A COMMON CONFLICT: COMMON FUND DOCTRINE AND MEDICAL PROVIDER LIENS IN TORT SETTLEMENTS

Abstract: Plaintiffs in negligent tort actions often recover less money than they need to resolve all of their accident-related debts due to the insufficient availability of liability insurance proceeds. Two significant debts common to these tort actions are liens for medical treatment of injuries that plaintiffs sustain and the attorney's fees plaintiffs incur in pursuing liable insurance companies. The law places plaintiffs' attorneys and medical lienholders in an inherently adversarial position. Medical lien statutes frequently grant attorney's fees first priority to settlement proceeds but also do not require medical lienholders to reduce their claims, even if available insurance funds are insufficient to pay all the plaintiff's debts. To resolve this impasse, plaintiffs' attorneys often petition courts to apply the Common Fund Doctrine (Doctrine), an equity principle derived primarily from class action litigation, to force medical lienholders to reduce their claims to pay a proportionate share of plaintiffs' attorney's fees. This Note argues that such an application is an inappropriate expansion of the Doctrine and provides enormous leverage to plaintiffs and their attorneys. Applying the Doctrine in this way exacerbates the impact of existing limitations on the recovery of medical debts through statutory liens and provides immense incentive for plaintiffs to hire legal counsel, even when it is unnecessary. This Note also argues that citing fairness or equity as a policy justification for the use of the Doctrine in these situations is intrinsically hypocritical, as such use of the Doctrine results in inequitable outcomes for medical lienholders. Finally, this Note contends that the Bankruptcy Code provides a strong, federal correlative for the handling of attorney's fees in settlement proceedings with insufficient funds and suggests that medical lienholders and personal injury attorneys should lobby to increase minimum insurance limits to reduce the frequency of insolvent settlements.

INTRODUCTION

Friends Peter, Michael, and Samir are having a quiet conversation at work when their coworker, Drew, approaches them.[1] Drew informs the group that another colleague, Tom, was recently in a serious car accident.[2] A drunk driver collided with Tom's vehicle at a high rate of speed as Tom backed out of his

[1] OFFICE SPACE (20th Century Fox 1999).
[2] *Id.*

driveway.[3] Drew announces that Tom, despite still recovering from a litany of significant injuries, is hosting a party because he received an enormous monetary sum in compensation for his damages.[4]

As Peter arrives at the party, a convalescent Tom is in exceptionally high spirits and gleefully introduces Peter to Tom's triumphant lawyer.[5] Knowing that Peter is depressed about his job, Tom takes Peter aside and attempts to encourage him.[6] Despite an uncertain prognosis and a lengthy rehabilitation period ahead of him, Tom shares that he considers his settlement to be both a blessing and a justification in the belief that good things can happen to those who long endure the frustration of a banal existence.[7]

These scenes from the dark satire *Office Space* embrace two of popular culture's most pervasive tropes about the law: that negligence torts always result in huge cash awards to the plaintiff and that personal injury lawyers are constantly seeking to turn any indication of injury into a quick profit.[8] In reality, personal injury cases are frequently difficult and convoluted.[9] There is often

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[3] *Id.* Consistent with the film's black humor, Tom had recently lost his job and had been contemplating suicide. *Id.* The drunk driver crashes into Tom immediately after Tom finds a new will to live and abandons his plans to kill himself. *Id.*

[4] *Id.* Though the film does not reveal the exact amount of Tom's settlement, Drew reports it is a seven-figure sum. *Id.*

[5] *Id.* The film juxtaposes Tom's giddiness with his extensive injuries for comedic effect. *Id.* Tom is nearly in a full body cast, has a cumbersome neck brace, and requires both supplemental oxygen and a wheelchair, yet he constantly grins from ear-to-ear and makes uncomfortably bad jokes about his serious physical condition. *Id.*

[6] *Id.*

[7] *Id.* Tom bolsters this point by revealing to Peter that Tom's settlement money has allowed him to develop a prototype for a ridiculous business idea that Tom devised years previously, but never had the time or financial resources to pursue. *Id.* Thus, the implication is that the settlement money has solved all of Tom's problems, notwithstanding any physical pain he now suffers. *Id.*

[8] *Id.*; *see also, e.g.*, MY COUSIN VINNY (20th Century Fox 1992) (providing a satirical representation of the opportunistic practices of personal injury lawyers). Personal injury attorney Vinny Gambini sees a man with a neck brace at a bar and unabashedly asks the man whether he was in an automobile accident. MY COUSIN VINNY, *supra*. Vinny is clearly disappointed to learn that a fall caused the man's injury. *Id.* Later, Vinny asks the injured man whether he fell at his own home or at someone else's and is again visibly irritated when he hears that the accident occurred in the man's own home. *Id.* The humor derives from the implication that Vinny, despite being in town to defend his cousin in a capital murder case, is still the archetypical personal injury lawyer: always looking for opportunities to make quick and easy money by litigating negligence. *Id.* Rather than expressing sympathy for the injured man, Vinny demonstrates annoyance that the man caused his own harm. *Id.*

[9] *See What Makes Personal Injury Cases So Complex?*, WELSH & WELSH (Apr. 19, 2017), https://welsh-law.com/2017/04/makes-personal-injury-cases-complex/ [https://perma.cc/J3LJ-C3LA] (discussing several complicating factors of personal injury claims). Personal injury cases generally involve unique facts and procedural concerns, and attorneys must prepare them accordingly. *Id.* Seeking compensation from a tortfeasor's insurance company is a painstaking effort, typically requiring, *inter alia*, a prolonged and detailed discovery process. *Id.* Should the tortfeasor's insurance company deny liability or fail to agree with the plaintiff's attorney on a settlement amount, litigation and resolution of personal injury cases can require years of work. *Id.* Crucially, tort liability as it pertains to automobile accidents is likely to become even more complicated as self-driving cars and other autonomous

no guarantee that the insurance proceeds will fully compensate plaintiffs for their losses, much less provide them with life-changing financial security.[10] Available insurance proceeds can be limited, especially when tort actions involve multiple injured plaintiffs, or might not be available at all, should the responsible party fail to carry applicable liability insurance coverage.[11] Furthermore, the injured plaintiff is rarely the sole claimant to settlement funds.[12]

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vehicle technology continues to develop. *See* Madeline Roe, Note, *Who's Driving That Car?: An Analysis of Regulatory and Potential Liability Frameworks for Driverless Cars*, 60 B.C. L. REV. 317, 333–34 (2019) (discussing the potential difficulties in establishing liability in accidents involving driverless cars).

[10] *See* Zachary Reynolds, Note, *Liens and Leeches: The Unfair Application of the Illinois Health Care Services Lien Act and the Need for Reform*, 67 DEPAUL L. REV. 105, 105–06 (2017) (providing an example of a serious automobile accident that resulted in comparatively paltry monetary recovery for the plaintiffs). The author provides one example of how the amount plaintiffs receive in settlement of a negligence suit and the amount plaintiffs actually pocket can be drastically different. *See id.* (referencing Blagota and Tomica Premovic, who brought a personal injury lawsuit against a negligent driver); *see also* Jeff Overly, *Ill. Hospital Tried to Swipe Patients' Settlement Cash, Suit Says*, LAW360 (May 1, 2012), http://www.law360.com/articles/335839/ill-hospital-tried-to-swipe-patients-settlementcash-suit-says [https://perma.cc/E2H6-87BH] (providing a more detailed discussion of the Premovic case). In the example case, the liable insurance company settled with two injured plaintiffs for $27,000. Reynolds, *supra*, at 106. The plaintiffs pocketed far less, however, given that the plaintiffs owed approximately $8,500 in medical expenses resulting from the accident. *Id.* The hospital that treated the plaintiffs asserted a hospital lien against the settlement for its total charges for services, instead of billing the plaintiffs' health insurance that would have paid the hospital at reduced contractual rates. *Id.* at 105–06. As a result, the plaintiffs used a significant portion of their settlement funds to pay the medical provider, thus dramatically reducing their personal share of the award. *Id.*

[11] *See* Reynolds*, supra* note 10, at 105–06 (providing an example of multiple plaintiffs receiving a modest collective award); *see also* Martinez v. St. Joseph Healthcare Sys., 871 P.2d 1363, 1364 (N.M. 1994) (providing an example of a plaintiff invoking her uninsured motorist coverage because, as the victim of a hit-and-run accident, she was unable to identify the tortfeasor's liability insurance policy or establish if one even existed). The plaintiff in *Martinez v. St. Joseph Healthcare System* encountered both the problem of not being able to pursue the tortfeasor and the problem of having limited insurance funds. *See* 871 P.2d at 1364 (illustrating that the insurance plan that provided compensation to the plaintiff was the plaintiff's own inadequate uninsured motorist policy). The plaintiff was the victim of a hit-and-run accident and was never able to pursue the liable party. *See id.* (noting that the plaintiff invoked her uninsured motorist coverage because she was the victim of a hit-and-run scenario). Although the plaintiff's uninsured motorist coverage was instrumental in providing her with funds necessary to resolve her accident-related damages, the coverage was insufficient to cover all of her debts. *See id.* (providing that the plaintiff's representative received the $105,000 limit of the plaintiff's uninsured motorist policy, but that the plaintiff's accident-related debts, including the attorney's fees and other legal expenses, exceeded that amount).

[12] *See, e.g.*, Kannaday v. Ball, 631 F. App'x 635, 636–37 (10th Cir. 2015) (providing an especially devastating set of facts, with the tortfeasor carrying $50,000 in total accident liability coverage but with three plaintiffs claiming aggregate hospital bills approaching $300,000); Ayla Ellison, *Physical and Financial Injuries: The Common Fund Doctrine and Its Application Under the Illinois Health Care Services Lien Act*, 34 N. ILL. U. L. REV. 305, 306 (2014) (providing the details of a case with a single injured plaintiff with multiple lienholders as claimants to the settlement funds). Insurance funds can insufficiently compensate plaintiffs because the tortfeasor's actions injured more than one individual. *See Kannaday*, 631 F. App'x at 636–37 (demonstrating how multiple personal injury claims against the same insurance policy for the same accident can quickly exhaust the available insurance proceeds). Insurance funds can also fail to make an injured person whole because multiple third par-

Any financial award the plaintiff receives must also compensate for costs the plaintiff incurs as a result of the accident or in pursuit of the settlement.[13] Should the plaintiff be unable to pay off all accident-related debts entirely from the settlement funds, creditors may be able to pursue the plaintiff directly.[14]

For medical providers, liability settlements are a viable means to resolve patient debts, despite the risks associated with the possibility of insufficient insurance proceeds.[15] If an injured plaintiff lacks health insurance coverage, pursuing reimbursement from a tort settlement might be the only source of recovery for a medical provider, short of billing the plaintiff directly.[16] Additionally, state laws, regulatory agencies, and insurance plan coordination of benefits rules often dictate that hospitals seek reimbursement for accident-related charges in a manner dependent on the coverage available.[17] For example, if an

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ties, including the plaintiff's attorney, have asserted liens against the settlement to secure payment for services rendered to the plaintiff in connection with the plaintiff's claim. *See* Ellison, *supra*, at 306 (demonstrating how attorney's fees, hospital bills, physician bills, and physical therapy bills all absorb portions of an injured plaintiff's monetary award).

[13] *See* Ellison, *supra* note 12, at 306 (providing an example where attorney's fees and multiple medical provider bills significantly reduced a plaintiff's personal share of a tort settlement).

[14] *See id.* at 310 (citing 770 ILL. COMP. STAT. ANN. 23/45 (West 2008)) (illustrating, as an example of the statutory authority granted to healthcare providers by one state, that the Illinois Health Care Services Lien Act permits a healthcare provider to pursue any balance left unpaid by the liability insurance settlement directly from the plaintiff).

[15] *See, e.g.*, *Martinez*, 871 P.2d at 1364 (providing an example where, had the plaintiff not carried adequate uninsured motorists insurance coverage, there likely would have been no proceeds for the defendant medical provider to pursue at all). Further complicating a plaintiff's decision to pursue a liability settlement are strong negative perceptions plaintiffs can have about medical providers taking a portion of a tort settlement that is, at least ostensibly, intended to compensate accident victims for more than just their medical debts. *See* Eric Peterson, *Shakedown*, SALT LAKE CITY WKLY. (Feb. 26, 2009), https://www.cityweekly.net/utah/shakedown/Content?oid=2136559 [https://perma.cc/FP3R-Y2RR] (illustrating one tort plaintiff's frustration with a medical provider for pursuing reimbursement directly from her insurance settlement instead of billing her Medicare coverage).

[16] *See* Ellison, *supra* note 12, at 305–06 (providing an example of a medical provider asserting a hospital lien against a plaintiff's tort settlement because the plaintiff did not have health insurance at the time of injury); *see also* Alex W. Schulte, Note, *Healthcare Liens and the Common Fund Doctrine: The Need for Legislative Action to Prevent Fee Shifting at the Expense of Healthcare Providers*, 98 IOWA L. REV. 1763, 1788 (2013) (discussing how any amount of the medical provider's bill that remains unpaid after resolution of the tort settlement requires the medical provider to pursue the plaintiff directly to recoup). Recent loss of employment can be especially detrimental to plaintiffs in these situations, as job loss results both in loss of employer-provided insurance benefits and loss of the necessary income to pay medical bills outright. Ellison, *supra* note 12, at 305–06.

[17] *See, e.g.*, UTAH CODE ANN. § 38-7-1(3)(a)–(b) (West 2018) (providing an example of a state hospital lien statute that precludes a provider from asserting a lien against a tort liability settlement if the injured party has health insurance, unless the health insurance plan does not cover or otherwise timely pay the provider's bill); 211 MASS. CODE REGS. 38.05 (2021) (providing medical providers in Massachusetts with the rules for billing automobile accident-related charges when a patient has both health insurance coverage and medical coverage under their automobile insurance policy); CTRS. FOR MEDICARE & MEDICAID SERVS., YOUR GUIDE TO WHO PAYS FIRST 20 (2021), https://www.medicare.gov/Pubs/pdf/02179-medicare-coordination-benefits-payer.pdf [https://perma.cc/UHF3-YRZE] (providing Medicare's guidance to subscribers that medical providers should seek reimburse-

accident victim's health insurance plan is secondary to any available liability coverage, a hospital must seek reimbursement from the liability insurance before it may bill the health plan.[18]

Further complicating the calculus of determining an injured plaintiff's recovery is the fact that difficult tort cases often result in plaintiffs hiring attorneys to resolve them.[19] The plaintiff normally pays attorney's fees from the funds the plaintiff receives in settlement.[20] Thus, although hiring an attorney may increase a plaintiff's settlement award, it may not increase what the plaintiff actually pockets in compensation for the plaintiff's damages.[21] This presents an immediate and obvious performance standard for the personal injury attorney.[22] The attorney must justify the plaintiff's increased costs to hire

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ment for charges relating to treatment of accident-related injuries from any available liability insurance plan prior to seeking reimbursement from Medicare).

[18] *See, e.g.*, CTRS. FOR MEDICARE AND MEDICAID SERVS., *supra* note 17, at 20 (providing Medicare's secondary payer rules). Automobile insurance plans, including uninsured and underinsured motorist coverage, constitute liability coverage for the purposes of coordinating multiple available insurance payers. *See id.* (providing Medicare's classification of automobile coverage as liability insurance). Health plans often retain subrogation rights should a medical provider bill them prior to settlement of the tort claim, or where they are otherwise a secondary payer. *See id.* (illustrating Medicare's subrogation rights). Subrogation, in the context of coordinating multiple available insurance plans, involves a primary payer, such as a medical benefits plan on the injured plaintiff's automobile insurance policy, seeking reimbursement from the liable insurance plan for any amount that the primary payer paid in reimbursement of accident-related charges. *See Subrogation*, BLACK'S LAW DICTIONARY (11th ed. 2019) ("The substitution of one party for another whose debt the party pays, entitling the paying party to rights, remedies, or securities that would otherwise belong to the debtor."). *See generally* MATTHIESEN, WICKERT & LEHRER, S.C., MED PAY/PIP SUBROGATION IN ALL 50 STATES (2021), https://www.mwl-law.com/wp-content/uploads/2018/02/MED-PAY-PIP-SUBRO-CHART.pdf [https://perma.cc/BBC8-3GCR] (providing the subrogation laws for automobile policy-based medical benefits coverage in each state).

[19] *See* Ellison, *supra* note 12, at 306 (suggesting that plaintiffs not only hire attorneys because they feel they need one in order to resolve their claims against liable insurance companies, but also that plaintiffs may be willing to pay legal fees at higher than market rates for increased chances of substantial financial recovery).

[20] *See id.* at 312–13 (detailing the process by which plaintiffs' attorneys can assert liens against their clients' insurance settlement to secure reimbursement of their fees).

[21] *See id.* at 313 (demonstrating how attorney's fees function similarly to medical provider liens in the disbursement of settlement funds); *see also* Martinez v. St. Joseph Healthcare Sys., 871 P.2d 1363, 1364 (N.M. 1994) (illustrating that, because the insurance company tendered the limits of the policy, the medical debt absorbed approximately 66% of those limits, and the attorney's contingency fee was 33% of the recovery, retaining an attorney did not increase the plaintiff's award). Notably, Illinois seems to have adopted its statutory language specifically to prevent attorney's fees from being overly burdensome in tort liability cases. 770 ILL. COMP. STAT. 23/10(c) (2020); Ellison, *supra* note 12, at 313. The Illinois Health Care Services Lien Act prohibits attorney's fees from absorbing over 30% of the plaintiff's liability settlement where the lien-to-settlement ratio exceeds 40%. Ellison, *supra* note 12, at 313 (citing 770 ILL. COMP. STAT. ANN. 23/10(c)).

[22] *See* Ellison, *supra* note 12, at 306 (illustrating the plaintiff's expectation that hiring an attorney, and more to the point, hiring an expensive attorney, increases the likelihood of securing a significant award on the plaintiff's behalf).

counsel by ensuring that the plaintiff's net financial gain is greater than it otherwise would have been without the attorney's services.[23]

Where available insurance proceeds do not make each injured plaintiff whole, personal injury attorneys must stretch the proceeds that their clients receive to cover all accident-related debts.[24] Critically, attorneys must often find a way for the plaintiff to pocket some money, even though the funds available are insufficient even to cover the plaintiff's losses.[25] Attorneys can explore several options for achieving this objective.[26] First, attorneys can simply reduce their fees to free up funds to pay other claimants.[27] Second, attorneys can request that the medical provider that treated the plaintiff reduce the amount of its claim against the liable insurance company.[28] Third, attorneys can require medical providers to reduce their claims via automatic reductions

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[23] *See id.* (implying, anecdotally, that a plaintiff's decision to hire a personal injury attorney, like most purchases, is subject to an economic cost/benefit analysis).

[24] *See Martinez*, 871 P.2d at 1364 (providing an itemization of one plaintiff's accident-related debts compared to the available insurance proceeds, thereby highlighting the need for the plaintiff's attorney to negotiate the debts to avoid leaving the plaintiff with considerable financial problems).

[25] *See id.* (providing an example of a plaintiff's attorney and the medical providers that treated her reducing their claims in order to facilitate settlement where the available insurance funds were insufficient to cover all accident-related debts).

[26] *See id.* (discussing the option of the plaintiff's attorney reducing their own fees); Ellison, *supra* note 12, at 309 (discussing statutorily-imposed reductions on medical providers under the Illinois Health Care Services Lien Act).

[27] *See, e.g.*, *Martinez*, 871 P.2d at 1364 (providing an example of a personal injury attorney reducing his fees to facilitate settlement of a case with extremely limited availability of insurance proceeds). Although this method may permit an attorney to free up funds without requiring authorization by anyone other than the attorney, both plaintiffs' attorneys and academics have noted that it raises a fundamental question of fairness: why should an attorney reduce legal fees so that other claimants, who undoubtedly benefit from the attorney's work in securing the settlement, do not have to do the same? *See* Yaeger v. City of Lincoln (*In re* Guardianship & Conservatorship of Bloomquist), 523 N.W.2d 352, 354, 360 (Neb. 1994) (noting that the plaintiffs argued for application of the Common Fund Doctrine (Doctrine) and that justification for the Doctrine's use is prevention of inequity); Ellison, *supra* note 12, at 322–23 (arguing that medical providers who share in the tort awards benefit from the work of the plaintiff's personal injury attorney and thus should share in the payment of attorney's fees).

[28] *See, e.g.*, *Martinez*, 871 P.2d at 1364 (providing an example of a case where a hospital claimant to settlement funds refused to reduce the amount of its claim despite a dearth of available proceeds, implying that the plaintiff's personal injury attorney had requested, either directly or indirectly, the hospital to do so). The obvious disadvantage to this strategy is that a medical provider has no obligation to reduce its claim unless imposed by statute or common law. *See id.* (providing an example of a case where a plaintiff's personal injury attorney and a hospital claimant to the plaintiff's settlement proceeds argued whether the controlling hospital lien statute required hospital lienholders to reduce their claims to pay a proportionate share of attorney's fees). Even if a plaintiff's attorney can convince a medical provider to reduce the amount of its claim against the settlement, there is legitimate question as to how effective this strategy ultimately is, given that medical providers can often simply pursue the plaintiff for any unpaid balances once the attorney disburses settlement funds. *See* Ellison, *supra* note 12, at 314 (indicating that medical providers are not limited to recovery simply via the enforcement of their claims against a plaintiff's settlement with the liable insurance company).

that either state statutes or binding common law impose.[29] Despite these options, the frequency at which plaintiffs pursue liability cases with insufficient available insurance funds, combined with the naturally-conflicting positions of attorneys and medical claimants, means that plaintiffs' attorneys and medical providers often disagree as to the proper course of action when there simply is not enough money to go around.[30]

Plaintiffs' attorneys have often tried to break these deadlocks by proposing to invoke the Common Fund Doctrine (Doctrine) to impose automatic reductions on medical providers.[31] The Doctrine provides that where a lawyer generates a common fund for the good of one or more third parties, the lawyer's fee should derive from that fund to ensure that each beneficiary effectively pays a fair share of the lawyer's fee.[32] In the context of a liability settlement

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[29] *See, e.g.*, *Martinez*, 871 P.2d at 1366 (reasoning that because New Mexico's medical lien statute does not levy a recovery cap upon medical providers, the court was free to consider whether imposing a mandatory reduction of medical liens to assist in paying attorney's fees would be appropriate); Ellison, *supra* note 12, at 309 (providing an example of how one state, Illinois, imposes a forced reduction on medical provider claims); *see also, e.g.*, VT. STAT. ANN. tit. 18, § 2251 (2017) (providing an example of a state statute that imposes an automatic reduction of hospital liens and therefore liens exceeding the amount of available insurance funds cannot attach to the entire settlement). For example, some states proscribe medical providers from absorbing more than a specified percentage of the plaintiff's settlement amount, regardless of how much the provider charges for the treatment it rendered to the plaintiff. *See* Ellison, *supra* note 12, at 309 (citing the respective statutes of Illinois, Indiana, Kansas, Massachusetts, Missouri, New Jersey, and Tennessee as examples). Other states permit a medical provider to assert a claim against a liability settlement only if the claim does not exceed a specific dollar amount, regardless of what the medical provider is actually charging the plaintiff. *See, e.g.*, VA. CODE ANN. § 8.01-66.2 (2015 & Supp. 2021) (providing that hospitals in the state of Virginia can assert liens against liability settlements, but only for $2,500 or less).

