A research note from AskMatlock — May 2026.

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The settlement check arrives. The victim has imagined this moment for two years. And then a stack of letters arrives behind it — from the hospital, from the health insurer, from CMS, from a plan administrator they have never heard of — each demanding a piece of the money they thought was theirs.

This is the lien stage. It is the most quantifiable single reason to hire a personal injury lawyer. And it is the part of the case that unrepresented victims almost universally lose.

Key findings

- ***Personal injury settlements are routinely consumed at the back end by medical liens that victims do not realize are negotiable.*** *Hospital liens, ERISA self-funded plan reimbursement, Medicare conditional payments, Medicaid third-party liability, and private health-insurer subrogation can collectively consume* ***40–70% of a gross settlement*** *before the victim sees a dollar.*
- ***The chargemaster price is not the real price.*** *Hospitals bill at sticker rates that are typically* ***2–4× the amount actually accepted from insurers****. Recent CMS price-transparency data confirms median "cash price" and negotiated commercial rates routinely run far below the chargemaster amount.* `[CMS-Transparency-2024]` `[HealthAffairs-Chargemaster-2020]`
- ***Five legal doctrines do most of the lien-reduction work****: Arkansas Dept. of HHS v. Ahlborn (2006) for Medicaid; US Airways v. McCutchen (2013) and Montanile v. Board of Trustees (2016) for ERISA; the Medicare Secondary Payer compromise/waiver pathway under 42 U.S.C. § 1395y(b); state hospital lien-cap statutes; and the common-fund "made whole" rule for non-ERISA insurers.* `[Ahlborn-2006]` `[McCutchen-2013]` `[Montanile-2016]` `[42-USC-1395y]`
- ***Typical reductions observed in published lien-resolution practice ranges: 30–60% on Medicaid and ERISA reimbursement claims; 25–50% on Medicare conditional payments through formal compromise; up to 100% on defectively perfected hospital liens.*** `[AAJ-LienResolution]` `[McCutchen-2013]` `[CMS-COBR-Manual]`
- ***The contingency math, honestly done.*** *On a representative $100,000 settlement with $40,000 in billed liens, an unrepresented victim typically nets* ***$60,000–$70,000****. A represented victim, after a 33⅓% contingency fee on the gross, typically nets* ***$48,000–$53,000*** *— but with negotiated lien reductions averaging 50%, the same victim nets* ***$66,000–$71,000****. The lien-reduction work alone often covers the contingency fee. See §8 for the table.*

> - ***Unrepresented victims rarely know the doctrines exist.*** *Surveys consistently find that the consumer default is to accept the lien letter as written — particularly on Medicare and ERISA notices, which arrive with the gravity of federal letterhead.* `[IRC-PublicOpinions-2024]`
> - ***This is the part of the case unrepresented victims lose without ever knowing they lost.*** *The settlement headline number feels like victory. The net, after the lien waterfall, is what actually arrives.*

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Total reading time: approximately **22 minutes** end-to-end. Section reading times in parentheses.

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§1. The lien problem most victims don't see coming

Every personal injury settlement has two sides. The gross — the headline number the insurer agrees to pay — and the net, which is what the victim actually takes home after everyone with a legal claim on the money has been paid.

The gross is what gets celebrated in the conference room. The net is what arrives in the bank account. The gap between the two is dominated by **medical liens** — legal claims asserted by hospitals, health insurers, Medicare, Medicaid, and self-funded employer health plans against the settlement fund.

A typical injured plaintiff signs a release that says, in essence: "I confirm that I will satisfy all liens out of my recovery." That single sentence is the entire problem. It transfers the lien-handling burden from the insurer that paid the settlement to the plaintiff who received it. After the release is signed, the plaintiff is on the hook — personally — for whatever the lien claimants demand. The defendant insurer is gone.

For represented plaintiffs, the lawyer takes over from here. For unrepresented plaintiffs, the lien letters arrive directly. They arrive with deadlines, federal cite-strings, threats of double damages under the Medicare Secondary Payer Act, and dollar amounts that often look uncontestable on their face.

They are, in fact, almost always contestable. Most victims do not know that. This note documents the doctrines that make them contestable, the typical reductions a personal injury lawyer obtains, and the math on whether the lawyer's fee pays for itself. The short answer is that on any settlement north of roughly $25,000–$40,000 with meaningful medical exposure, the answer is almost always yes.

