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MONTHLY ELECTRONIC SUBROGATION NEWSLETTER FEBRUARY 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

DISTRICT OF COLUMBIA COURT OF APPEALS REJECTS MADE WHOLE DOCTRINE AS DEFAULT RULE

Moore v. CapitalCare, Inc., 461 F.3d 1 (C.A.D.C. 2006).

The District of Columbia Court of Appeals has finally ended its holdout as the last federal appellate circuit not to have weighed in on the effect of ERISA Plan language on the made whole doctrine. *Moore v. CapitalCare, Inc.*, 461 F.3d 1 (C.A.D.C. 2006). In *Moore v. CapitalCare, Inc.*, Moore was severely injured in an automobile accident and as a result required extensive medical care. She is the beneficiary of an ERISA-covered health insurance plan which paid more than $200,000 in accident-related benefits on Moore's behalf. Moore also recovered a $1.3 million settlement for her injuries from a personal injury lawsuit. Moore sued the Plan administrator, seeking both a money judgment and a declaration that medical benefits paid under the Plan were chargeable to the Health Maintenance Organization (HMO) coverage rather than indemnity component of Plan. The subrogation/reimbursement clause of the Plan read as follows:

> *12. Subrogation. (a) To the extent that benefits for covered services are provided or paid under this Contract, the Corporation shall be subrogated and succeed to any rights of recovery of a Participant for expenses incurred against any persons or organizations except insurers on policies of health insurance issued to and in the name of the Participant. (b) The Participant shall pay the Corporation all amounts recovered by suit, settlement, or otherwise from any third party or his insurer to the extent of the benefits provided by this Contract. (c) Attorneys's [sic] fees, court costs, and any other costs expended in the course of securing recovery by suit, settlement, or otherwise, shall be subtracted from the amount to be paid to the Corporation; the amount to be subtracted shall be as follows:*

(1) If the case is settled out of court - one-quarter of the amount of benefits paid or to be paid for covered services; or
(2) If the case is settled as a result of litigation - one-third of the amount of benefits paid or to be paid for the covered services. Id.

The District Court awarded Moore unpaid benefits and gave the Plan an equitable lien against the settlement funds. Moore appealed the reimbursement award, arguing that the Plan was not entitled to reimbursement because she was not "made whole" by her settlement. The Court of Appeals held that the Plan language trumped the made whole doctrine, and even if the language of the subrogation provision was viewed as ambiguous, that Plan administrator's interpretation of that provision as applied to Moore's partial recovery was reasonable. Subsection (a) of the Plan's subrogation provision provided that the plan "*shall ... succeed to any rights of recovery of a Participant* " and subsection (b) provided that the "*Participant shall pay the Corporation all amounts recovered by suit, settlement, or otherwise from any third party or his insurer to the extent of the benefits provided by this Contract*." The court held that this was sufficient to overcome the made whole doctrine, and specifically rejected the opportunity to adopt the made whole doctrine as a default rule.

HEALTH INSURANCE SUBROGATION

MADE WHOLE DOCTRINE IN TEXAS CLARIFIED

Veazey v. Allstate Texas Lloyds, 2007 WL 29239 (N.D. Tex. 2007).

On January 3, 2007, a federal district court for the Northern District of Texas decided a case under Texas law which dealt with the extent and breadth of the made whole doctrine, and the burden of proof in such cases. *Veazey v. Allstate Texas Lloyds,* 2007 WL 29239 (N.D. Tex. 2007). Far too many subrogation professionals simply assume that the made whole doctrine stands for the proposition that until the insured recovers all of its losses – insured and uninsured – from the third party, the insurance company has no right of subrogation. While this harsh application of the made whole doctrine may be the rule in some states, such as Wisconsin, the *Veazey* holding states that the insured has no right to any recovery made by the subrogated carrier for any insured damages already covered by Allstate – even if the insured were not made whole for its uninsured losses – and that the burden of proof was on the insured to prove that some portion of Allstate's subrogation recovery was for the uninsured damages sustained by the insured. It is important that all subrogation professionals know the difference between the strict application of the made whole doctrine (insured cannot recover unless the insured is made whole for both insured and uninsured damages) and the more liberal application of the doctrine (insurance company can subrogate and recover the insured damages from the third party, even though the insured is not made whole for its uninsured damages).