[30] *See, e.g.*, Bryner v. Cardon Outreach, L.L.C., 2018 UT 52, 428 P.3d 1096, 1098 (providing a class of plaintiffs that derives from several initial tort suits; each individual plaintiff disagreed with the defendant, a billing agent for medical providers, regarding whether the state's hospital lien statute requires medical providers to reduce their claims in order to pay a proportionate share of plaintiffs' attorney's fees).

[31] *See, e.g.*, *id.* at 1102–03 (providing one case with a class of plaintiffs all seeking to apply the Doctrine to reduce medical provider liens in their respective settlements). Where medical provider lien statutes do not specifically provide for automatic reductions to medical liens according to their proportionate share of attorney's fees, those in favor of applying the Doctrine to the same effect generally cite to the New Mexico Supreme Court's decision in *Martinez* as persuasive authority. *See, e.g.*, Alaska Native Tribal Health Consortium v. Settlement Funds Held for or to Be Paid on Behalf of E.R. *ex rel.* Ridley, 84 P.3d 418, 431 (Alaska 2004) (agreeing with the *Martinez* court and applying its holding to the instant case); *see also Martinez*, 871 P.2d at 1368 (holding that a medical provider is responsible for paying a proportionate share of a plaintiff's attorney's fees). Notably, most state courts have declined to follow the *Martinez* decision, holding instead that there is no binding authority or adequately persuasive policy reason to force medical providers to reduce their liens to pay a proportionate share of plaintiffs' attorney's fees. *See, e.g.*, Wendling v. S. Ill. Hosp. Servs., 950 N.E.2d 646, 649–50 (Ill. 2011) (providing an extensive list of cases from states that have declined to apply the Doctrine in these situations).

[32] Ellison, *supra* note 12, at 314 (quoting Scholtens v. Schneider, 671 N.E.2d 657, 662 (Ill. 1996)). These discussions generally define third parties very broadly to include any claimant other than the plaintiff or the plaintiff's attorney that receives a benefit under the settlement. *Id.*

where the plaintiff's debts exceed the insurance proceeds, courts apply the Doctrine by compelling each third-party claimant to reduce its claim by its proportionate share of the total attorney's fees.[33]

Some proponents of using the Doctrine cite essential questions of fairness to justify its use.[34] Under this framework, courts can support using the Doctrine where the plaintiff shoulders all the risks and costs of retaining an attorney but shares the proceeds of such representation with third parties, including lienholders, who do not pay for the representation.[35] Thus, advocates argue fairness dictates that all who share the proceeds of a settlement must also share equally in the risks and costs incurred to obtain that settlement.[36]

Other proponents of using the Doctrine in the tort settlement context point to the Doctrine's value as an equity principle.[37] Principles of equity seek to eliminate unjust enrichment.[38] Proponents justify the use of the Doctrine because the settlement unjustly enriches medical providers unless they contribute

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[33] *See, e.g.*, *Martinez*, 871 P.2d at 1364 (providing the figures of one case to illustrate how the Doctrine applies in practice). In *Martinez*, the plaintiff's attorney secured $101,628.93 in settlement proceeds. *Id.* The attorney's fees totaled $35,824.20. *Id.* The defendant medical provider's lien secured $29,308.97. *Id.* In attempting to impose a mandatory reduction of the medical provider's lien by applying the Doctrine, the attorney filed a declaratory action to recoup $10,606.04 from the medical provider as the medical provider's fair contribution to the attorney's fee. *Id.* Simple math reveals how the attorney might have calculated the provider's share: $10,606.04 is approximately 29% of the total attorney's fees, and the medical provider's lien of $29,308.97 is approximately 29% of the total settlement award, the common fund that the attorney's efforts created. *See id.* (providing the base amounts of the total settlement, attorney's fees, and medical provider lien to make this calculation). The rationale for the proposed reduction thus becomes clear: if a third-party claimant is asserting a claim to 29% of the established fund, it should pay 29% of the attorney's fees the plaintiff incurred to generate that fund. *See id.* (providing the financial figures supporting this position).

[34] *See id.* at 1366 (distinguishing the instant case's engagement with a fundamental fairness analysis from previous cases that effectuated an equity and unjust enrichment analysis).

[35] *See id.* at 1366–67 (characterizing the potentiality of a plaintiff bearing all the costs and risks of pursuing a settlement and all the plaintiff's relevant creditors enjoying the proceeds from that settlement while contributing nothing towards it as unduly burdensome and inherently prejudicial to the plaintiff).

[36] *Id.*

[37] *See Bryner*, 428 P.3d at 1102–03 (illustrating the plaintiff's contention that the court should apply the Doctrine to impose a pro-rata distribution of attorney's fees); Wendling v. S. Ill. Hosp. Servs., 950 N.E.2d 646, 648 (Ill. 2011) (noting that justification for the Doctrine includes preventing medical providers from gaining from the attorney's work without paying for it).

[38] *See* Ellison, *supra* note 12, at 326 (noting that a medical lienholder's securing of its full lien amount, without paying a share of plaintiffs' attorneys' fees, constitutes unjust enrichment because it contravenes equitable disbursement of settlement funds); *see also Equity*, BLACK'S LAW DICTIONARY, *supra* note 18 (illustrating the roots that equity has in both fair-dealing and judicial intervention where meticulous or literal adherence to the law produces unjust results). Precisely defined, unjust enrichment is either: (1) "[t]he retention of a benefit conferred by another not as a gift, but instead in circumstances where compensation is reasonably expected"; or (2) "[a] benefit obtained from another, not intended as a gift and not legally justifiable, for which the beneficiary must make restitution or recompense." *Unjust Enrichment*, BLACK'S LAW DICTIONARY, *supra* note 18. *See generally infra* note 99 and accompanying text (providing the *Martinez* court's distinction between the fairness argument and the unjust enrichment argument).

a proportionate share of attorney's fees.[39] Specifically, advocates assert that all lienholders in a liability settlement, medical providers included, benefit from the work of the plaintiff's attorney.[40] Lienholders benefit because the attorney's work allows the plaintiff to pay lienholders from the settlement and discharges the plaintiff's debt to the lienholder, but the lienholder does not contribute to the legal fees essential to obtaining those benefits.[41]

Despite these contentions, a majority of courts have ruled against applying the Doctrine when there is no binding authority imposing an obligation on medical lienholders to contribute to attorney's fees.[42] These courts have pointed to a variety of factors in explaining their decisions, and often emphasize that: (1) medical lienholders maintain a creditor-debtor relationship with tort plaintiffs, which establishes a right to payment independent of the settlement outcome; and (2) a plaintiff hires legal counsel under contract, and any benefit that a medical lienholder realizes therefrom is simply ancillary to the services

[39] *See, e.g.*, *Bryner*, 428 P.3d at 1103 (providing an example of how one plaintiff argues disgorgement of unjust enrichment as justification for use of the Doctrine to reduce medical provider liens).

[40] *See* Ellison, *supra* note 12, at 321–22 (analyzing what constitutes a "benefit" under unjust enrichment law in Illinois to argue that medical lienholders should pay a portion of plaintiffs' attorney's fees); Reynolds, *supra* note 10, at 123 (arguing that imposing reductions on medical liens to compel medical lienholders to share in the plaintiff's legal fees is one way to prevent claimant freeriding). Freeriding, in this context, refers to a medical provider doing nothing more to secure a settlement with the liable insurance company than filing a lien for its accident-related charges. *See* Reynolds, *supra* note 10, at 123 (citing Brase *ex rel.* Brase v. Loempker, 642 N.E.2d 202, 205 (Ill. App. Ct. 1994)) (arguing that requiring hospitals to reduce their liens for legal expenses averts provider freeriding by forcing providers to participate in the process to secure a settlement); *see also Brase*, 642 N.E.2d at 205 (providing an example of freeriding by a subrogee who sought full recovery of its claim despite largely disengaging from settlement proceedings).

[41] Ellison, *supra* note 12, at 322. This is a significant issue for those who argue against application of the Doctrine, as there is question as to whether a medical provider, the creditor in a business transaction with the plaintiff-debtor, truly benefits from the attorney's establishment of the common fund. *See Bryner*, 428 P.3d at 1103 (illustrating the Utah Supreme Court's holding that a medical provider does not actually benefit from the work of the plaintiff's attorney because the medical provider's right to payment is contractual). By this rationale, the work of a plaintiff's attorney adds no value to a medical provider-claimant, as the medical provider has a right to payment that exists independently of the tort action. *Id.*; *see also infra* Part III.B (discussing the position that the plaintiff's attorney's work is essential for a lienholder to effectuate a recovery, and arguing that such a position misrepresents a medical lienholder's involvement in the settlement and its rights and obligations as a creditor of medical debt).

[42] *See Wendling*, 950 N.E.2d at 649–50 (providing an extensive list of decisions on the issue, from a significant breadth of state courts). The *Wendling* court notes that most courts that have considered applying the Doctrine to reduce medical liens in tort liability settlements with limited insurance proceeds have declined to do so. *Id.* Specifically, the *Wendling* court lists decisions from fourteen states that held that medical lienholders do not have to pay a share of attorney's fees. *Id.* The court also provides a list of courts from three other states that held the opposite view, ruling in favor of the plaintiff and requiring the medical lienholders to pay a share of the attorney's fees. *Id.* at 650.

that the plaintiff hired the attorney to provide.[43] Notwithstanding these holdings, recent academic discussions suggest that it is unfair for medical lienholders not to contribute to plaintiffs' legal costs, and implore both the courts and lawmakers to reconsider the issue.[44]

Part I of this Note discusses the principal components of tort liability settlements and how they contribute to this issue.[45] Part II of this Note analyzes and interprets the breadth of legal arguments both for and against applying the Doctrine within the context of liability settlements with limited available insurance proceeds.[46] Part III of this Note identifies underlying assumptions upon which such arguments rely.[47] Part III also discusses the problems associated with utilizing the Doctrine to grant automatic reductions of medical lien balances.[48] Part IV of this Note proposes relying on the Bankruptcy Code as a strong model for how to treat attorney's fees in the context of indigent settlements and suggests that medical providers and personal injury attorneys work together to raise state-based minimum insurance limits to reduce the frequency at which injured parties must settle for less than their claims are worth.[49]

I. GOVERNING FACTORS IN THE DISBURSEMENT OF SETTLEMENT PROCEEDS: PLAINTIFFS' ATTORNEYS VS. MEDICAL PROVIDERS

The need for plaintiffs' attorneys to negotiate with medical providers largely depends on state laws regarding required insurance coverage, medical lien rights, and applicability of the Doctrine within the tort settlement context.[50] Section A of this Part discusses the variety of state-imposed automobile

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[43] *See, e.g.*, *id.* at 649 (stating that most courts that have considered applying the Doctrine have decided against it); Bashara v. Baptist Mem'l Hosp. Sys., 685 S.W.2d 307, 310 (Tex. 1985) (holding that a hospital does not have an obligation to pay for a plaintiff's legal fees just because the plaintiff's attorney generated a settlement from which the hospital received reimbursement for its charges); *Bryner*, 428 P.3d at 1103 (holding that the contract for services and consent to treatment form the basis of the medical provider's right to payment; thus, a medical provider claimant to a liability settlement is not a true beneficiary of the common fund the attorney establishes by securing the insurance proceeds).

[44] *See* Ellison, *supra* note 12, at 320–26 (discussing the issue as explored in *Martinez* and expanding the *Martinez* court's analysis to argue that more courts should apply the Doctrine as the *Martinez* court did); *see also* Reynolds, *supra* note 10, at 137 (arguing that both state legislatures and the courts should reevaluate the breadth of decisions that heretofore have advantaged medical lienholders over injured plaintiffs, including those pertaining to use of the Doctrine).

[45] *See infra* notes 50–107 and accompanying text.

[46] *See infra* notes 108–159 and accompanying text.

[47] *See infra* notes 160–208 and accompanying text.

[48] *See infra* notes 160–208 and accompanying text.

[49] *See infra* notes 209–239 and accompanying text.

[50] *See* Reynolds, *supra* note 10, at 121–25 (discussing the conflict between attorney liens and medical provider liens and the use of the Doctrine to address the conflict); MATTHIESEN, WICKERT & LEHRER, *supra* note 18, at 1–2 (discussing the impact that state-specific automobile insurance laws have on an injured plaintiff's capacity to sue a tortfeasor for damages).

insurance coverages and how they contribute to or help prevent the problem of plaintiff debts far exceeding available insurance proceeds.[51] Section B of this Part discusses the origin of medical liens and their relationship to attorney liens.[52] Section C of this Part provides a brief history of the Doctrine and how courts have traditionally applied it.[53]

A. State Control of Available Insurance Coverage

Automobile accidents are widespread and familiar torts.[54] Consequently, state requirements for automobile insurance coverage are often determinative factors in how frequently tort plaintiffs face settlement offers that do not cover all the plaintiff's tort-related debts.[55] States are stringent, relaxed, or compromising in establishing thresholds for the minimum amount of insurance coverage all persons must carry to be legal automobile operators.[56]

A plethora of automobile insurance options and policy upgrades exist.[57] Some are only available in specific markets, and states differ on which types of

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[51] *See infra* notes 54–75 and accompanying text.

[52] *See infra* notes 76–93 and accompanying text.

[53] *See infra* notes 94–107 and accompanying text.

[54] *See Car Accident Statistics in the U.S.*, DRIVER KNOWLEDGE, https://www.driverknowledge.com/car-accident-statistics/ [https://perma.cc/5BD3-ZMU3] (providing national car accident statistics for the United States). The average number of annual car accidents in the United States is over six million. *Id.*; *see also* Nora Freeman Engstrom, *When Cars Crash: The Automobile's Tort Law Legacy*, 53 WAKE FOREST L. REV. 293, 294–95 (2018) (providing that the number of automobile accidents in the United States eclipses six million annually, that such accidents result in injuries to approximately 4.6 million people, and that about half of the injured accident victims pursue tortfeasors for damages).

[55] *See, e.g.*, Kannaday v. Ball, 631 F. App'x 635, 636–37 (10th Cir. 2015) (providing a fact pattern that demonstrates how easily liability insurance proceeds can exhaust without making an injured plaintiff whole). The facts of *Kannaday v. Ball* provide an especially tragic example of how standard liability insurance can provide insufficient coverage against catastrophic loss. *Id.* The tortfeasor in *Kannaday*, Stephanie Hoyt, conducted an illegal U-turn in front of an oncoming semi-truck. *Id.* at 636. Hoyt perished in the subsequent collision, and the three passengers in Hoyt's car were each severely hurt. *Id.* at 636–37. Hoyt carried both personal injury protection coverage and liability coverage on her vehicle, in compliance with Kansas law. *Id.* Hoyt's liability policy limits were $50,000 for a single accident, severely inadequate to cover the nearly $300,000 of medical debt that her three injured passengers accrued in aggregate. *Id.* Regrettably, Hoyt's passengers also lacked underinsured coverage to help mitigate their losses. *See id.* at 642 (noting that Hoyt's insurance had erroneously determined that only one of Hoyt's passengers did not have underinsured coverage).

[56] *See* MATTHIESEN, WICKERT & LEHRER, *supra* note 18, at 2 (discussing both the types of automobile insurance coverage each state requires and the system of calculation each state uses to establish its threshold for minimum coverage); Kayda Norman, *Minimum Car Insurance Requirements by State*, NERDWALLET, https://www.nerdwallet.com/article/insurance/minimum-car-insurance-requirements [https://perma.cc/2M7W-9DAQ] (providing a chart of the minimum automobile liability and uninsured and underinsured motorist coverage required in each state).

[57] *See* MATTHIESEN, WICKERT & LEHRER, *supra* note 18, at 1–2 (providing a concise history of no-fault laws and a discussion of their current application amongst the states that continue to enact them); Norman, *supra* note 56 (discussing both automobile liability coverage and uninsured and underinsured motorists coverage, and the types of protections they provide).

coverage they require.[58] Three automobile insurance policy options have a substantive impact on the availability of insurance proceeds and on the opportunity for an injured person to sue in tort: (1) no-fault coverage, including personal injury protection and medical payments coverage; (2) bodily injury liability coverage; and (3) uninsured and underinsured motorist coverage.[59] Generally, the more of these policy options a state requires the greater the likelihood injured parties will recover adequate monetary awards in compensation for their accident-related losses.[60]

1. No-Fault Insurance Coverage

The first of these automobile insurance policy options is no-fault coverage.[61] No-fault provides coverage for loss, including reimbursement of medical claims, for all subscribers on the policy regardless of who was at-fault for causing an accident.[62] Crucially, where states require no-fault coverage, policyholders must meet a threshold before they can sue a liable party in tort.[63] This can permit an injured party's insurance policy to cover at least some claims, thus increasing the amount of insurance money available and improving the odds that the injured party will receive sufficient reimbursement for all accident-related debts.[64] State insurance laws dictate whether a state requires

[58] *See* MATTHIESEN, WICKERT & LEHRER, *supra* note 18, at 3–22 (providing a comprehensive chart of the no-fault laws of each state); Norman, *supra* note 56 (providing a chart of the minimum automobile liability and uninsured and underinsured motorist coverage required in each state).

[59] *See* MATTHIESEN, WICKERT & LEHRER, *supra* note 18, at 3–22 (elucidating in comprehensive detail the different first-party automobile insurance laws in each state); Norman, *supra* note 56 (providing a comprehensive illustration of the different automobile insurance policy requirements of every state).

[60] *See* MATTHIESEN, WICKERT & LEHRER, *supra* note 18, at 1–2 (discussing, for example, the advantages each type of no-fault coverage provides to insured subscribers).

[61] *Id.*

[62] *Id.*

[63] *Id.* at 2; *see also infra* note 64 and accompanying text (providing further discussion of the different approaches states employ in regulating both the availability of no-fault coverage and the ability of accident victims to sue tortfeasors for damages).

[64] *See* MATTHIESEN, WICKERT & LEHRER, *supra* note 18, at 2 (discussing the different types of no-fault coverage available, and the thresholds they impose for pursuing a tortfeasor). Regarding no-fault coverage, each state follows one of four models: (1) modified no-fault; (2) add-on no-fault; (3) choice no-fault; and (4) tort. *Id.* Modified no-fault states require all drivers at minimum to meet a statutory obligation of no-fault coverage before they can sue an at-fault tortfeasor for accident-related damages. *Id.* The minimum no-fault threshold in these states can be monetary, verbal, or a blended model of the two. *Id.* Monetary threshold no-fault states impose a precise dollar figure of no-fault coverage. *Id.* For example, Utah requires all drivers to carry at least $3,000 in no-fault coverage that they must normally exhaust before they may pursue a tort action. *Id.* at 20. Verbal threshold no-fault states are similar, except that these states base the minimum threshold on injury classifications rather than on dollar balances. *Id.* at 2. For example, Florida establishes that drivers can sue in tort if an injured party dies or suffers extreme or debilitating injury. *Id.* at 7. Florida, Hawaii, Kansas, Massachusetts, Michigan, Minnesota, New York, North Dakota, and Utah are modified no-fault states. *Id.* at 2. Add-on no-fault states do not require drivers to carry no-fault coverage, but they do offer no-fault

either policyholders to obtain no-fault coverage or insurers to offer it as a non-mandatory policy option.[65]

2. Liability Insurance Coverage

The second critical insurance policy option is liability coverage.[66] Liability coverage does not protect against the policyholder's own losses that occur as a result of an accident.[67] Rather, liability insurance covers the damages other people incur because of the policyholder's negligence.[68] Although most states require every legal driver to carry a minimum amount of liability coverage, the threshold for meeting the minimum liability coverage requirement differs significantly from state to state.[69] Where state minimum liability insurance requirements are lower, the odds are greater that an injured plaintiff will assert a

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coverage as a policy option. *Id.* Should drivers in add-on no-fault states choose to purchase no-fault coverage, they do not have to exhaust it before pursuing a tort claim. *Id.* Arkansas, Delaware, Maryland, Oregon, South Carolina, South Dakota, Texas, Virginia, and Washington are add-on no-fault states. *Id.* Choice no-fault states require no-fault coverage and provide drivers with the option of opting out of the tort system entirely. *Id.* Should a driver opt into the tort system, then automobile insurance coverage works in choice no-fault states exactly as it does in modified no-fault states. *Id.* All drivers must carry a minimum amount of no-fault coverage that they must exhaust before the driver can pursue a tort claim. *Id.* Should drivers opt out of the tort system, they only retain no-fault coverage, and have no ability to sue in tort should the driver's no-fault coverage fail to cover all the driver's accident-related debts. *Id.* By opting out of the tort system, however, other parties cannot sue the driver in tort either. *Id.* Kentucky, New Jersey, and Pennsylvania are choice no-fault states. *Id.* Tort states do not require no-fault coverage at all. *Id.* Injured parties have no bar to suing an at-fault party in tort, and the tortfeasor's liability coverage will be the primary automobile insurance-based source of compensation available for a plaintiff's accident-related damages. *Id.*

[65] *Id.*; *see also supra* note 64 and accompanying text (discussing the different no-fault coverage options available in each state). For a concise history of automobile no-fault coverage in the United States, see Engstrom, *supra* note 54, at 309–15.

[66] *See* Norman, *supra* note 56 (establishing automobile liability insurance requirements for each state).

[67] *See* Sarah Schlichter, *What Is Liability Car Insurance and How Much Do You Need?*, NERDWALLET, https://www.nerdwallet.com/article/insurance/auto/liability-car-insurance [https://perma.cc/PD5X-CTT2] (noting the accident-related damages that automobile liability covers).

[68] *Id.* Notably, there are two types of liability coverage within an automobile insurance policy: bodily injury liability and property damage liability. *Id.* Bodily injury liability covers damages to the plaintiff's person and covers medical debts, lost wages, and legal expenses. *Id.* Property damage liability covers damage to the plaintiff's property. *Id.* Bodily injury liability policies have two separate limits: a smaller number that sets the maximum per individual claimant, and a larger number that sets the aggregate maximum for all claimants involved in the same accident. *Id.*

[69] *See* Norman, *supra* note 56 (providing the exact amount of coverage drivers in each state must carry to meet state minimum coverage requirements). Alaska, for example, has comparatively high minimum bodily injury liability coverage, requiring $50,000 in individual and $100,000 in total accident bodily injury liability coverage. *Id. But see* Schlichter, *supra* note 67 (noting that Alaska is one of very few states that permits some drivers not to carry liability coverage). By contrast, California imposes very low minimum bodily injury liability coverage, requiring $15,000 in individual and $30,000 in total accident bodily injury liability coverage. Norman, *supra* note 56. Unlike no-fault coverage, minimum required liability coverage always maintains a monetary threshold. *See id.* (discussing the common format for expressing liability insurance limits).

claim for accident-related debts exceeding the value of a liable party's insurance policy; conversely, the more liability coverage a state requires, the better the odds that tort plaintiffs will recover adequate settlements.[70] This also means that states with higher minimum liability insurance thresholds present fewer scenarios where either an attorney or a medical claimant must reduce its claims for settlements to finalize.[71]

3. Uninsured and Underinsured Motorists Insurance Coverage

The third impactful insurance policy option is uninsured and underinsured motorist coverage.[72] This coverage protects policyholders when an uninsured or underinsured tortfeasor causes injury to them.[73] If an injured plaintiff carries this type of coverage, the plaintiff can file a claim on the plaintiff's own policy if the tortfeasor has insufficient insurance proceeds to cover all the plaintiff's accident-related debts, including attorney's fees.[74] Like no-fault coverage, state

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[70] *See, e.g.*, Kannaday v. Ball, 631 F. App'x 635, 636–37 (10th Cir. 2015) (providing a personal injury case that demonstrates how damages can quickly outpace available coverage). The at-fault driver in *Kannaday* was insured under a Kansas automobile insurance policy and carried the minimum bodily injury liability limits permitted by Kansas law: $25,000 per claimant and $50,000 per accident. *Id.* Each injured plaintiff's hospital bill far exceeded the tortfeasor's per-claimant policy limit: within days of receiving a demand letter to split the available proceeds evenly amongst the three claimants, the tortfeasor's insurance company learned that one claimant's medical claim was in excess of $44,000, another claimant's medical claim was in excess of $95,000, and the final claimant's medical claim was in excess of $158,000. *Id.* at 637. In the aggregate, the injured plaintiffs had medical claims of nearly $300,000 and only $50,000 available to pursue from the tortfeasor's insurance policy. *Id.* Notably, this $300,000 figure constituted only these plaintiffs' combined hospital bills; it did not include any other costs these plaintiffs incurred as a result of the accident, including attorney's fees. *See id.* (characterizing the debts specifically as pertaining to medical treatment).

