first week, was designed to provide compensation to victims swiftly. However, one impediment to a settlement was that a large number of the victims had outstanding liens for child support.

To understand why these child support liens, or liens generally, represented a potential impediment to a rapid resolution of the claims and potentially the ability to achieve a global settlement in a mass compensation event, we must turn to how liens factor into litigation.

The conventional wisdom on how claim resolution works is that there are essentially three parties in litigation: the injured party (and typically his or her lawyer), the potentially liable defendant, and the defendant's insurer.<sup>3</sup> The reality is far more complex. Traditionally, liens

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<sup>2</sup> The canonical mass litigation event is in many ways the Vioxx litigation. In November 2007 the pharmaceutical company Merck agreed to pay \$4.85 billion to settle 27,000 lawsuits (with over 47,000 plaintiffs). This payment was the resolution of years of litigation, including some 20 trials. The global settlement was one of the largest ever in civil litigation. Clearly, litigating 27,000 cases individually would have brought the court system to a standstill. For a more detailed discussion of the settlement, see Berenson, 2007.

<sup>3</sup> Most law and economics models of settlement leave out the insurer. In the standard model, there is only a plaintiff and a defendant (see Shavell, 2009, or Spier, 2007, for a more complete discussion of settlement models). Even in the simplest models, the presence of liens reduces the likelihood of settlement. For a discussion of liens in the traditional law and economics models, see Swedloff, 2008. For a discussion of the role of insurance in the tort system more generally, see Abraham, 2009.

in the civil justice system represent a claim by a creditor against a plaintiff's (the debtor's) cause of action.<sup>4</sup> This lien could be for back taxes, child support, or other financial obligations.<sup>5</sup> The lien has two effects. The first is that it potentially reduces the payment the plaintiff receives in settlement or at trial dollar for dollar, up to the amount of the lien. Second, the very presence of a lien can influence the disposition of the case. For example, unless the lien is resolved, it is often difficult to settle a claim simply because the plaintiff may have liens larger than a settlement offer, thus making the plaintiff indifferent when faced with the choice between taking the settlement and "rolling the dice" at trial, since the money would have been paid to the lien holder anyway. Even if liens do not exceed the settlement amount, their impact on the settlement payment received by the plaintiff likely reduces the incentive to settle because it reduces the expected net amount of settlement or award.

That traditional influence of liens on litigation still holds today.<sup>6</sup> What has changed within the last 15 years, however, is that Medicare and increasingly other forms of government-provided insurance have been given far more extensive lien rights, particularly with regard to the requirement that defendants' insurers notify the Center for Medicare Services (CMS) of any payment to the plaintiff that third party insurers consider Medicare's interest in any settlement. Because these

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<sup>4</sup> Thomson Reuters Business's FindLaw has produced a useful guide for practitioners on how to resolve liens in personal injury cases (FindLaw, 2018).

<sup>5</sup> A lien and a claim for reimbursement are very different in the context of litigation. Most importantly for our discussion here, a lien can be enforced against settlement funds or other proceeds from a compensation fund, whereas a claim for reimbursement or unpaid debt must go through a collection action (FindLaw, 2018).

<sup>6</sup> Liens can be thought of as coming in two varieties. The first are statutory liens, in which there are existing laws governing the lien holders' rights. Statutory liens would include Medicare, Medicaid, and other public health insurance programs. Contractual liens, by contrast, are defined by the plaintiff's contract with his or her health insurance company. While there are laws governing lien holders' rights in contractual lien cases (see the later discussion of "made-whole" or common fund doctrines), it is possible for many contractual liens to insert language in the policyholder's contract to avoid them. Our focus in this paper is primarily on the expansion of lien rights for statutory liens such as those resulting from Medicare (FindLaw, 2018).

requirements extend beyond the plaintiff to the plaintiff's lawyer and the defendant, they have made resolving these liens a requirement of settlement. The expansion of statutory rights by the Medicare Secondary Payer (MSP) Act, under which Medicare liens take priority over all other liens, has led to Medicare liens being described as "super liens," since they are taken directly out of the plaintiff's settlement regardless of other claims or state law. The expansion of such "super lien" rights into Medicaid and other statutory liens has compounded the complexity of settlement (see Dixon and Kuznitsky, 2017).

To understand how burdensome litigants find medical liens, consider the Reno Air disaster. On September 16, 2011, at the Reno Air Races, an aircraft crashed into the assembled spectators, killing 10 people on the ground plus the pilot and injuring 69 others. Because most of the injured and several of those who eventually died received treatment at local hospitals, lawyers for the defendant reached out to the hospitals and asked them not to file bills. The aim was to avoid creating liens with Medicare and potentially other health care providers, as the existence of these liens would make resolution of the claims more difficult.

Specifically,

The lawyer handling this matter asked hospitals to not file with Medicare for reimbursement. In this lawyer's experience, Medicare's policies are inflexible and inconsistent, and communication is difficult, which can slow and defeat compensation. It is a much better strategy, therefore, to deal directly with the hospital or provider. (Dixon and Kuznitsky, 2017, p. 14)<sup>7</sup>

Moreover, anecdotal evidence suggests that liens, particularly health care liens, are becoming more frequent. Participants at a RAND conference on the role of liens in claim resolution, the proceedings of

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<sup>7</sup> Although the author of the quote did not specify how the existence of liens could "slow and defeat compensation," others at the conference suggested that lack of communication from Medicare, difficulties getting information on compensation by Medicare, and difficulties getting agreement from Medicare on a plan for future medical expenses that protects Medicare's interest all contribute to delay.



which are discussed in greater detail in Dixon and Kuznitsky (2017), suggested that liens are something of a classic collective action problem. If statutory lien holders' rights grow, more potential lien holders have an incentive to pursue their claim.<sup>8</sup> As expanded statutory rights for Medicare, Medicaid, and other public health insurers free these providers from the "made-whole" obligation in many state laws—that is, that the total payment to lien holders has to be less than or equal to total compensation to the plaintiff—lien holders have every incentive to draw a hard line on their liens, raising the possibility that the plaintiff will have no incentive to pursue the case at all. For this reason, understanding the frequency of liens and whether expanded lien rights lead potential lien holders to pursue more liens is particularly important.

Historically the financial and transactional burdens of resolving health care liens in large settlement programs has fallen on plaintiffs' counsel or, less frequently, plaintiffs themselves. Increasingly, however, not only plaintiffs and their lawyers but now defendants and third-party insurers must deal with liens against the injured parties for failure to pay child support, reimbursement for medical care, and so on and must create a settlement that is structured to cover future medical care that might otherwise fall on the individual's personal insurance. In addition, the defendant's obligation with regard to lien holders may vary greatly across lien types. Liens have become burdensome enough that several participants at the RAND conference noted they have turned down cases because the potential liens are too large, resulting in the claims being uncompensated.

In this paper we examine the different types of health care liens and trends in prevalence, as well as how these liens have changed the landscape of claim resolution, at least for the large compensation funds in our dataset. We use a unique dataset on the resolution of a number of mass compensation events, as well as smaller claims.

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<sup>8</sup> More specifically, Medicaid and other forms of public insurance have been moving toward Medicare's "super lien" status, which requires that their liens be paid first and that they not be bound by state laws governing how much of the total settlement proceeds can be collected by lien holders. See the discussion of Medicaid liens later.



## Background on Lien Rights for Health Care Providers

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### Medicare: The 800-Pound Gorilla

Any discussion of liens, and in particular health care liens, must begin with Medicare, the U.S. government health insurance for people over 65 and the disabled.<sup>1</sup> The reason is that Medicare, in an effort to comply with its statutory requirement to be the secondary payer<sup>2</sup> for its beneficiaries, has become the “800-pound gorilla”<sup>3</sup> at settlement negotiations. This status as alpha primate arises from the way in which the federal government has redefined the role of Medicare liens in the civil justice system. This has led some commentators to distinguish Medicare liens from liens filed by other parties by referring to Medicare liens as “super liens.” As we discuss further later, Medicaid liens, as well as other liens dealing with health-care-related insurance payments, are rapidly following Medicare’s evolution into super liens.

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<sup>1</sup> Technically, Medicare coverage extends to “people who are 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease” (U.S. Centers for Medicare and Medicaid Services, n.d.).

<sup>2</sup> In insurance parlance, the type of coverage is called a *payer*. When there is more than one payer, the primary payer is the insurer who has the obligation to cover the expense. Once the primary payer has reached the policy limit, or if the primary payer is unable to pay for some other reason, the expense falls to the secondary payer.

<sup>3</sup> Although the origin of the Medicare liens and King Kong analogy is somewhat obscure, Schmidt (2006) cites Tate and Holloway (2005) as first using this characterization.

Before 1980, Medicare was the primary payer for liability cases,<sup>4</sup> and although it could undertake a subrogation action and essentially join the plaintiff's case, it was not owed reimbursement by the plaintiff for medical care (Swedloff, 2008).<sup>5</sup> This changed with the passage of the MSP Act in 1980. Under the act, which was passed to reduce Medicare costs, Medicare was no longer supposed to pay for medical costs covered by another primary payer or plan. Medicare can pay such costs conditionally, when it expects the cost to be reimbursed.

Under the MSP Act, it was not obvious that Medicare's reimbursement rights extended to tort liability (Schmidt, 2006). The MSP Act defines a primary plan broadly to include workers' compensation, auto insurance or liability insurance, and self-insurance. A series of court decisions limited the attempts of the Center for Medicare Services (CMS) to recover conditional payments in tort cases, and the MSP Act's provisions were largely unenforced with respect to tort cases.<sup>6</sup>

In 2003, Congress passed the Medicare Prescription Drug, Improvement, and Modernization Act, which contained provisions that overturned the court rulings that the MSP Act did not apply to tort claims. The act made Medicare's claims preminent, in that Medicare is paid

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<sup>4</sup> Medicare was a secondary payer in workers' compensation cases before 1980. The MSP Act amended the statute to expand Medicare's secondary payer status to liability cases effective December 5, 1980.

