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MONTHLY ELECTRONIC SUBROGATION NEWSLETTER APRIL 2007

TO CLIENTS AND FRIENDS OF MATTHIESEN, WICKERT & LEHRER, S.C.:

This monthly electronic subrogation newsletter is a service provided exclusively to clients and friends of Matthiesen, Wickert & Lehrer, S.C. The vagaries and complexity of nationwide subrogation have, for many lawyers and insurance professionals, made keeping current with changing subrogation law in all fifty states an arduous and laborious task. It is the goal of Matthiesen, Wickert & Lehrer, S.C. and this electronic subrogation newsletter, to assist in the dissemination of new developments in subrogation law and the continuing education of recovery professionals. If anyone has co-workers or associates who wish to be placed on our e-mail mailing list, please provide their e-mail addresses to Rose Thomson at rthomson@mwl-law.com. We appreciate your friendship and your business.

HEALTH INSURANCE SUBROGATION

Health Subrogation Not a Part of the Bankruptcy Estate

Another Health Subrogation Victory for Matthiesen, Wickert & Lehrer, S.C.

By Ryan L. Woody

Swanson v. J.W. Hutton, Inc. and Wausau Benefits, Inc., 06-2403 Bkrtcy. (E.D. Wis. March 22, 2007).

The intersection of health subrogation and bankruptcy can be a confusing area for many subrogation professionals and attorneys. However, when the two areas collide, the health subrogation professional should be prepared to fight back. MWL recently handled the defense of a non-ERISA health Plan that had been sued by the bankruptcy trustee.

The trustee alleged that the Plan accepted a preferential transfer in violation of the Bankruptcy Code. What occurred was a very common situation. The health Plan accepted approximately $18,000 in satisfaction of its subrogation interest in a Plan member's third party tort suit. The problem arose when the Plan member filed bankruptcy shortly after the settlement. The Bankruptcy Code § 547prohibits certain transfers within 90 days of filing bankruptcy that allow one creditor to receive more than the other creditors. Under the Bankruptcy Code, in order to establish and avoid a preference, the trustee has the burden to prove each of the elements under § 547(b). Accordingly, the trustee must show that the alleged transfer was made:

(1) to or for the benefit of a creditor;
(2) for or on account of an antecedent debt owed by the debtor before such transfer was made;
(3) made while the debtor was insolvent;

(4) made --
(a) on or within 90 days before the date of the filing of the petition; or
(b) between 90 days and one year before the date of the filing of the petition, if such creditor at the time of such transfer was an insider; and
(5) that enables such creditor to receive more than such creditor would receive if --
(a) the case were a case under chapter 7 of this title;
(b) the transfer had not been made; and
(c) such creditor received payment of such debt to the extent provided by the provisions of this title. 11 U.S.C. § 547(b) (*emphasis added*).

MWL argued that the transfer did not violate the Bankruptcy Code, because a Plan's subrogation interest can never become property of the bankruptcy estate. A health subrogation lien is simply not a "debt" and the Plan's interest is not akin to a general creditor. Instead the subrogation recovery is distinct in that it was at all times property of the health Plan.

The Plan relied upon the Sixth Circuit's recent decision in *In re Bergman*, 467 F.3d 536, 2206 Fed.App. 03897 (6th Cir. 2006). The *Bergman* court decided the issue of "whether an insurer's contractual subrogation rights create a property right in the insurer, so that this contractual right is not properly included in the bankruptcy estate." Id at 538. In *Bergman*, the bankruptcy trustee had instituted a third party lawsuit on the debtor's behalf against a third party responsible for an automobile accident involving the debtor. Anthem Blue Cross & Blue Shield ("Anthem") had provided health insurance to the debtor and claimed a $3,000 subrogation interest in that lawsuit. The Anthem policy provided a contractual right of subrogation. After settling the personal injury action, the trustee brought an adversarial proceeding against Anthem to declare that it was a general unsecured creditor. The Sixth Circuit wrote that, "[s]ince the insurance company had a contractual right to subrogation before its insured filed bankruptcy, the Trustee could not properly acquire it for the benefit of the general creditors." Id. at 539. Because "Anthem acquired a pre-petition property right in any future recovery", the court held that it was not a part of the bankruptcy estate under § 541 of the Bankruptcy Code. Id. Accordingly, the *Bergman* court found that Anthem was entitled to its post-petition subrogation claim.

The Plan also cited the legislative history of the Bankruptcy Code, which evidences that Congress did not intend for a subrogation interest in medical payments to become part of the bankruptcy estate. Specifically, Congress indicated the following regarding § 541:

> *"Section 541 will not apply in those instances where property which ostensibly belongs to the debtor is in reality, held by the debtor in trust for another. For example, if the debtor has incurred medical bills that were covered by insurance and the insurance company had sent payment of those bills to the debtor before the debtor had paid the bill for which the payment was reimbursement, the payment would actually be held in constructive trust for the person to whom the bill was owed. The payment would not, therefore, become property of the estate pursuant to Section 541."* H.R. Rep. No 595, 95th Cong., 1st Sess., 367-8 (1977); S. Rep. No. 989, 95th Cong., 2nd Sess., 82-3 (1978) reprinted in 1978 U.S. Code Cong. & Admin. News 5787, (*emphasis added*).