[71] *See* Martinez v. St. Joseph Healthcare Sys., 871 P.2d 1363, 1364 (N.M. 1994) (providing a case where the reduction of both attorney's fees and medical liens was necessary to effectuate a workable settlement due to the paucity of available insurance funds compared to accident-related debts). For example, in *Martinez v. St. Joseph Healthcare System*, the lack of adequate insurance proceeds derived from the fact that an uninsured motorist policy was the only source of recovery for the plaintiff, rather than from insufficient liability insurance limits. *Id.* The effect, however, is the same. *See id.* (demonstrating that more insurance coverage would have reduced the need for lien reductions and increased the chances of the plaintiff recovering an award commensurate with the damages).

[72] *See* Schlichter, *supra* note 67 (providing a listing of states that require uninsured and underinsured motorist coverage as part of the standard automobile insurance policy).

[73] *See* Norman, *supra* note 56 (explaining both underinsured and uninsured motorist coverage and what types of damages they cover).

[74] *See Martinez*, 871 P.2d at 1364 (providing an example of uninsured motorist coverage constituting the entirety of a plaintiff's settlement award). Plaintiffs may also invoke uninsured coverage when the tortfeasor cannot be identified, such as in hit-and-run accidents. *See id.* (providing an example of a plaintiff filing an uninsured motorist claim because the plaintiff could never successfully locate the tortfeasor of a hit-and-run accident). Uninsured and underinsured motorists coverage can be exceptionally important in the disbursement of settlement funds, especially where liability coverage is limited. *See Kannaday*, 631 F. App'x at 637 (noting that the insurance adjuster's settlement disbursement decisions relied substantially on which plaintiffs had underinsured coverage and which did not).

insurance laws determine whether a state requires uninsured or underinsured motorist coverage or offers it as a non-mandatory policy option.[75]

B. Medical Liens and Priority Issues with Attorney's Fees

Where state laws permit, medical providers may file liens when they treat patients injured in automobile accidents or via other torts.[76] Liens derive from three different sources: statute, common law, and equity.[77] Medical provider liens are statutory liens.[78] Such liens exist under a specific, legislatively-enacted statute and provide a lien interest to parties who file their liens accord-

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[75] *See* Norman, *supra* note 56 (providing a state-by-state report of the minimum automobile insurance requirements). Presently, twenty states and Washington D.C. require drivers to carry uninsured motorist coverage, underinsured motorist coverage, or both. *Id.* These states include: Connecticut, Illinois, Kansas, Maine, Maryland, Massachusetts, Minnesota, Missouri, Nebraska, New Hampshire, New York, North Carolina, North Dakota, Oregon, South Carolina, South Dakota, Vermont, Virginia, West Virginia, and Wisconsin. *Id.* Typically, the amount of uninsured or underinsured motorist coverage a state requires tracks the state's minimum per-claimant and per-accident bodily injury liability coverage. *Id.*

[76] *See, e.g.*, 770 ILL. COMP. STAT. 23/10 (2020) (providing the law of Illinois as an example of the rights and obligations states often impose on medical lienholders in tort settlements); Reynolds, *supra* note 10, at 110–13 (providing a summary of the procedures and limitations the Illinois Health Care Services Lien Act imposes on medical lienholders). There are many types of liens, but generally speaking, a lien expresses "[a] legal right or interest that a creditor has in another's property, lasting usu[ally] until a debt or duty that it secures is satisfied." *Lien*, BLACK'S LAW DICTIONARY, *supra* note 18. More specifically, a hospital lien is "[a] statutory lien asserted by a hospital to recover the costs of emergency and ongoing medical and other services. The lien applies against any judgment, compromise, or settlement received by a hospital patient either from a third person who caused the patient's injuries or from the third person's insurer." *Id.* Language common to state medical provider lien statutes track the common characteristics of hospital liens that these definitions identify; specifically, liens that attach to the patient plaintiff's settlement become ineffective once the patient-plaintiff resolves the debt obligation the lien secures. *See, e.g.*, UTAH CODE ANN. § 38-7-1 (West 2018) (providing the Utah hospital lien statute's attachment provisions); *id.* § 38-7-5 (requiring a medical lienholder to release its lien once the patient pays the amount for which the provider files it).

[77] *See* Reynolds, *supra* note 10, at 108 (citing 51 AM. JUR. 2D *Liens* § 7 (2016)). Medical provider liens, as statutory liens, are distinguishable from both common law liens and equity liens. *See id.* (citing R.J. Robertson, *Attorney Liens in Illinois: An Analysis and Critique*, 30 S. ILL. L.J. 1, 3 (2005)). Common law liens attach to property to which the lienholder has added value and grants to the lienholder a right of possession. *See id.* (citing Robertson, *supra*, at 3) (providing a bailment scenario as an example of a common law lien). Equitable liens arise when the lienholder, by agreement or contract, provides labor, goods, or services, increasing the value of personal property or real estate. *Id.* at 108 n.23. The lien disgorges any unjust enrichment afforded to the property owner by realizing the increase in the property's value without paying for the services that provided him with that benefit. *Id.*

[78] *See Martinez*, 871 P.2d at 1365 (classifying medical liens in New Mexico as statutory); Bashara v. Baptist Mem'l Hosp. Sys., 685 S.W.2d 307, 309 (Tex. 1985) (discussing the medical lien statute in Texas and the legislative intent in enacting it); Bryner v. Cardon Outreach, L.L.C., 2018 UT 52, 428 P.3d 1096, 1098 (discussing a medical lien dispute as depending entirely on the correct interpretation of a specific provision of Utah's hospital lien statute); Reynolds, *supra* note 10, at 108 (noting that medical provider liens in Illinois are examples of statutory liens); *see also* UTAH CODE ANN. § 38-7-1 (providing an example of a state medical lien statute).

ing to the statute's requirements.[79] Medical provider liens are unique in that they do not grant an interest in real or personal property.[80] Rather, they grant an interest in any proceeds provided to an injured party by a liable party in settlement of tort-related damages.[81] The interest granted is a right to payment in the amount for which the lienholder files the lien, which is the debt obligation the patient plaintiff incurred in exchange for treatment.[82]

Medical lien statutes are the product of state legislatures.[83] There is significant variation as to which rights a medical provider can assert against the

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[79] *See* Reynolds, *supra* note 10, at 108 n.24. (citing Robertson, *supra* note 77, at 4 & n.20).

[80] *See, e.g.*, COLO. REV. STAT. ANN. § 38-27-101(4) (West 2021) (establishing that medical provider liens in Colorado create only a right to payment from the plaintiff's personal injury settlement); 770 ILL. COMP. STAT. 23/10(a) (2020) (illustrating that medical provider lien rights in Illinois are inextricable from the plaintiff's tort settlement); N.M. STAT. ANN. § 48-8-1(A) (2020) (demonstrating that medical providers in New Mexico may assert liens only against any tort settlement the plaintiff pursues); UTAH CODE ANN. § 38-7-1(1)(a) (establishing that medical liens in Utah attach only to a plaintiff's tort settlement).

[81] *See, e.g.*, UTAH CODE ANN. § 38-7-1(1)(a) ("[A] hospital located within the state that furnishes emergency, medical, or other service to a patient injured by reason of an accident is entitled to assert a lien upon that portion of the judgment, settlement, or compromise going or belonging to the patient . . . ."). Notification requirements often reiterate that medical provider liens attach to pending insurance settlement proceeds by requiring lienholders to name either the tortfeasor or the liable insurance company (or both) on the lien and to serve copies of the lien to them before settlement occurs. *E.g.*, *id.* § 38-7-2(1)–(2). Utah's medical lien statute, for example, provides that:

> A hospital lien upon damages recovered or to be recovered for personal injuries or death shall be effective if: (1) a verified written notice is filed in the district court of the county in which the hospital asserting the lien is located containing: . . . the name of the person, firm, or corporation alleged to be liable to the injured party for the injuries and damages sustained . . . (2) the hospital sends by certified mail with return receipt requested, prior to the payment of any money to the injured person or his attorney or heirs or legal representatives as compensation for the injuries and/or damages sustained, a copy of the written notice, together with a statement of the date of filing, to the person, firm, or corporation alleged to be liable to the injured party for the injuries and/or damages sustained . . . .

Id.

[82] *See, e.g.*, COLO. REV. STAT. ANN. § 38-27-101(1)–(4) (establishing both that medical liens secure compensation for treatment the plaintiff receives and that the amount of filed medical provider liens must be for "reasonable and necessary" charges). Medical lien release requirements frequently reinforce medical liens as establishing nothing more than a right of payment by stipulating that lienholders must release medical liens upon receipt of payment from the liability settlement. *See, e.g.*, UTAH CODE ANN. § 38-7-5 (West 2018 & Supp. 2021) ("The hospital shall, upon receipt of payment of the lien or the portion recoverable under the lien: (1) execute and file, at the expense of the hospital, a release of lien . . . ."). This distinguishes hospital liens from both common law liens and equitable liens. *See* Reynolds, *supra* note 10, at 108 (discussing the rights both common law liens and equitable liens confer on lienholders).

[83] *See, e.g.*, Reynolds, *supra* note 10, at 110–13 (discussing the evolution of medical liens in Illinois, culminating with passage of the Illinois Health Care Services Lien Act in 2003 and amendment in 2012).

tort settlement of an injured party.[84] Generally, where medical lien statutes restrict the rights of providers to assert liens is in: (1) the timing of the lien filing; and (2) the amount the lienholder can seek to recover.[85] Lenient states provide few, if any, limitations on medical provider lien rights.[86] Other states impose relatively moderate limitations, such as timely filing provisions permitting providers to file liens up until the date the settlement funds disburse.[87] Still other states regulate the practice of medical lien-filing so heavily that it is either difficult for providers to assert liens properly or difficult for providers to justify asserting liens at all because they secure little financial recovery.[88] Finally, some states have no lien statutes at all.[89]

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[84] *See* Ellison, *supra* note 12, at 306 (noting that state legislatures create the statutes that grant medical lien rights).

[85] *See, e.g.*, COLO. REV. STAT. ANN. § 38-27-101(1)–(4) (limiting the recovery of medical provider liens to "reasonable and necessary charges" for the lienholder provider's services); *see also* UTAH CODE ANN. § 38-7-2(2) (West 2018) (providing that medical providers in Utah must file and mail their liens prior to disbursement of the settlement funds for the liens to be valid). The Virginia medical lien statute caps the amount a hospital lien may secure at $2,500. VA. CODE ANN. § 8.01-66.2 (2015 & Supp. 2021). The Texas medical lien statute permits lien filing only if the plaintiff patient sought treatment from a hospital within seventy-two hours of the accident. TEX. PROP. CODE ANN. § 55.002 (West 2021). The Texas statute further allows medical providers to include only charges stemming from the first 100 days of treatment in the amount the lien secures. *Id.* § 55.004(b)(1). Statutory lien provisions often impose notification requirements upon lienholders as well. *See, e.g.*, Ellison, *supra* note 12, at 312 (discussing the notification requirements under the Illinois Health Care Services Lien Act).

[86] *See, e.g.*, UTAH CODE ANN. § 38-7-1 (providing an example of a state medical lien statute with few consequential restrictions impacting would-be medical lienholders). In terms of timing restrictions, Utah's statute requires only that lienholders file their liens with the proper district court and notify the tortfeasor or the tortfeasor's liability insurance carrier prior to the disbursement of any funds from the settlement. *Id.* § 38-7-2(2). Notably, this allows medical providers to file and assert liens even after the plaintiff and the liable party have agreed to a settlement amount, as long as no money has actually changed hands. *See id.* (establishing that medical providers in Utah have a right to assert a lien until the date settlement funds disburse, not the date the parties reach a settlement agreement). In terms of amount restrictions, Utah's statute requires only that medical providers do not file their liens in excess of reasonable charges for their services, and that medical providers do not assert liens against extremely paltry settlements of less than $100. *Id.* § 38-7-1(1)(c).

[87] *See* MATTHIESEN, WICKERT & LEHRER, S.C., HOSPITAL LIEN LAWS IN ALL 50 STATES *passim* (2020), https://www.mwl-law.com/wp-content/uploads/2019/09/HOSPITAL-LIEN-LAWS-IN-ALL-50-STATES-CHART-00215685x9EBBF.pdf [https://perma.cc/89HQ-JYVZ] (providing a comprehensive chart of the hospital lien laws in all states, distinguishing states with extensive restrictions from states with moderate or mild restrictions). Utah is an example of a state with mild timely filing restrictions. *See* UTAH CODE ANN. § 38-7-2(2) (providing that medical lienholders must provide notice of a filed lien to the plaintiff before the plaintiff receives any money from the tortfeasor's insurance company). Illinois is an example of a state with relatively modest recovery restrictions. *See* Ellison, *supra* note 12, at 309 (describing that the Illinois Health Care Services Lien Act limits the sum a medical lien can claim from an injured plaintiff's settlement to no more than one-third of the tort settlement, regardless of the amount of the medical provider's charges).

[88] *See* MATTHIESEN, WICKERT & LEHRER, S.C., *supra* note 87 *passim* (distinguishing between states with extensive restrictions from states with moderate or mild restrictions). Virginia imposes some of the most severe restrictions of all states; medical liens in Virginia can secure only a maximum of $2,500, notwithstanding whatever outstanding balance the plaintiff owes in relation to the medical

Medical lien statutes are typically silent on the use of the Doctrine.[90] Most state statutes address priority issues between attorney liens and medical provider liens by specifically stating which liens the settlement proceeds are to pay first.[91] Thirty-two states establish that attorney liens have priority over medical liens.[92] The remaining state lien statutes either establish priority for medical provider liens over attorney liens or limit the percentage of the settlement that medical provider liens may absorb.[93]

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provider's treatment of the plaintiff's accident-related injuries. VA. CODE ANN. § 8.01-66.2. Statutes can also impose arduous filing deadlines; Alabama, for example, requires medical providers wishing to assert a lien to do so within twenty days of the patient plaintiff's discharge from the medical provider's facility. ALA. CODE § 35-11-371(b)(2) (2021).

[89] *See* Ellison, *supra* note 12, at 312 (citing Thomas v. Okla. Orthopedic & Arthritis Found. Inc., 903 P.2d 279, 284 (Okla. 1995)) (maintaining that medical providers cannot assert liens in states that do not have a medical lien statute). Medical providers in these states have no legal basis for asserting liens against tort settlements and must instead seek reimbursement for treatment of accident-related injuries via other means. *Id.*

[90] *See* Martinez v. St. Joseph Healthcare Sys., 871 P.2d 1363, 1366 (N.M. 1994) (noting the court's recognition of the New Mexico Court of Appeals' interpretive framework on this issue of the Doctrine, given that the state's medical lien statute is silent); Bryner v. Cardon Outreach, L.L.C., 2018 UT 52, 428 P.3d 1096, 1102–03 (noting the court's recognition that endorsement for application of the Doctrine is not in the text of the state lien statute, so support must instead come from a specific interpretation of the statute); Ellison, *supra* note 12, at 315 (noting that the Illinois Health Care Services Lien Act is silent on the applicability of the Doctrine).

[91] *See* MATTHIESEN, WICKERT & LEHRER, S.C., *supra* note 87, at 2 (providing a list of states with medical provider lien statutes that grant priority to attorney liens, and another list of states with statutes that grant priority to medical provider liens); *see also, e.g.*, UTAH CODE ANN. § 38-7-1 (providing an example of one state hospital lien statute that maintains a priority scheme where attorney's fees are superior in position to medical liens by establishing that medical liens attach to the portion of the plaintiff's settlement that remains after the plaintiff pays attorney's fees).

[92] MATTHIESEN, WICKERT & LEHRER, S.C., *supra* note 87, at 2. These states are: Alabama, Alaska, Arizona, Arkansas, Georgia, Idaho, Indiana, Iowa, Kansas, Louisiana, Maine, Maryland, Massachusetts, Minnesota, Missouri, Montana, Nebraska, Nevada, New Mexico, New York, North Carolina, Oklahoma, Oregon, Rhode Island, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, and Wisconsin, and the District of Columbia. *Id.* Utah, for example, establishes priority for payment of attorney's fees by stating that medical provider liens attach only to the portion of the injured plaintiff's settlement that remains *after* the plaintiff's attorney takes her fee. UTAH CODE ANN. § 38-7-1. Vermont imposes a more stringent rule, providing attorney liens with priority status *and* prohibiting medical liens from absorbing the entire settlement amount that remains after the attorney takes their fee, thereby reserving at least some money for the plaintiff. *See* VT. STAT. ANN. tit. 18, § 2251 (2017) (establishing that medical liens must not attach either to $500 or to one-third of the settlement amount, whichever is less, and that medical liens occupy junior status to the plaintiff's attorney's lien); *see also* MATTHIESEN, WICKERT & LEHRER, S.C., *supra* note 87, at 28 (distinguishing Vermont's statute as unique, even amongst other state statutes that grant priority statute to attorney's liens).

[93] MATTHIESEN, WICKERT & LEHRER, S.C., *supra* note 87, at 2. States that grant priority to medical provider liens over attorney liens include California, Colorado, Connecticut, Delaware, New Hampshire, and New Jersey. *Id.* Virginia's statute has perhaps the most severe limitation on recovery for medical lienholders, limiting hospital lien recoveries to $2,500, regardless of what the plaintiff owes the provider. VA. CODE ANN. § 8.01-66.2.

C. Common Fund Doctrine and Its Roots in Equity

The American Rule holds that, unless exceptional circumstances apply, litigants pay their own legal expenses.[94] The Doctrine presents one such exceptional circumstance, providing an opportunity for plaintiffs to avoid taking on their own attorney's fees where equity considerations demand it by imposing a proportional sharing requirement on all other claimants to the plaintiff's settlement award.[95] Litigants have used the Doctrine for well over a century, and currently the Doctrine most commonly applies to class action suits.[96]

A class action proceeding provides a traditional, rational context for use of the Doctrine because a class action pursues a judgment or settlement on behalf of more than one plaintiff.[97] Proponents of using the Doctrine outside the class action context assert that strict adherence to the American Rule in other circumstances might result in some claimants enjoying the benefits of a judgment or settlement, while others bear all of the risk and all of the legal fees required to obtain it.[98] Use of the Doctrine finds a foothold in these situations on fairness or unjust enrichment grounds because a third-party claimant's receipt of settlement funds without assuming the risks of a lawsuit or contributing to litigation costs can substantially disadvantage the plaintiff.[99]

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[94] *See* Ellison, *supra* note 12, at 316 (citing Morris B. Chapman & Assocs., Ltd. v. Kitzman, 739 N.E.2d 1263, 1271 (Ill. 2000)) (discussing the American Rule). The American Rule also stipulates that litigants cannot ordinarily receive attorney's fees as damages from the opposing party. *Id.* Exceptions apply where a fee-shifting statute governs or where contract provisions shift attorney's fees. *Id.*

[95] *Id.*

[96] *See id.* at 314–15 (providing a brief history of the Doctrine and its use within the context of litigation).

[97] *See id.* (identifying the Doctrine's purpose of avoiding the scenario where many parties benefit from a judgment or settlement, but few pay the legal costs necessary to obtain it).

[98] *See id.* at 315 (providing insurance subrogation cases and wrongful death lawsuits as two examples outside the class action context where litigants have used the Doctrine).

[99] *See id.* at 321 (providing the elements of unjust enrichment, as defined by the Illinois Supreme Court, to argue that such a scenario meets the practical definition of the term). The elements of unjust enrichment identified by the Illinois Supreme Court are: "(1) [a non-paying party] receives a benefit (2) to [a paying party's] detriment, and (3) the [non-paying party's] retention of that benefit violates the principles of justice, equity, and good conscience." *See id.* (referencing the Illinois Supreme Court's reasoning in *HPI Health Care Services, Inc. v. Mt. Vernon Hospital, Inc.*, 545 N.E.2d 672, 679 (Ill. 1989)). The *Martinez* court aptly distinguishes fairness from unjust enrichment in this context. *See* Martinez v. St. Joseph Healthcare Sys., 871 P.2d 1363, 1366–67 (N.M. 1994) (noting that the court did not view the instant case as engaging an unjust enrichment issue, but rather one of fairness). The unjust enrichment argument focuses on the gain the medical lienholder realizes from the work of the plaintiff's attorney and asserts that it is unjust for the lienholder to enjoy that gain without compensating for it. *See id.* (discussing how the defendant in *Martinez* cited to cases that held that the lienholder's gain was attendant to an attorney's duties to their client, and identifying such as unjust enrichment arguments). Contrastingly, the fairness argument focuses on the risk the plaintiff takes on in deciding to sue the tortfeasor, and maintains that it is improper for the plaintiff to assume all of the risk, but share the award. *See id.* at 1366–68 (discussing the role of risk in the assessment of fairness and holding that fairness dictates that lienholders should contribute a share of the plaintiff's legal fees). To summarize the difference another way, the fairness argument pivots on the process by which

In considering whether to apply the Doctrine in tort settlements, courts have endeavored to determine whether the position of medical lienholders in such proceedings is comparable to that of class action plaintiffs.[100] If it is, then the rationale for applying the Doctrine in class actions should also justify the Doctrine's use in tort settlements.[101] If it is not, then plaintiffs petitioning courts to force medical lienholders to contribute a proportionate share of attorney's fees must find another basis for their argument.[102]

Notably, many courts have determined that medical lienholders in tort settlements are in a different position than class action plaintiffs.[103] These courts reason that a medical lienholder does not receive a benefit from the plaintiff's attorney securing a tort settlement because the medical lienholder's right to payment arises from the service contract executed between the plaintiff and the medical provider at the time of the plaintiff's treatment.[104] Consequently, the medical provider and plaintiff are in a creditor-debtor relationship, under which the medical provider retains a right to payment whether or not the plaintiff receives a tort settlement.[105] Thus, courts often decline to apply the Doctrine in tort settlements.[106] Courts hold that because the plaintiff's attorney

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the provider seeks to recover the debt; the unjust enrichment argument focuses on the interplay between the attorney, the plaintiff, and the provider, and whether the contractual obligation the plaintiff has to the provider precludes the attorney from conferring any kind of gain on the provider stemming from the attorney's own contractual obligation to the plaintiff. *See* Schulte, *supra* note 16, at 1783 (summarizing the *Martinez* court's approach to the issue).

[100] *See, e.g.*, Bryner v. Cardon Outreach, L.L.C., 2018 UT 52, 428 P.3d 1096, 1103 (holding that a hospital and a plaintiff are engaged in a creditor-debtor relationship due to the contract formed between the two parties at the time the plaintiff received treatment).

[101] *See Martinez*, 871 P.2d at 1366–67 (holding that the work of the plaintiff's attorney in securing a settlement effectuates the medical provider's lien, permitting the provider to seek reimbursement from a fund rather than from the patient directly; this characterizes the provider's position more closely to a class claimant than to a traditional creditor).