<sup>5</sup> Subrogation allows the insurer to be "substituted" for the insured with regard to the insurer's interest in the claim. Key to the doctrine is that the insurer's recovery right is not greater than the insured's with respect to the third party liable for the insured's injury. That is, the upper bound on what a subrogating insurer can recover from an injured party is 100 percent of whatever the injured party recovers from the defendant. Moreover, many states set the amount below 100 percent in an effort to preserve some financial incentive for the injured party to sue. The concern is that the injured potential plaintiff might not be made whole if his or her recovery, less the subrogating insurers' share, is less than his or her total remaining injury cost. Out of this concern, a number of states have passed "made-whole" doctrines that limit the subrogating insurers' ability to recover unless the insured is made whole—that is, recovers all of his or her damages from the third party.

<sup>6</sup> Schmidt (2006) cites *United States v. Baxter Int'l, Inc.*, 345 F.3d 866, 875 (11th Cir. 2003) and *Thompson v. Goetzmann*, 337 F.3d 489, 498 (5th Cir. 2003) as examples of the differing approaches across cases. In *Goetzmann* the Fifth Circuit denied Medicare's right to collect from settlement funds, while the Eleventh Circuit disagreed. Schmidt (2006) also argues that the trend in trial courts favored the *Goetzmann* decision.

first out of settlement funds, over the plaintiff, and the Medicare super lien was created (see Schmidt, 2006).

Although Medicare's lien rights were established, its enforcement powers were somewhat limited and compliance was by no means universal (Helland and Kipperman, 2011). Congress dramatically increased enforcement mechanisms in the Medicare, Medicaid, and State Children's Health Insurance Program Extension Act of 2007 by imposing a reporting requirement on anyone considered to be a primary payer under the MSP Act. The act also imposed mandatory third-party insurer reporting requirements and established the potential to impose stiff penalties for noncompliance.<sup>7</sup> Specifically, the act required that a third-party insurer report the existence of a claim involving a Medicaid beneficiary and cause third-party insurers to preclear any payments to ensure that Medicare's interests are protected (see Helland and Kipperman, 2011).

Commonly referred to as a lien, Medicare's reimbursement rights are actually a bundle of rights<sup>8</sup> that include subrogation rights and an independent right to sue any party involved in the litigation to recover CMS's conditional payments. This suit can recover double damages plus fines and interest from any primary insurer and anyone else receiving a payment (e.g., the plaintiff's lawyer paid by a contingent fee).<sup>9</sup>

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<sup>7</sup> As of this writing, the issue of fines is somewhat ambiguous. The "up to \$1,000 a day penalty" prescribed in Sec. 111 of the Medicare, Medicaid, and State Children's Health Insurance Program Extension Act (codified in 42 U.S.C. 1395y(b)(8)), as further extended by the SMART (Strengthening Medicare and Repaying Taxpayers) Act (2012), requires CMS to promulgate regulations that further identify how those penalties are to be set and enforced. As of this writing, no regulations have been issued by CMS, despite the statutory mandate in the SMART Act. Thus, even though there are penalties on the books, it appears they cannot be implemented absent these regulations (see 42 U.S.C. 1395y(b)(8)(I), which requires CMS to issue final regulations regarding penalty provisions after the public comment period has ended in 2013).

<sup>8</sup> The private cause of action and double damages are other statutory rights that Medicare has to enforce its conditional payment recoveries (see 42 U.S.C. 1395y(b)(2)(B)(iii) and 42 U.S.C. 1395y(b)(3)(A))—hence our characterization of them as a bundle of rights.

<sup>9</sup> The fines can be up to \$1,000 per day for failure to report or erroneous reporting. See 42 U.S.C. 1395y(b)(2)(B)(iii):

In order to recover payment made under this subchapter for an item or service, the United States may bring an action against any or all entities that are or were required or

The year after all major reporting requirements went into effect, 2012, proved to be the most active period thus far in repayment of health care liens, according to several lien resolution companies. Moreover, post-2012, basically all large litigation events are focused on resolving MSP Act reimbursement and reporting requirements before settlement. This uptick in repayment has not gone unnoticed by other government and private insurers who have begun to take steps to recoup their own costs. Perhaps because almost all settling parties are trying to comply with MSP Act reimbursement and reporting requirements, the Medicare super lien has become the model for other lien holders asserting claims.<sup>10</sup>

Thus, settlement of a large claim now involves determining the primary payer and balancing competing recovery rights across lien holders, all while dealing with the recovery contractors representing each competing claim. Almost all settlement agreements now contain extensive lien resolution language and agreements on obligation determination; holdback provisions to pay liens discovered in the future; agreements on the exchange of information necessary for Medicare, Medicaid, and State Children's Health Insurance Program Extension Act of 2007 reporting; and future cost allocations. The effect of the changes is stark:

As one participant at a recent RAND conference on the impacts of liens on the settlement process observed, liens were not part of the conversation with pharmaceutical and medical device claims

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responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3) (A) collect double damages against any such entity.

An example of the use of this statute is found in *U.S. v. Harris*, 2009 WL 891931 (N.D.W.Va. Mar. 26, 2009), in which an attorney representing a Medicare beneficiary was found liable for his failure to repay Medicare's conditional payment to his client.

<sup>10</sup> The SMART Act did change several aspects of the Medicare super lien. For example, it made penalties for reporting violations discretionary, rather than mandatory, on the part of CMS. It also implemented a three-year statute of limitations for CMS to pursue recovery.

that were settled years ago—they were the plaintiffs’ and the plaintiffs’ lawyers problem. (Dixon and Kuznitsky, 2017, p. 10)

Those days are gone. Today Medicare has the most comprehensive and developed lien resolution process of all lien types. Complex litigation now always involves MSP Act compliance and reporting, and increasingly compliance is “outsourced” to resolution companies that have developed subject-matter expertise and invested in technology to ease some of the associated lien resolution burdens. Moreover, defendants will not make a payment to the injured party until the most important liens, typically Medicare, are resolved.

While the process has become increasingly standardized, in terms of reporting, this does not mean it is still not complex. Settling parties must determine which of Medicare’s past payments for the plaintiff’s medical care are relevant to the case and ensure that Medicare’s future interests are protected (i.e., that the settlement provides for future medical care resulting from the defendant’s conduct). While it is now easier to notify Medicare of the possibility of a conditional payment, the negotiations over the value of its lien remain.

## **Medicaid: The Importance of the State-Federal Partnership for Liens**

Medicaid provides free health insurance for 74 million low-income Americans. The insurance system, created in 1965, is a joint state-federal partnership in which all 50 states (and territories) administer their own Medicaid programs but with certain requirements on the coverage states provide, which must be met if the state is going to receive a federal match.

On one basic level, Medicaid liens are more complicated than those for Medicare due to the fact that Medicaid is a means-tested program and people can go on and off the program over time—technically, on a month-to-month basis. This means that checking whether someone is eligible for Medicaid is inherently more difficult than it is for Medicare. This wrinkle and other complicated differences persist despite the fact that the Affordable Care Act has increased federal efforts to harmonize state Medicaid lien resolution with MSP Act principles.

The most important issue confronting states seeking to enforce liens against the outcome of litigation is that it was unclear whether Medicaid, like Medicare, has a super lien. Federal Medicaid statutes allow for subrogation but do not allow for Medicaid to put a lien on a Medicaid recipient's settlement during that individual's lifetime. The issue was litigated in the *Ahlborn* case, which initially indicated that Medicaid was limited to recovering only the portion of a legal judgment specifically allocated to medical bills.<sup>11</sup> Heidi Ahlborn of Arkansas was injured in an accident and Medicaid paid for her treatment. Subsequent to the payment, she sued the driver of the other car, recovering \$550,000. The Arkansas Department of Human Services, which administers Medicaid in Arkansas, sought to claim a \$219,156.78 lien on any recovery Ahlborn received. Ahlborn sued, alleging that only 16.5 percent of her settlement was for past medical expenses and so the Department of Human Services could recover only \$90,750. The court, in reviewing the Arkansas Medicaid lien statute, held that Medicaid could recover her total medical bills from the settlement. The Eighth Circuit reversed, and the U.S. Supreme Court unanimously affirmed the Eighth Circuit's ruling, holding that the Arkansas statute violated the federal anti-lien statute.

That limitation seemed to gain further traction in *Wos v. E.M.A.*,<sup>12</sup> where the plaintiff, an unnamed minor, was born with multiple injuries suffered during delivery. These injuries required a lifetime of skilled nursing care, the estimated cost of which was over \$42 million. The parties settled the resulting suit for \$2.8 million, the policy limit of the doctor's insurance, but did not specifically apportion the settlement between medical and nonmedical costs. North Carolina Medicaid, following its state Medicaid lien statute, asserted that one-third of the damages was for medical costs and therefore owed to North Carolina's Medicaid program. Typically, if policy limits are less than the value of the claim, and lost wages or pain and suffering constitute a significant fraction of the recovery, the lien claimant cannot receive full recovery, the theory being that since the plaintiff did not recover all damages,

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<sup>11</sup> *Arkansas Dept. of Health and Human Services v. Ahlborn*, 126 S. Ct. 1752 (2006).