George Veazey's Lexus caught fire in his garage due to a manufacturer's defect, resulting in a total loss of his dwelling and contents, and requiring significant living expenses. Allstate paid Veazey $1,375,523 under a homeowner's policy for these items of damage – policy limits under the policy. The insureds claimed damages of $9 million and sued Toyota. Allstate intervened into that lawsuit. Allstate settled directly with Toyota for $900,000, and assigned to them its entire $1,375,523 subrogation interest. The insured then settled its claim against Toyota for an

undisclosed amount, and immediately filed suit against Allstate, claiming that he was not made whole for all of his damages, and therefore Allstate should not be able to subrogate.

The plaintiff argued that because they recovered more than the $1,375,523 paid by Allstate, but less than the $9 million in damages they sustained, they are not made whole and Allstate should not be allowed to keep the $900,000 Toyota paid it in settlement. He asked for reimbursement of the $900,000. The federal court granted Allstate's summary judgment, holding that the made whole doctrine did not apply. The made whole doctrine is an equitable doctrine which is applied when there are insufficient funds to cover the insured's damages. However, the doctrine does NOT mean that until the insured recovers 100% of his claimed damages, the carrier cannot subrogate.

The plaintiffs relied on the landmark made whole case of *Ortiz v. Great Southern Fire and Cas. Ins. Co.,* 597 S.W.2d 342 (Tex. 1980), which introduced the doctrine in Texas. However, in *Ortiz,* the insured suffered $15,000 in fire damage ($4,000 real property and $11,000 personal property), of which only the $4,000 was covered by insurance. The insured settled with the third party for $10,000. The insurance company filed suit against the insured to assert an interest in the $10,000 settlement. The Texas Supreme Court held that if any portion of the $10,000 was intended as compensation for the $4,000 in real property which was covered by insurance, the insurance company would be able to subrogate for that amount. In *Ortiz,* the court held that the made whole doctrine applied, barring the insurance company from recovering any portion of the $10,000 settlement, because the insurance company could not prove what portion, if any, of that settlement was for damage to real property. While it is assumed that the third party would not settle and leave a claim open, it was held to be the insurance company's burden to prove that some portion of the settlement was for the insured damages as opposed to the uninsured damages. This is because the insurance company brought the suit, and as plaintiff, had the burden of proof.

In *Veazey,* the suit was brought by the insured to recover from the insurance company, and so the insured had the burden of proof of showing that the third party settlement included some of his uninsured losses – a burden he failed to meet. Therefore, the court allowed Allstate to keep the $900,000 it recovered in settlement with Toyota. The federal court held that if any portion of a third party recovery is intended as compensation for the damages for which the insurance company paid on its policy, then that insurance company has the right to be subrogated for such amounts – even if the insured is not made whole. Allstate is entitled to subrogate to the extent that the sum of insurance collected by the insured, plus the amount allocated (in the third party settlement) to the covered real property loss, that exceeds the real property loss suffered by the Veazeys. The court also went on to say that the third party which settled Allstate's $1,375,523 subrogation interest for $900,000 and received an assignment of that interest from Allstate, could offset whatever it owed to the insured by the full $1,375,523 subrogation interest. The court clearly stated that Veazey had no right to any payments made by Toyota which represented damages already covered by the Allstate policy, and because Veazey was the one who filed suit, he had the burden of proving what damages the Allstate settlement with Toyota represented.

Far too often plaintiff's attorneys and insureds argue that an insurance company is simply not entitled to any subrogation unless and until the insured is made completely whole for all of its damages. The *Veazey v. Allstate* decision, even though it is only a federal district court holding, clearly shows that this is not the case.

FEDERAL COURT HOLDS THAT SUBROGATED ERISA PLAN MAY REMOVE CASE UPON INITIAL COMPLAINT

By Ryan L. Woody

As we all know, an ERISA Plan's subrogation rights enjoy the benefit of federal preemption. However, this complex body of federal law can become even more dicey when put into the hands of a state court trial judge. Most state courts will try to apply the familiar principles of insurance subrogation, including doctrines like made whole and common fund. For this reason, it is helpful to avoid a state court's adjudication of your ERISA lien if at all possible. However, this may not be possible if you are dealing with a lawsuit filed in Wisconsin. This is because Wis. Stat. §803.03 requires plaintiffs to join all necessary parties, which includes subrogated ERISA carriers. The question then arises, how should an ERISA Plan respond when it is joined as a party in Wisconsin? The United States District Court for the Eastern District of Wisconsin recently decided that question in *Fagan v. Destafinis, et al.*, 2:06-CV-00380-CNC (Dec. 14, 2006).