[102] *See Bryner*, 428 P.3d at 1098 (discussing the argument that the correct interpretation of the language of Utah's hospital lien statute imposes a proportionate sharing requirement for the plaintiff's legal expenses); Ellison, *supra* note 12, at 321 (arguing that even if the relationships are not comparable, unjust enrichment could still exist).

[103] *See, e.g.*, Wendling v. S. Ill. Hosp. Servs., 950 N.E.2d 646, 651 (Ill. 2011) (distinguishing a medical lienholder in a tort settlement from a class plaintiff on the basis that the lienholder lacks standing to sue); *Bryner*, 428 P.3d at 1103 (holding that the Doctrine does not apply to a medical lienholder because, as a creditor, the medical provider has a right to payment independent of the plaintiff's pursuit of a tortfeasor and the medical provider has recourse for collecting its debt other than filing a lien); Lynch v. Deaconess Med. Ctr., 776 P.2d 681, 684 (Wash. 1989) (illustrating the court's characterization of the plaintiff as a debtor and the medical lienholder as a creditor and providing the court's refusal to extend the Doctrine to such an association).

[104] *Bryner*, 428 P.3d at 1103.

[105] *Id.*

[106] *Id.*

provides medical lienholders no real benefit, it cannot be the case that medical lienholders owe a proportionate share of the plaintiff's attorney's fees.[107]

II. Pros and Cons: Case Law, Academia, and the Arguments Framing the Debate

Most courts have disallowed use of the Doctrine to impose mandatory reductions of medical liens in tort settlements, though some courts have applied the Doctrine in such a way.[108] Section A of this Part discusses the arguments in favor of applying the Doctrine to compel medical providers to contribute a proportionate share to attorney's fees and why many courts have rejected them.[109] Section B provides the contrary position by illustrating the rationale of courts that held the Doctrine should apply in such scenarios.[110] Section C discusses recent academic considerations of the Doctrine and the arguments made in favor of expanding its usage to tort settlement contexts.[111]

A. The Majority Position: It Is Inappropriate to Apply the Doctrine to Compel Medical Lienholders to Reduce Their Liens

Many state courts have heard the issue of whether to apply the Doctrine to impose automatic reductions of medical liens to assist plaintiffs in paying for attorney's fees.[112] A substantial majority have declined to impose the Doctrine for such purposes.[113] In rendering a holding, each court has considered some combination of three principal factors plaintiffs use to argue that the court should apply the Doctrine: (1) construction of the relevant lien statute;

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[107] *See id.* (holding that because the hospital's right to payment derives from a service contract executed at the time of treatment, the hospital is not reliant on the attorney's securing of a settlement in order to collect on the patient's debt).

[108] *See, e.g.*, Martinez v. St. Joseph Healthcare Sys., 871 P.2d 1363, 1366 (N.M. 1994) (discussing many cases in several states rejecting the idea that medical lienholders should contribute to plaintiffs' attorney's fees and breaking with those states in holding that medical lienholders in New Mexico must do so).

[109] *See infra* notes 112–135 and accompanying text.

[110] *See infra* notes 136–150 and accompanying text.

[111] *See infra* notes 151–159 and accompanying text.

[112] *See* Wendling v. S. Ill. Hosp. Servs., 950 N.E.2d 646, 649–50 (Ill. 2011) (providing an extensive, though not exhaustive, list of cases, from seventeen different states, exploring the issue of applying the Doctrine to hospital liens within a tort settlement context).

[113] *See id.* (illustrating the Supreme Court of Illinois's agreement with many other states that medical lienholders are distinguishable as claimants in a tort action, as courts do not compel them to contribute to the plaintiff's legal costs, even if the medical lienholder benefits from the efforts of the plaintiff's retained counsel); *see also* Yaeger v. City of Lincoln (*In re* Guardianship & Conservatorship of Bloomquist), 523 N.W.2d 352, 358–59 (Neb. 1994) (noting that courts generally do not permit use of the Doctrine to reduce medical liens, and hold that standard because medical providers have a creditor-debtor relationship with the plaintiffs of pending tort settlements).

(2) unjust enrichment stemming from implied-in-fact contracts and quantum meruit; and (3) subrogation rights in tort settlements.[114]

1. Statutory Construction of State Medical Provider Lien Laws

In statutory lien states, courts have often evaluated statutory construction to determine whether lawmakers intended for courts either to impose automatic reductions of medical liens to guarantee proportionate sharing of plaintiffs' attorney's fees, or to apply the Doctrine to do so.[115] Although medical lien statutes are generally silent on the Doctrine, courts consider two conventional lien statute attachment provisions to divine legislative intent regarding reductions of medical liens.[116] First, courts reference the governing statutory attachment language to determine whether the law already limits the portion of an injured plaintiff's settlement that a medical lien may recover.[117] Where a lien statute prohibits medical liens from securing payment equal to the medical provider's total billed charges, courts have permitted no additional forced re-

[114] *See Yaeger*, 523 N.W.2d at 357–58 (providing a brief explanation of the lack of homogeneity amongst multiple state lien statutes); Martinez v. St. Joseph Healthcare Sys., 871 P.2d 1363, 1366 (N.M. 1994) (providing a list of cases in various states that dealt with issues of unjust enrichment, implied contracts, and subrogation rights). Precisely defined, quantum meruit is either: (1) "The reasonable value of services; damages awarded in an amount considered reasonable to compensate a person who has rendered services in a quasi-contractual relationship"; (2) "A claim or right of action for the reasonable value of services rendered"; (3) "At common law, a count in an assumpsit action to recover payment for services rendered to another person"; (4) "A claim for the market value of a party's performance under an implied-in-fact contract or an express contract that does not specify a price"; or, (5) "A claim for the value of benefits provided without a contract, as when the plaintiff brings a claim for restitution and that value provides the measure of recovery." *Quantum Meruit*, BLACK'S LAW DICTIONARY, *supra* note 18. For a discussion of subrogation within the context of liability insurance settlements, see *supra* note 18 and accompanying text.

[115] *See Martinez*, 871 P.2d at 1365 (illustrating the court's methodology in first evaluating whether the New Mexico Hospital Lien Act provides any guidance regarding how a tort settlement must resolve legal costs, including attorney's fees). For example, in *Martinez v. St. Joseph Healthcare System*, the court noted that the state Hospital Lien Act does not specifically indicate whether medical providers must reduce their liens to pay a proportionate share of plaintiffs' attorney's fees. *Id.* As a result, the court felt free to evaluate the idea as a matter of policy. *See id.* (quoting Torrance Cty. Mental Health Program, Inc. v. N.M. Health & Env't Dep't, 830 P.2d 145, 150 (N.M. 1992)) (indicating that the lack of a statutory requirement authorized the court to use its own judgment).

[116] *See, e.g.*, Harlow v. Lloyd, 809 P.2d 1228, 1231 (Kan. Ct. App. 1991) (identifying the provision of a medical lien statute that identifies the portion of an injured plaintiff's settlement against which medical liens actually attach as an indication of legislative intent regarding lien reductions); *Martinez*, 871 P.2d at 1365–66 (identifying a medical lien statute's establishment of a cap on the amount a medical lien can recover from a settlement, regardless of what the injured plaintiff actually owes the medical provider, as indicative of the legislature's opinion on when, and to what extent, a medical provider must reduce its lien).

[117] *See, e.g.*, *Martinez*, 871 P.2d at 1365–66 (noting that because Illinois and Kansas, for example, established hard caps in their respective lien statutes, their legislatures likely did not want other factors, such as the Doctrine, to impose additional reductions of medical liens).

ductions to medical liens.[118] Second, courts look to the attachment language of medical lien statutes to determine to which portion of the plaintiff's pending tort settlement a medical lien attaches; specifically, courts must determine if a lien attaches to the entire settlement or only to the portion that remains after the plaintiff's attorney deducts legal fees.[119] Where such language exists, courts have held that lawmakers intended the relevant provisions to establish a priority system for competing lien claimants, rather than mandatory reductions of medical liens.[120]

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[118] *See, e.g.*, Maynard v. Parker, 387 N.E.2d 298, 300 (Ill. 1979) (illustrating that the court found the inclusion of a recovery cap in the Illinois Hospital Liens Act determinative in holding that the Doctrine does not apply to medical liens); *see also* Wendling v. S. Ill. Hosp. Servs., 950 N.E.2d 646, 649 (Ill. 2011) (noting the role of the cap in the *Maynard* court's earlier decision to reject use of the Doctrine). Even courts that have authorized the use of the Doctrine to impose reductions on medical liens have hinted that they would not have done so if the medical lien statutes of their states included a limit upon the amount of a tort settlement that medical liens may recover. *See Martinez*, 871 P.2d at 1366 (noting that the court felt a review of whether use of the Doctrine in a medical lien context was necessary because New Mexico, unlike other states whose courts have considered the same question, does not have a medical lien statute that imposes a limit on medical lien recoveries).

[119] *See, e.g.*, Bryner v. Cardon Outreach, L.L.C., 2018 UT 52, 428 P.3d 1096, 1102 (providing the court's interpretation that the Utah hospital lien statute's attachment language establishes that hospital liens attach to the portion of the plaintiff's settlement that remains *after* the plaintiff's attorney takes their fee; thus, the language engages issues of priority rather than issues of lien reductions). These medical lien statute provisions often seek to impose priority rules vis-à-vis attorney liens and medical provider liens but do so in a way that opens up the possibility of statutorily-endorsed reductions of medical liens. *See id.* at 1098 (demonstrating the need for the court to determine whether the Utah hospital lien statute's attachment language establishes priority for attorney liens or whether it requires medical lienholders to reduce their liens in order to contribute a share of plaintiffs' legal fees); *see also Harlow*, 809 P.2d at 1231 (illustrating the need for the court to examine the same alleged ambiguity within the Kansas statute). Utah's medical lien statute provides a clear example of how the statutory language can obfuscate legislative intent within the statute's attachment rules. *See Bryner*, 428 P.3d at 1098 (demonstrating how two interpretations of the Utah statute's attachment provision can produce either a priority rule or an automatic pro-rata reduction of medical liens to contribute to attorney's fees). The Utah statute provides that medical providers may declare a lien against the injured plaintiff's tort settlement, minus whatever amount the plaintiff pays in legal fees. *See id.* at 1099–1100 ("[A] hospital . . . is entitled to assert a lien upon that portion of the judgment . . . going or belonging to the patient . . . less the amount paid by the patient . . . for attorney fees . . . incidental to obtaining the judgment . . . .") (quoting UTAH CODE ANN. § 38-7-1 (West 2018)). Plaintiffs have contended that this language requires medical lienholders to reduce their liens in order to contribute a fair portion of the plaintiffs' attorney's fees. *Id.* at 1098. The Supreme Court of Utah has disagreed, holding that the plain language of the provision establishes only that medical providers may assert liens against whatever portion of the injured plaintiff's tort settlement remains after the plaintiff's attorney takes legal fees. *See id.* at 1102 (providing the court's interpretation, augmented by additional statutory language, that establishes that medical liens are not subject to any other forced reduction).

[120] *See, e.g.*, *Harlow*, 809 P.2d at 1231 (holding that the law rarely compensates the unsecured portion of a lienholder's claim by granting it portions of a fully-secured lienholder's recovery). The court in *Harlow v. Lloyd* utilized a pie analogy to illustrate a conventional legal analysis on lienholder priority disputes. *Id.* In deference to the analogy, the court noted that claimants who receive a whole slice of pie do not typically also receive portions of those who do not. *See id.* (noting the difference between being the first claimant to receive a payout and receiving full reimbursement by taking portions of the shares of other claimants). The court explained that the Kansas medical lien statute, in permitting medical providers to assert liens against an injured plaintiff's tort settlement so long as the

2. Unjust Enrichment and Quantum Meruit

Plaintiffs emphasize the need for courts to apply the Doctrine to impose automatic reductions of medical liens to prevent medical lienholders from enjoying unjust enrichment.[121] Broadly defined, unjust enrichment occurs whenever one party retains something of value, at the expense of another party, without providing compensation for it.[122] In applying the Doctrine to impose reductions of medical liens in tort settlements, unjust enrichment is the damage principle underlying a claim of quantum meruit.[123] Claims of quantum meruit require, on the facts, that the defendant receive something of value from the plaintiff, for which the defendant had reason to believe the plaintiff expected remuneration or other reimbursement.[124]

Plaintiffs seeking to impose medical lien reductions on claims of quantum meruit frequently argue that the efforts of the plaintiffs' attorneys in settling tort cases benefit medical providers.[125] Yet if medical providers collect the full amounts of their liens, they fail to offer reimbursement for the attorney's services.[126] Courts that have considered this argument have rejected it.[127] These

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medical liens do not obstruct the fee arrangement the plaintiff constructs with their attorney, merely establishes that attorney liens enjoy priority to medical liens in tort settlements. *See id.* (noting that the system of priority was what the legislature envisioned when it wrote the statute). Further, the court held that a medical lienholder simply receiving its statutorily authorized share without reducing for attorney's fees does not constitute a hindrance to the plaintiff's fee arrangement with their lawyer. *See id.* (noting that the establishment of the attorney's fees as having priority over medical liens provides sufficient safeguarding of the plaintiff-attorney contract).

[121] *See, e.g.*, Bashara v. Baptist Mem'l Hosp. Sys., 685 S.W.2d 307, 310 (Tex. 1985) (illustrating the theory that medical lienholders receiving full payment on their liens without contributing to plaintiffs' attorney's fees results in inequitable recovery).

[122] *See* Hayden v. Medcenter One, Inc., 2013 ND 46, 828 N.W.2d 775, 781 (citing Zuger v. N.D. Ins. Guar. Ass'n, 494 N.W.2d 135, 138 (N.D. 1992)) (providing the primary components of unjust enrichment claims). Where a plaintiff asserts unjust enrichment realized by a defendant, a court looks for several elements. *Id.* The facts must present the defendant's receipt of a benefit, at the expense of another, without rationalization of either the benefit or the expense and with equity as the only available remedy. *See id.* (providing the elements of an unjust enrichment claim). For a comprehensive definition of unjust enrichment, see *supra* note 38 and accompanying text.

[123] *See Hayden*, 828 N.W.2d at 781 (explaining that unjust enrichment requires a claim of one party against another for reimbursement but without a contract, either express or implied).

[124] *See Bashara*, 685 S.W.2d at 310 (quoting City of Ingleside v. Stewart, 554 S.W.2d 939, 943 (Tex. Civ. App. 1977)) (providing the essential elements of a quantum meruit claim); *see also supra* note 114 and accompanying text (providing a comprehensive definition of quantum meruit).

[125] *See, e.g.*, *Bashara*, 685 S.W.2d at 310 (providing an example of a plaintiff's quantum meruit claim against a medical lienholder for services the plaintiff's attorney provided in securing the plaintiff's tort settlement).

[126] *See id.* (illustrating a plaintiff's claim that the defendant medical provider received unjust enrichment by not contributing to the plaintiff's attorney's fees). These fact patterns often compare the facts with the hypothetical scenario of the medical provider having to pay attorney's fees had the medical provider, instead of the plaintiff, hired the attorney to settle the tort claim. *See, e.g.*, *id.* (noting that such a hypothetical is at least facially understandable).

[127] *See, e.g.*, *id.* (illustrating that a hospital recovering the amount of its lien does not meet the elements of a claim in quantum meruit).

courts reasoned that the plaintiff bears the responsibility for paying for the attorney's services because it was the plaintiff, not medical lienholders, who retained the attorney under contract.[128] Any benefit that medical lienholders receive is merely attendant to the attorney's satisfaction of contractual obligations.[129]

3. Subrogation Rights in Tort Settlements

Finally, courts have considered whether the rights of medical lienholders in tort settlements should mirror those of subrogees or those of creditors.[130]

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[128] *See id.* (quoting Sisters of Charity of Providence of Mont. v. Nichols, 483 P.2d 279, 283 (Mont. 1971)). There are four principal components to a claim of quantum meruit. *See id.* (quoting *City of Ingleside*, 554 S.W.2d at 943) (setting out the components of a quantum meruit claim). First, there must be something of value, whether goods or services. *Id.* Second, the plaintiff in the quantum meruit claim must have produced the items or services of value for the benefit of the person the claim pursues for payment. *Id.* Third, the person the claim pursues for payment must have taken delivery of and utilized the item or service of value. *Id.* Fourth, the person the claim pursues for payment must have had reasonable notice that the plaintiff anticipated compensation in return for providing the items or services of value. *Id.* Most courts have held that quantum meruit claims fail in the case of medical provider liens because the medical provider is not the person the claim pursues for payment. *See, e.g.*, *id.* (noting that although the attorney's efforts support a medical provider's recovery of the amount secured via its lien, it is the injured tort plaintiff, the medical provider's patient, and not the medical provider itself, that is the person owing charges for the attorney's rendered services). Instead, these courts have held that it is the injured plaintiffs who contract to retain the attorneys, and it is not proper for the plaintiffs to impart their responsibility to pay the attorneys onto another claimant to the tort settlement. *See id.* (quoting Landman v. State, 97 S.W.2d 264, 265 (Tex. Civ. App. 1936)) (noting that the law does not provide recourse for litigants to pass their contractual obligations to pay their attorney's fees onto another party that benefits from the attorney's work); *see also* Broadlawns Polk Cnty. Hosp. *ex rel.* Fenton v. Estate of Major, 271 N.W.2d 714, 716 (Iowa 1978) (quoting Lamar v. Hall & Wimberley, 129 F. 79, 84 (5th Cir. 1904)) (first citing Grimball v. Cruse, 70 Ala. 534, 544 (1881); and then citing Roselius v. Delechaise, 5 La. Ann. 481, 482 (1850)) (noting the customary principle that an implied-in-fact compensation agreement does not exist between a settlement claimant and an attorney the claimant did not hire just because the claimant received value from the attorney's work). Had the medical provider retained the attorney, not the tort plaintiff, a claim of quantum meruit would be appropriate. *See Bashara*, 685 S.W.2d at 310 (noting that a hospital would surely owe the tort plaintiff's attorney a fee had the hospital hired the attorney to recover on the hospital's lien).

[129] *See Bashara*, 685 S.W.2d at 310 (holding that the advantages a medical provider enjoys in a tort settlement as a result of the services of the tort plaintiff's attorney are insufficient to maintain responsibility of the medical provider to pay a portion of the attorney's fees). Courts rendering this holding note that the fact that resolution of the tort plaintiff's debts, for which the tort plaintiff hired the attorney, does not impose an implied-in-fact contract between the attorney and medical lienholders. *See id.* (quoting *Sisters of Charity*, 483 P.2d at 283) (citing *Broadlawns*, 271 N.W.2d at 716) (noting that the contract between the attorney and the tort plaintiff required the attorney to collect on medical liens, but that obligation does not indebt medical lienholders to the attorney).

[130] *See* Maynard v. Parker, 387 N.E.2d 298, 300 (Ill. 1979) (characterizing the relationship between the tort plaintiff and the medical provider as being that of a debtor and a creditor); Harlow v. Lloyd, 809 P.2d 1228, 1231 (Kan. Ct. App. 1991) (noting the distinction between subrogor-subrogee arrangements and the relationship that exists between a medical provider and a patient it treated); *Bashara*, 685 S.W.2d at 310 (implying that, because the tort plaintiff and medical lienholders do not stand on even footing within a tort settlement, the medical providers occupy the role of a creditor, not that of a subrogee); Lynch v. Deaconess Med. Ctr., 776 P.2d 681, 684 (Wash. 1989) (noting that many courts have considered the forced reduction of medical liens to pay for plaintiffs' attorney's fees as an

Common law tradition holds that a subrogee, because it stands in the shoes of a subrogor in the settlement, assumes a proportionate share of the legal costs incurred to secure a financial award.[131] Courts do not impose the same liability on creditors in a tort action, because a creditor's right to payment from the tort plaintiff debtor exists independently of whether the tort plaintiff receives a financial award.[132] Courts have considered how to characterize a medical

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output of equitable remedies). For a detailed discussion of subrogation in the tort settlement context, see *supra* note 18 and accompanying text. In a subrogation, a replacement claimant (the subrogee) assumes the position of an original claimant (the subrogor) against a settlement, often by paying a debt on the original claimant's behalf, either in part or in full. *Subrogee*, BLACK'S LAW DICTIONARY, *supra* note 18; *Subrogor*, BLACK'S LAW DICTIONARY, *supra* note 18.

[131] *See, e.g.*, *Ex parte* State Farm Mut. Auto. Ins. Co., 118 So. 3d 699, 708 (Ala. 2012) (noting that many jurisdictions have held that a subrogee should pay a proportionate share of the attorney's fees necessary to secure a tort plaintiff's settlement, unless the plaintiff and the subrogee had agreed otherwise). The decision to impose liability for a share of plaintiffs' attorney's fees upon subrogees is due, at least in part, to subrogation's roots in equity. *See id.* at 704 (noting that subrogation is the process by which an insurance plan that issued payment on behalf of its injured subscriber seeks reimbursement from a tortfeasor). There is an obvious ideological parallel between the subrogation process and the application of the Doctrine. *See id.* (invoking the language "ought to bear" in describing a subrogee's pursuit of a tortfeasor—language that is also commonly found in arguments for applying the Doctrine for proportionate sharing purposes); Martinez v. St. Joseph Healthcare Sys., 871 P.2d 1363, 1366–67 (N.M. 1994) (holding that medical providers that recoup their debts from a tort settlement have an equity-based obligation to pay a share of plaintiffs' attorney's fees). Given that subrogation is so innately tied to equitable principles, and given that a subrogee's right to payment frequently actualizes because of the injured plaintiff's attorney's efforts to create a settlement, courts impose obligatory contributions to the attorney's fees upon subrogees where a case meets the elements of the Doctrine. *See Ex parte State Farm*, 118 So. 3d at 704–05 (first citing Gov't Emps. Ins. Co. v. Capulli, 859 So. 2d 1115, 1127 (Ala. Civ. App. 2002), and then citing Blue Cross & Blue Shield of Ala. v. Freeman, 447 So. 2d 757, 760 (Ala. Civ. App. 1983) (discussing similar historical holdings from Alabama courts). The elements are: (1) formation of a common fund; and (2) a subrogee's receipt of gain due to the efforts of the plaintiff's attorney. *See id.* at 708 (identifying the analysis the court used to determine whether to apply the Doctrine). If the facts satisfy these elements, a court may require a subrogee to share in paying the plaintiff's attorney's fees except where the subrogee itself contributed to creation of the common fund. *See id.* at 709 (citing *Blue Cross*, 447 So. 2d at 759–60) (noting the lack of justification for applying the Doctrine if the subrogee itself participated in generating the settlement, as opposed to relying on the plaintiff's attorney to do so).