<sup>12</sup> *Wos v. E.M.A.*, 568 U.S. \_\_\_\_ (Mar. 20, 2013).



the lien claimant should also take a haircut (see FindLaw, 2018, p. 3). The Court rejected North Carolina's assertion that if the parties had not allocated the recovery in the settlement to economic and noneconomic damages, North Carolina was entitled to one-third of the settlement. The Court also held that North Carolina's statute also violated federal anti-lien laws, which prohibit Medicaid from placing a lien against beneficiaries' other property to recover assistance paid on the beneficiaries' behalf.

Combined, the *Ahlborn* and *Wos* cases limited state Medicaid authorities' options in recovering liens (although this would be legislatively modified). In both cases the parties had not included Medicaid in the settlement negotiations. Because of this, Medicaid administrators were placed in a legal position inferior to their counterparts' in Medicare. If the plaintiff's medical costs had been paid by Medicare—and not by Medicaid, as was actually the case—the plaintiff would have clearly owed the full amount of the liens, less procurement costs, to CMS. Since Medicaid was involved, however, the recovery was limited to the allocated medical costs in the settlement or judgment. After these decisions, the generally accepted principle is that federal Medicaid statutes allowing states to implement secondary payer laws are only a limited exception to the anti-lien statute and that the state can only assert a lien over the portion of the settlement dealing with past medical expenses.

The respite to plaintiffs was short lived. The Bipartisan Budget Act (2013) essentially overturned the *Ahlborn* and *Wos* cases. Section 202(b) of the act strengthens the exception to the federal anti-lien statute to also permit state Medicaid agencies to recover from settlements even the portion of the settlement that is not attributable to past medical expenses, essentially putting Medicaid in the same position as Medicare with respect to lien rights. Although the implementation of this law has been delayed numerous times, and most recently was scheduled to go into effect in October 2017, going forward, once the states figure out how to implement this law, "Medicaid Secondary Payer" will become a reality, with Medicaid, like Medicare, essentially having super lien rights.

## Medicare Part C

Medicare Part C providers are private health insurance plans that administer Medicare benefits to eligible Medicare beneficiaries and then receive a capitated payment from CMS. Part C plans have seen dramatic growth in the last ten years, with over 2,000 plans available in 2017 and 33 percent of Medicare beneficiaries enrolled (Henry J. Kaiser Family Foundation, 2017).

Because Part C plans are a hybrid of private insurance and Medicare, the secondary payer lien rights of Part C plans were ambiguous before *In re Avandia*.<sup>13</sup> The key question is whether Part C plans are covered by MSP Act statutes, even though they are administered by private plans. In 2011 CMS issued a memorandum supporting the Part C plans' having the same rights as Medicare under the MSP Act. A number of plaintiffs litigated this assertion, and lower courts generally found that Part C had more-limited rights than CMS.<sup>14</sup> Essentially, the lower courts found that Part C plans were private plans and therefore did not have Medicare's super lien rights.

In 2012 the Third Circuit ruled in *In re Avandia* that Part C plans could function as Medicare with respect to lien recovery rights, including the private cause of action. In 2013 the Supreme Court denied certiorari on the plaintiff's appeal. The decision allows Part C plans essentially the same rights as CMS with regard to settling parties.<sup>15</sup> Thus, Medicare, Medicaid, and Medicare Part C plans now all have super lien rights.

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<sup>13</sup> *In re Avandia Mktg., Sales Practices & Products Liab. Litigation*, 685 F.3d 353 (3d Cir. 2012). For a more complete discussion of the evolution of Part C plans' lien rights under the MSP Act, see Medlin and Thomas, 2014.

<sup>14</sup> See *Konig v. Yeshiva Imrei Chaim Viznitz of Boro Park, Inc.*, 2012 U.S. Dist. LEXIS 45448 (E.D.N.Y. Mar. 30, 2012); and *Parra v. PacifiCare of Arizona, Inc.*, 2011 U.S. Dist. LEXIS 33630 (D.Ariz. Mar 28, 2011).

<sup>15</sup> One potential difference is that, as of this writing, CMS does not provide complete verification of entitlement for Part C plans, making it more difficult to verify whether a plaintiff might have been eligible for Part C. Medicare Part D providers also have MSP lien rights (see Jordan, 2017).

## Private Insurance

Private insurance plans, because they are offered by private insurance companies, do not have a statutory basis for their subrogation or lien rights. Federal statutes do not specifically create such rights for private insurers and, thus, lien rights are typically created by contractual terms between the private health insurer and the insured. Nonetheless, there are some key differences in lien rights depending on whether the lien is a federally based Employee Retirement Income Security Act of 1974 (ERISA) plan or not. These are discussed in this section. For non-ERISA plans, many states have statutory requirements that limit lien holders' recovery rights.<sup>16</sup>

### **Federally Based Private Plans (Employee Retirement Income Security Act and Federal Employees Health Benefits Act)<sup>17</sup>**

In 2016, according to the U.S. Census Bureau's report *Health Insurance Coverage in the United States* (Barnett and Berchick, 2017), 67.5 percent of Americans received health insurance from a private insurer and 55.7 percent received it as a benefit of their employment.<sup>18</sup>

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<sup>16</sup> For example, in California the California Hospital Lien Act requires hospitals to demonstrate the reasonableness of their charges. California also provides that for plaintiffs who retain an attorney, the total amount of any payment to lien holders cannot exceed one-third of received settlement funds after the payment of attorney's fees (Cal. Civil Code § 3040(c) (2)). California law also limits lien amounts for noncapitated charges, limits hospital liens to 50 percent, and provides for liens to be proportionally reduced due to relative fault. The made-whole statutes in California require that a lien cannot be enforced until the defendant is "made whole," which means that injuries to the plaintiff that are not covered by insurance, and hence would only be compensated via the settlement, have highest priority. Finally, California has a common fund rule under which liens are reduced by the same percentage as the contingent fee the client is being charged, under the theory that the lien holder and the client should share in the expense of hiring the attorney who facilitates both of their recovery (see FindLaw, 2018, and *U.S. Airways, Inc. v. McCutchen*, 133 S. Ct. 1537 (2013)).

<sup>17</sup> In *Coventry Health Care of Missouri, Inc. v. Nevils*, 137 S. Ct. 1190 (April 18, 2017) (Coventry II), the Supreme Court held that state law must yield to private Federal Employees Health Benefits Act (FEHBA) contracts' subrogation provisions, putting FEHBA providers on the same footing as ERISA.

<sup>18</sup> According to the report, Medicaid is the next most prevalent, after employer-sponsored plans, at 19.4 percent; then Medicare, at 16.7 percent; direct purchase from a private insurer, at 16.2 percent; and finally military coverage, at 4.6 percent.

These employer-based health insurance plans are subject to the ERISA, the federal law that regulates employer-based health plans.<sup>19</sup> Because employer-based plans are subject to federal statutes, which do not create subrogation or lien rights, it is generally up to the insurer to include lien rights in their contracts. The statute does provide for federal preemption of state law. The contractual nature of this agreement means that insurers' rights are tied to the insured and not to third parties, who by definition could not be part of the contract. In other words, ERISA plans generally do not contemplate seeking payment from third parties for costs recovered through litigation. For this reason, ERISA plans can seek recovery only from an insured member if the insurer specifically identifies funds that the insured holds, such as an interest in a civil case or funds from litigation. No lien rights automatically obtain. Unlike Medicare, and post-2017 Medicaid, there is no statute that creates a duty on the part of the plaintiff or defendant to report settlement payments to ERISA plans. Absent contractual provisions to the contrary, the defendant will not be held responsible for ensuring that liens are resolved. The plaintiff, however, if still receiving benefits from an ERISA plan, can have those benefits disrupted if this obligation is not properly resolved.<sup>20</sup>

### **Other Plans (Individual Insurance Markets, Affordable Care Act Exchange Plans, State and Local Government Plans)**

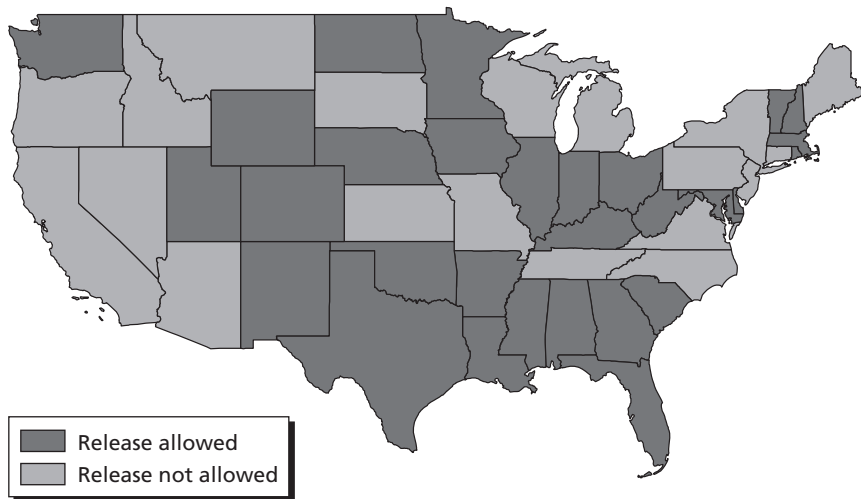
The situation is somewhat different for non-ERISA plans, such as those sold on the individual insurance market, the Affordable Care Act exchanges, or state and local government plans. These plans, like ERISA plans, also typically assign lien rights via contract; however, a number of states hold that a settling party can be held liable if they have knowledge of the health plan's claim before settlement. In these

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<sup>19</sup> Federal employees are covered by FEHBA (1959).

