MATTHIESEN, WICKERT & LEHRER, S.C.

A FULL SERVICE INSURANCE LAW FIRM

1111 E. Sumner Street, P.O. Box 270670, Hartford, WI 53027-0670
(800) 637-9176 (262) 673-7850 Fax (262) 673-3766
http://www.mwl-law.com

MONTHLY ELECTRONIC SUBROGATION NEWSLETTER AUGUST 2008

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 or removed from 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.

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Workers' compensation subrogation professionals are more frequently having to deal with employees hired, working and/or receiving benefits in one state, yet injured in another. Third-party lawsuits filed in the foreign state provide confusion and opportunities for reimbursement of your benefits. State A may allow for an injured worker to sue a co-employee, while the State B might not. Extraterritorial subrogation law and conflict of law rules apply differently in almost every case, but routinely present situations where the law of the state in which benefits are being paid trump the law of the injury state - where the third-party suit is filed. Knowing and understanding extraterritorial subrogation law is critical in our national economy where our insureds and their employees are routinely injured in states other than the state under which they receive benefits.

Workers' compensation is a creature of statute. The terms and conditions under which benefits are paid, and the amount and duration of those benefits, vary from state to state. These laws are packaged neatly, yet differently, into a cohesive statutory scheme in each state. The same can be said for the rules regarding who, what, when, where, and how an injured worker can pursue a negligent third-party tortfeasor in a third-

party action, and what the subrogated carrier's rights of subrogation and/or reimbursement are. Allowing a worker to utilize part of a state's statutory workers' compensation scheme (amount and duration of benefits), yet applying the subrogation rules (or only part of them) of the state in which the worker is injured in, is hardly equitable. Therefore, most states are adopting what is referred to as the *Larson Rule* – allowing the subrogation law of the state under which benefits are being paid to be applicable to a third-party action filed in a different state. It allows for a cohesive and uniform application of the statutory scheme of workers' compensation and gives predictability to the worker, employer, and the system as a whole.

Supreme Court Building
Hartford, Connecticut

The *Larson Rule* is the rule of the future, seemingly being applied more frequently in our interstate economy. Sometimes, however, a state drops the ball and slides back to the old days, when the law to be applied depended on rules which didn't take the workers' compensation system into consideration. Connecticut is an example of such a state. For the last fifteen years, Connecticut followed the *Larson Rule*. As recently as last year, their Supreme Court confirmed that the law of the state paying the benefits determined the subrogation rights of the carrier and governed who qualified as a third-party and who was exempt from suit due to the exclusive remedy rule (a/k/a "The Employers Can't Be Sued Rule"). On June 17, 2008, Connecticut fell off the wagon.

In *Jaiguay v. Vasquez*, the Connecticut Supreme Court contravened and contradicted both itself and the logic of the *Larson Rule*. The facts of that case were that on June 19, 2001, Joel Vasquez and the decedent plaintiff, Hugo Jaiguay, both New York residents, left Primo's Landscaping, their employer in Rye Brook, New York, in a 1992 pickup truck driven by Vasquez. At the time, seven other Primo's employees were riding in the truck even though the truck's maximum occupancy was five persons. Vasquez crossed the state border and was driving along King Street in Greenwich, Connecticut when he crossed the center line of the road and collided with an oncoming vehicle. At the time of the accident, Vasquez, who had a New York state driver's permit but not a driver's license, was traveling approximately seventy miles per hour in a zone with a speed limit of thirty miles per hour, and had just passed a sign warning of a sharp curve in the road ahead. The plaintiff/decedent was pronounced dead at the scene of the accident. According to Vasquez, for some weeks prior to the accident, the truck's brakes had not been working properly, a fact that he had brought to the attention of a co-worker, who had promised to inform Primo's Landscaping's mechanic of the problem. Vasquez eventually pleaded guilty in Connecticut to negligent homicide with a motor vehicle and was sentenced to six months imprisonment. Jaiguay's family received workers' compensation death benefits under New York's workers' compensation laws.

The issue arose as to whether to apply the workers' compensation scheme of New York or Connecticut to the third party lawsuit. New York's law does not allow an employee such as Jaiguay to sue a co-employee such as Vasquez, while Connecticut's law has an exception to the exclusive remedy rule which allows a suit against a co-employee whose negligence in the operation of a motor vehicle injures a co-employee.