[132] *See, e.g.*, Wendling v. S. Ill. Hosp. Servs., 950 N.E.2d 646, 651–52 (Ill. 2011) (holding that hospital lienholders do not have to pay a proportionate share of attorney's fees because of their status in the tort settlement as a creditor). Illinois case law provides a comprehensive examination of the different responsibilities of creditors and subrogees to contribute to attorney's fees because the Supreme Court of Illinois reversed the Appellate Court on the issue. *See id.* (providing the Supreme Court of Illinois's holding that the Appellate Court was mistaken when it expanded the Doctrine to cover hospital lienholders). The Appellate Court noted that creditors and subrogees are characteristically different because their rights to payment derive from different sources. *See* Howell v. Dunaway, 924 N.E.2d 1190, 1195 (Ill. App. Ct. 2010) (citing Maynard v. Parker, 387 N.E.2d 298 (Ill. 1979)) (distinguishing the payment responsibilities of debtors and subrogors), *rev'd sub nom.* Wendling v. S. Ill. Hosp. Servs., 950 N.E.2d 646 (Ill. 2011). Subrogees in tort settlements have a right to payment only if a settlement agreement between the plaintiff and the tortfeasor generates a common monetary fund. *Id.* Contrastingly, creditors in tort settlements have a right to payment whether or not the plaintiff and the tortfeasor ever reach settlement. *Id.* Thus, traditional consideration of the applicability of the Doctrine holds that subrogees pay a proportionate share of attorney's fees because their rights to

lienholder in a tort action, either as a subrogee or a creditor.[133] Several of those courts have ruled that medical lienholders are best classified as creditors.[134] Under that finding, a majority of courts have held that medical lienholders are

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reimbursement flow from the creation of a settlement, whereas creditors do not pay for attorney's fees because their rights to payment do not. *See id.* (providing the conventional view that a subrogee's gain from the settlement is "direct" and a creditor's is "incidental"). The Appellate Court broadened the applicability of the Doctrine by holding that there exists a distinction between a traditional creditor and a lienholder. *See id.* (establishing that within a tort action, a creditor and a lienholder are two separate classes of party). To the Appellate Court, there are two fundamental characteristics of a lienholder that distinguishes it from a normal creditor. *Id.* First, a lienholder's primary purpose in settlement proceedings is to foreclose on a lien, not resolve a debt; second, a hospital lien, by statute, has no binding effect absent a settlement. *See id.* (noting that these two characteristics cause the lienholder to enjoy a benefit from the settlement that is more akin to the direct gain of a subrogee than to the incidental gain of a creditor). The Supreme Court of Illinois disagreed, holding that regardless of the settlement's role in providing liens with legal weight, the lienholder does not have a private right of action against the party responsible for causing the plaintiff's injuries. *Wendling*, 950 N.E.2d at 651. Further, the Supreme Court of Illinois held that the Appellate Court's characterization of lienholder rights being more like those of subrogees than creditors did not change the fact that plaintiffs' attorneys work to create settlements for plaintiffs, not for the group of parties that may have a claim to settlement proceeds. *Id.* at 652.

[133] *See, e.g.*, *Wendling*, 950 N.E.2d at 651–52 (providing the Illinois Supreme Court's methodology in distinguishing medical lienholders as creditors as opposed to subrogees); *Bashara*, 685 S.W.2d at 310 (holding that a medical lienholder is a creditor because the lien stems from a contract for services with the injured plaintiff, and because the lienholder does not have even footing with the plaintiff in the tort action); Bryner v. Cardon Outreach, L.L.C., 2018 UT 52, 428 P.3d 1096, 1103 (illustrating the Utah Supreme Court's reasoning in holding that medical lienholders are creditors); *Lynch*, 776 P.2d at 684 (following *Maynard* in holding that a medical lienholder is a creditor).

[134] *See, e.g.*, *Maynard*, 387 N.E.2d at 300 (providing an early designation, which many subsequent courts have followed, of medical lienholders as creditors in tort proceedings); *Bryner*, 428 P.3d at 1103 (illustrating the classification of medical lienholders as creditors as the Utah Supreme Court examined use of the Doctrine in tort settlement contexts in 2018). There are three commonly cited rationales for classifying medical lienholders as creditors within the context of a liability settlement. *See Maynard*, 387 N.E.2d at 300 (providing the contract rationale); *Bashara*, 685 S.W.2d at 310 (providing the equity of position rationale); *Wendling*, 950 N.E.2d at 651 (providing the attendant gain rationale). First, there is the rationale that medical lienholders are creditors because their right to payment derives from a contract for services injured patients complete prior to discharge from medical treatment. *See Maynard*, 387 N.E.2d at 300 (noting that injured plaintiffs owe a debt to treating medical providers whether or not the plaintiff secures a damage award from the tortfeasor). Second, there is the rationale that medical lienholders are creditors because they cannot directly sue the tortfeasor to enforce their right to payment; instead, they can only foreclose their liens against their debtor—the plaintiff. *See Bashara*, 685 S.W.2d at 310 (noting that the plaintiff alone has a private right of action against the tortfeasor, and medical lienholders merely have a right of payment against the plaintiff). Third, there is the rationale that medical lienholders must be creditors because they do not straightforwardly gain from the work of the plaintiff's attorney, given that the settlement is merely one option for the medical provider to collect the debt the injured plaintiff owes. *See Wendling*, 950 N.E.2d at 651 (noting that the plaintiff's debt to the medical provider exists regardless of whether the plaintiff receives a tort settlement, and that the medical provider may continue to collect from the injured plaintiff for outstanding balances that remain even after satisfaction of the lien).

not obligated to reduce their liens to pay a proportionate share of the legal fees and costs the plaintiff debtor incurred to render the tort settlement.[135]

B. The Minority Position: Courts Should Apply the Doctrine to Compel Medical Lienholders to Reduce Their Liens

Despite a strong majority of jurisdictions holding that it is inappropriate to apply the Doctrine to compel medical providers to contribute a proportionate share of plaintiffs' attorney' fees in tort settlements, a minority of courts have disagreed and held otherwise.[136] These courts have generally cited equity and policy concerns in favor of applying the Doctrine.[137] Principally, the minority view grants considerable weight to two specific points in determining the arbiter of the issue on the appropriate use of the Doctrine: the significance of the plaintiff's attorney's work to the lienholder, and the significance of a medical provider's decision to collect on its debt by filing a lien.[138]

First, the minority view has disagreed with the majority that medical lienholders enjoy only an attendant advantage from the work of the injured plaintiff's attorney.[139] By statute, a medical lien requires the existence of a tort

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[135] *See, e.g.*, *Wendling*, 950 N.E.2d at 648, 652 (following the court's own decision in *Maynard* in refusing to apply the Doctrine to medical lienholders because they are creditors of the injured plaintiff); *Bryner*, 428 P.3d at 1103 (holding that a medical lienholder is not liable for any portion of the injured plaintiff's attorney's fees because, as a creditor, the hospital's right to payment exists independently of the tort settlement and the hospital can foreclose on that right independently of the injured plaintiff's actions against the tortfeasor).

[136] *See* Alaska Native Tribal Health Consortium v. Settlement Funds Held for or to Be Paid on Behalf of E.R. *ex rel.* Ridley, 84 P.3d 418, 434–35 (Alaska 2004) (providing the Alaska Supreme Court's justification of the minority view); Yaeger v. City of Lincoln (*In re* Guardianship & Conservatorship of Bloomquist), 523 N.W.2d 352, 360 (Neb. 2004) (providing the Nebraska Supreme Court's justification of the minority view); *Martinez*, 871 P.2d at 1367 (providing the New Mexico Supreme Court's justification of the minority view).

[137] *See, e.g.*, *Alaska Native*, 84 P.3d at 434–35 (quoting *Martinez*, 871 P.2d at 1367) (following the *Martinez* court's equity and policy rationales); *Martinez*, 871 P.2d at 1367 (illustrating the New Mexico Supreme Court's concern that allowing a medical lienholder to enjoy the fruits of the plaintiff's attorney's labor without contributing to the costs to retain the attorney is both inequitable and contrary to the public policy of the State).

[138] *See Martinez*, 871 P.2d at 1366 (supporting the need for medical lienholders to contribute to attorney's fees by asserting that medical liens are dependent on the work of plaintiff's attorneys to properly attach and effectuate); *see also Yaeger*, 523 N.W.2d at 360 (supporting the need for medical lienholders to contribute to attorney's fees by asserting that the work of the plaintiff's attorney is what makes the debt actually collectible via the lien process).

[139] *See Martinez*, 871 P.2d at 1367 (illustrating the New Mexico Supreme Court's disagreement that the advantages medical lienholders receive on account of plaintiffs' attorneys' work is merely negligible or ancillary). *But see Bashara*, 685 S.W.2d at 310–11 (quoting Maynard v. Parker, 369 N.E.2d 352, 355 (Ill. App. Ct. 1977), *aff'd*, 387 N.E.2d 298 (Ill. 1979)) (providing the majority view that the injured plaintiff hires an attorney to resolve a claim against the tortfeasor, and that any benefit claimants to the tort settlement receive are simply supplementary results of the attorney's principal objective).

settlement in order to attach.[140] Therefore, the efforts of the plaintiff's attorney to generate a settlement are essential to the effectiveness of the lien.[141] Consequently, the minority view holds that it is erroneous to classify the attorney's work as merely incidental to the medical provider.[142] As such, the medical provider should contribute a proportionate share to the payment of the attorney's fees.[143]

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[140] *See, e.g.*, COLO. REV. STAT. ANN. § 38-27-101(4) (West 2021) (establishing that medical provider liens in Colorado attach to the plaintiff's personal injury settlement); 770 ILL. COMP. STAT. 23/10(a) (2020) (demonstrating same in Illinois); N.M. STAT. ANN. § 48-8-1(A) (2020) (demonstrating same in New Mexico); UTAH CODE ANN. § 38-7-1(1)(a) (West 2018) (establishing same in Utah).

[141] *See Martinez*, 871 P.2d at 1367 (noting that without the tort settlement, the medical lien fails the statutory attachment requirements, rendering it useless as a debt collection device). Viewing the relevant hospital lien attachment requirements in context, the New Mexico statute explicitly establishes that hospital liens in the state attach to settlement proceeds, not to the personal property of the injured plaintiff debtor. *See* N.M. STAT. ANN. § 48-8-1(A)–(B) ("Every hospital located within the state . . . is entitled to assert a lien upon that part of the judgment, settlement or compromise going, or belonging to such patient . . . . A hospital lien may be filed upon damages recovered, or to be recovered, either as a result of a judgment, or upon a contract of settlement or compromise . . . ."). The point is not unique to New Mexico, as the language of the New Mexico statute has close parallels within the medical lien statutes of other states. *Compare id.* (providing the attachment provision for hospital liens in New Mexico), *with* UTAH CODE ANN. § 38-7-1 ("[A] hospital located within the state . . . is entitled to assert a lien upon that portion of the judgment, settlement, or compromise going or belonging to the patient . . . .").

[142] *See Martinez*, 871 P.2d at 1367 (holding that because medical liens attach to a settlement, and because a plaintiff's attorney obtains the settlement, the attorney's work cannot be merely auxiliary to medical providers' lien recoveries); *see also Alaska Native*, 84 P.3d at 434–35 (quoting *Martinez*, 871 P.2d at 1367) (agreeing with the New Mexico Supreme Court's analysis in *Martinez* in holding that the work of the plaintiff's attorney is critical to the collectability of medical liens). For the New Mexico Supreme Court, the fact that a medical provider has a creditor-debtor arrangement with the plaintiff patient means that the provider would ordinarily employ its own attorneys to collect an outstanding debt from the plaintiff. *Martinez*, 871 P.2d at 1367. The fact that this necessity to collection is supplanted by the plaintiff's hiring of legal counsel to secure a tort settlement means that the work of that counsel must also be necessary to the medical provider. *See id.* (holding that if a required element of collection is replaced by an alternative method, the alternative method cannot be attendant to collection). The Supreme Court of Alaska agrees. *See Alaska Native*, 84 P.3d at 435 (noting that medical lienholders are indistinguishable from subrogees in that both require the creation of a Common Fund to exercise their rights to payment).

[143] *See Alaska Native*, 84 P.3d at 435–36 (quoting *Martinez*, 871 P.2d at 1367) (following the New Mexico Supreme Court's rationale in *Martinez* in holding that medical lienholders cannot, in all fairness, benefit in the manner that they do from the work of the plaintiff's attorney and not contribute towards the payment of legal fees and costs). Especially critical to the minority view's evaluation is the idea that without an enforceable lien, the medical provider would need to utilize its own resources—legal or otherwise—at its own expense, to collect on the debt the injured plaintiff owes. *See id.* at 435 (quoting *Martinez*, 871 P.2d at 1367) (noting that the plaintiff hiring an attorney saves the medical provider from having to incur its own legal costs to enforce its lien). The minority view is consequently wary of the slippery slope that it feels the majority view fails to anticipate: that without having to contribute a proportionate share of the legal fees necessary to procure a settlement, medical lienholders take advantage of a specific debt-recovery model at the expense of their own patients. *See Martinez*, 871 P.2d at 1367 (reasoning that the majority view encourages medical lienholders to do nothing in enforcing their liens because plaintiffs' attorneys, for which medical lienholders do not have to pay, do all the necessary legal work).

Second, the minority view has provided an alternative perspective on the creditor-debtor issue.[144] Where the majority view holds that the medical provider is a creditor whose right to payment exists autonomously of whether the plaintiff pursues a tort action, the minority view emphasizes the importance of the medical provider *expressing* that right to payment via the lien process.[145] In the minority view, a medical provider's right to reimbursement as effectuated against an individual is not particularly useful.[146] Alternatively, a medical lien asserted against a pending insurance payout is very useful.[147] Thus, independent of the attachment requirements of a particular lien statute, the settlement grants the medical provider a reasonable expectation of payment.[148] For the minority view, it is not the source of the plaintiff's debt obligation to the medical provider that is important.[149] Instead, the work of the plaintiff's attorney,

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[144] *See* Yaeger v. City of Lincoln (*In re* Guardianship & Conservatorship of Bloomquist), 523 N.W.2d 352, 360 (Neb. 1994) (illustrating the Nebraska Supreme Court's unique perspective on how the medical lienholder, although not engaging with the tort settlement in the same manner as a subrogee, nonetheless heavily relies on the efforts of the plaintiff's attorney).

[145] *See Martinez*, 871 P.2d at 1366–67 (noting the provider's decision to collect via filing a lien, an effort that requires a settlement to have any effect, in turn requires the work of the plaintiff's attorney); Schulte, *supra* note 16, at 1777 (citing *Martinez*, 871 P.2d at 1366–67) (summarizing the *Martinez* court's methodology as focusing not on the provider's right to payment, but rather on the means by which it chose to collect). *Compare Yaeger*, 523 N.W.2d at 360 (noting that medical lien cases often involve patients who have no ability to pay for their medical treatment short of recovering a tort settlement), *with* Bryner v. Cardon Outreach, L.L.C., 2018 UT 52, 428 P.3d 1096, 1103 (providing the majority position that medical lienholders are creditors of the injured plaintiffs and therefore not dependent on the tort settlement). The minority view holds that hospital lien statutes provide a source of recovery for debts that would otherwise be unrecoverable. *Yaeger*, 523 N.W.2d at 360. The minority view notes that, although the medical lien statute does not represent a positive boon in equity terms, it does present a process that serves medical providers, and to which medical providers should therefore contribute remuneration. *Id.*

[146] *See Yaeger*, 523 N.W.2d at 360. (describing a filed medical lien without the potential for a tort settlement as "worthless"). The court notes that the attachment requirements of medical lien statutes, specifically that the plaintiff must pursue a judgment or settlement for medical liens to attach, places medical lienholders in the same position as subrogees from a practical standpoint. *See id.* (noting that although medical lienholders do not technically replace the plaintiff as beneficiary to the settlement funds, medical lienholders are equally as reliant on the plaintiff's attorney as the plaintiff).

[147] *See id.* (noting that a medical provider has no incentive to assert a lien except where its patient decides to pursue a liability action against a tortfeasor). The implication the minority view makes does not simply engage the fact that hospital lien statutes impose provisions requiring a tort settlement to attach. *Id.* Rather, it extends to the idea that medical providers have no reason *at all* to try to collect from these patients absent a settlement. *See id.* (reasoning that these types of account debts represent little chance of collection for medical providers, and medical providers otherwise simply adjust these debts off their accounts receivable).

[148] *See id.* (implying that the settlements cannot occur without the work of the plaintiff's attorney, and that medical liens provide no benefit to medical lienholders if the plaintiff does not receive a settlement).

[149] *See Martinez*, 871 P.2d at 1367 (disregarding the actual source of the plaintiff's debt obligation with the medical provider in favor of emphasizing the importance of the plaintiff's attorney's work in securing a settlement to effectuate the medical provider's lien).

which provides the lien with collectability, should induce the medical provider to pay a proportionate share of the attorney's fees.[150]

C. The Academic Position: The Doctrine Helps Solve Equity Issues and Provides Incentive for Patients to Pursue Tortfeasors

Although many courts have long settled the issue of whether applying the Doctrine to reduce medical provider liens is appropriate within their jurisdictions, there remains a call within the legal community for courts to adopt the minority position.[151] Plaintiffs' attorneys still bring the issue to the courts and vigorously challenge lower courts who side with the majority view.[152] Legal academics have implored the courts to reconsider applying the Doctrine to impose proportionate sharing of attorney's fees upon medical lienholders.[153] Academics have also pushed for state legislatures to amend medical lien statutes to ensure that the policy of preventing unjust enrichment at the root of the Doctrine has legal effect.[154]

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[150] *See Yaeger*, 523 N.W.2d at 360–61 (holding that, although the medical lienholder does not actually supplant the plaintiff as a claimant to settlement funds, as a subrogee would, the medical lienholder is utterly reliant upon the plaintiff's attorney to provide funds for the medical provider to collect).

[151] *See, e.g.*, Ellison, *supra* note 12, at 328 (petitioning for greater adoption of the Doctrine in tort settlements); Reynolds, *supra* note 10, at 137 (lobbying for several policies pertaining to medical liens that would increase the percentage of tort settlements that patients would actually pocket, including broader application of the Doctrine).

[152] *See, e.g.*, Bryner v. Cardon Outreach, L.L.C., 2018 UT 52, 428 P.3d 1096, 1096 (providing an example of plaintiffs' attorneys bringing a class action complaint on the issue of the applicability of the Doctrine to tort settlements all the way to the Utah Supreme Court as recently as 2018).

[153] *See* Reynolds, *supra* note 10, at 136–37 (arguing that courts should reconsider application of the Doctrine, in addition to other solutions, to guarantee equitable outcomes for plaintiffs). These arguments favor common law use of the Doctrine, given the difficulties inherent in effecting change through the legislature. *Id.*

[154] *See* Ellison, *supra* note 12, at 326–27 (arguing that the Illinois legislature must change the Illinois Health Care Service Lien Act to include a provision requiring medical lienholders to reduce the lien to share in the plaintiff's legal fees). *But see* Schulte, *supra* note 16, at 1789 (arguing that state legislatures should change their respective medical lien laws specifically to prohibit use of the Doctrine to impose automatic reductions of medical liens to pay a share of attorney's fees). One argument specifies that medical lienholders would need to reduce their liens only where plaintiffs' attorneys were successful in obtaining a financial recovery from tortfeasors. Ellison, *supra* note 12, at 327. The rationale behind implicating the Doctrine only where the attorney secures a money remedy is simple: because the medical lien secures a financial obligation the plaintiff has with the medical provider, a financial award is the only means by which a plaintiff's attorney's efforts can bestow a benefit upon the medical provider. *See id.* at 322 (describing the benefit requirement of unjust enrichment in Illinois and noting that both ways in which a medical lienholder can enjoy unjust enrichment by not contributing to a plaintiffs' attorney's fees—either because the lienholder receives money or because it is able to discharge a debt—require the attorney to obtain a judgment from the tortfeasor). Prior to the call for re-examination of the Doctrine as it pertains to hospital liens, which more recent scholarship has partially followed, the early scholarship on this issue argued that lawmakers, particularly in states where courts had not ruled on the issue, should plainly indicate whether their medical lien statutes impose a fee sharing requirement on providers. *See id.* at 327–28 (arguing for amendment of the Illi-

In evaluating the body of case law on the issue, the academic community has embraced the unjust enrichment argument and maintains that applying the Doctrine would be an effective way to prevent medical providers from realizing unjust enrichment.[155] Central to this argument is the idea that in collecting the full amount of their liens while not sharing the plaintiff's legal fees, medical providers co-opt lien statutes to seize an advantage at the expense of the plaintiff.[156] In addition to questions of fairness, the scholarship poses a related, yet far more damaging, consequence of this scheme.[157] If injured patients cannot recover sufficient compensation for their injuries, they have no incentive to endure the challenges of pursuing the tortfeasor at all.[158] Such a decision, in

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nois Health Care Service Lien Act to effectuate the Doctrine in specified circumstances); Reynolds, *supra* note 10, at 136–37 (agreeing that lienholders should contribute to attorney's fees, but arguing that to impose such a requirement courts should simply reconsider applying the Doctrine rather than rely on a prolonged legislative process); Schulte, *supra* note 16, at 1784–85 (arguing that clarifying the issue through statutory amendment is necessary because courts in multiple states have ruled on opposite sides of the debate). The early scholarship further argued against forcing medical providers to contribute to plaintiff's attorney's fees, citing providers' important role in treating the uninsured and the valuable protections that lien statutes afford providers as important justifications for this position. *See* Schulte, *supra* note 16, at 1785–88 (illustrating the important public policy ramifications of imposing additional financial burdens on hospitals that treat many patients who have no means to pay and that rely substantially on the protections and collection avenues lien statutes afford).

[155] *See* Ellison, *supra* note 12, at 321–27 (arguing that the scenario of a medical lienholder recovering a debt by asserting a lien without paying a proportionate share of the plaintiff's legal fees meets each of the three elements of unjust enrichment in Illinois, and that applying the Doctrine would eliminate it). The Illinois Supreme Court has identified three factors for unjust enrichment. *Id.* at 321. First, the defendant to an unjust enrichment claim obtains some form of gain. *Id.* Second, the gain the defendant realizes must come at the disadvantage of the plaintiff. *Id.* Finally, the defendant's preservation of its gain must affront fundamental notions of legal fairness. *Id.* Critical to the argument that medical lienholders enjoy unjust enrichment in tort settlements is an examination of what constitutes a gain within a state's unjust enrichment paradigm. *See id.* (initiating the argument that medical lienholders receive unjust enrichment by looking to Illinois case law for guidance on what constitutes a gain). Where the common law has not specifically stated what constitutes gain within an unjust enrichment scenario, practitioners can look to the courts for illustrations of what can meet the standard. *See id.* at 321–22 (noting that the Illinois Supreme Court has not given specific direction on what amounts to gain, so case law from the lower courts provides the only possible direction). Especially pertinent to the case of a medical lienholder, at least one state has established that when the defendant to an unjust enrichment claim either receives a monetary benefit or the plaintiff precludes the defendant from suffering monetary forfeiture, that meets the gain requirement. *Id.* at 322.

[156] *See id.* at 322–26 (discussing unjust enrichment to medical providers who assert liens without paying a proportionate share of plaintiffs' attorney's fees).

[157] *See* Reynolds, *supra* note 10, at 135–36 (noting that excessive costs incident to both treatment and settlement can impact the financial forecasts and calculations an injured plaintiff must make in determining whether to sue).