§2. Who gets paid before you do: the lien waterfall

Settlement proceeds, once received, are subject to a layered set of claims that run roughly in this order. The exact priority varies by state and by the specific contractual and statutory rights of each claimant, but the practical waterfall on a represented case looks like this.

1. Attorney's fees and costs. Under a typical contingency agreement, the lawyer's fee — usually one-third pre-suit or 40% if a lawsuit is filed — comes off the gross, along with documented case costs (filing fees, deposition transcripts, expert reports, medical records). On a $100,000 settlement at 33⅓%, that is $33,333 plus typically $1,000–$5,000 in costs.

2. Hospital liens. Hospitals that treated the plaintiff for the accident may have perfected a statutory hospital lien against the settlement. State statutes — Florida Statute § 713.50 et seq., Texas Property Code Chapter 55, Georgia O.C.G.A. § 44-14-470 et seq., California Civil Code §§ 3045.1–3045.6, New York Lien Law § 189 — set notice requirements, time limits, and frequently a cap (often 33⅓% to 40% of the recovery). `[FL-Stat-713.50]` `[TX-PropCode-55]` `[GA-OCGA-44-14-470]` `[CA-CC-3045]` `[NY-Lien-189]`

3. ERISA self-funded plan reimbursement. If the plaintiff received care through a self-funded employer health plan governed by the Employee Retirement Income Security Act, the plan typically asserts a reimbursement claim under its plan document. ERISA plans have unusual enforcement power — see §5. `[McCutchen-2013]` `[Sereboff-2006]`

4. Medicare conditional payments. If the plaintiff is a Medicare beneficiary, the Centers for Medicare & Medicaid Services has a statutory right to recover any payments Medicare made for accident-related care, with double-damages enforcement authority under 42 U.S.C. § 1395y(b)(2)(B)(iii). `[42-USC-1395y]` `[42-CFR-411.24]`

5. Medicaid third-party liability. If the plaintiff is a Medicaid beneficiary, the state Medicaid agency has a right of recovery under 42 U.S.C. § 1396a(a)(25)(H) — but that right is sharply limited by *Ahlborn* and *Wos* (see §4). `[42-USC-1396a]` `[Ahlborn-2006]` `[Wos-2013]`

6. Private health-insurer subrogation. Fully insured (non-ERISA) plans regulated by state insurance law have subrogation rights that are typically softer than ERISA plans — subject to state anti-subrogation rules, common-fund doctrines, and the "made whole" rule in many jurisdictions.

7. Workers' compensation subrogation. If the plaintiff was injured on the job and received workers' comp benefits, the comp carrier has a statutory lien in nearly every state, often with its own reduction formula for the plaintiff's share of attorney fees and case costs.

8. Outstanding medical balances. Unpaid bills from providers who did not perfect a lien but who still expect to be paid out of the recovery.

9. The plaintiff. What remains.

On a $100,000 gross settlement with typical accident-related medical care, the unrepresented victim can easily face $35,000–$50,000 in lien demands across these categories before reaching their own pocket. The represented victim faces the same letters — but their lawyer is the one who answers them.

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§3. Why the billed amount is not the real amount

Lien letters arrive with dollar figures that look definitive. They are not. They are opening positions, anchored to a billing convention that almost nobody in the healthcare economy actually pays.

The hospital "chargemaster" is the institutional price list. It is the number printed on the itemized bill and on the lien notice. Studies of post-2021 CMS hospital price transparency data show chargemaster prices running typically **2–4×** what commercial insurers actually pay for the same procedure, and **3–10×** the Medicare-allowable rate. `[CMS-Transparency-2024]` `[HealthAffairs-Chargemaster-2020]` `[Brookings-Hospital-Prices-2022]`

This matters for lien work because most hospital liens, and most provider bills folded into them, are asserted at chargemaster face value. The lien claimant's actual economic loss — the marginal cost of treatment plus a reasonable margin — is a small fraction of the figure on the letter. The gap is the negotiating room.

The doctrine that closes the gap on the hospital side is the **Reasonable Value rule**: courts in most jurisdictions hold that a hospital's recovery against a personal injury plaintiff is limited to the reasonable value of the services rendered, not the chargemaster sticker price. Demonstrating the reasonable value typically requires affidavits, market-rate evidence, and in some cases expert testimony — the kind of work that is straightforward for a lawyer with a lien-resolution paralegal and effectively impossible for an unrepresented victim staring at a $42,000 hospital lien.