In a long and tortured opinion, the Connecticut Supreme Court recounted the see-saw history of Connecticut's extraterritorial subrogation law. For years, Connecticut had applied the well-thought out *Larson Rule*. However, in *Jaiguay*, the Court reversed its own opinion of only a year earlier, and backed away from that rule, applying the "most significant relationship" test. This test – usually applied only in tort cases in which workers' compensation is not involved – requires the trial court to look at the following factors in determining whose law to consider the following factors in making its decision:

(a) the needs of the interstate and international systems;
(b) the relevant policies of the forum;
(c) the relevant policies of other interested states and the relative interests of those states in the determination of the particular issue;

(d) the protection of justified expectations;
(e) the basic policies underlying the particular field of law;
(f) the certainty, predictability and uniformity of result; and
(g) the ease in the determination and application of the law to be applied.

As a result, the court determined New York's exclusive remedy law would apply – not because benefits were paid from that state, but because of the above test. Therefore, it was held that neither Jaiguay's family nor his employer's workers' compensation carrier could sue Vasquez (a co-employee). They came to the right decision, but for the wrong reason. Application of the most significant relationship test will make future extraterritorial subrogation efforts in Connecticut difficult to predict and will effectively allow a piece-meal situation to arise in which part of a state's workers' compensation laws will be applicable, while part will not.

While the court in *Jaiguay* did seem to limit application of the most significant relationship test to tort cases which involve a claim brought under an exception to the exclusivity provisions of our Workers' Compensation Act. This may be more common than in other conflict situations, because Connecticut's statute allowing a third-party case to be filed against a co-employee as a result of negligence in the operation of an automobile, while is fairly unique among states.

Therefore, the rights and liabilities of a plaintiff and/or a subrogated carrier in a third-party action with respect to an issue in tort are determined by the local law of the state which, with respect to that issue, has the most significant relationship to the occurrence and the parties under the principles stated above. A court will look to all of the factors involved and determine which state has the most significant relationship to the incident. The only thing predictable about third-party suits filed in Connecticut which involve multiple states is that they will be unpredictable.

For questions about extraterritorial subrogation involving more than one state, please contact Gary Wickert at gwickert@mwl-law.com.

INSURANCE SUBROGATION

TEXAS SUPREME COURT SAYS INSURER'S USE OF STAFF ATTORNEYS AND CAPTIVE FIRMS MAY BE CONFLICT

***Unauthorized Practice of Law Committee v. American Home Assurance Co. and Travelers Indemnity Co.*, 2005 WL 6167598 (Tex. 2008).**

MWL attorneys have argued in front of the Texas Supreme Court on several occasions. The wait for a decision usually is around six months. In *Unauthorized Practice of Law Committee v. American Home Assurance Company,* the case, dealing with the ability of an insurance company to use staff attorneys and captive law firms to defend its insureds was appealed to the Texas Supreme Court in 2004, but not decided until 2008. After four long years and numerous amicus curiae briefs from interested organizations such as insurance companies, NAMIC, Texas Association of Defense Counsel, and the Property Casualty Insurance Association of America, the The Texas Supreme Court has held that an insurer may use staff counsel to represent insureds in some circumstances, turning back an almost 10-year effort by the Unauthorized Practice of Law Committee ("UPLC") to stop the practice. However, there are strings attached.

One of the main issues in the case was precisely who an attorney, who was engaged by an insurance company pursuant to an indemnity or liability policy, represented. The Court had never held that an insurance defense lawyer cannot represent both the insurer and insured, only that the lawyer must represent the insured and protect his interest from compromise by the insurer.

The long-awaited decision holds that an insurer may use staff attorneys to defend a claim against an insured, provided the insurer's interest and the insured's interest are aligned, but not otherwise. Their interests are congruent when they are aligned in defeating the claim and there is no conflict of interest between the insurer and the insured. We also hold that a staff attorney must fully disclose to an insured his or her affiliation with the insurer.

Liability insurance policies commonly provide that the insurer must indemnify the insured from liability for covered claims and give the insurer the duty, and also the right, to defend such claims. The right to defend in many policies gives the insurer complete, exclusive control of the defense. Insurance companies retain attorneys in private practice to represent insureds in defending claims against them, but for decades, in Texas and other states, insurers have also used staff attorneys-salaried company employees-to save costs.