<sup>20</sup> In 2013 the U.S. Supreme Court resolved a circuit split on the applicability of various state limitations on liens' application to ERISA plans. The Court held that these limitations did not apply and that the contract terms of an ERISA plan were not overridden by state law; see *U.S. Airways, Inc. v. McCutchen*, 133 S. Ct. 1537 (2013). We know of no systematic study of ERISA plans detailing whether the ruling has caused plans to modify the lien rights in their contracts.

**Figure 2.1**  
**States in Which Plaintiff Cannot Release Defendant from Lien Liability**  
**If Defendant Has Full Knowledge of Subrogation Claim**



SOURCE: Garretson Resolution Group, 2016.

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states, release of the defendant's liability via settlement does not bar the insurer's claim for subrogation if the defendant knows of the health insurer's claim.

Figure 2.1 provides a map of the lower 48 states in which state law prevents the plaintiff in a civil case from releasing a defendant who has full knowledge of the insurer's subrogation claim from liability.<sup>21</sup>

Several participants at the aforementioned conference felt that state and local government health plans through private insurers are increasingly expanding lien rights along the lines of the MSP Act (Dixon and Kuznitsky, 2017).

<sup>21</sup> Note that Hawaii but not Alaska also has a law preventing the plaintiff from releasing the defendant from liability.

### Private Lien Resolution Programs

Increasingly, private health insurance plans are participating in Private Lien Resolution Programs (PLRPs).<sup>22</sup> In PLRPs, which are initiated by lien recovery administrators or parties to a mass tort, the lien holders agree to adopt certain recovery rules in order to speed up the resolution. In many ways, these agreements are the by-product of the individualized nature of private health plans' lien rights.

### Other Issues in Lien Resolution

One final issue in health care lien resolution relates to the fiduciary duty the plaintiff's attorney owes his or her client. A plaintiff's lawyer who is not individually minimizing lien responsibility is potentially breaching his or her fiduciary duty to their client and liable for a malpractice claim.<sup>23</sup> This paradigm is further complicated by the attorney's ethical duties under American Bar Association Model Rule 1.15, Duty to Safekeep Property—followed in one form or another by all states—which requires attorneys who are on notice of a valid third-party lien to hold those funds as a fiduciary, for the benefit of the client and third party. This duty includes a duty to notify the client and third party, and to deliver the property to the client and third party. This rule exists, in large part, to protect attorneys from the irreconcilable conflict of interest that would follow a client's instructions to ignore statutory liens, such as Medicare, where the attorney can be held liable for not ensuring a proper resolution. The complexity of lien rights across health care providers, states, and lien types makes it difficult to resolve some liens, and the requirement for individual attention only compounds this difficulty, as it limits the ability of plaintiffs' attorneys to use formulas or grid-based systems—for example, all liens get a 10-percent haircut.

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<sup>22</sup> For a more extensive discussion of PLRPs, see Garretson Resolution Group, 2013. A number of lien resolution companies provide PLRPs, all on essentially the same model.

<sup>23</sup> See *Burrows v. Arce*, 997 S.W.2d 229 (Tex. 1999), which finds that an attorney forfeits his or her fee if the individual is not advocating for the individual interests of his or her client.

## Summary

Appendix Table A.1 provides a summary of the super lien rights held by the different types of lien holders. The key takeaway from Table A.1 is that there is wide variation in rights assigned to different lien holders and the responsibilities of the various parties to litigation or the compensation event to deal with these liens.





## Research Questions

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Given the complexity and variety of lien rights in the civil justice system and the fact that the preponderance of liens, and certainly the most costly liens, are still related to health care expenditures, it would be useful to know how frequently health care liens appear in large litigation events. In the remainder of this paper, we provide the results of a study using a unique data source on the frequency and value of liens in mass compensation events ranging from pharmaceutical litigation, including MDLs, to consumer products claims and hospital malpractice.

### The Data

The data come from the Garretson Resolution Group, which provides complex claims administration and lien resolution services in mass tort, class action, and voluntary compensation programs. The Garretson Resolution Group, which was founded in 1998, has data on over 350,000 different claims and 450,000 liens spanning almost 20 years. Our sample contains anonymized data on 100 “compensation events,” by which we mean the plaintiffs had a common cause of their injury. Thus, for our purposes, GM’s settlement with plaintiffs whose injuries resulted from faulty ignition switches, the Vioxx litigation involving tens of thousands of plaintiffs, or the Reno Air Show injuries would each represent a compensation event. Although each might involve hundreds of plaintiffs across multiple law firms, we aggregate the claims for the purposes of this study. The earliest claims date from 1992, although we exclude data before 2008 due to concerns regard-

ing whether the data before that date are representative of the population. The data contain information on the number of liens in a claim, information on the nature and size of the lien, and information on the defendant.

The unit of observation in the dataset is the plaintiffs' law firm; many compensation events have multiple law firms representing multiple plaintiffs (e.g., law firm X represents ten victims of compensation event 1, while law firm Y represents eight different victims in compensation event 1). The data provide anonymized identifiers for the compensation event, as well as information on the number of liens for a variety of different lien types (Medicare, Medicaid, other government insurance programs, PLRPs, and private insurance contracts not in a PLRP) and the type of compensation event (medical device implantation, pharmaceutical ingestion, pharmaceutical injection, exposure, medical product malfunction, consumer product, medical malpractice, and a catchall other category). The data also contain information on the average age of claimants, key dates, and the value of liens. Since we are primarily interested in the compensation events overall, we aggregate the data up to the compensation event level.

There is one important limitation of our data that cannot be avoided. To be included in our data, the plaintiffs or defendants must have contracted with the Garretson Group to resolve their claims. As such, the sample is not representative of the prevalence of liens in the civil justice system, as we would expect compensation events going to the Garretson Group to be significantly larger, to be more expensive, and perhaps to involve more plaintiffs and therefore more liens than other cases in the civil justice system. Nonetheless, Garretson employees have indicated that they do not feel the events and claims they handle differ systematically in terms of lien exposure from other, large compensation events dealing with similar issues.

The data contain information on both claimants and cases. The reason for this distinction is that an individual claimant may be party to multiple cases if, for example, there are two defendants in a case. As shown in Table 3.1, we have 28,600 different claimants in our sample, and this translates into 31,900 cases in our 100 compensation events.

**Table 3.1**  
**Breakdown of Claimants and Cases over**  
**100 Compensation Events**

	<b>Number Claimants</b>	<b>Number Cases</b>
Total (sample)	28,600	31,900
Mean	2,952	3,502
Minimum	2	2
Maximum	48,468	56,205

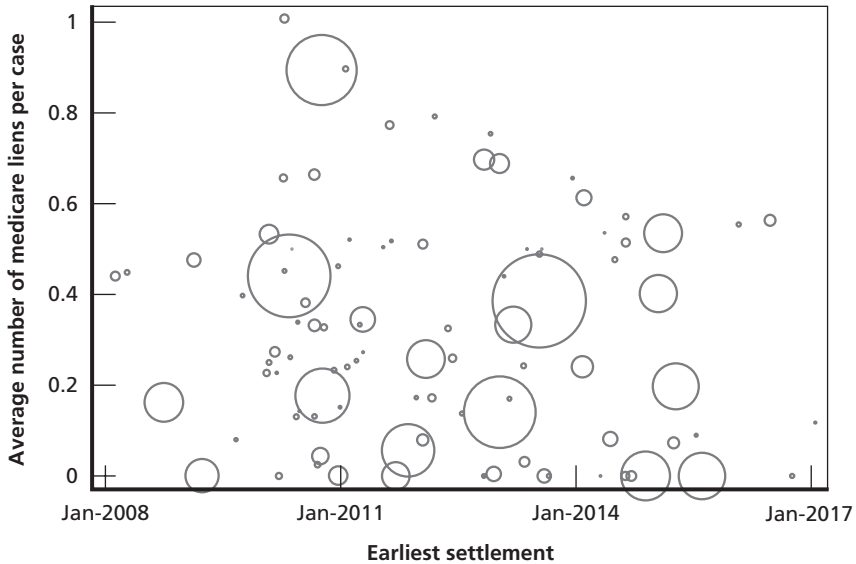
There is wide variation in the number of claimants and cases by event. The average event has approximately 2,900 claimants and 3,500 cases, but the smallest event has only 2 claimants (and cases), while the largest has over 48,000 claimants and over 56,000 cases.<sup>1</sup>

To give a better sense of the temporal dimension of the data and the size of the different events, consider Figure 3.1, which shows the data on Medicare liens and cases per event from January 1, 2008, to 2017. The  $y$  axis shows the average number of Medicare liens per case for each event, and the  $x$  axis is the date the first case in the event was resolved. The size of the circles represents the number of cases in the event. The sample shows a broad distribution of events after 2007 with a wide variation in the frequency of Medicare liens across events. The graph for other types of liens, discussed later, is similar.

The figure shows that the number of events is broadly distributed over the nine years for which we have comprehensive data. There are four earlier events, resolved before 2008, but the coverage for these early years is less comprehensive, and henceforth we focus the analysis on the 96 events resolved in 2008 or later. Additionally, the figure shows that the number of cases varies significantly across events. This can generally be thought of as a measure of the number of injured parties in the

<sup>1</sup> As part of this process, Garretson Resolution Group reviewed all the datasets to ensure that (1) any protected health information was deidentified per the Health Insurance Portability and Accountability Act of 1996, as amended, and (2) all relevant confidentiality terms associated with these compensation events were followed.

**Figure 3.1**  
**The Distribution of Events and Medicare Liens per Case over the Sample Period (96 compensation events)**



NOTES: Sample size = 96 compensation events in which the first case was resolved after January 2008. Area of symbol proportional to number of cases.