The Bankruptcy Court agreed with the Plan's position that the subrogation interest would never become property of the bankruptcy estate. The court rejected the trustee's argument that a health subrogation interest is of no greater priority than any other general creditor. In doing so, the court adopted the Sixth Circuit's rationale in *Bergman* and properly dismissed any and all claims against the health Plan. It should be noted that the *Bergman* decision has now been appealed to the U.S. Supreme Court and the parties await a decision on whether the court will hear the case.

Should you have any questions regarding this case or the intersection of bankruptcy and health subrogation, please contact Attorney Ryan Woody at rwoody@mwl-law.com.

WORKERS' COMPENSATION SUBROGATION

WORKERS' COMPENSATION SUBROGATION: Which Payments Can Be Recovered?

By Gary L. Wickert

In many respects it is as daunting and elusive as the search for the Holy Grail. All fifty states allow for recovery of workers' compensation benefits paid to or on behalf of a claimant injured in the course of his or her employment. Not a single one, however, enunciates precisely which payments or costs paid by a compensation carrier constitute "compensation" and can be recovered. The result is an ongoing debate and argument with claimants' attorneys over what can and can't be included in a carrier's lien for recovery purposes.

In addition to medical expenses, death benefits, funeral costs and/or indemnity benefits for lost wages and loss of earning capacity resulting from a compensable injury, workers' compensation insurance carriers also expend considerable dollars for case management costs, medical bill audit fees, rehabilitation benefits, nurse caseworker fees, and the like. Subrogation professionals and trial lawyers are not the only ones confused. Trial judges, too, scratch their heads and stare blankly into the courtroom when asked whether a carrier can include such payments in their subrogation liens. As is often the case when there is no answer in law – a good argument can often carry the day.

Judges like things that fit neatly into legal categories and definitions. When subrogating for more than basic medical and indemnity benefits, look first to the underlying workers' compensation subrogation statute. In Texas, for example, the statute reads as follows:

> *"…the net amount recovered by a claimant in a third-party action shall be used to reimburse the carrier for benefits, including medical benefits that have been paid for the compensable injury."* V.T.C.A. Labor Code § 417.002.

Therefore, the question becomes whether or not such things as case management costs and medical bill audit fees are considered benefits or medical benefits which have been paid "for the compensable injury". "Case management" is a collaborative process of a medical assessment, planning, facilitation and advocacy for options and services to meet an injured worker's health needs through communication and available resources in order to promote quality and cost-

effective recoveries and outcomes. Fee audits ensure compliance with state fee guidelines, prevent fraud, and keep liens to an absolute minimum. These efforts hold down costs of workers' compensation for employers and ensure that the smallest lien possible is taken from an injured worker's third-party recovery. Refusing to reimburse costs such as these is not only illogical, it's foolish. But logic doesn't always win the day, so let's look at the law.

The Texas Department of Insurance – Workers' Compensation Division actually requires these services and expenses. Therefore, the carrier should be able to recover them. The Texas Administrative Code provides as follows:

> "*(a) The ground rules and the medical service standards and limitations as established by the Fee Guidelines shall be used to properly calculate the payments due to the healthcare providers.*" Tex. Admin. Code Tit. 28, § 134.1.

The Texas Supreme Court has also indirectly weighed in on the issue. It has confirmed that § 417.002(a) requires that a carrier be reimbursed out of any third-party recovery for all benefits paid for an injury. Texas Workers' Comp. Ins. Fund v. Serrano, 962 S.W.2d 536 (Tex. 1998). It says that the statute does not limit reimbursement to only those benefits that are reasonable and necessary. Because the injured worker receives the benefit of all amounts paid, the carrier is entitled to reimbursement without proving that the amounts paid to or for the worker were reasonable and necessary medical expenses. The assumption is that if it was paid, it should be reimbursed. The court essentially gave broad definitions to the terms "medical benefit" and "healthcare". The Serrano court allowed reimbursement for costs and payments introduced in that case which indicated on their face that they were paid in accordance with Commission guidelines.

Each state should be evaluated and argued differently, because each state's statute is different. In California, for example, the applicable statute reads as follows:

> *"Any employer who pays, or becomes obligated to pay compensation, or who pays, or becomes obligated to pay salary in lieu of compensation, or who pays or becomes obligated to pay an amount to the Department of Industrial Relations pursuant to Section 4706.5, may likewise make a claim or bring an action against the third person. In the latter event, the employer may recover in the same suit, in addition to the total amount of compensation, damages for which he or she was liable including all salary, wage, pension, or other emolument paid to the employee or to his or her dependents."* Cal. Labor Code § 3852.