In that case, Barbara Fagan filed suit in the Milwaukee County Circuit Court on April 21, 2005 alleging medical malpractice against her dentist Paul DeStefanis and his liability insurer. Id. at *1. Pursuant to Wis. Stat. § 803.03, Fagan joined Wausau Benefits, Inc. as administrator of a self-funded ERISA Plan. Fagan asserted no claims against Wausau but sought "a judgment determining the rights of Wausau Benefits, Inc. as against the Plaintiff…upon any claim of subrogation or reimbursement". Id. at *1-2. Wausau filed an Answer in state court alleging its right of subrogation. The case was later settled at mediation on March 14, 2006 without the approval of Wausau. Shortly thereafter, Fagan filed a motion for declaratory judgment arguing that the Plan's lien should be extinguished and for the first time seeking additional sanctions under 29 U.S.C. § 1132(c)(1)(B). Id. at *2. Wausau moved to remove the motion citing complete federal preemption of Fagan's claims. Fagan moved to remand and the questions became when was the case first removable and was Wausau's removal timely. Id. at *3.

In determining whether the complete preemption doctrine applies to a participant's claims, the Seventh Circuit had outlined the following three determinative factors: (1) whether the plaintiff is eligible to bring a claim under § 502 of ERISA; (2) whether the plaintiff's cause of action falls within the scope of an ERISA provision that plaintiff can enforce via § 502 of ERISA; and (3) whether the plaintiff's state law claim cannot be resolved without an interpretation of the contract governed by ERISA. *Speciale v. Seybold*, 147 F.3d 612, 615 (7th Cir. 1998), quoting *Jass v. Prudential Health Care Plan Inc.*, 88 F.3d 1482, 1487 (7th Cir. 1996).

In *Seybold*, the court considered a removal by the Wal-Mart ERISA Plan of a state court petition to adjudicate the lienholder's rights. 147 F.3d 612. In applying these factors, the *Seybold* court determined that the specific relief sought in that case was merely the apportionment of the settlement fund, which did not involve the interpretation of the ERISA Plan. Id. at 617. However, had the issue in the case been the interpretation of a Plan provision, removal would have been proper. Id. at 615-16. In fact, in the concluding paragraph of the opinion, the court specifically noted in finding removal improper that "Wal-Mart's subrogation right has not been questioned.

What remains is simply a determination on the apportionment of the funds under state law." Id. at 617. What *Seybold* stands for is that an adjudication of a lien, without more, is not completely preempted by ERISA § 502(a), 29 U.S.C. § 1132(a).

Fagan argued that her initial complaint was removable and therefore Wausau's removal was untimely. Wausau argued that because Fagan's initial complaint did not seek benefits from the Plan but merely an adjudication of the Plan's subrogation rights, the *Seybold* decision controlled, and the case did not become removable until Fagan filed a motion seeking sanctions under ERISA to extinguish the lien. The court looked to the three factors laid out in *Seybold*. *Fagan v. Destafanis, et al.,* at *5. It found that: (1) Fagan was eligible to bring a claim under § 502(a); (2) Fagan's initial complaint against Wausau could fall under § 502; and (3) Fagan's statement requesting "judgment determining the rights of Wausau Benefits" required an ERISA "contract interpretation". Id. Accordingly, the district court found that removal was improper and the case became removable when the original complaint was filed in Milwaukee County naming Wausau Benefits as a party. Id. at *6.

Despite Seventh Circuit decisions that seem to preclude removal where the original pleading seeks only adjudication or determination of an ERISA lien, this decision allows every complaint that joins a subrogated ERISA Plan to be removed to federal court. Compare *Hart v. Wal-Mart Stores, Inc. Associates Health and Welfare Plan*, 360 F.3d 674, 676 (7th Cir. 2004); *Speciale v. Seybold*, 147 F.3d 612 (7th Cir. 1998); *Blackburn v. Sundstrand Corp*., 115 F.3d 493 (7th Cir. 1997). Nevertheless, this decision provides substantial leverage for subrogated ERISA Plans that have been joined as a party in Wisconsin. Should a Plan fear the uncertainty of a state court adjudication where the made whole or common fund doctrines come into play, the Plan should quickly remove the case to federal court based on ERISA's complete preemption.

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