RAND RR2393-3.1

event. There are several large circles, with claims in the tens of thousands, and a large number of smaller events. Finally, there appears to be no trend in the number of Medicare liens per claim between 2008 and 2017 and no correlation between the number of cases in the event and the average number of Medicare liens; both large and small events and earlier and later events have a large number of Medicare liens.<sup>2</sup>

We classify eight different event types:

- pharmaceutical ingestion, which covers typical pharmaceutical cases such as Vioxx

<sup>2</sup> We have generally eschewed the word *lawsuit* in this report in favor of *claim* and *cases*. The difference between *claim* and *case* is discussed earlier. The issue is that not all of the injured parties in the mass litigation events in the data have filed lawsuits, and several were part of compensation schemes outside the court system.

**Table 3.2**  
**Number of Events by Category and Average Total Payment by**  
**Event (2008–2017)**

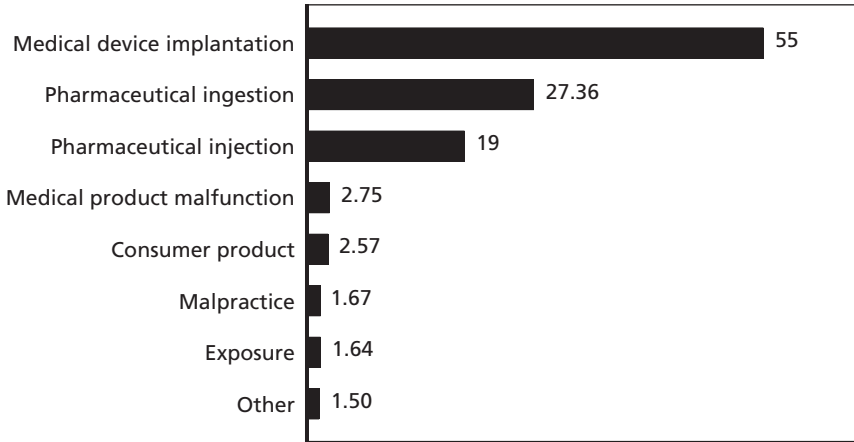
Category of the Program Litigation	Number of Events	Average Total Settlement in Dollars (nearest 1,000)
Pharmaceutical ingestion	39	245,650,000
Exposure	25	48,720,000
Medical device implantation	13	280,460,000
Consumer product	7	75,960,000
Medical product malfunction	4	19,070,000
Other	4	2,540,000
Malpractice	3	5,910,000
Pharmaceutical injection	1	23,230,000
<b>Total</b>	<b>96</b>	

- exposure cases, such as asbestos claims
- medical device implantation cases, which involve a defective medical device such as a hip replacement that does not necessarily need to be removed
- consumer product claims, such as the GM ignition cases
- medical product malfunction claims,<sup>3</sup> which are similar to medical device implantation claims but cover devices that were not implanted or were implanted for a short period of time
- malpractice cases involving hospitals or doctors
- pharmaceutical injection cases, which involve injectable drugs rather than oral or other delivery methods.<sup>4</sup>

<sup>3</sup> For example, the I Flow Pain Pump, which was designed to be used after surgery to administer pain medication, was implanted in the body but only for brief periods.

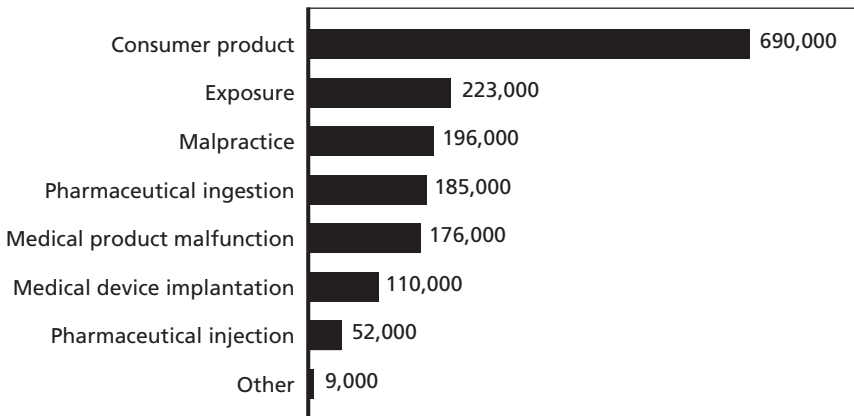
<sup>4</sup> Our data, by construction, do not allow us to identify any specific event in order to protect the confidentiality of Garretson Group clients. We include well-known cases listed earlier (GM, Reno Air, and Vioxx) only for illustrative purposes and not to indicate that the case is actually included in our data.

**Figure 3.2**  
**Average Number of Law Firms Involved per Event**



NOTE: Sample size = 96 compensation events.  
RAND RR2393-3.2

**Figure 3.3**  
**Average Total Payment by Law Firm (U.S. dollars)**



NOTE: Sample size = 96 compensation events.  
RAND RR2393-3.3

In Table 3.2 we present the breakdown of our compensation events by the frequency of each event type and the average total payment per event for an event type.

Pharmaceutical litigation is, perhaps unsurprisingly, given pharmaceutical litigation's prominence among federal MDL cases, the largest compensation event type in the Garretson data. Exposure cases rank second in terms of number of events, ahead of device implantation cases. Interestingly, device implantation cases are the largest in terms of average aggregate settlement, with pharmaceutical ingestion cases a close second.

In Figure 3.2 we provide a breakdown of the number of law firms for each event type. Medical device events involve the largest number of different plaintiff law firms at 55, while pharmaceutical cases, the next largest, have an average of 26 different attorney firms.

Figure 3.3 provides the breakdown of the aggregate settlement payments across law firms. The largest payments to firms and their clients are in consumer products cases; however, since there are only eight consumer products cases and each case has an average of 2.375 firms, the large payment may simply be the result of the concentrated number of firms in these cases.





## Results

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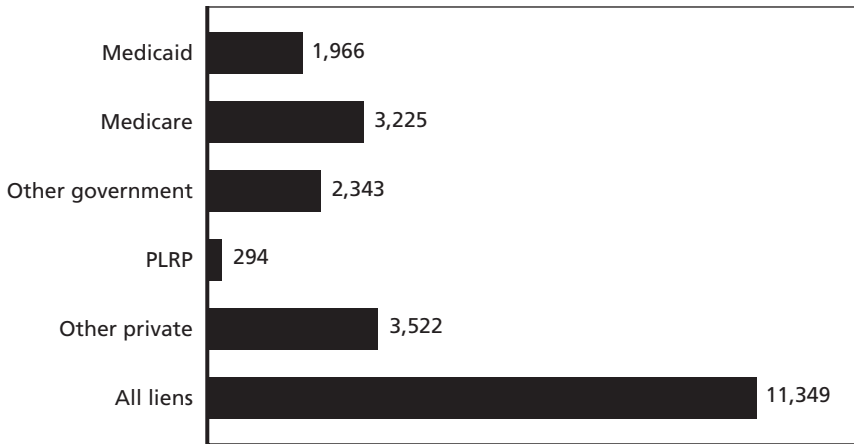
In this section we turn to the central questions of our study: How prevalent are liens in our sample of claims, and how large are these liens both in absolute value and as a percentage of the settlement paid to plaintiffs and their attorneys?

### The Frequency of Liens

A few definitions will help in understanding the results. We define a *claim* as the individual plaintiff—that is, someone with an injury allegedly resulting from the defendant’s actions. There are numerous claims within each compensation event. The average claim in our sample has one lien of any type. The median is also one, and only one compensation event has no liens of any type. Because our data do not contain information on liens that were asserted but eventually dropped, which according to Garretson employees is a relatively common occurrence, we cannot tell whether these claims had no liens or whether the lien resolution process saw lien holders waive their lien rights.

In Figure 4.1 we provide the total resolved value of liens by lien type in our sample. We break liens into five different categories based on the variation in their lien rights discussed earlier. The first are Medicare and Medicaid; followed by other government liens, such as liens from the U.S. Department of Veterans Affairs; liens associated with PLRPs; other private liens, primarily from ERISA and non-ERISA private health plans; and finally an overall category. The most expensive liens are from private plans, with Medicaid, other government, and

**Figure 4.1**  
**Average Resolved Value of Liens by Lien Type (U.S. dollars)**



NOTE: Sample size = 96 compensation events.

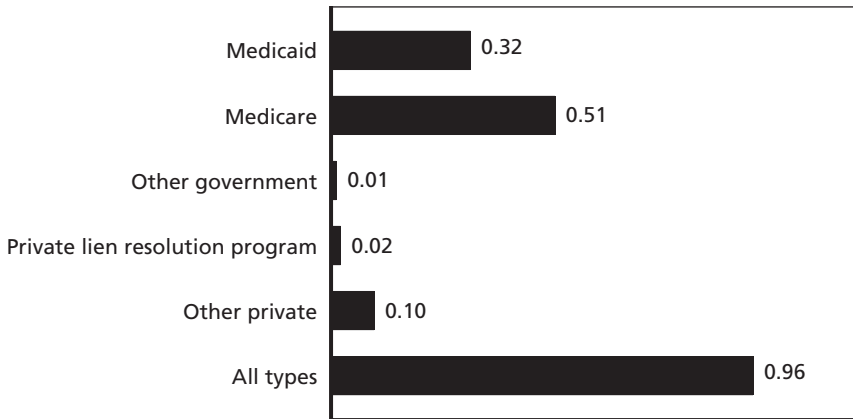
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Medicare liens having smaller average values. One interpretation of this is that Medicaid and Medicare have the most developed lien resolution systems and the most extensive lien rights.<sup>1</sup> This would mean that it is worth pursuing smaller Medicare liens that the private plans, for example, would not find lucrative to attempt to recover. Confounding this interpretation is the fact that private insurance fee schedules are generally higher than Medicare, so we would expect liens for private insurance to be higher.