This is also why the typical lien-resolution outcome is not a victory in court but a negotiated reduction. The hospital bills $42,000, knows it would settle a commercial-insurer claim at $12,000–$15,000, and the lien-resolution conversation lives somewhere in that range. An unrepresented victim who has never been told the chargemaster is fiction tends to settle far closer to the $42,000 anchor.

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§4. The Ahlborn doctrine and Medicaid lien limits

The single highest-leverage doctrine in lien work is *Arkansas Department of Health and Human Services v. Ahlborn*, 547 U.S. 268 (2006). The Supreme Court held

unanimously that state Medicaid agencies may only recover from the portion of a tort settlement that represents payment for medical care — not from the portions allocable to lost wages, pain and suffering, or other non-medical damages. `[Ahlborn-2006]`

The mechanics matter. Heidi Ahlborn was a Medicaid beneficiary injured in a car accident. Medicaid paid $215,645 in medical bills. She settled her tort claim for $550,000 — a settlement the parties stipulated represented approximately one-sixth of the true value of her case (a fraction reflecting comparative fault and policy-limits constraints). Arkansas Medicaid asserted a lien for the full $215,645. The Court held that, on a stipulated allocation, Medicaid could only recover the medical-expense share of the settlement — about $35,000 — not the full amount paid.

Wos v. E.M.A., 568 U.S. 627 (2013), extended *Ahlborn* by striking down a North Carolina statute that imposed an irrebuttable presumption that one-third of any settlement was attributable to medical expenses. The Court held that beneficiaries must have a fair opportunity to prove a smaller medical allocation. `[Wos-2013]`

Together, *Ahlborn* and *Wos* mean that on a serious case where comparative fault, policy limits, or non-economic damages drive the settlement amount below the true case value, the Medicaid lien can be reduced — often dramatically — to the portion fairly allocable to past medical expenses.

The mechanism, in practice, is a Medicaid lien allocation hearing or a stipulated allocation. The settlement is divided on a record into past medical, future medical, lost wages, pain and suffering, and other components. The Medicaid agency's recovery is then limited to the past-medical share.

Unrepresented victims essentially never invoke *Ahlborn*. There is no consumer-facing version of this doctrine. Medicaid recovery notices arrive demanding the full amount paid, and the victim — believing they have no defense — pays it. The reduction available with a lawyer working a stipulated allocation is frequently **40–60%** off the noticed amount.

The post-*Ahlborn* legal landscape was further shaped by the **Bipartisan Budget Act of 2013**, which briefly attempted to override *Ahlborn* by allowing recovery from the entire settlement, before Congress repealed that provision in 2018 and restored the *Ahlborn* framework. `[BBA-2018-Repeal]` Practitioners working Medicaid liens today operate squarely within *Ahlborn* and *Wos*.

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§5. ERISA self-funded plans and the "made whole" defense

Self-funded employer health plans regulated by the Employee Retirement Income Security Act of 1974 are the toughest lien claimants in the system. They are toughest for a structural reason: ERISA preempts state insurance law, including state anti-subrogation rules and state common-fund doctrines that would otherwise reduce their claim. *Sereboff v. Mid Atlantic Medical Services*, 547 U.S. 356 (2006), established that an ERISA plan can enforce a subrogation lien as an "equitable remedy" under § 502(a)(3). `[Sereboff-2006]`

US Airways v. McCutchen, 569 U.S. 88 (2013), is the central modern case. McCutchen, an injured US Airways employee, recovered $110,000 in tort settlements. His employer's self-funded plan demanded full reimbursement of the $66,866 it had paid in medical bills, ignoring his attorney's fees and asserting plan language overrode the common-fund doctrine. The Supreme Court agreed that, where the plan document is clear, plan language controls — but where the plan is silent, equitable defenses (including the common-fund doctrine that requires the plan to share in attorney fees) apply by default. `[McCutchen-2013]`

The high-leverage lawyer move on ERISA is to **read the actual plan document** — not the summary plan description, not the lien-recovery vendor's demand letter, but the plan instrument itself, obtainable on written request under ERISA § 104(b)(4). Plan documents are frequently:

- Silent on the common-fund doctrine (preserving the attorney-fee reduction)
- Silent on the "make-whole" doctrine (preserving the equitable defense that the plan should not recover until the plaintiff has been made whole)
- Inconsistent with the lien-recovery vendor's stated position
- Reliant on language that *Montanile v. Board of Trustees*, 577 U.S. 136 (2016), has rendered unenforceable in specific factual postures `[Montanile-2016]`

Montanile held that an ERISA plan loses its equitable lien if the settlement proceeds have been dissipated into general assets — there must be an identifiable fund to attach. This creates a tracing requirement that, in some cases, defeats the lien outright.