The workers' compensation carrier is entitled to recover in the same third-party lawsuit with the employee, the total amount of its expenditures for "compensation" and any other special damages, such as salary, wage, pension or other emolument paid to the employee. Cal. Labor Code § 3856(c). California law then defines "compensation" as:

> *"…compensation under this division and includes every benefit or payment conferred by this division [Division IV] upon an injured employee, or in the event of his or her death, upon his or her dependents, without regard to negligence."* Cal. Labor Code § 3207.

"Compensation" therefore, includes medical and hospital expenses (Cal. Labor Code §§ 4600-4608), medical-legal expenses (Cal. Labor Code §§ 4620-4628), vocational rehabilitation

expenses (Cal. Labor Code §§ 4635-4647), disability indemnity payments (Cal. Labor Code §§ 4650-4663), death benefits (Cal. Labor Code §§ 4700-4709), and interest (Cal. Labor Code § 5800). Most penalties are arguably recoverable as mandated by Division IV, and even the cost of utilization review should now arguably be recoverable as the use of such process is now mandated by California law. Cal. Labor Code § 4610. However, the cost of utilization review may not be a "benefit" or "payment conferred on an injured employee". Aside from the logical arguments above, California law apparently does not directly support recovery of these items. But it does require mitigation of damages, and one Court of Appeals decision does allow a plaintiff to recover the cost of mitigation efforts as a recoverable item of damages. Kleinclause v. Marin Realty Co., 94 Cal.App.2d 773 (1949).

Another interesting and cogent argument is an analogy to the right to a future credit. When a recovery by a claimant is made, the carrier is given a credit toward future "benefit" payments. A close look at this law reveals that "medical-legal" costs should be costs against which a carrier can press a credit, implying that they constitute "compensation" under California law and should be recoverable by a workers' compensation carrier. Adams v. W.C.A.B., 18 Cal.3d 226 (1976).

Arguments in each state should be fashioned from the only tools available – statutory language and common sense. In North Carolina, for example, the workers' compensation statute provides for reimbursement to the carrier of "all benefits by way of compensation or medical compensation expense paid or to be paid". N.C.G.S.A. § 97-10.2. Further legal archaeology reveals the definition of compensation as follows:

> *"The term 'compensation' means the money allowance payable to an employee or to his dependents as provided for in this Article, and includes funeral benefits provided therein."* N.C.G.S.A. § 97-2.

North Carolina case law reveals no further clarification on exactly what "medical compensation expenses" refer to, but the door seems open wide enough to include some of the case management costs referenced above, yet not quite wide enough to include interest. Buckner v. City of Asheville, 438 S.E.2d 467 (N.C. App. 1994). In North Carolina, however, there is also the possible appeal to the Industrial Commission to have something declared as a "benefit" recoverable in subrogation. Before the Commission can declare that a carrier is entitled to a particular expense, it must make a factual determination that the services were rehabilitative in nature and reasonably "required to effect a cure of give relief" to the claimant. Walker v. Penn Nat'l Security Ins. Co., 608 S.E.2d 107 (N.C. App. 2005). This state has a higher burden to meet in order to recover something as a "benefit" in subrogation.

Illinois has totally ignored the cost savings to the claimant of such case management fees and expenditures. It has declared such items unrecoverable because such medical rehabilitative services provided by the claims coordinator at the insurance company's direction were presumably provided for the benefit of the carrier and were not reimbursable necessary medical or rehabilitative services. Cole v. Byrd, 656 N.E.2d 1068 (Ill. 1995). The particular expense at issue was the medical rehabilitation coordinator services of a licensed professional nurse provided by Professional Rehabilitation Management (PRM).

When attempting to recover for costs or expenses beyond the basic indemnity and medical benefit payments, a subrogation professional's first strategy should be to look at the law of the particular state involved, to determine exactly what the subrogation statute allows the carrier to recover. For

example, if it allows for recovery of “benefits” or “compensation” paid, then the definitions of those terms in other areas of the workers’ compensation law should be determined, and an argument fashioned that those definitions include case management type fees and expenses. If that proves to be a dead end, a logical argument should be made that by discouraging the spending of such amounts, the subrogation lien will actually increase, and the recovery of the injured worker will decrease. Such expenditures actually assist in holding down the cost of workers’ compensation insurance premiums, and every incentive to hold down liens and reduce fraud will make workers’ compensation systems more cost-effective and affordable for businesses. As a last resort, simply include these reasonable costs in the lien totals provided to plaintiffs’ lawyers, putting the burden on them to affirmatively challenge such expenses. While it is perhaps a stretch to include attorney’s fees and other overhead charges in the lien total, it is reasonable to expect reimbursement of expenses and costs which actually benefit the claimant by keeping the benefits total to its absolute minimum. If the totals are not questioned, there is no foul. If they are, remember the words of Mark Twain, “Whatever you say, say it with conviction.”