[158] *See id.* (discussing the factors that plaintiffs consider in deciding to sue). Courts holding the minority position have also considered whether litigation is cost prohibitive to plaintiffs if lienholders do not contribute to a plaintiffs' legal expenses. *See* Yaeger v. City of Lincoln (*In re* Guardianship & Conservatorship of Bloomquist), 523 N.W.2d 352, 360 (Neb. 1994) (discussing how some tort victims may see no point in pursuing a tortfeasor if their damages are in excess of the tortfeasor's insurance coverage). Suing a tortfeasor can cost injured patients significant amounts of money. Reynolds, *supra* note 10, at 135–36. The American Rule dictates that, absent special circumstances, litigants must bear

the aggregate, would have a negative impact on the injured persons and significantly diminish the remedies available at law to both injured parties and to the medical providers who treat them.[159]

III. Challenging the Minority Position: Deconstructing the Arguments for Applying the Common Fund Doctrine to Medical Lienholders in Tort Settlements

Proponents of the minority position assert several arguments in claiming that courts should apply the Doctrine to reduce medical liens in tort settlements.[160] Section A of this Part challenges the argument that fundamental principles of fairness dictate that medical providers should pay a proportionate share of attorney's fees.[161] Section B challenges the assertion that the only way a medical lienholder can recover payments from tort settlements is through the work of a plaintiff's attorney, and therefore that medical lienholders should contribute to attorney's fees.[162] Section C challenges the argument that medical lien statutes exist primarily to mitigate the concern providers have about treating patients with no ability to pay by guaranteeing at least a partial recovery.[163]

their own costs of litigation. *See id.* at 135 (noting that the standard in the United States is for litigants to manage their own legal expenses); *see also* Ellison, *supra* note 12, at 316 (discussing American litigants' responsibility for paying their own legal fees, except in unique circumstances). Thus, in deciding whether to sue, an injured plaintiff must understand how much settlement money is potentially available, and how much of that settlement money will remain after paying legal fees and both secured and unsecured debts. *See* Reynolds, *supra* note 10, at 135–36 (noting that the cost of litigation is considerable and that the Illinois Health Care Services Lien Act permits medical lienholders to pursue from the injured plaintiff any portion of their lien not resolved in the settlement). One argument in favor of applying the Doctrine to compel medical providers to contribute a proportionate share of attorney's fees is that doing so would increase the likelihood of the injured plaintiff pocketing at least some of the settlement funds. *See id.* at 115–16, 135–36 (discussing the cost of pursuing a tortfeasor as a significant impediment to some accident victims, and the role the Doctrine has in apportioning at least some of those costs). This would likely increase the number of plaintiffs who might seek tort settlements as a remedy. *See id.* at 137 (suggesting that use of the Doctrine would improve the likelihood of positive results for tort plaintiffs).

[159] *See* Reynolds, *supra* note 10, at 138 (expressing the need for legislative action in Illinois to minimize negative financial outcomes for injured plaintiffs in tort actions).

[160] *See, e.g.*, Martinez v. St. Joseph Healthcare Sys., 871 P.2d 1363, 1367 (N.M. 1994) (holding that medical lienholders are reliant on the work of the plaintiff's attorney to secure a settlement, and thus should contribute a proportionate share of attorney's fees); Ellison, *supra* note 12, at 308–09 (arguing that the main thrust of medical lien statutes is to grant medical providers security in treating uninsured patients, not to guarantee full recovery for billed charges); Reynolds, *supra* note 10, at 137 (arguing that courts should re-analyze the Doctrine from the vantage point of what is most fair to the plaintiff).

[161] *See infra* notes 164–183 and accompanying text.

[162] *See infra* notes 184–200 and accompanying text.

[163] *See infra* notes 201–208 and accompanying text.

A. The Fairness Argument: Equity Principles Dictate that Medical Lienholders Should Contribute to the Plaintiff's Legal Fees

Both case law and legal scholarship that push for the adoption of the minority position maintain that fundamental principles of fairness and the elimination of unjust enrichment dictate that medical lienholders should pay a proportionate share of the legal fees incurred to generate a tort settlement.[164] This argument derives from the idea that the injured plaintiff incurs substantial risk in filing suit and the plaintiff's attorney confers a unique and considerable benefit upon the medical lienholder, for which the medical lienholder ultimately does not pay.[165] Such a result, proponents argue, is inherently and facially inequitable.[166]

The fairness position overlooks the fact that applying the Doctrine to force medical lienholders into reducing their liens results in inequitable outcomes.[167] Many state medical lien statutes already impose a cap on the amount medical liens can secure from a tort settlement, notwithstanding the amount the plaintiff patient owes to the treating provider.[168] To impose an *additional*

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[164] *See, e.g.*, Yaeger v. City of Lincoln (*In re* Guardianship & Conservatorship of Bloomquist), 523 N.W.2d 352, 360–61 (Neb. 1994) (holding that because medical lienholders are completely reliant on the plaintiff's attorney's work to recover on their liens, fairness dictates that medical lienholders should contribute an equitable share of attorney's fees); Ellison, *supra* note 12, at 325–26 (implying that medical lienholders who do not pay a fair portion of attorney's fees are parasitically impacting injured plaintiffs); *see also Martinez*, 871 P.2d at 1366 (distinguishing the fairness argument from the unjust enrichment argument in the context of applying the Doctrine to a hospital lien). For further discussion of the fairness justification in comparison to the unjust enrichment justification, see *supra* note 99 and accompanying text.

[165] *See* Ellison, *supra* note 12, at 321–26 (discussing how the work of the plaintiff's attorney confers upon medical lienholders an advantage that meets the benefit requirement of unjust enrichment as defined in Illinois). Proponents of applying the Doctrine to medical lienholders in tort settlements point to two distinct benefits the injured plaintiff's attorney provides to medical lienholders. *See id.* at 322 (enumerating what the Illinois courts have identified as conferring a benefit in unjust enrichment claims). First, these proponents argue the work of the plaintiff's attorney provides medical lienholders with a financial award that technically belongs to the injured plaintiff. *Id.* Second, the work of the plaintiff's attorney amounts to the plaintiff resolving a debt owed to medical lienholders, providing medical lienholders with resolution of an outstanding legal obligation. *Id.*

[166] *See, e.g.*, Alaska Native Tribal Health Consortium v. Settlement Funds Held for or to Be Paid on Behalf of E.R. *ex rel.* Ridley, 84 P.3d 418, 436 (Alaska 2004) (holding that medical lienholders who do not pay a proportionate share of the legal expenses injured plaintiffs incur to facilitate tort settlements receive unjust enrichment); *Yaeger*, 523 N.W.2d at 360 (noting that medical lienholders should not receive the benefits of the plaintiff's legal representation without contributing to the costs of that representation); *Martinez*, 871 P.2d at 1366 (holding the application of the Doctrine to medical lienholders in tort actions is a very fitting means of ensuring essential justice and an equitable outcome).

[167] *See, e.g.*, Bryner v. Cardon Outreach, L.L.C., 2018 UT 52, 428 P.3d 1096, 1103 (implying that it is unfair to require a medical provider to help pay for the plaintiff's attorney because the plaintiff owes the medical provider a debt whether or not the plaintiff hires an attorney or even pursues a tort settlement at all).

[168] *See, e.g.*, 770 ILL. COMP. STAT. 23/10(a) (2020) (limiting the aggregate charges of all liens of a settlement to 40% of the total settlement amount); TEX. PROP. CODE ANN. § 55.004(b) (West 2021)

forced reduction upon medical lienholders to contribute to attorney's fees would produce a double recovery for the plaintiff patient, resulting in a statutorily-generated windfall.[169] Even where medical lien statutes don't cap the amount a lien may recover, they frequently include priority provisions that establish that funds secured in tort settlements must first pay the plaintiff's legal fees before reimbursing any other lienholder or secured creditor.[170] Combining statutory priority rights with mandatory contributions to attorney's fees for medical lienholders would place medical lienholders in an inequitably disadvantageous position.[171]

(capping hospital liens either to charges pertaining to the first one hundred days of treatment following an accident, or to half the plaintiff's entire tort recovery, or to the amount, minus attorney's fees, that the fact-finder sets aside for medical services, whichever is less); VA. CODE ANN. § 8.01-66.2 (2015 & Supp. 2021) (capping hospital liens to $2,500, regardless of the extent of charges the patient accrues); *see also* McVey v. M.L.K. Enters., L.L.C., 2015 IL 118143, 32 N.E.3d 1112, 1117 (discussing how improper application of the Doctrine in tort settlements where the applicable lien statute caps the amount medical lienholders can secure through their liens can result in an inappropriate recovery to the plaintiff at the expense of medical lienholders).

[169] *See, e.g.*, Maynard v. Parker, 387 N.E.2d 298, 300 (Ill. 1979) (identifying the statutory cap on lien recoveries as a significant consideration in the court's decision not to apply the Doctrine). Courts have recognized the potential for medical lienholders to incur double reductions even where courts have ultimately applied the Doctrine to compel medical lienholders to contribute to plaintiff's attorney's fees. *See Martinez*, 871 P.2d at 1365–66 (noting that the New Mexico Supreme Court felt justified in breaking with the Illinois Supreme Court because the Illinois Health Care Service Lien Act caps medical lien recovery to a specific maximum percentage of the total settlement, whereas the New Mexico hospital lien statute does not). Such courts have held that legislatures that imposed a cap within their medical lien statutes did not want medical lienholders to experience additional reductions to the cap. *Id.* at 1366. Thus, courts do not apply the Doctrine in those jurisdictions. *See id.* (applying legislative intent to distinguish New Mexico's application of the Doctrine in tort settlements from Illinois's rejection of the Doctrine).

[170] *See, e.g.*, UTAH CODE ANN. § 38-7-1(1)(a)–(b) (West 2018) (establishing that medical liens in Utah attach to the portion of the injured plaintiff's settlement that remains *after* the plaintiff's attorney deducts their fees). Plaintiffs' attorneys in Utah have challenged the attachment language of Utah's hospital lien statute, contending that the language does not establish priority to attorney liens, but rather requires medical providers to automatically deduct from their liens an amount equal to the sum the plaintiff pays in legal fees. *See, e.g.*, *Bryner*, 428 P.3d at 1098 (illustrating the plaintiff's argument that the attachment language of Utah's hospital lien statute establishes a reduction requirement for medical liens, not priority for attorney's fees). The Supreme Court of Utah disagreed. *See id.* 1102 (holding that for an interpretation of the attachment provision of Utah's hospital lien statute to impose an automatic reduction of medical liens to contribute to plaintiffs' attorney's fees, the interpretation would need to add significantly to the statutory language).

[171] *See Bryner*, 428 P.3d at 1102 (illustrating the Utah legislature's anticipation of the inequity that results from granting priority to attorney's fees and imposing a fee sharing requirement on medical lienholders). The Utah Supreme Court adeptly recognized that imposing priority to attorney liens itself constitutes a reduction of the amount a lienholder may recover from a settlement, and that a fee sharing requirement would amount to an additional reduction. *See id.* (noting that the attachment language of Utah's hospital lien statute allows for plaintiffs' attorneys to take their fee before any medical lienholders receive payment, but permits no *additional* decrease to a medical provider's enforcement of its lien without the medical provider's consent); *see also* UTAH CODE ANN. § 38-7-1(1)(a)–(b) (providing the Utah hospital lien statute's attachment language that grants priority to attorney's fees over a medical lien, but does not permit any further lien reductions absent the lienholder's con-

Proponents of imposing a mandatory contribution to attorney's fees upon lienholders also point to prevention of unjust enrichment as justification, but such a rationale is unpersuasive.[172] Unjust enrichment requires a receiving party to benefit, without providing reimbursement, where it was reasonable for the conferring party to anticipate reimbursement.[173] In general, it is not reasonable for a tort plaintiff to expect a medical lienholder to provide pro-rata reimbursement for attorney's fees because the American Rule holds that litigants pay their own legal fees absent exceptional scenarios.[174] Where common law

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sent). A hypothetical, derived from the author's personal experience negotiating medical provider liens on behalf of hospitals, is helpful to illustrate how this works. A plaintiff has a single medical bill for $50,000 and hires an attorney to resolve her tort claim. The relevant medical lien statute establishes that medical provider liens attach only to the portion of the settlement that remains after the injured party pays the attorney. If the available settlement is, for example, $100,000, the attorney would take a presumptive 33% of the settlement amount, meaning that the lien would attach to the remaining $66,666.67. This is more than enough to cover the medical provider's full lien amount, and so there is no compounded disadvantage to the medical provider if a court applies the Doctrine to impose a fee sharing reduction of the medical lien. Contrastingly, if the settlement amount is, for example, $50,000—the same amount as the lien—then there is a concerted impact resulting in a double reduction of the medical lien. The attorney would still take a presumptive 33% of the settlement, meaning the medical lien would attach to the $33,333.33 that remains. This automatically reduces the medical provider lien from $50,000 to $33,333.33. If a court then applies a fee sharing requirement, the medical provider will need to reduce its lien again, presumably by another 33% to $22,222.22, all while the lien statute completely entitles the attorney to take their full fee. The lower the total settlement amount gets, the worse this scheme becomes for lienholders, without impacting the attorney's prospects for remuneration at all.

[172] *See* Ellison, *supra* note 12, at 321 (noting that a principal objective of the Doctrine is to offset unjust enrichment); *see also* Lynch v. Deaconess Med. Ctr., 776 P.2d 681, 683 (Wash. 1989) (discussing the plaintiff's contention that a reduction of the defendant's medical lien was necessary to counteract unjust enrichment).

[173] *Unjust Enrichment*, BLACK'S LAW DICTIONARY, *supra* note 18.

[174] *See* Ellison, *supra* note 12, at 316 (citing Morris B. Chapman & Assocs., Ltd. v. Kitzman, 739 N.E.2d 1263, 1271 (Ill. 2000)) (noting that successful suit against a liable party typically does not include reimbursement for legal expenses). Exceptions include circumstances where either the parties agree to fee-shift or a statutory provision grants fee-shifting. *Id.* Medical lien statutes do not generally include explicit language regarding fee-shifting, though courts have evaluated use of the Doctrine where lien statutes do not stipulate what constitutes full payment of the lien. *See, e.g.*, *Martinez*, 871 P.2d at 1366 (noting that the court was not bound, as other state courts were, to render a decision regarding use of the Doctrine based purely on the language of the state medical lien statute). Plaintiffs negotiate attorney fees at the time of contract, with a contingency fee based on a percentage of monies recovered being a common model in tort cases. *See* David Goguen, *Lawyers' Fees in Your Personal Injury Case*, ALLLAW, https://www.alllaw.com/articles/nolo/personal-injury/lawyers-fees.html [https://perma.cc/B6QF-RAC7] (indicating that contingency fee pricing structures for legal fees are common in personal injury suits, and that such fees often range from 33% to 40% of the amount the attorney secures in settlement). Such an arrangement incentivizes the attorney to obtain the highest possible settlement so that the attorney can realize the highest possible fee. *See* Ellison, *supra* note 12, at 318 (discussing the monetary incentives for plaintiffs' attorneys when courts applying the Doctrine calculate the legal fees based on a percentage of the settlement award). At least one court has noted that medical providers have no say in which attorney the plaintiff hires to settle the case, and for what fee arrangement. *See* Wendling v. S. Ill. Hosp. Servs., 950 N.E.2d 646, 651–52 (Ill. 2011) (illustrating the hospital's lack of decision-making authority in acquiring legal services for which the plaintiff expects the medical provider to pay).

has expanded upon the general definition of unjust enrichment to include instances where one party receives a gain at the expense of another party, unjust enrichment still does not provide justification for medical lien reductions.[175] The plaintiff owes a debt to the medical provider for services rendered.[176] The medical provider receives a gain when the plaintiff's attorney pays its lien using settlement funds.[177] The payment of that debt, however, comes at the *plaintiff's* benefit as well, not at the plaintiff's impairment.[178]

The minority position seeks to circumvent the American Rule problem by imposing the Doctrine, citing the goal of averting freeriding for support.[179] Courts have defined freeriding in this context as gaining from the creation of a common fund without participating in the process to obtain it.[180] Medical lienholders do not freeride because they contribute to securing the settlement.[181]

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[175] *See* Ellison, *supra* note 12, at 321 (citing HPI Health Care Servs., Inc., v. Mount Vernon Hosp., Inc., 545 N.E.2d 672, 679 (Ill. 1989)) (providing the Illinois Supreme Court's definition of unjust enrichment).

[176] *See, e.g.*, *Bryner*, 428 P.3d at 1103 (noting that medical providers acquire a right to payment upon administering treatment to the plaintiff patient).

[177] *See* Ellison, *supra* note 12, at 322 (discussing the different categories of gain and how recovery of a lien-secured debt qualifies). Though the medical provider's receipt of a gain is undisputed for the purposes of this specific point, whether the provider does in fact receive a gain, and if so, what type of gain, is a foundational topic of the debate. *Compare Wendling*, 950 N.E.2d at 651 (noting that because the plaintiff owed the debt to the hospital regardless of whether the plaintiff successfully sued the tortfeasor, payment of the lien via settlement funds was merely a supplementary gain to the hospital), *with* Ellison, *supra* note 12, at 322 (arguing that the hospital receives a gain, either because it receives cash value on its lien, or because it receives the discharge of a debt liability).

[178] *See* Ellison, *supra* note 12, at 322 (discussing the various categories of "benefit" under the Illinois Supreme Court's definition of unjust enrichment). Here, the minority argument folds in on itself. *See id.* (noting that one form of "benefit" under the Illinois definition of unjust enrichment is the elimination of a debt obligation). The minority position argues that the medical provider lienholder receives a gain from the plaintiff's attorney because the attorney's efforts produce a settlement that pays off the debt the lien secures. *Id.* By that rationale, the plaintiff must also gain, because the plaintiff owns the debt obligation. *See Wendling*, 950 N.E.2d at 651 (noting that the plaintiff is ultimately responsible for payment of the hospital claim). It is unpersuasive to argue that the elimination of the debt obligation is simultaneously a gain to the hospital and an impairment to the plaintiff, when resolution of the lien debt is an objective of both parties in pursuing their respective claims against the tortfeasor. *See* Ellison, *supra* note 12, at 322 (arguing that the settlement permits the hospital to resolve the debt, constituting a gain).

[179] *See* Ellison, *supra* note 12, at 326 (citing Principal Mut. Life Ins. Co. v. Baron, 964 F. Supp. 1221, 1224 (N.D. Ill. 1997)) (maintaining that courts apply the Doctrine to stop lien claimants from freeriding).

[180] *See, e.g.*, Brase *ex rel.* Brase v. Loempker, 642 N.E.2d 202, 204–05 (Ill. App. Ct. 1994) (providing the elements necessary to apply the Doctrine to demonstrate the Doctrine's basis in the prevention of freeriding).

[181] *See, e.g.*, Martinez v. St. Joseph Healthcare Sys., 871 P.2d 1363, 1364 (N.M. 1994) (providing an example of a medical lienholder having a considerable impact on the amount of the settlement offer). *Martinez v. St. Joseph Healthcare System* provides a fact pattern that illustrates the impact a medical lien can have on securing a settlement. *Id.* The uninsured motorist policy tendered its full limits of over $100,000. *Id.* The total medical debt was over $63,000, including a hospital lien securing nearly $30,000. *Id.* Were it not for the considerable amount of medical debt, nearly half of which

Medical providers treat patients, calculate charges for services, and file liens, at their own expense, to assist the plaintiff in proving damages and generating a demand to the insurance company.[182] Attempting to impose the Doctrine on a medical provider simply because the provider asserted its right to payment as a claim against a liable insurance company instead of against the plaintiff represents a fundamentally misguided appropriation of the concept of freeriding.[183]

B. The Savior Argument: Because Medical Providers Would Have No Source of Recovery Without the Work of the Plaintiff's Attorney, They Should Contribute to the Plaintiff's Legal Fees

Proponents of the minority position argue that medical lienholders should reduce their liens to contribute a share of the plaintiff's attorney's fees because plaintiffs' attorneys establish medical lienholders' only reasonably reliable source of reimbursement.[184] Such an assertion is untrue and a significant exaggeration.[185] Tort settlements occur regularly without plaintiffs ever hiring an attorney.[186] Further, tort settlements are not the only source of recovery for a

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derived from a single hospital lien, it is questionable, if not unlikely, that the insurance company would have tendered the full policy limits. *See id.* (illustrating that the entirety of the plaintiff's claim against the insurance company consisted of medical debt, attorney's fees and expenses, and a small funeral expense claim). Notably, given a contingency fee arrangement with the plaintiff, the attorney benefitted enormously from the settlement offer, absorbing over $38,000 in fees and other expenses before reductions, the most of any claimant against the settlement. *Id.*

[182] *See, e.g.*, *id.* (illustrating a medical provider's efforts to treat a patient, compile charges, and assert a lien against the patient's pending tort settlement); *see also supra* note 181 and accompanying text. Notably, the courts recognize that filing a lien is not the only recourse a medical provider has for recovering its debt from the plaintiff; the medical provider has other options. *See, e.g.*, Bryner v. Cardon Outreach, L.L.C., 2018 UT 52, 428 P.3d 1096, 1103 (noting that a medical provider is not dependent on the lien process to collect on its debt). For example, the medical provider could forego filing a lien and pursuing the settlement, choosing instead to treat the debt as a financial adjustment. Yaeger v. City of Lincoln (*In re* Guardianship & Conservatorship of Bloomquist), 523 N.W.2d 352, 360 (Neb. 1994). Should a hospital choose to adjust a debt rather than file a lien to collect on it, the plaintiff loses the value of the lien in proving damages to the tortfeasor's insurance company. *See Martinez*, 871 P.2d at 1364 (providing the details of a tort suit where the amount of medical debt informed the extent of the settlement offer); *see also supra* note 181 and accompanying text (summarizing the impact of the lien adjustment in *Martinez* on the settlement amount).

[183] *See Brase*, 642 N.E.2d at 204–05 (holding that proper imposition of the Doctrine requires a party to gain from the work of the plaintiff's attorney without themselves contributing to the settlement).

[184] *See, e.g.*, *Yaeger*, 523 N.W.2d at 360 (noting that asserting a medical lien against a patient is generally fruitless). The minority position further contends that because the plaintiff's attorney effectuates the medical lien by securing a tort settlement, the medical lienholder is hypothetically, if not statutorily, indebted to the attorney. *Id.*

[185] *See, e.g.*, *Bryner*, 428 P.3d at 1103 (noting that asserting a medical lien is only one of several ways a medical provider can seek to collect a tort-related debt from a patient); *see also* Reynolds, *supra* note 10, at 118–21 (establishing that medical providers have other, insurance-based options for reimbursement independent of the providers' rights to assert liens).

[186] *See* Engstrom, *supra* note 54, at 299 (providing that approximately half of all automobile accident victims who pursue a tortfeasor for damages do so without retaining an attorney); David Goguen,

medical provider seeking reimbursement for treatment of accident-related injuries.[187] Medical lien statutes often preclude medical providers from asserting liens until providers have exhausted other sources of recovery, and thus anticipate that providers will file liens for less than their total charges.[188] The Affordable Care Act provides a marketplace for various health insurance plans, and state legislatures have subsequently established state-based individual mandates for minimum essential health insurance coverage.[189] Thus, the argument that medical providers are reliant on the efforts of personal injury attorneys to avoid poor financial outcomes where the provider's patient is a tort victim is outdated and mischaracterizes medical providers' other options.[190]

Negotiating a Personal Injury Settlement Without a Lawyer, ALLLAW, https://www.alllaw.com/articles/nolo/personal-injury/negotiating-accident-settlement-without-lawyer.html#:~:text=It's%20certainly%20possible%20to%20represent,for%20yourself%20and%20your%20case [https://perma.cc/F7HD-6LQC] (providing tips to injured parties on when to consider hiring legal counsel to settle accident claims, and when to attempt to settle such claims without retaining representation). Settling a tort claim without an attorney is especially worthy of consideration where the damages are not substantial and where there is no dispute as to liability. Goguen, *supra.*

[187] *See supra* note 185 and accompanying text.