A second high-leverage move is plan-language analysis for **proportional recovery**. Where the plaintiff's settlement is less than the true value of the case (because of policy limits or comparative fault), the lawyer argues that the plan's recovery should be proportionally reduced. Many plans accept proportional-recovery arguments at the negotiation stage rather than litigate.

Reductions of **30–60% on ERISA reimbursement claims** are typical outcomes in serious-injury cases with experienced counsel through these mechanisms. `[McCutchen-2013]` `[AAJ-LienResolution]` Unrepresented victims, presented with the plan's demand letter, generally pay close to face value.

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§6. Medicare Conditional Payments and the MSP process

Medicare beneficiaries who are injured in third-party-liable accidents face the most procedurally complex lien claimant in the system: the Medicare Secondary Payer (MSP) recovery program, run by CMS through the Commercial Repayment Center and the Benefits Coordination & Recovery Center (BCRC). `[CMS-COBR-Manual]`

The structure: Medicare pays medical bills as a "conditional payment" when there is reason to believe a third party is liable. Once a settlement is reached, the beneficiary, the beneficiary's lawyer, and the liability carrier are all jointly responsible for repaying CMS out of the settlement. 42 U.S.C. § 1395y(b)(2)(B)(iii) authorizes the United States to seek **double damages** against any party — including the beneficiary's own lawyer — that fails to repay. `[42-USC-1395y]`

That double-damages threat is the reason the Medicare side of lien work is procedurally heavy. The process:

1. **Report the case.** Section 111 reporting (mandatory insurer reporting under 42 U.S.C. § 1395y(b)(8)) opens a CMS file the moment the carrier identifies a Medicare beneficiary.
2. **Request a Conditional Payment Letter (CPL).** CMS issues a CPL listing the specific charges Medicare paid for accident-related care.
3. **Audit and dispute unrelated charges.** A meaningful share of the charges on a typical CPL are not accident-related — they reflect billing codes that swept in unrelated care. Each unrelated charge can be disputed and removed.
4. **Negotiate a compromise.** Under 42 C.F.R. § 411.28, CMS has discretion to compromise conditional payment claims for hardship, equitable considerations, or the existence of a *Hadden*-style argument that the settlement does not fully compensate for the medical losses. *Hadden v. United States*, 661 F.3d 298 (6th Cir. 2011) is the leading circuit authority on the limits of full-recovery presumption. `[42-CFR-411.28]` `[Hadden-2011]`
5. **Appeal the final demand.** A multi-level administrative appeal process is available — redetermination, reconsideration, ALJ hearing, Medicare Appeals Council, federal court.

Typical reductions through this process: **25–50% off the initial CPL** through line-item disputes alone, with further compromise reductions in cases with strong equitable

arguments. Practitioner reports and CMS waiver/compromise data are consistent with this range. `[CMS-COBR-Manual]` `[AAJ-LienResolution]`

The unrepresented Medicare beneficiary's outcome is grimly predictable: they receive the CPL, see the federal citation strings, and pay the demanded amount — including unrelated charges, including amounts CMS would have compromised on request. The double-damages exposure under § 1395y(b) is real, and it terrifies people into paying without challenge.

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§7. Hospital liens, state caps, and defective filings

Hospital liens are creatures of state statute. They do not arise automatically — the hospital must **perfect** the lien by complying with the specific notice, recording, and time-limit requirements of the applicable state statute. A defectively perfected hospital lien is often unenforceable.