Some evidence that Medicare is pursuing smaller liens, due to its far more extensive and developed lien rights, is found in Figure 4.2.

<sup>1</sup> One issue with the data is that we do not know whether a particular event had a PLRP program for some subset of the private liens; thus, the lower PLRP resolved value reflects a number of zeros, which may mean the recovery was zero from the PLRP program or that the event did not have a PLRP program. Computed with zeros being interpreted as no program, the average PLRP recovery for events with any PLRP recovery was \$4,355.36. We have a somewhat different issue with other government insurance, where zero might mean no recovery for other government-provided insurance or that no liens were asserted. When we treat zeros as meaning no liens, the average is \$5,627.80.

**Figure 4.2**  
**Average Number of Liens per Claimant by Claim Type**



NOTE: Sample size = 96 compensation events.

RAND RR2393-4.2

The average compensation event has 0.956 total resolved liens and 0.506 Medicare liens per claimant. The next closest lien type, in terms of frequency, is Medicaid. All other lien types are far less common.

Figure 4.3 breaks out the different lien types as a percentage of the total value of the claim. For the typical claim, all resolved liens constitute about 12 percent of the total value of settlement. The various lien types are between 4 percent and 5 percent of total value, with Medicaid being noticeably smaller at 1.9 percent.<sup>2</sup>

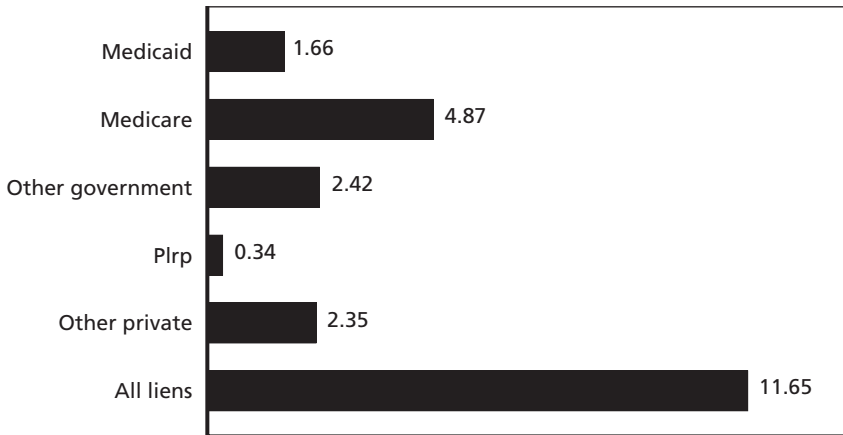
Finally, in Figure 4.4 we provide a histogram of the number of liens per case for our sample of compensation events.

## Recovery Relative to Medicare Liens

The foregoing discussion suggests that Medicare liens are more frequent and, at least for the purposes of this sample size, have smaller

<sup>2</sup> As stated earlier, a key issue is that we do not know whether an event had any PLRPs. Since PLRPs are not present in all events, we are treating a zero as no PLRP. This will, by construction, reduce the mean number of liens in a PLRP program.

**Figure 4.3**  
**Lien Value as a Percentage of Total Claim Value**



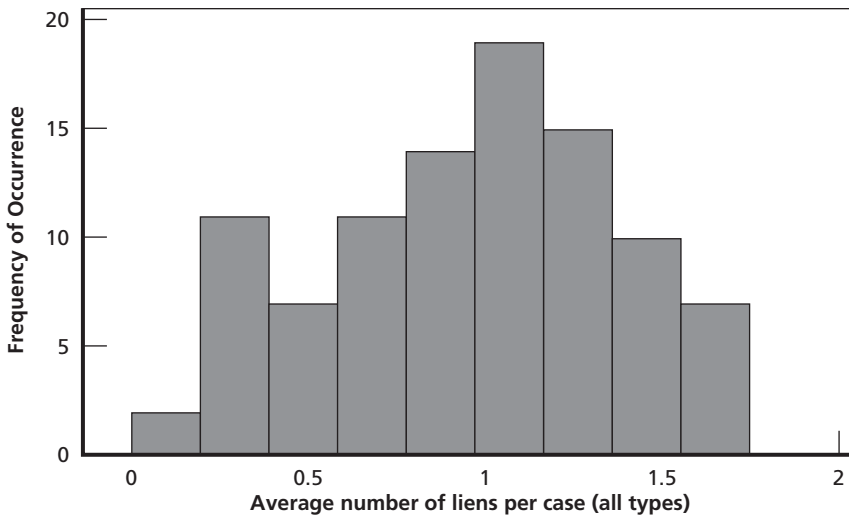
NOTE: Sample size = 96 compensation events.

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average recoveries, at least relative to private liens. As discussed earlier, this result may be partly due to Medicare's extensive recovery process, which includes statutory reductions for attorney fees and expenses.<sup>3</sup> Medicaid, by contrast, is the second most frequent lien type, but the average Medicaid lien recovery value is less than the average Medicare lien recovery value. One potential reason for this result is that state statutory remedies, including hardship exceptions and waiver protocols, are potentially more relevant when considering the means-tested eligibility criteria applicable to Medicaid programs. Although Medicare's recovery process also includes waivers for hardship and reduc-

<sup>3</sup> See 42 C.F.R. § 411.37, which describes the amount of Medicare's recovery when the primary payment is made as a result of a judgment or settlement. Note that 42 C.F.R § 411.24 also states that if a conditional payment is made by Medicare, CMS may initiate recovery as soon as it learns that a payment has been made or could be made under workers' compensation, any liability or no-fault insurance, or an employer group health plan. CMS need not take legal action to recover. CMS is entitled to the lesser of either the full conditional payment or the full primary payment the primary insurer is obligated to pay. If CMS must take legal action, it is entitled to double the conditional payment. Finally, CMS has the direct right of recovery from any primary payer.

**Figure 4.4**  
**The Distribution of Resolved Liens**



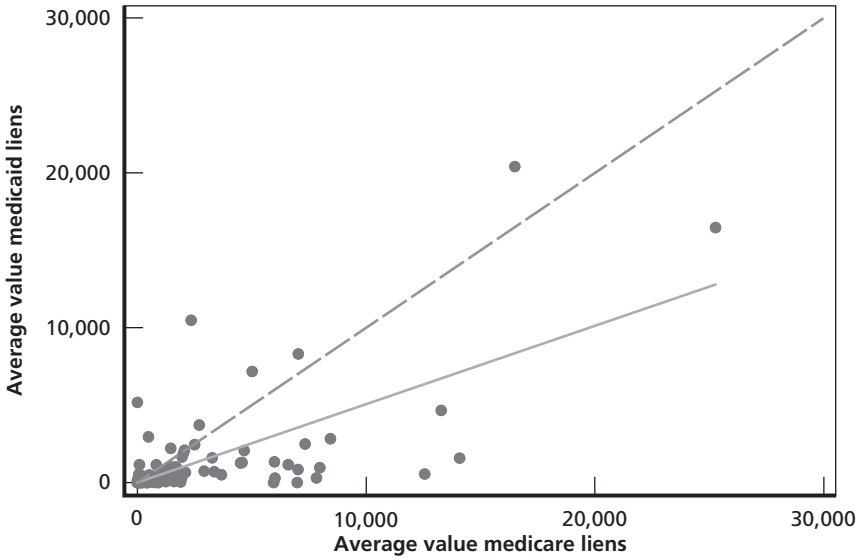
NOTE: Sample size = 96 compensation events.

RAND RR2393-4.4

tions based on a variety of circumstances, where there is no income or asset test to receive Medicare coverage, those remedies may not be as successful as would be the case when someone who lives below the federal poverty line is requesting a lien reduction. There are, however, reasons to suspect that pre-2017 restrictions on Medicaid's lien rights may have also reduced its ability to recover relative to Medicare liens. As noted earlier, the *Ahlborn* and *Wos* cases limited state Medicaid programs' lien rights, at least relative to Medicare.<sup>4</sup> In Figure 4.5 we graph the average recovery per lien for Medicare and Medicaid liens for each of our 100 compensation events. The 45-degree, dotted line demarcates equality between the average Medicaid and Medicare lien recovery. We find that, for the majority of our events, the Medicaid

<sup>4</sup> In *Ahlborn* the Supreme Court held that the Medicaid statute's anti-lien provision preempts a state's effort to take any portion of a Medicaid beneficiary's tort judgment or settlement that is not designated as payments for medical care. The *Wos* decision prohibited states from attempting to recover the full value of a Medicaid lien when the full value had not been recovered in the case. The MSP Act provides no such restrictions for Medicare's recovery.

**Figure 4.5**  
**Medicare Versus Medicaid Liens**



NOTE: Sample size = 96 compensation events.