[188] *See, e.g.*, UTAH CODE ANN. § 38-7-1(3)(a)–(b) (West 2018) (establishing that medical providers in Utah may not assert liens upon accident-related debts that are reimbursable from a patient's health insurance plan or workers' compensation plan, except where the patient's health insurance plan either denies coverage of services charged or does not issue payment within six months of billing); *see also, e.g.*, COLO. REV. STAT. ANN. § 38-27-101(1)–(2) (West 2021) (establishing that a medical provider must seek payment from an injured patient's principal health insurance coverage before the medical provider may assert a lien under Colorado law). The assumption accompanying a statute's disallowance of lien filing until after a provider exhausts all other sources of recovery is that providers will file liens only for the self-pay portion of bills that remain after another insurance plan has covered the rest. *See, e.g.*, UTAH CODE ANN. § 38-7-1(3)(b)(ii)–(iii) (providing Utah's rule that a provider cannot file a lien if a health plan has issued payment according to its contractual rates, except for copay and deductible balances).

[189] *See* 42 U.S.C. § 18031(b)(1) (2018) (providing the Affordable Care Act's requirement for all states to establish a marketplace from which citizens can purchase qualified health insurance coverage; *see also, e.g.*, CAL. GOV'T CODE § 100705(a)–(b) (West 2021) (establishing California's state individual health insurance mandate); D.C. CODE ANN. § 47-5102(a) (West 2020) (establishing same for the District of Columbia); 44 R.I. GEN. LAWS § 44-30-101(b) (2010 & Supp. 2020) (establishing same for Rhode Island). Generally speaking, states identify government-funded health plans, including Medicare and Medicaid, most health plans offered through a subscriber's employer, and individual coverage purchased through the Affordable Care Act's exchange marketplaces as qualifying as minimum essential coverage. *See, e.g.*, GOV'T § 100710(g) (citing California's definition of minimum essential coverage in CAL. HEALTH & SAFETY CODE § 1345.5 (West 2021)); D.C. CODE ANN. § 47-5101(11) (illustrating that DC's definition tracks the federal definition in 26 U.S.C. § 5000A(f), with several additions); 44 R.I. GEN. LAWS § 44-30-101(a)(2) (illustrating that Rhode Island's definition also tracks to the federal definition).

[190] *See* UTAH CODE ANN. § 38-7-1(3) (establishing that asserting a lien against an injured plaintiff's liability settlement cannot possibly be the sole source of recovery for medical providers who treat accident victims because the Utah hospital lien statute identifies several types of insurance coverage that medical providers must pursue *before* they may assert a lien). This is not to suggest, however, that the ability to file liens is immaterial to a medical provider's collection strategy; to the contrary, liens provide far greater hope for recovery of uninsured "self-pay" debts than simply billing patients for them. *See* Schulte, *supra* note 16, at 1787 (identifying liens as a critical tool in self-pay

Those holding to the minority position often contend that medical lienholders who do not want to contribute to the legal costs associated with settling tort actions are free to disengage in the active proceedings and simply file a lien and await payment.[191] Such an assertion trivializes the costs and risks medical providers assume in filing liens and the adverse impact personal injury attorneys can have on medical providers' share of tort settlements.[192] To file a lien generally represents a significant break with a medical provider's normal financial management practices and can require the medical provider to wait months or years for a recovery that may never come.[193] Further, especially where settlement funds are extremely limited in comparison to accident-related debts, the hiring of a personal injury attorney can generate *less* reimbursement to providers because funds that were scarce to begin with must now also cover

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collections). It is true that medical lien statutes frequently preclude filing of liens when other coverage is available to pay, meaning that often providers only file liens with respect to patients who, without recourse against the tortfeasor's liability coverage, are otherwise uninsured. *See id.* (discussing liens as an important tool in a provider's collection process against uninsured and underinsured patients); *see also supra* note 188 and accompanying text (providing examples of hospital lien statutes that preclude lien filing when a patient has other available coverage and discussing the rationale behind such limitations). That said, "uninsured" in this context can mean that a patient lacks coverage, but it can also mean that a patient has coverage but that coverage has denied payment. *See, e.g.*, UTAH CODE ANN. § 38-7-1(3)(b)(i) (establishing that medical providers in Utah can assert liens either when a patient's health insurance plan has either denied payment or simply has not responded to the provider's request for payment 180 days after billing). In these scenarios, the lien still does not represent the provider's *sole* source of recovery, as the minority position contends, even if it is the *best* one; the provider may still appeal the health insurance plan's denial or pursue the patient directly. *See id.* (implying that hospitals may file liens in lieu of following up on a health insurance plan's express or presumed denial).

[191] *See, e.g.*, Alaska Native Tribal Health Consortium v. Settlement Funds Held for or to Be Paid on Behalf of E.R. *ex rel.* Ridley, 84 P.3d 418, 435 (Alaska 2004) (citing Martinez v. St. Joseph Healthcare Sys., 871 P.2d 1363, 1367 (N.M. 1994)) (following the New Mexico Supreme Court's rationale in *Martinez* and holding that the lack of an obligation to contribute to the injured plaintiff's attorney's fees incentivizes medical lienholders not to get involved with the settlement proceedings and then later collect payment when the attorney disburses the settlement funds).

[192] *See, e.g.*, 770 ILL. COMP. STAT. 23/10 (2020) (illustrating how a medical lien statute can limit the maximum recovery permitted to medical lienholders in tort settlements). For example, some medical lien statutes cap the portion of a settlement to which a medical lien may attach, and medical providers rarely, if ever, know how much the tortfeasor will issue the injured plaintiff in compensation for the plaintiff's damages when providers are determining whether to file a lien. *See id.* (providing an example of a state-imposed hard cap on lien recoveries). Thus, asserting liens can be a considerable risk to medical providers because they have no way of knowing how much the lien will actually secure. *See id.* (providing an example of how a state lien statute can add to the uncertainty and risk of asserting medical liens by imposing both a hard cap on lien-based recovery and a cap based on the aggregate securitization of all medical liens).

[193] *See* UTAH CODE ANN. § 38-7-1(3) (demonstrating that filing and foreclosing on a hospital lien is a debt collection process that can frequently take many months, if not years, to resolve). For example, Utah providers, by statute, may not even assert liens where a patient has a commercial health insurance plan until the hospital has billed that plan and the plan has not remitted payment to the provider after a six-month period reserved for the health plan's adjudication of the claim. *Id.*

extensive legal fees.[194] In such scenarios, there is no need to apply the Doctrine to impose mandatory contribution to attorney's fees, because lienholders effectively pay the plaintiff's legal fees already, due to mathematically required reductions to the pro-rata share.[195] The table below illustrates how medical providers end up paying the plaintiff's legal fees in limited fund scenarios, not by imposition of the Doctrine, but through the power of the priority system medical lien statutes establish for attorney liens.[196]

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[194] *See id.* § 38-7-1(1)(a) (providing the attachment provision of Utah's medical lien statute that establishes that medical liens attach only to the share of settlement funds that remains *after* the plaintiff's attorney takes their full fees and costs); *see also* Harlow v. Lloyd, 809 P.2d 1228, 1231 (Kan. Ct. App. 1991) (establishing that the attachment provision of Kansas's medical lien statute also imposes a priority system); Bryner v. Cardon Outreach, L.L.C., 2018 UT 52, 428 P.3d 1096, 1102 (holding that the Utah medical lien statute's attachment provision grants priority to attorney liens). The math behind this contention is simple: if a medical lien statute's attachment provision permits medical liens to attach only to what remains of the tort settlement proceeds after the plaintiff's attorney takes their fee, then a medical lien has the greatest chance of securing the medical provider's full charges when the attorney's fees are zero. *See* UTAH CODE ANN. § 38-7-1(1)(a)–(b) (establishing that, although medical provider liens are secondary in priority to attorney liens, the Utah statute does not otherwise require medical providers to reduce their claims to settlement proceeds). Thus, the only way an attorney can actually bring value to a medical lienholder is to secure a greater tort settlement amount than what the patient plaintiff could have secured on their own. *See* Ellison, *supra* note 12, at 306 (discussing how even plaintiffs themselves consider the potential for an attorney to recover more from the settlement than the plaintiffs could recover themselves in determining whether to retain counsel). Notably, where a tortfeasor offers the full limits of their insurance policy as a remedy for the plaintiff's damages, it is not possible for an attorney to increase the plaintiff's award unless the attorney sues the tortfeasor directly. *See, e.g.*, Martinez v. St. Joseph Healthcare Sys., 871 P.2d 1363, 1364 (N.M. 1994) (providing an example of limited settlement funds constraining an attorney's efforts to settle a case).

[195] *See* UTAH CODE ANN. § 38-7-1(1)(a) (establishing that medical liens in Utah can attach only to the settlement funds that remain after the plaintiff's attorney takes their fee). This is not an issue in settlements where there are enough funds available to pay all lienholders and other plaintiff debts in full, because pro-rata reductions are unnecessary in such situations. *See, e.g.*, *Martinez*, 871 P.2d at 1364 (demonstrating the mathematical necessity of lien reductions where settlement funds are insufficient to cover the debtor's financial obligations). Where the amount of the plaintiff's debts exceed the amount of settlement funds available, however, lienholders will need to reduce their claims to a pro-rata share in order to permit the available funds to cover all the plaintiff's outstanding liabilities. *Id.* Mathematically, the necessary pro-rata reduction will be less if the plaintiff settles with the tortfeasor on their own than it would be if the plaintiff hired an attorney, simply because the attorney's fee is an additional debt that negatively impacts the amount of funds available to the plaintiff's debt holders. *See id.* (providing a case where the insurance limits were insufficient to cover the patient's debts and the attorney's fees absorbed a significant portion of the funds).

[196] The illustration and case study derives from the Author's ten years' experience enforcing hospital liens on behalf of medical providers and represents hypothetical settlement disbursements based on common liability policy limits. In both scenarios, the tortfeasor has issued a settlement offer equal to the limit of their liability insurance policy. Thus, whether the plaintiff hires an attorney is financially immaterial. An attorney cannot recover in settlement more than the limits of the tortfeasor's insurance policy, which the tortfeasor has offered here. *See, e.g.*, *Martinez*, 871 P.2d at 1364 (providing an illustration of how paltry settlement limits can prevent an attorney from settling a case). Further, both scenarios present the same complication. The amount of insurance proceeds available are insufficient to cover all of the plaintiff's outstanding medical debts. Where the plaintiff does not hire an attorney, the amount available to the medical lienholders is the full $25,000 insurance policy. Where the plaintiff hires an attorney, the attorney's customary contingency fee reduces the amount

Line Item	Settlement 1 (No Attorney)	Settlement 2 (Attorney)
Tort Settlement Amount	$25,000	$25,000
Attorney's Fees	$0.00	$8,333.33 (33% of settlement)
Proceeds for Medical Providers	$25,000	$16,666.67
Total Medical Liabilities	$50,000 (two liens)	$50,000 (two liens)
Medical Lien #1	$30,000	$30,000
Pro-rata Share (Recovery)	60% ($15,000)	60% ($10,000)
Lien Reduced By	50% ($15,000)	66.67% ($20,000)
Medical Lien #2	$20,000	$20,000
Pro-rata Share (Recovery)	40% ($10,000)	40% ($6,666.67)
Lien Reduced By	50% ($10,000)	66.67% ($13,333.333)
Remainder to Plaintiff	$0.00	$0.00

available to medical lienholders by a third. Thus, hiring an attorney here has the opposite effect of conferring a benefit upon medical lienholders; it actually results in medical lienholders recovering *less* than they otherwise would have. *See, e.g.*, Ellison, *supra* note 12, at 322 (discussing both monetary payment and resolution of a debt as traditional benefits under Illinois' unjust enrichment paradigm). This simple example illustrates the danger of either courts or legislatures unilaterally determining that medical lienholders always benefit from the work of a plaintiff's attorney in tort settlements. Not only would forcing medical lienholders to contribute a proportionate share of attorney's fees in the second scenario be innately unfair, given that they did not receive any type of gain as a result of the attorney's work, but it would also result in medical lienholders granting hefty reductions *on top of* the 67% reductions they are already taking as their pro-rata share. This would result in huge losses to medical lienholders in compensation for rendering services to a patient they likely had no choice but to treat. By comparison, the attorney gets to collect a *full* contingency fee, despite providing no actual impact on the amount of the plaintiff's financial award. Notably, both the medical lienholder's right to payment and the attorney's right to payment derive from contract. *See Bryner*, 428 P.3d at 1103 (establishing that the plaintiff patient agrees to pay the hospital by contract at the time of treatment); Ellison, *supra* note 12, at 318 (illustrating the calculation of attorney's fees on a contingency basis). Notwithstanding contractual protections of rights to payment, only the attorney is guaranteed a full recovery absent a statutory cap, given the priority system that medical lien statutes establish. *See, e.g.*, UTAH CODE ANN. § 38-7-1(1)(a) (providing the prioritization of attorney's fees over all liens in Utah's medical lien statute). This substantially weakens equity as a justification for applying the Doctrine, as the attorney already maintains a favorable position over a creditor whose right to payment pre-dates the attorney's. *See Bryner*, 428 P.3d at 1103 (establishing that a plaintiff's debt to the hospital derives from the paperwork the plaintiff patient completes at the time the hospital provides treatment). On the contrary, the essential points of the minority argument appear very inequitable: (1) the medical provider treats the plaintiff patient immediately after an accident, far too early for the provider or the patient to have any conception of the probability of a tort settlement; (2) the patient-plaintiff later hires legal counsel, who has the ability to assess the likelihood of a positive settlement outcome before deciding whether or not to represent the patient plaintiff for a minimum of 33% of the settlement proceeds; and (3) the attorney later implores the courts to impose the Doctrine to force reductions on liens subordinate to the attorney's own—despite those liens being first in time—in order for those lienholders to contribute a proportionate share of the attorney's fees. *See* TEX. PROP. CODE ANN. § 55.002 (West 2021) (demonstrating the Texas statute's rule that for medical providers to assert valid liens, the plaintiff must seek treatment at a hospital within seventy-two hours of the accident, a period that, by implication, will be too early for the plaintiff to have a realistic understanding of settlement possibilities); *Bryner*, 428 P.3d at 1103 (noting the impracticality of imposing a contribution requirement on a creditor whose right to payment exists independently of the plaintiff patient's tort settlement); Ellison, *supra* note 12, at 317–20 (providing the methods courts use to calculate attorney's fees when applying the Doctrine, including as a percentage of settlement proceeds).

As a final counterpoint, the minority view is a slippery slope towards encouraging injured patients to hire an attorney in every negligence tort scenario.[197] If application of the Doctrine forced medical lienholders to reduce their liens to pay a proportionate share of a plaintiff's attorney's fees, then tort plaintiffs might feel compelled to hire an attorney, even when legal services are unnecessary, under the false presumption that doing so could only be, at worst, cost neutral.[198]

Line Item	Settlement 1 (No Attorney)	Settlement 2 (Attorney)
Tort Settlement Amount	$100,000	$100,000
Attorney's Fees	$0.00	$33,333.33 (33% of settlement)
Proceeds for Medical Providers	$100,000	$66,666.67
Total Medical Liabilities	$50,000 (two liens)	$50,000 (two liens)
Medical Lien #1	$30,000	$30,000
Fee Share Reduction (Recovery)	0% ($30,000)	33% ($20,000)
Lien Reduced By	$0.00	$10,000
Medical Lien #2	$20,000	$20,000
Pro-rata Share (Recovery)	0% ($20,000)	33% ($13,333.33)
Lien Reduced By	50% ($10,000)	$6,666.67
Remainder to Plaintiff	$50,000.00	$33,333.34

The above comparison shows that hiring an attorney in jurisdictions that impose a mandatory fee-sharing requirement, either through application of the Doctrine or otherwise, can result in *both* the plaintiff and medical lienholders

[197] *See, e.g.*, Yaeger v. City of Lincoln (*In re* Guardianship & Conservatorship of Bloomquist), 523 N.W.2d 352, 360 (Neb. 1994) (holding that medical lienholders should contribute a proportionate share of plaintiffs' attorney's fees because medical providers are reliant on the plaintiffs' attorney to recover on medical liens, thereby implying that attorneys are necessary to settle a tort claim).

[198] The second chart demonstrates how this can happen within a hypothetical settlement arrangement. In either scenario, the sum of the plaintiff's accident-related debt is comprised of two medical liens totaling $50,000. The liability insurance policy tenders full settlement limits of $100,000. Because the settlement proceeds are higher than the total medical debt, pro-rata reductions of the medical liens are not necessary. Without an attorney, the medical providers receive full payment, and the plaintiff collects the remaining settlement funds of $50,000. With an attorney, one-third of the settlement amount is reserved for the attorney's fees, and each medical provider must reduce its lien by 33% due to application of the Doctrine to impose a fee sharing requirement. As a result, each party recovers exactly one-third of the total settlement amount: the attorney, the plaintiff, and the class of lienholders. Although this may seem equitable, both the plaintiff and the lienholders secured less money from the settlement in order to compensate an attorney who did not secure any additional settlement funds over what the plaintiff would have received by settling the claim without retaining legal counsel. Unless the plaintiff receives a settlement offer from the insurance company before hiring an attorney, the plaintiff will likely never know if the attorney's representation results in a net gain over what the plaintiff would have recovered pro se.

recovering less than they would have if the plaintiff had settled on their own.[199] From an unjust enrichment perspective, such a result seems to provide a significant windfall to the attorney, to the detriment of the attorney's client and medical lienholders.[200]

C. The Legislative Intent Argument: Medical Lien Statutes Provide Security in Treating Potentially Uninsured Patients, Not an Expectation of Full Reimbursement

Proponents of the minority position have cited a simple policy justification for medical liens statutes: state legislatures did not intend for such statutes to guarantee full recovery.[201] Rather, the statutes provide hospitals the ability to use liens as a security against the risk of treating uninsured patients.[202] Thus, medical providers should not balk at imposed reductions to contribute a proportionate share of plaintiffs' attorney's fees because medical lien statutes do not impose a reasonable expectation of dollar-for-dollar reimbursement on the amount such liens secure.[203] This argument represents hospital treatment in a

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[199] *See supra* note 198 and accompanying text (providing an illustration and discussion of how an attorney's involvement in settlement proceedings can result in smaller recoveries for both the plaintiff and lienholders than what the plaintiff might be able to secure without the aid of counsel).

[200] *See supra* note 198 and accompanying text (demonstrating how the attorney can recover a full fee without generating a better recovery than what the plaintiff could have secured on their own); *see also* Ellison, *supra* note 12, at 321 (providing the Illinois Supreme Court's description of the components of unjust enrichment). Under the second chart's hypothetical scenario, the attorney arguably realizes unjust enrichment. The attorney receives a monetary gain at the expense of the plaintiff, and the attorney's retention of that gain, in compensation for services that decreased, rather than bolstered, the plaintiff's recovery, would be an affront to justice and fairness. *See id.* at 321–26 (elaborating on what constitutes a gain and what constitutes a violation of justice in accordance with the Illinois Supreme Court's definition of unjust enrichment); *supra* note 198 and accompanying text (providing an accounting of two hypothetical scenarios that comparatively demonstrate how a plaintiff might recover more from a settlement by not hiring an attorney than by doing so).

[201] *See Yaeger*, 523 N.W.2d at 360 (holding that medical lien statutes merely provide a means by which medical providers can collect on debts associated with treating indigent patients, not a means of collecting accident-related debts at total charges). *But see* Schulte, *supra* note 16, at 1788 (arguing the majority position but also contending that legislatures passed hospital lien statutes to serve as an important bulwark against financial risks hospitals take in treating uninsured patients).

[202] *See* Ellison, *supra* note 12, at 308–09 (suggesting that the primary policy reason for lien statutes is to increase medical provider confidence in admitting and treating patients who may not have any means to pay for the medical services rendered to them). At least one state supreme court has determined that the legislative intent behind enactment of a medical lien statute is to grant medical providers additional protection from treating patients who have no ability to pay. *See* Univ. of S. Ala. v. Progressive Ins. Co., 904 So. 2d 1242, 1246–47 (Ala. 2004) (quoting *Ex parte* Univ. of S. Ala., 761 So. 2d 240, 244 (Ala. 1999)) (maintaining that the state legislature enacted its medical lien statute as a protective measure for medical providers). Some proponents of the use of the Doctrine infer from that policy justification that medical providers should not look to medical lien statutes as a means to recover the full amount of the provider's billed charges. *See Yaeger*, 523 N.W.2d at 360 (holding that medical lien statutes are a means of recovery for medical providers, not a guarantee of full payment).

[203] *See Yaeger*, 523 N.W.2d at 360 (noting that medical lien statutes permit providers to collect on debt that providers would otherwise almost certainly adjust off as non-recoverable).

manner that is contradictory to federal law.[204] Hospitals must treat and stabilize patients who seek treatment through the emergency room, regardless of the patient's ability to pay.[205] Thus, to say that medical lien statutes grant medical providers the confidence to treat accident patients who may not have insurance is irrelevant.[206] Medical providers have to treat those patients regardless of the financial risk such patients present.[207] Further, even absent federal laws that require hospitals to treat any patient who comes into their emergency rooms, the application of the Doctrine to impose fee sharing would significantly negate the security that medical lien acts grant to medical providers in treating uninsured patients.[208]

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[204] *Compare* Ellison, *supra* 12, at 308–09 (quoting *Univ. of S. Ala.*, 904 So. 2d at 1246–47) (maintaining that medical lien statutes offer medical providers the peace of mind necessary to admit and treat patients despite not being able to establish beforehand whether or not the patient is capable of compensating the medical provider for its services), *with* Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd (providing the federal law requirements for medical providers, in situations of medical emergency, either to render stabilizing treatment to a patient or to conduct an appropriate transfer of a patient to an alternative medical facility, regardless of whether or not the patient has the ability to pay for such services).

[205] *See* 42 U.S.C. § 1395dd(b)(1) (establishing the requirements federal law imposes on providers who admit patients on an emergency basis). Federal law requires medical providers to provide stabilizing treatment to anyone who presents an "emergency medical condition." *Id.* The law defines "emergency medical condition" broadly, including essentially any malady that, if left unexamined or untreated, could result in significant health complications for the patient. *Id.* § 1395dd(e)(1).

[206] *See id.* § 1395dd(b)(1) (providing the federal law requirements for emergency medical treatment by a medical facility). Although a state statute can ease the potential financial burdens the federal law imposes, the implication that the state statute grants medical providers the financial security that they require to comply with federal law is simply inaccurate. *See supra* note 204 and accompanying text (comparing the suggestion that medical providers might turn away injured patients if not for the security that medical lien statutes provide with the requirements of the Emergency Medical Treatment and Active Labor Act). A medical provider must comply with federal law, regardless of any rights or obligations the provider's state jurisdiction establishes. *See* U.S. CONST. art. VI, cl. 2. (establishing that federal law supersedes state law when a conflict exists between the two).

[207] 42 U.S.C. § 1395dd(b)(1); *see also supra* note 205 and accompanying text (discussing the federal law requirements for emergency medical treatment).

[208] *See* Ellison, *supra* note 12, at 308–09 (arguing that a substantial advantage that medical lien statues provide is the assurance that a treating medical provider will be able to recover the charges for its services); Schulte, *supra* note 16, at 1788 (arguing that protection against the financial risks associated with treating patients who have insufficient means to pay is a critical function of medical lien statutes). Forced reductions of medical liens to pay for attorney's fees, especially where medical lien statutes already cap recovery, significantly weaken the argument that liens grant medical providers the financial surety necessary to treat potentially indigent patients. *See* Ellison, *supra* note 12, at 308–09 (providing the argument that medical lien statutes confer the substantial benefit of financial security on medical providers). If a lien statute can offer only an extremely qualified right to payment—subject to a legal contract to which the medical provider is not party but to which its right to payment is bound—asserting a lien does little to improve the medical provider's odds of securing reasonable reimbursement for its services. *See Yaeger*, 523 N.W.2d at 360 (illustrating the grim odds of recovery for a medical provider that does not attach a lien to a tort plaintiff's settlement).