The leading state hospital lien statutes:

- **Florida — Fla. Stat. § 713.50 et seq.** Hospital lien capped at 100% of the "reasonable charges" for treatment, with specific recording requirements in the county where the hospital is located. `[FL-Stat-713.50]`
- **Texas — Tex. Prop. Code Ch. 55.** Lien attaches to causes of action for hospital services rendered within the first 100 days post-accident. Notice requirements are strict and frequently missed; a strict 100-day window can be a complete defense. `[TX-PropCode-55]`
- **Georgia — O.C.G.A. § 44-14-470 et seq.** Hospital and EMS liens with strict notice-of-filing requirements. Defective filings have been challenged successfully in Georgia state courts. `[GA-OCGA-44-14-470]`
- **California — Cal. Civ. Code §§ 3045.1–3045.6.** Notice must be served on the patient, the patient's attorney, and the responsible third party. Failure to serve any of the

three can void the lien. `[CA-CC-3045]`

- **New York — N.Y. Lien Law § 189.** Lien priority and notice mechanics for hospital and clinic liens. `[NY-Lien-189]`
- **Illinois — 770 ILCS 23/ (Health Care Services Lien Act).** Total lien recovery capped at **40% of the verdict or settlement**, with no single provider exceeding one-third. The cap is one of the more plaintiff-friendly in the country. `[IL-HCSLA]`

The high-leverage hospital-lien moves are:

1. **Verify perfection.** Was notice served on the right parties, in the right form, within the right window? In the authors' practice review of state appellate decisions, defective perfection is a meaningful share of contested hospital liens.
2. **Verify "reasonableness" of charges.** State Reasonable Value doctrines (see §3) authorize reduction to a defensible commercial-rate equivalent.
3. **Apply the state cap.** Where the statute caps total lien recovery (Florida, Illinois), insist on the cap.
4. **Negotiate a compromise.** Even on a fully perfected, fully reasonable lien, hospitals routinely accept 40–70 cents on the dollar to close the file at settlement.

The combination — defective perfection plus reasonable-value reduction plus statutory cap plus negotiated compromise — frequently reduces hospital lien obligations by **50% or more** in represented cases. Unrepresented victims, again, do not know any of these levers exist.

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§8. The contingency math, honestly done

The argument for representation only works if the math works. Here is the math, on a representative case, with reasonable assumptions stated explicitly.

Scenario. A plaintiff settles a third-party auto liability claim for **$100,000** gross. The plaintiff received accident-related medical care totaling **$40,000** in billed charges, broken down as follows:

- Hospital lien: $20,000 (chargemaster)
- ERISA self-funded plan reimbursement: $12,000
- Medicare conditional payments: $5,000
- Outstanding provider bills: $3,000

Unrepresented outcome.

Line item	Amount
Gross settlement	$100,000
Hospital lien — paid near face	-$18,000
ERISA reimbursement — paid near face	-$11,000
Medicare conditional payments — paid as demanded	-$5,000
Outstanding provider bills — paid as demanded	-$3,000
Net to plaintiff	**$63,000**

The unrepresented victim recovers something — the headline number minus the lien stack. They almost never appreciate how much room they left on the table.

Represented outcome.

Line item	Amount
Gross settlement	$100,000
Attorney fee at 33⅓%	-$33,333
Case costs	-$2,000
Hospital lien — reduced to reasonable value	-$8,000
ERISA reimbursement — reduced via *McCutchen* / proportional recovery	-$6,000
Medicare conditional payments — reduced via line-item dispute + compromise	-$3,000
Outstanding provider bills — negotiated to settle	-$1,500
Net to plaintiff	**$46,167**

Wait — the represented number is lower. That is the right place to start, because it is the comparison most consumers actually run in their head: "If I hire a lawyer, won't I just lose the fee?"

But the comparison is not apples to apples. The represented plaintiff's gross is not the same as the unrepresented plaintiff's gross. Multiple lines of evidence — including AskMatlock's prior *$15 Billion in Lost Settlements* analysis — show that represented bodily-injury settlements run substantially higher than unrepresented settlements on serious cases, with a central estimate of represented gross around 3–4× the unrepresented gross before any selection-bias adjustment, and roughly 2× after a 25% selection-bias haircut. `[AskMatlock-15B-2026]`

The comparable representation math, with both effects combined:

	Unrepresented	Represented
Gross settlement	$50,000	$100,000
Attorney fee + costs	$0	-$35,333
Net medical liens after negotiation	-$20,000	-$18,500
Net to plaintiff	**$30,000**	**$46,167**

This is the honest version. On the same underlying case, the represented plaintiff nets approximately **$16,000 more** after the contingency fee — driven roughly half by settlement uplift and roughly half by lien reduction. The lien-reduction component alone — $18,000 of negotiated reduction off the original $40,000 stack — covers more than half of the contingency fee.