In general and outside of the insurance context, a corporation can employ in-house attorneys to represent its own interests but cannot engage in the unauthorized practice of law by providing legal representation to others with different interests. The Court held that because of its potential indemnity obligation, an insurer has a direct, substantial financial interest in defending claims against its insured, and often an insurer's and insured's interests are aligned toward defeating such claims. But their interests can diverge - for example, when all or part of the claim may not be covered. The issue in this case was whether a liability insurer that uses staff attorneys to defend claims against its insureds is representing its own interests, which is permitted, or engaging in the unauthorized practice of law, which is not. Two states, North Carolina and Kentucky, do not permit such use of staff attorneys, but several states do.

Liability insurance policies that obligate the insurer to defend claims against the insured typically give the insurer "complete and exclusive control" of that defense. There are exceptions and variations, but the Court focused on policies in which the insurer's right to control the defense is "full and absolute". Insurers often retain attorneys in private practice to represent insureds, overseeing and directing their work and paying their fees. Sometimes an insurer uses a "captive" firm of attorneys who, though not the insurer's employees, have no other clients. Insurers also use lawyers employed as salaried corporate staff to represent insureds. In every instance, the insured's lawyer "owes the insured the same type of unqualified loyalty as if he had been originally employed by the insured" and "must at all times protect the interests of the insured if those interests would be compromised by the insurer's instructions."

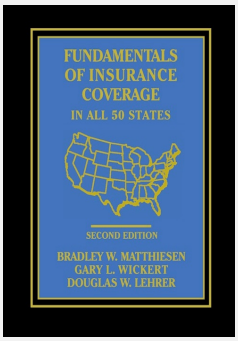
Texas Supreme Court
Austin, Texas

Under this new decision, although insurers may continue to use staff counsel and captive firms, the employment contract between the defense counsel and insurer must provide that the counsel represents the insurer. The UPLC was disappointed in the decision. Mark Ticer, one of its attorneys, stated publicly that he believes the Supreme Court found the result it wanted to reach and wrote an opinion around the result, leaving questions unanswered. He is partly right, because the Supreme Court did not state or even hint at what qualifies as a "conflict".

Justice Phil Johnson, a former insurance defense lawyer, wrote in a dissenting opinion that he believes the issue before the court boils down to statutory construction. He feels the issue is a simple as whether an insurance corporation's defense of its insureds by the use of staff attorneys constitutes the practice of law as defined by the State Bar Act. Johnson feels it is. For the time being, the Supreme Court says he is wrong.

The right to use staff counsel and captive law firms is not unfettered, however. In situations where there is divergence of interests, it would be inappropriate for the staff attorney to represent the insurer. It seems that the new decision has changed the rules for insurers that use staff attorneys to defend insureds against claims, and it may limit insurers' use of staff counsel far more than it may appear. One area in which the Court clearly acknowledges the need to retain separate, private counsel for an insured is when there are coverage issues.

The Supreme Court majority opinion indicates that ordinarily there is no conflict when an insurer writes a routine reservation-of-rights letter. Such a letter puts an insured on notice that the insurer is questioning whether a claim against the insured is covered under the policy. According to UPLC, this is a conflict requiring independent, private coverage counsel. Of course, the law in this area varies from state to state.



This is an area in which Matthiesen, Wickert & Lehrer, S.C. provides national coverage representation for its clients. Utilizing local counsel and years of expertise, MWL has written a book entitled, "*Fundamentals of Insurance Coverage in All 50 States*." Its table of contents can be viewed at http://www.mwl-law.com/PracticeAreas/Fundamentals-of-Insurance-Coverage-All-50-States.asp. If you are in need of insurance coverage opinions or litigation representation, or if a conflict or "incongruity" appears in the course of a liability claim with an insured, consider utilizing MWL to provide coverage representation and advice. At least in Texas, we can be sure that the Texas Supreme Court will revisit this issue again soon, further refining and clarifying precisely what sort of "conflict" prohibits the use of captive firms or staff counsel.