IV. THE WAY FORWARD: ALTERNATIVE SOLUTIONS TO IMPOSING THE COMMON FUND DOCTRINE TO REDUCE MEDICAL PROVIDER LIENS

The issue of whether courts should compel medical lienholders to reduce their liens illustrates that the paucity of available funds in tort settlements in comparison to tort-related medical debt is a significant and frequent problem.[209] Complicating this problem is the fact that there is no universal standard for addressing medical provider liens because such liens are a product of state law.[210] The recent call from academia urges courts to reconsider the applicability of the Doctrine in these contexts and lawmakers to consider amending medical lien laws to require providers to contribute a portion of plaintiffs' attorney's fees.[211] Such results would deprive medical providers of important rights and significantly disadvantage them.[212] This Part offers two alternative ideas to consider.[213]

Section A of this Part proposes the federal Bankruptcy Code as a model for how lawmakers, in writing or amending hospital lien statutes, should consider which creditors should contribute to attorney's fees, and which should not, when tort settlement funds are scarce.[214] Section B discusses updating state automobile insurance laws as an alternative approach to blanket forced reductions of medical liens, by use of the Doctrine or otherwise, when tort funds are unable to make plaintiffs whole.[215]

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[209] *See generally* Alaska Native Tribal Health Consortium v. Settlement Funds Held for or to Be Paid on Behalf of E.R. *ex rel.* Ridley, 84 P.3d 418 (Alaska 2004) (providing analysis of the issue in one state court); McVey v. M.L.K. Enters., L.L.C., 2015 IL 118143, 32 N.E.3d 1112 (same); Wendling v. S. Ill. Hosp. Servs., 950 N.E.2d 646 (Ill. 2011) (same); Maynard v. Parker, 387 N.E.2d 298 (Ill. 1979) (same); Harlow v. Lloyd, 809 P.2d 1228 (Kan. Ct. App. 1991) (same); Yaeger v. City of Lincoln (*In re* Guardianship & Conservatorship of Bloomquist), 523 N.W.2d 352 (Neb. 1994) (same); Martinez v. St. Joseph Healthcare Sys., 871 P.2d 1363 (N.M. 1994) (same); Bashara v. Baptist Mem'l Hosp. Sys., 685 S.W.2d 307 (Tex. 1985) (same); Bryner v. Cardon Outreach, L.L.C., 2018 UT 52, 428 P.3d 1096 (same); Lynch v. Deaconess Med. Ctr., 776 P.2d 681 (Wash. 1989) (same).

[210] *See* Reynolds, *supra* note 10, at 110–13 (discussing the process by which Illinois enacted its Health Care Services Lien Act); *see also supra* note 80 and accompanying text (discussing how several states establish lien rights for medical providers).

[211] *See* Ellison, *supra* note 12, at 326–27 (arguing for amendment of the Illinois Health Care Services Lien Act to add a requirement for medical lienholders to contribute a proportionate share of plaintiff's legal fees to effectuate the purpose of the Doctrine); Reynolds, *supra* note 10, at 137 (arguing that courts should reevaluate previous decisions not to impose the Doctrine in the context of tort settlements).

[212] *See supra* Part III (arguing against the various defenses for applying the Doctrine to impose a fee sharing requirement on medical lienholders).

[213] See *infra* Parts IV.A, IV.B.

[214] *See infra* notes 216–233 and accompanying text.

[215] *See infra* notes 234–239 and accompanying text.

A. The Federal Bankruptcy Code Model: Unsecured Creditors Pay Attorney's Fees

Like tort settlements, Chapter 7 bankruptcy provides a scenario where the representative of an indebted individual creates a fund to pay the individual's secured and unsecured creditors.[216] The Bankruptcy Code establishes the rules for prioritizing each of the individual's debts in the distribution scheme of the individual's liquidated assets.[217] The Bankruptcy Code is a federal code.[218] Therefore, the Bankruptcy Code can provide a single, compelling source for understanding how best to visualize the relationship between attorney's fees and creditors as lawmakers consider amending current hospital lien laws.[219]

The Bankruptcy Code's priority system establishes that secured creditors receive the first distribution of a debtor's assets.[220] Second in right to distribution are what the Bankruptcy Code terms "priority claims," unique debts that policy considerations dictate should retain special status over other types of

[216] *See* 11 U.S.C. § 704(a) (establishing the duties of the Chapter 7 bankruptcy trustee, including the collection and liquidation of all assets of the debtor into a fund for distribution to the debtor's creditors); *see also id.* § 726(a)(6) (establishing that the Chapter 7 debtor receives a distribution of liquidated assets only after all creditors release their allowed claims). Under the Bankruptcy Code, a creditor includes, but is not limited to, an entity that possesses a "claim against the debtor that arose at the time of or before the [bankruptcy court's issuance of an] order for [bankruptcy] relief concerning the debtor." *Id.* § 101(10)(A); *see also id.* § 101(5)(A) (defining a "claim" under the Bankruptcy Code as a "right to payment"); *id.* § 101(15) (defining an "entity" under the Bankruptcy Code as "includ[ing a] person, estate, trust, governmental unit, and United States trustee"); *id.* § 101(41) (defining a "person" as including "[an] individual, partnership, and corporation"). The Bankruptcy Code does not define either a secured creditor or an unsecured creditor, but it does define security interest as a "lien created by an agreement." *Id.* § 101(51). The Bankruptcy Code further defines "lien" as a "charge against or interest in property to secure payment of a debt or performance of an obligation." *Id.* § 101(37). Thus, a secured creditor is a creditor with a property interest against the debtor that secures a debt that the debtor owes to the creditor, and an unsecured creditor is a creditor without such protection for its right to payment against the debtor. *See id.* § 101(10)(A), (37), (51) (providing the Bankruptcy Code definitions of "creditor," "lien," and "security interest," respectively). Further, the Bankruptcy Code establishes that a creditor's right to payment is secured up to the value of the estate's interest in the asset that secures the creditor's claim. *Id.* § 506(a)(1). To the extent the creditor's claim exceeds the estate's interest in the asset, the creditor's right to payment is unsecured. *Id.*

[217] *Id.* § 726(a). The Chapter 7 priority scheme establishes three broad categories of claims: (1) secured claims; (2) priority unsecured claims; and (3) non-priority unsecured claims. *Id.* § 726(a)(1)–(5).

[218] *See* U.S. CONST. art. I, § 8, cl. 4 (relegating the authority to pass laws relating to bankruptcy to Congress alone and establishing that bankruptcy laws must be uniform).

[219] *See id*. art. VI, cl. 2. (providing for the supremacy of federal law over state law); *see also* 11 U.S.C. § 503(b)(1)(A)(i) (establishing that fees for bankruptcy trustees and bankruptcy attorneys are administrative expenses under the Bankruptcy Code); *id.* § 725 (establishing the treatment of secured creditors in Chapter 7 bankruptcy proceedings); *id.* § 726(a)(1) (providing the priority scheme for allowed, priority, unsecured claims).

[220] *See* 11 U.S.C. § 725 (stating that the bankruptcy trustee, prior to distribution, must dispose of any property subject to a lien interest, thereby implying that the trustee must pay all secured creditors, including lienholders, before paying any unsecured claims).

debts.[221] At the bottom of the priority system are non-priority claims, including general unsecured claims, non-compensatory financial obligations, and allowed interest.[222]

Lienholders in bankruptcy proceedings are, by definition, secured creditors.[223] Thus, the Bankruptcy Code entitles lienholders to first priority in the distribution of the debtor's assets.[224] Specifically, a lienholder receives dollar-for-dollar reimbursement on its claim in bankruptcy so long as the debtor has sufficient equity in the asset against which the lienholder has asserted its lien.[225]

Fees for debtor representation in bankruptcy—both those of a bankruptcy trustee and bankruptcy attorneys—are administrative expenses under the Bankruptcy Code.[226] Administrative expenses are among the first priority

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[221] *See id.* § 726(a)(1) (establishing that allowed priority claims receive distribution prior to any other unsecured claims). Priority claims include, *inter alia*, domestic support obligations, administrative expenses, gap credit extended between the date of petition and the date of court approval in involuntary bankruptcy cases, employee wages and benefit plans, and various tax liabilities. *See id.* § 507(a) (describing each of the ten categories of priority claims).

[222] *See id.* § 726(a)(2)–(4) (providing the priority scheme for distribution to non-priority unsecured claims). Any funds available after distribution to all claimants under the priority scheme go to the debtor. *Id.* § 726(a)(6). The language of medical lien statutes can establish a similar distribution model. *See, e.g.*, UTAH CODE ANN. § 38-7-1(1)(a) (West 2018) (establishing that the settlement funds to which medical liens attach are the property of the plaintiff). In a tort settlement scenario, the plaintiff's legal representative pools together the plaintiff's property—here, the settlement funds—and distributes it to pay off creditors according to a priority scheme. *See id.* (noting that medical liens attach to the plaintiff's settlement funds). The plaintiff pockets whatever is left after creditors, including the plaintiff's attorney, receive payment and release their claims to the settlement. *See id.* (noting both that medical liens attach to the settlement funds and that the plaintiff is responsible for paying attorney's fees). The Chapter 7 bankruptcy priority scheme establishes an exceptionally similar disbursement methodology. *See* 11 U.S.C. § 726(a)(6) (establishing that Chapter 7 bankruptcy proceedings remit funds to the debtor only once all of the debtor's creditors have released their claims upon the property of the debtor's estate).

[223] *See* 11 U.S.C. § 101(37) (providing that a lien in the context of bankruptcy secures a creditor's right to payment from a debtor).

[224] *See id.* § 725 (providing the portion of the Bankruptcy Code priority scheme that compels the bankruptcy trustee to resolve the claims of secured creditors prior to those of unsecured creditors).

[225] *See id.* § 506(a)(1) (establishing that the value of a lienholder's interest in the property of the debtor is equal to the amount to which the creditor has a right to payment from the debtor, so long as the value of the debtor's interest in the property subject the lien is sufficient to cover the debt); *id.* § 726(b) (establishing that all creditors at the same tier of priority on the Chapter 7 distribution scheme share a pro rata recovery if the debtor's assets are insufficient to pay all debts of the tier in full).

[226] *See id.* § 507(a)(2) (providing that all administrative expenses identified in 11 U.S.C. § 503(b) of the Bankruptcy Code are second in right amongst all priority unsecured claims, with only domestic support obligations outranking them). The Bankruptcy Code establishes a litany of debts in 11 U.S.C. § 503(b) that constitute administrative expenses, including fees of the bankruptcy trustee and any legal representation the bankruptcy trustee retains. *See id.* § 503(b)(1)(A)(i) (establishing that bankruptcy trustee and attorney's fees are included in administrative expenses, as costs incurred after the debtor petitions for bankruptcy and pursuant to the maintenance of the debtor's estate).

claims paid but are still subordinate to all secured claims.[227] Thus, claims relating to the debtor's retaining of representation to liquidate the debtor's assets and pay off the debtor's creditors receive remuneration from the same pool of funds as the claims of the debtor's unsecured creditors.[228]

Policy considerations justify this priority scheme.[229] Administrative expenses receive payment after secured creditors but before unsecured creditors, meaning that unsecured creditors effectively pay for the debtor's bankruptcy representation.[230] This makes sense, as lienholders pay to assert their liens, and unsecured creditors, outside of bankruptcy, would need to do the same to guarantee recovery from a debtor.[231] Thus, if secured creditors receive priority payment because of the efforts and costs they incur to assert a lien, and unsecured creditors rely solely on the efforts of the bankruptcy trustee for payment, it makes sense that unsecured creditors pay administrative fees and secured creditors do not.[232] The Bankruptcy Code further illustrates this policy justifi-

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[227] *See id.* § 725 (confirming that secured creditors receive payment on their liens in bankruptcy prior to any other distribution of liquidated assets); *see also id.* § 507(a)(2) (establishing that attorney's fees incurred to settle a Chapter 7 bankruptcy case, as administrative expenses, occupy an exceptionally high position amongst unsecured claims in bankruptcy, second only to domestic support obligations); *id.* § 726(a)(1)–(2) (establishing that non-priority unsecured claims receive a distribution only after priority unsecured claims receive payment, implying that unsecured, non-priority claimants effectively pay for administrative expenses, including fees of the bankruptcy trustee and legal counsel).

[228] *See supra* note 227 and accompanying text (providing the Bankruptcy Code's Chapter 7 priority scheme with respect to secured creditors, unsecured creditors, and bankruptcy attorney's fees).

[229] *See Chapter 7—Bankruptcy Basics*, U.S. COURTS, https://www.uscourts.gov/services-forms/bankruptcy/bankruptcy-basics/chapter-7-bankruptcy-basics [https://perma.cc/MGR8-LY2Y] (establishing that the principal function of the Chapter 7 bankruptcy trustee is to grant the best recovery possible to unsecured creditors). Chapter 7 is an equitable proceeding for unsecured creditors, not secured creditors. *Id.* Secured creditors, if their liens are valid, enforceable, and allowed, technically do not participate in the distribution scheme, because the bankruptcy trustee resolves their liens prior to distribution. 11 U.S.C. § 725. Thus, because a secured creditor's right to payment is dependent on the debtor's equity in the asset subject to the lien, and not on the bankruptcy trustee's liquidation of the asset, it makes sense that secured creditors make no contribution to payment of any fees pursuant to administration of the bankruptcy case, including bankruptcy trustee fees and attorney's fees. *See id.* (providing that the bankruptcy trustee is required to settle all secured creditor claims prior to distribution to the debtor's unsecured obligations).

[230] *See* 11 U.S.C. § 507(a)(2) (providing administrative expenses with second highest priority amongst unsecured priority claims in bankruptcy); *see also id.* § 725 (establishing by implication that bankruptcy trustees in a Chapter 7 proceeding are to pay secured claims before distribution to any bankruptcy claimant); *id.* § 726(a)(1)–(2) (establishing that priority unsecured claims receive a distribution in bankruptcy before non-priority unsecured claims).

[231] *See, e.g.*, UTAH CODE ANN. § 38-7-2 (West 2018) (providing the filing and notice requirements for asserting a hospital lien in one state, thereby illustrating the steps a medical provider must take at state law to receive the protections on its right to payment that a lien affords).

[232] *See supra* note 227 and accompanying text. Notably, this proposed priority scheme gives value to the minority position's argument that without an obligation to contribute to attorney's fees, lienholders contribute nothing to settlement proceedings yet enjoy the all the benefits therefrom. *See, e.g.*, Martinez v. St. Joseph Healthcare Sys., 871 P.2d 1363, 1367 (N.M. 1994) (holding that lienholders who do not pay attorney's fees can simply remain idle and await payment). Medical lienholders in

cation by subordinating to a status inferior to administrative expense claimants those creditors who could have filed a lien prior to commencement of the debtor's bankruptcy case but failed to do so.[233]

B. Updating of State Automobile Insurance Laws to Raise Minimum Coverage Limits

Legislatures and courts should not force medical providers to reduce their liens in *all* cases, especially where tort proceeds are sufficient to make the plaintiff whole.[234] It is especially hard in these types of cases to make the equity argument.[235] If there is plenty of money available for all creditors to receive

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tort settlements do not fail to contribute simply because they do not share in the attorney's fees. *See supra* notes 180–182 and accompanying text (arguing, *inter alia*, that in filing a lien, a medical provider assists a plaintiff in proving damages). Further, filing a hospital lien and awaiting settlement represents both risk and sunk costs for a medical provider. *See supra* notes 191–193 and accompanying text (arguing that choosing to assert a lien against a plaintiff's tort settlement is a business process for hospitals, with some disadvantages). Creditors in lien settlements who do not file liens, however, likely fit much more into the *Martinez v. St. Joseph Healthcare System* court's characterization of creditors who remain inoperative while settlement proceedings commence and then expect reimbursement when they finalize. *See* 871 P.2d at 1367 (describing the court's views of the roles of plaintiff's attorneys and medical lienholders in settlement proceedings). For this reason, the gain that an unsecured creditor realizes from the work of the plaintiff's attorney is far less incidental than that of secured creditors, and it is therefore equitable for secured creditors not to contribute to attorney's fees, but for unsecured creditors to do so. *See id.* (providing the court's reasoning as to why the benefit a creditor receives from the work of a plaintiff's attorney is not merely attendant).

[233] *See, e.g.*, 11 U.S.C. § 507(a)(8) (providing eighth position priority claim status to unsecured tax claims). The government can assert liens to secure a debtor's tax obligations. *See* 26 U.S.C. § 6321 (providing lien rights to the government on owed but uncollected taxes). Where the government asserts a valid, enforceable, and unavoidable tax lien against a debtor in Chapter 7 bankruptcy, the government is a secured creditor in that debtor's bankruptcy. *See* 11 U.S.C. § 101(37) (defining a lien within the scope of bankruptcy as securing a right to payment). Where the government does not act on its right to assert a tax lien prior to the commencement of the debtor's bankruptcy case, the bankruptcy priority scheme subordinates the debtor's tax debts to unsecured status. *See id.* § 507(a)(8) (providing one example of subordinated status for unsecured tax debts).

[234] *See* Harlow v. Lloyd, 809 P.2d 1228, 1233 (Kan. Ct. App. 1991) (noting the argument that courts should apply the Doctrine only in cases where there are not enough settlement funds for the plaintiff to pay all of their debts, including those owed to medical lienholders and to his attorney).

[235] *See Martinez*, 871 P.2d at 1364 (providing a case where the plaintiff's debts exceeded the settlement funds). Where the settlement funds are insufficient to cover all of the plaintiff's debts, reductions in medical liens permit the plaintiff to pocket money, regardless of whether the plaintiff uses those reductions to pay attorney's fees. *See id.* (providing itemized debt amounts to demonstrate how reductions work mathematically). To permit the plaintiff to pocket money where the plaintiff otherwise would not is an equity justification for the reduction of medical liens. *See id.* at 1366 (agreeing with the idea that fairness dictates that plaintiffs should not shoulder all litigation costs). To permit the plaintiff simply to pocket more of the settlement than the plaintiff already would, and to ensure the plaintiff's attorney recovers a full fee, is less justifiable from an equity perspective. *See* Bryner v. Cardon Outreach, L.L.C., 2018 UT 52, 428 P.3d 1096, 1103 (holding that it is impractical and unreasonable to compel a medical lienholder to contribute to attorney's fees independent of the result of the tort suit).

full recovery and for the plaintiff to pocket some funds as well, there should be no detriment to the plaintiff for them to pay each debt in full.[236]

Rather than trying to free up limited funds by applying an equity doctrine largely out of context or calling on state legislatures to amend medical lien statutes, proponents of the minority view should lobby state legislatures to increase the minimum required insurance coverage.[237] If excess settlement funds largely mitigate medical providers' need to contribute to attorney's fees, then those seeking to impose that requirement should instead seek to maximize the frequency of cases where sufficient settlement funds are available.[238] To the extent such a lobbying effort is not possible, or in the rare case afterward where settlement funds are still insufficient, plaintiffs' attorneys and medical lienholders should submit to a true pro-rata arrangement.[239]

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[236] *See Harlow*, 809 P.2d at 1231 (noting that where there are sufficient financial proceeds to settle all of the plaintiff's tort-related damages, there is no justification for any lienholder to absorb a portion of the proceeds that are intended for another lienholder).

[237] *See* Reynolds, *supra* note 10, at 136 (noting the painstaking effort necessary to amend a medical lien statute). *Kannaday v. Ball* provides an excellent case study on how current minimum insurance limits can fail miserably to cover accident victims. 631 F. App'x 635, 636–37 (10th Cir. 2015) (illustrating that the tortfeasor's $50,000 per accident liability limits were entirely inadequate to cover the injured victims' aggregate medical bills of nearly $300,000). Curiously, although proponents of using the Doctrine to compel medical providers to reduce their liens have proposed a number of solutions to support insolvent tort plaintiffs, they do not suggest raising insurance limits as a possible solution. *See* Reynolds, *supra* note 10, at 136–37 (providing stricter rules regarding health insurance billing and hospital charge calculation as possible answers to the problem, but not addressing the paucity of liability insurance coverage as a possible source); *see also* Ellison, *supra* note 12, at 326–27 (offering an amendment of the Illinois Health Care Services Lien Act to require use of the Doctrine as a solution, but not proposing to change Illinois liability insurance laws as an alternative option). Perhaps the most obvious disadvantage of this strategy is that portions of the public might not be able to afford increased liability insurance premiums, though the fact that the price of liability insurance is currently not a significant issue for drivers somewhat mitigates this concern. *See* Engstrom, *supra* note 54, at 303 (noting that public apprehension about the price of automobile liability coverage is relatively mild).

[238] *See Harlow*, 809 P.2d at 1232–33 (following the suggestion that whether to apply the Doctrine to impose forced reductions on medical lienholders in tort settlements to contribute a proportionate share of attorney's fees justifiably applies only to scenarios with insufficient settlement funds).

[239] *See* Reynolds, *supra* note 10, at 106 (noting that the basis of the tort system is the idea of making the plaintiff whole). The serious and tragic facts of *Martinez* provide an example where all claimants against a settlement, including the attorney, should work together to provide as much money for the injured party as possible. 871 P.2d at 1364. The accident in *Martinez* was a hit-and-run. *Id*. The plaintiff never successfully located the tortfeasor and died before settling the claim (due to unspecified causes), leaving behind a minor child. *Id. Martinez* also demonstrates that although medical provider liens can constitute significant claims against the plaintiff's settlement, attorney's fees can as well. *See id.* (providing an example of a case where the tortfeasor's insurance company settled with the plaintiff for just over $101,000 and the plaintiff's legal fees and costs amounted to over $38,000). In fact, because attorney's fees often accrue as a percentage of the secured settlement amount, it is arguable that attorney's fees are nearly guaranteed to absorb a significant portion of the settlement funds. *See* Goguen, *supra* note 174 (discussing the contingency model for attorney's fees). Thus, for a tort settlement with insufficient funds to realize its goal of making the plaintiff whole, a pro-rata reduction of all claims, including attorney's fees, is logical and equitable. *See* Reynolds, *supra* note 10, at 106

CONCLUSION

Tort settlements are an important source of financial recovery, both for injured plaintiffs and for the medical providers who treat them. Where settlement funds are in limited supply, hiring an attorney can be a double-edged sword. On the one hand, plaintiffs' attorneys can be instrumental in negotiating down debts and ensuring that the funds that are available cover all of a plaintiff's tort-related losses. On the other hand, attorney's fees impose a considerable additional expense upon a complicated financial proceeding where there is often already not enough money to go around.

Understandably, attorneys who vigorously defend their client's interests have looked to the courts to grant relief in such circumstances by ordering medical lienholders to reduce their liens. Attorneys claiming equity concerns as justification for such forced reductions, however, should look for more equitable options. Approaching the issue as a zero-sum game only produces results where somebody loses. If the issue is that tort settlements too often result in insufficient funds, then attorneys and medical providers should work together to lobby state legislatures to change the often paltry minimum insurance requirements that drive poor settlement outcomes. That is the leash that holds the dog, and addressing insufficient state-enacted minimum insurance coverage is the only way to ensure better outcomes for all tort settlement claimants.

SCOTT J. SHELTRA

(discussing the restorative purpose of the tort system). Notably, the attorney and the other lienholders in *Martinez* had previously reduced their fees, and the attorney brought suit to compel the hospital to do the same. 871 P.2d at 1364. Thus, pursuant to the full pro-rata arrangement that the attorney was trying to produce, the result is *Martinez* is justifiable, despite the court's adoption of the minority position. *See id.* at 1368 (providing the court's decision to apply the Doctrine to impose fee sharing liability on the medical lienholder).