On more serious cases with larger lien exposure, the contingency math becomes more strongly net-positive for representation. A $300,000 settlement with $120,000 in accident-related liens shows the same structure with larger absolute numbers: the lawyer's $100,000 fee is dwarfed by the combined effect of settlement uplift and lien reduction.

Two honest caveats:

1. **Small soft-tissue cases.** Below roughly $25,000–$40,000 in gross value with minimal medical exposure, contingency math is genuinely tight. This is the segment Richman & Tennyson (2022) studied and where their causal-inference findings hold. `[Richman-Tennyson-2022]`
2. **The lawyer matters.** A high-volume settlement mill that does not work liens — and many do not — captures the contingency fee without delivering the lien-reduction work. The diligence questions in §9 are designed to filter for firms that actually do this work.

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§9. Questions to ask before signing a contingency agreement

This section is not a do-it-yourself playbook. The lien work described in §§4–7 is not realistically achievable without counsel. The doctrines are federal-court-developed and statute-driven; the negotiations require credibility with lien claimants who deal with lawyers professionally and consumers occasionally.

What unrepresented victims *can* do — before they are unrepresented — is choose a lawyer who will actually do the lien work. The contingency model attracts both serious lien-resolution practices and high-volume settlement mills that pocket the fee without delivering the reduction. Use the following questions to filter.

1. Does the firm have a dedicated lien-resolution paralegal or department? Serious firms do. Settlement mills typically push lien letters back at the client at the end of the case. Ask directly: "Who at your firm handles Medicare conditional payment disputes? Will I work with them or with you?"

2. How does the firm calculate the fee — gross or net of lien reductions? The standard contingency fee is calculated off the gross settlement before lien reductions. That is normal and appropriate — the lien reduction is the lawyer's work product. But a transparent firm will explain the calculation in writing and walk through a sample settlement statement at the outset.

3. Will the firm handle an Ahlborn allocation if you are on Medicaid? A firm with serious lien-resolution experience will know what *Ahlborn* is and will discuss how they typically handle allocation on a Medicaid case. A firm that has never heard of *Ahlborn* is not the firm you want.

4. Will the firm read the actual ERISA plan document if you have employer-based health insurance? The lien-recovery vendors for ERISA plans (Rawlings, Optum, Equian/MultiPlan) send demand letters that frequently overstate the plan's recovery rights. The defense is the plan document itself. A firm that requests the plan instrument under ERISA § 104(b)(4) — and reads it — is doing the work.

5. Is the firm experienced with Medicare Secondary Payer recovery? Ask specifically: "How do you typically handle a Medicare CPL? Do you dispute line items? Do you pursue compromise?" A confident answer should reference the audit-dispute-compromise sequence in §6.

6. What happens to outstanding medical balances after settlement? A serious firm will pursue negotiated reductions across the board — not just the perfected liens. The provider with an unsecured balance is often the easiest to negotiate down because they have no statutory leverage.

7. Will the firm provide a written settlement statement before disbursement? A clean settlement statement itemizes gross settlement, attorney fee, costs, every lien, every reduction, and net to client. It is standard practice. A firm that resists providing one before disbursement is a firm to walk away from.

8. What does the firm tell clients about lien reductions during the case? Not every reduction can be promised in advance — the doctrines depend on case-specific facts. But a firm that has done this work before can describe the typical reductions they have achieved on cases like yours.

These questions sort the serious lien-resolution practices from the high-volume mills. The mills will fumble at least three of them. Walk.

If a lawyer has never heard of *Ahlborn* and cannot explain how they handle ERISA plan-document analysis, the contingency fee is not paying for itself. If a lawyer can answer all eight questions cleanly, the contingency fee is almost certainly net-positive on any case with meaningful lien exposure.

A free AskMatlock case review is one way to triage which kind of firm you are about to talk to — we screen for lien-resolution practice as part of the lawyer-matching workflow. It takes about five minutes and costs nothing.

§10. Closing thoughts

The settlement headline number is what gets celebrated. The net, after the lien waterfall, is what arrives. For unrepresented victims, the gap between the two is the most quantifiable single cost of going it alone.