RAND RR2393-4.5

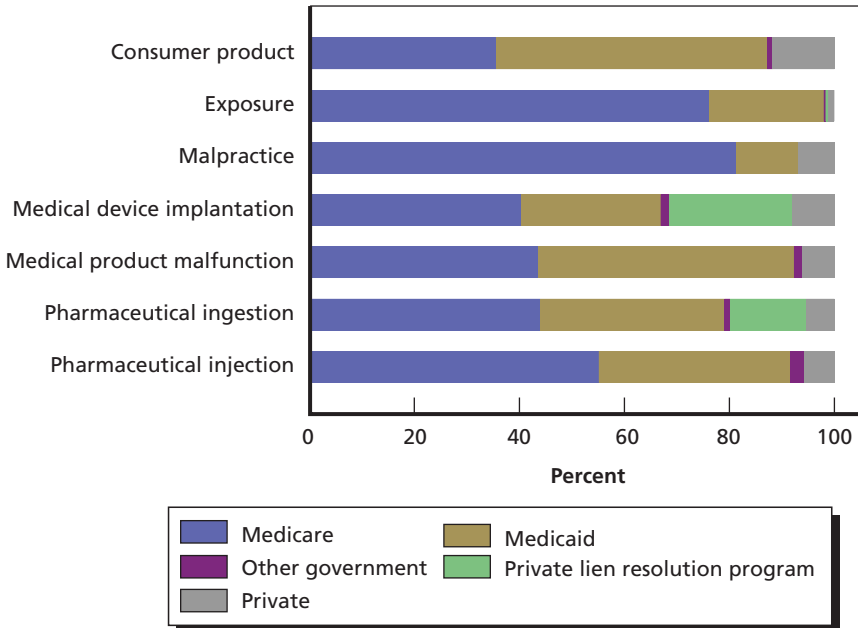
recovery is smaller than the Medicare recovery (i.e., below the 45-degree line). The solid line represents the least squares estimate of regressing Medicare recovery on Medicaid recovery and indicates that as Medicare recovery increases, so does Medicaid lien recovery, but at a slower rate.

This suggests that for higher-valued liens, Medicaid recovers less than Medicare. Although there are a number of reasons this might be the case, it is consistent with the theory that the more restrictive lien rights under *Ahlborn* and *Wos* reduce Medicaid’s percentage of recovery.

### Liens by Event Type

Thus far we have characterized the frequency and value of liens across all 96 of our compensation events. The evidence from the Garretson Group data is that liens are relatively common in large compensation

**Figure 4.6**  
Average Proportion of Lien Type per Event by Event Type



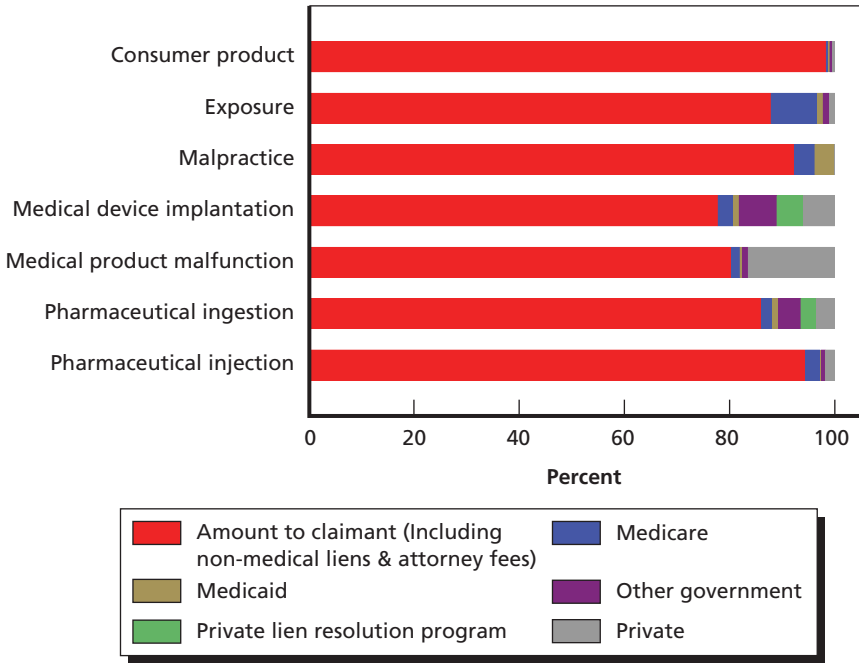
NOTES: Sample size = 96 compensation events. Note that this figure shows the total value of all liens as a fraction of the total payment by all defendants in a compensation event averaged over the sample.

RAND RR2393-4.6

events and that the amount of compensation to lien holders and the frequency of liens are in part a function of the comprehensiveness of the lien holders' rights with regard to plaintiffs and defendants. In this section we break out the number and value of liens by the different types of compensation events in our data. Figure 4.6 presents the frequency of different lien types across the different event types. Consistent with our findings discussed earlier, Medicare liens are the most frequent, followed by Medicaid liens. The other lien type frequencies vary across the different event types.<sup>5</sup>

<sup>5</sup> We include the numerical values of the breakdown of Figures 4.6–4.8 in Table A.2.

**Figure 4.7**  
**Average Lien Payment as a Percentage of Total Payment**



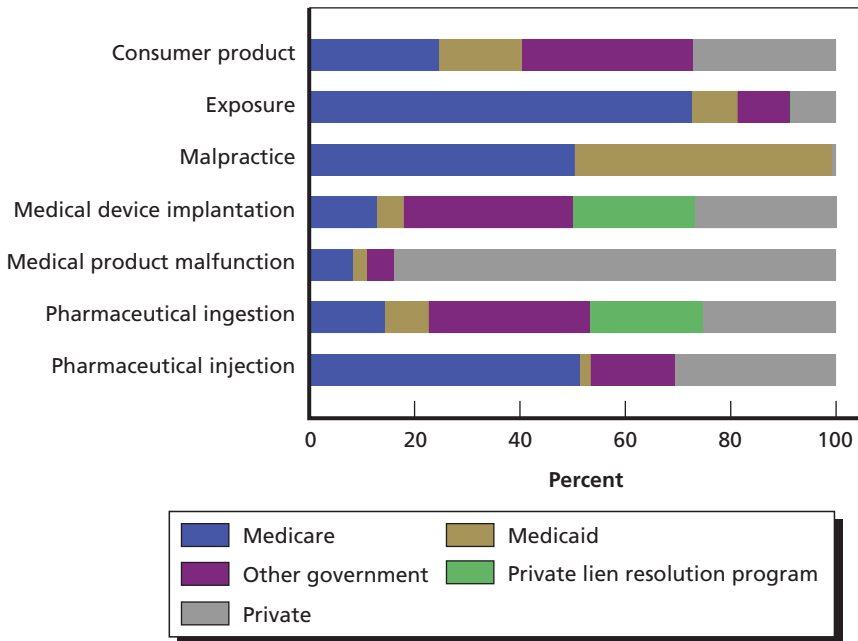
NOTES: Sample size = 96 compensation events. Note that this figure shows the total value of all liens as a fraction of the total payment by all defendants in a compensation event averaged over the sample.

RAND RR2393-4.7

In Figure 4.7 we break out the recovered value of the different lien types as a percentage of the total payment made by the defendant to the average plaintiff in the compensation event. The red bar represents the amount received by or for the benefit of the plaintiff. This is the gross amount, so attorneys’ fees (typically one-third), expenses, and non–health care liens would need to be deducted from this amount to capture the net amount to clients. As shown in the chart, liens, on average, make up less than 20 percent of the value of the average claim. Although this no doubt masks considerable variation in lien value for individual claims, it does not appear that liens are overwhelming client recovery. Nevertheless, a reduction in recovery of 10–20 percent as a



**Figure 4.8**  
Average Lien Payment Proportion by Type



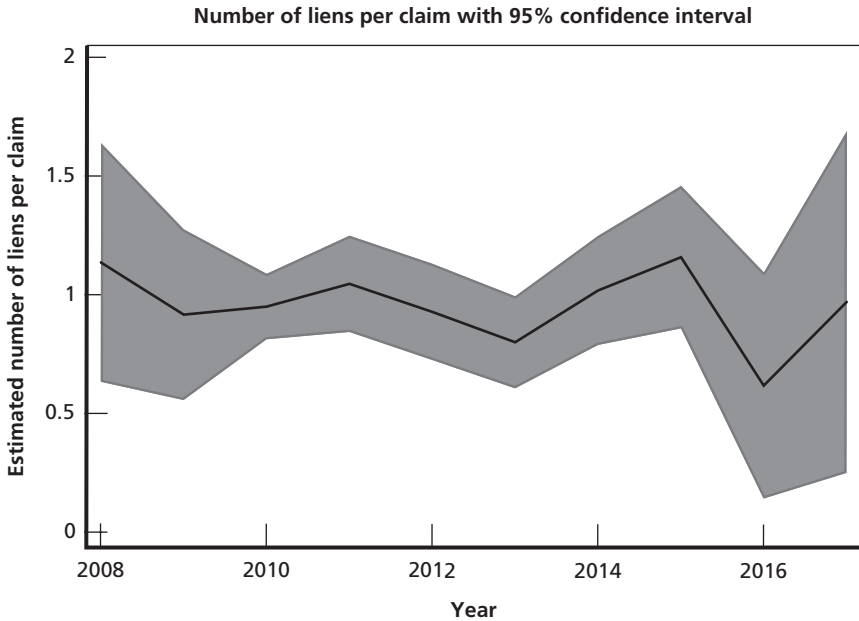
NOTES: Sample size = 96 compensation events. Note that this figure shows the total value of all liens as a fraction of the total payment by all defendants in a compensation event averaged over the sample.

RAND RR2393-4.8

result of liens, less expenses, and before deducting attorneys' fees and any non-health-related liens, represents a nontrivial reduction on client recovery.

Finally, in Figure 4.8 we break out the percentage of total recovery by liens for the types of liens that are receiving the payment. The key question is whether one type of lien is responsible for a disproportionate share of the average 20 percent of claim value going to liens. The results in Figure 4.8 do not suggest a pattern. In some claim types, such as exposure and malpractice claims, Medicare liens dominate recovery, but in other claim types this is not the case.