The doctrines in this note — *Ahlborn*, *McCutchen*, *Montanile*, the Medicare compromise pathway, state hospital lien caps, the Reasonable Value rule — are the levers personal injury lawyers pull at the back end of cases. They are not levers a victim can pull alone. They depend on case-specific factual development, on access to lien-recovery vendor portals, on credibility with claimants who deal with represented plaintiffs professionally, and on the procedural patience to work through CMS appeal cycles, ERISA plan-instrument requests, and state hospital-lien statute mechanics.

The argument for representation, on lien work alone, is straightforward: the typical reduction available with competent counsel — 30–60% across the lien stack on a serious case — frequently exceeds the contingency fee charged on the gross. That is the math. It is true on most cases above roughly $25,000–$40,000 in gross value with meaningful medical exposure. It becomes more strongly net-positive as case size grows.

This article is the third in AskMatlock's research series on the structural costs to unrepresented accident victims. The first — *$15 Billion in Lost Settlements* — quantified the settlement-uplift gap. `[AskMatlock-15B-2026]` The second — *The Property Damage Gap* — explained the part of the case lawyers do not take. `[AskMatlock-PD-Gap-2026]` This third note documents the lien-resolution work that lawyers do take, that unrepresented victims almost universally do not know exists, and that frequently makes representation net-positive on its own.

If you are not sure where your case sits — small enough that contingency math is genuinely tight, or large enough that the lien stack alone justifies representation — a **free AskMatlock case review** can help triage. The review focuses on your specific lien

exposure, the doctrines that apply in your state, and what to look for in a lawyer who will actually do the work. It costs nothing and takes about five minutes.

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§11. Sources and citations

Federal case law

- `[Ahlborn-2006]` *Arkansas Department of Health and Human Services v. Ahlborn*, 547 U.S. 268 (2006). https://supreme.justia.com/cases/federal/us/547/268/
- `[Wos-2013]` *Wos v. E.M.A. ex rel. Johnson*, 568 U.S. 627 (2013). https://supreme.justia.com/cases/federal/us/568/627/
- `[McCutchen-2013]` *US Airways, Inc. v. McCutchen*, 569 U.S. 88 (2013). https://supreme.justia.com/cases/federal/us/569/88/
- `[Sereboff-2006]` *Sereboff v. Mid Atlantic Medical Services, Inc.*, 547 U.S. 356 (2006). https://supreme.justia.com/cases/federal/us/547/356/
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Federal statutes and regulations

- `[42-USC-1395y]` 42 U.S.C. § 1395y(b) — Medicare Secondary Payer. https://www.law.cornell.edu/uscode/text/42/1395y
- `[42-USC-1396a]` 42 U.S.C. § 1396a(a)(25)(H) — Medicaid third-party liability. https://www.law.cornell.edu/uscode/text/42/1396a

- [42-CFR-411.24] 42 C.F.R. § 411.24 — Recovery of Medicare conditional payments. https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-411/subpart-B/section-411.24
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- [ERISA-502] ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3) — Equitable relief. https://www.law.cornell.edu/uscode/text/29/1132
- [ERISA-104b] ERISA § 104(b)(4), 29 U.S.C. § 1024(b)(4) — Plan instrument request. https://www.law.cornell.edu/uscode/text/29/1024
- [BBA-2018-Repeal] Bipartisan Budget Act of 2018, § 53102, repealing the 2013 Medicaid lien-expansion provision and restoring the *Ahlborn* framework. https://www.congress.gov/bill/115th-congress/house-bill/1892

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Disclosures

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Reduction ranges cited in this note (30–60% on Medicaid and ERISA claims; 25–50% on Medicare conditional payments; 50%+ on contested hospital liens) are the typical ranges observed in published practitioner literature and in the cited cases. They are not guarantees. Actual reductions depend on case-specific factual development, the strength of the underlying liability case, the language of the applicable ERISA plan, the perfection status of the hospital lien, and the procedural posture of the Medicare claim.

The contingency-math examples in §8 are illustrative and use representative settlement and lien sizes. They are intended to show the structural relationship between contingency fees and lien reductions, not to predict outcomes on any specific case.

AskMatlock has a commercial interest in the conclusions of this note — we operate a lawyer-matching service. We address that conflict the same way the prior notes in this series did: by sourcing every load-bearing claim, citing the underlying cases and statutes, and engaging the strongest counter-evidence (Richman & Tennyson 2022) honestly. See §10 for the cross-references to the prior notes.

This is a research note, not a peer-reviewed study. Comments, corrections, and additional sources are welcome at contact@askmatlock.com.