**Figure 4.9**  
Trend in Number of Liens



NOTE: Sample size = 96 compensation events (2008–2017).

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## Trends in Liens

In this section we turn to whether the number of health care liens per claim is increasing in our dataset. As noted earlier, the Garretson Group data is not ideal for estimating trends, as the claims in the data have all hired the Garretson Group for its lien resolution services. As such, any trend will be confounded with any changes in the composition of the clients of the lien resolution company.

To mitigate this, we run a regression of the number of liens per claim on year and event type fixed effects.<sup>6</sup> That is, we control for the

<sup>6</sup> The fixed effects are an indicator variable equal to one if the first case in the event was resolved in a given year (i.e., the indicator variable for year 2009 equals one if the first case for event X was resolved in 2009). We omit 2008 to avoid colinearity with the intercept term. We

composition of case types in the sample, given that the number of liens does seem to vary with case type. The results are shown in Figure 4.9. We find no obvious trend in the number of liens per claim over time since 2008. The result, however, must be interpreted with caution, as the test is limited by our ability to control for composition effects.

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also omit four events for which the first case was resolved before 2008. Finally, we include fixed effects for case type. The regression results are provided in Table A.3.



## Conclusion and Implications

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In this study we examine the change in the laws governing lien rights and present the data on the frequency and value of liens. The qualitative analysis of lien rights suggests that Medicare liens have, particularly since 2003, acquired something of a “super lien” status that allows them to compel parties to notify Medicare if a Medicare beneficiary is involved in litigation and must be included in settlement negotiations in a way that protects Medicare’s interest.

The effect of this expanded set of lien rights, at least relative to other lien holders, appears in the data in that Medicare liens are, on average, more frequent and recover less money than private liens. This may seem counterintuitive but is consistent with Medicare recovering on liens that other parties would not find as lucrative to pursue.

We find that Medicaid liens, while similar in frequency, recover less than Medicare liens. We suggest that this may be because, during our sample period, the *Ahlborn* and *Wos* cases had restricted Medicaid’s lien rights relative to Medicare, something Congress reversed in 2013, and after 2017 Medicaid will have similar opportunities to assert greater lien rights as has Medicare.

Further, we find that the amount paid out to resolve liens in our dataset is on average about 20 percent of the total claim value and that no particular lien type dominates the recovery. We do find that Medicare liens are the most frequent lien type across our different types of claims. Finally, we find no evidence of a trend in the number of health care liens, although some care must be taken in interpreting these results, as the Garretson Group data represent only claims that retained Garretson

to resolve health care liens associated with the claim. For this reason, changes in the composition of the Garretson Group's business could mask any trends. Finally, it is worth reiterating that our sample covers only health-care-related liens and, as such, there may be trends in other types of liens (e.g., liens for child support or tax liens).

The current frequency of liens in mass compensation events suggests a potential problem with the push to expand lien rights in non-Medicare statutory liens. Specifically, as lien rights grow, liens will almost certainly become more frequent and command a greater share of recovery funds. This suggests that the risk of plaintiffs being unwilling to pursue claims is real, even if the data surveyed here do not necessarily suggest that liens are at some sort of tipping point.

One factor we have not considered here, but hope to examine in future research, is the impact of liens on judges and case management. Anecdotally the presence of liens in mass litigation has necessitated the involvement of the presiding judge in settlement negotiations. The concern is that if lien holders will not reduce their share of the recovery and plaintiffs' attorneys receive  $33 \frac{1}{3}$  percent of the recovery, there may not be enough left for the plaintiff. Judges in such cases are faced with the controversial choice of withholding approval of settlements, giving lawyers less than their expected fees or being actively involved in the settlement process.

The results also suggest why liens may cause case delays. Two recent studies, Helland and Klick (2018) and Heaton (2018), have both found evidence that Medicare liens produce delays in resolving cases. Both studies attribute this to the complexity of lien resolution. While both studies used a broader set of cases than the mass compensation events used here, it seems likely that the complexity of resolving claims will only grow as more statutory liens follow Medicare's example.

# Appendix

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**Table A.1**  
**Summary of Statutory Requirements by Lien Type**

"Super Lien" Characteristic	Private Plans					
	Medicare	Medicaid	Medicare Part C Plans	ERISA and FEHBA	Individual Plans, Affordable Care Act Exchange Plans, and State and Local Government Plans	PLRPs
Defendant responsible for liens if settlement is not preapproved by relevant authorities	Yes	Varies by state statute <sup>a</sup>	Yes since <i>In re Avandia</i> in 2013	No, but plaintiff is, by contract with individual insurer	Varies by state and individual insurance contract	No, but plaintiff is, by contract with individual insurer
Double payment for damages possible (i.e., defendant must reimburse lien holder if the lien holder's interests are not satisfied by the plaintiff)	Yes	Varies by state statute	Yes since Supreme Court denied cert in <i>In re Avandia</i> in 2013	No, unless there is a contract provision with individual insurer	Varies by state and individual insurance contract	No, unless there is a contract provision with individual insurer



Reporting requirements (i.e., plaintiff or defendant must notify potential lien holder of the existence of litigation)	Yes	No, although this varies by state statute; it is unclear yet whether individual states have the ability to check eligibility or enrollment	CMS does not have the ability to verify Part C enrollment	No statutory reporting requirement but possible via insurance contract	Varies by state and individual insurance contract	No statutory reporting requirement but possible via insurance contract
Fines for nonreporting	CMS may impose up to \$1,000 per day for failure to report or erroneous reporting	No until 2017, however, see discussion in text	Yes, however see discussion in text	No statutory fines	No statutory fines	No statutory fines

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<sup>a</sup>For example, Rhode Island’s Medical Assistance Intercept System (MAIS), introduced in March 2013, requires all insurers who register to do business in Rhode Island to register with the Rhode Island Insurance Commissioner so that when an insurer is to make a payment to a Medicaid beneficiary insured, the system triggers a report that identifies the Medicaid lien and requires payment as part of that process. Although it appears no other state has a similarly comprehensive system, that may well change, as Rhode Island recently issued a report indicating that MAIS, from March 2013 to March 2016, generated \$3 million in recovered Medicaid liens (see MAIS, 2016).

**Table A.2**  
**Data on Proportion of Lien Type by Event and Average Lien Payment as a Percentage of Total Payment**

**Panel A: Data for Figure 4.6**

<b>Program Type</b>	<b>Medicare</b>	<b>Medicaid</b>	<b>Other Government</b>	<b>PLRP</b>	<b>Private</b>
Consumer product	35.38	52.97	3.03	0.00	8.63
Exposure	76.77	21.48	0.20	0.09	1.46
Malpractice	77.27	14.19	0.00	0.00	8.54
Medical device implantation	47.23	24.54	2.38	3.12	22.73
Medical product malfunction	42.20	44.96	6.43	0.00	6.41
Other	64.09	25.98	0.00	0.00	9.93
Pharmaceutical ingestion	51.10	37.22	0.98	2.94	7.76
Pharmaceutical injection	55.14	36.46	2.63	0.00	5.76

**Panel B: Data for Figure 4.7**

<b>Program Type</b>	<b>Amount to Claimant<sup>a</sup></b>	<b>Medicare</b>	<b>Medicaid</b>	<b>Other Government</b>	<b>PLRP</b>	<b>Private</b>
Consumer product	95.06	0.93	1.35	0.86	0.00	1.80
Exposure	90.69	4.33	1.45	2.12	0.02	1.39
Malpractice	93.26	5.11	1.48	0.00	0.00	0.15

Medical device implantation	77.39	4.24	2.55	7.64	1.64	6.55
Medical product malfunction	88.17	2.57	0.82	1.20	0.00	7.24
Other	97.12	1.62	0.42	0.00	0.00	0.84
Pharmaceutical ingestion	89.99	3.12	1.60	2.41	0.41	2.48
Pharmaceutical injection	94.35	2.91	0.12	0.91	0.00	1.72

**Panel C: Data for Figure 4.8**

<b>Program Type</b>	<b>Medicare</b>	<b>Medicaid</b>	<b>Other Government</b>	<b>PLRP</b>	<b>Private</b>
Consumer product	34.40	28.16	19.52	0.00	17.92
Exposure	71.48	14.31	7.09	0.17	6.96
Malpractice	79.20	18.43	0.00	0.00	2.37
Medical device implantation	25.78	13.42	28.42	5.09	27.29
Medical product malfunction	18.78	30.45	20.15	0.00	30.62
Other	43.32	33.26	0.00	0.00	23.42
Pharmaceutical ingestion	41.20	19.64	20.47	2.75	15.93
Pharmaceutical injection	51.41	2.04	16.04	0.00	30.51

<sup>a</sup>Including nonmedical liens and attorneys' fees.

**Table A.3**  
**Regression Results for Figure 4.9**

VARIABLES	Total Number of Liens
Year	
2009	(0.312) -0.185
2010	(0.265) -0.0887
2011	(0.274) -0.207
2012	(0.275) -0.334
2013	(0.272) -0.115
2014	(0.280) 0.0257
2015	(0.295) -0.514
2016	(0.355) -0.162
2017	(0.442) -0.374**
Exposure	(0.171) 0.200
Malpractice	(0.261) 0.124
Medical device implantation	(0.184) 0.0227
Medical product malfunction	(0.236) -0.680***
Pharmaceutical ingestion	(0.230) 0.0701
Pharmaceutical injection	(0.166) -0.00116
Other	(0.468) (0.312)
Constant	1.209*** (0.300)

NOTE: n = 96 (2008–2017).

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