HEALTH INSURANCE SUBROGATION

TURNING OFF THE SPIGOT:

Future Credits in Health Insurance Subrogation

By Gary L. Wickert


Gary L. Wickert

In workers' compensation subrogation settings, once a worker receives a recovery from a third-party tortfeasor, and the carrier has been reimbursed for the past benefits it has paid, the balance going to the pocket of the worker is usually calculated and applied as a credit against future benefits. Unless and until that credit is used up, the workers' compensation carrier doesn't have to make any future benefit payments. Far too many within the health insurance industry fail to realize, or fail to act on, the fact that they may have a similar right to a credit which can save them millions of dollars in claim benefits when a Plan beneficiary makes a large third-party recovery.

A workers' compensation future credit is usually dictated by the workers' compensation subrogation statute of a particular state. Conversely, the right of a health insurance Plan to take a future credit or vacation is not set forth in any particular statute, but derives from the specific terms of the Plan itself. A Plan is not entitled to receive a credit against future benefits, regardless of how much the beneficiary recovers in the third-party personal injury action, unless the Plan so provides. Whether a particular Plan provides such a right is the $64,000 question.

Many health insurers do not actively pursue any rights to a future credit which they might have a legal right to claim. The reasons vary - some do not act because they never realized they had the right to do so. Others have policies against doing so for any number of reasons. In November of 2007, the *Wall Street Journal* reported that while the cost of covering workers continues to escalate, employers and health Plans are getting more aggressive in their subrogation efforts. Not long thereafter, however, the *Journal* also highlighted the infamous Debbie Shanks Wal-Mart case, in which Wal-Mart tried to recoup more than $400,000 of a $1 million third-party recovery. A virtual debate between Roger Baron, a professor of law at the University of South Dakota and known enemy of subrogation, and Gary Wickert, was aired on the national radio program, *Radio Health Journal*, which can be heard through a link located on the MWL website home page. As a result of such negative and uninformed publicity, many

carriers tread lightly when it comes to subrogating health insurance Plans. Yet subrogation remains one of the chief weapons in the war against rising health care costs. Following through on a Plan's subrogation swing by pursuing its right to a future credit is a natural extension of the subrogation philosophy – and can save a Plan millions in future benefits where the Plan beneficiary has become a multi-millionaire as a result of a third-party recovery.

The law regarding future credits in health insurance settings is more elusive than the Holy Grail. But we are not left totally in the dark. A Plan's right to suspend benefit payments when the beneficiary makes a large third-party recovery is determined solely by the language of the particular Plan and/or Summary Plan Description involved. In the 7th Circuit, where both the beneficiary and the Plan settle separately with the tortfeasor without allocating specific portions of the settlements to future expenses, and where they had already released the tortfeasor, the Plan remains liable for future medical expenses. *Davis v. Nepco Employees Mut. Benefit Ass'n*, 51 F.3d 752 (7th Cir. 1995); *Shell v. Amalgamated Cotton Garment*, 43 F.3d 364 (8th Cir. 1994). A federal court in Minnesota similarly held that once a Plan beneficiary settles with a third-party, any post-settlement payments made by the Plan do not provide the Plan with a right of reimbursement. *Shell v. Amalgamated Cotton Garment*, 43 F.3d 364 (8th Cir. 1994). These decisions hold that a Plan is entitled to reimbursement only for those payments made prior to the time the Plan participant settles their claims with the tortfeasor. Specific language in a health Plan is required in order to create a right to a credit. *Salsbury v. Miller*, 582 N.W.2d 504 (Wis. App. 1998) (*unreported decision)*.

Precisely what language is necessary to create a right to a credit varies greatly. Plans rarely contain specific and unambiguous language setting forth such a right. More frequently, it comes disguised in the form of an exclusionary provision or excess insurance clause hinging on recoveries from third parties. The 9th Circuit dealt with a Plan containing language which excluded coverage for injuries caused by third-party tortfeasors, but promised to "advance the benefits of this agreement" subject to a lien on any recovery from any third party "to the extent of the benefits advanced." *Qualls v. BlueCross of Cal., Inc.*, 22 F.3d 839 (9th Cir. 1994); see also, *McIntyre v. Carpenters Health & Security Trust of Western Wash.*, 2006 WL 118249 (W.D. Wash. 2006). The court held that the Plan was obligated to advance benefits only to the extent that it retained a lien against payments by the third party. Once a third-party settlement was reached with the tortfeasor, there were no benefits to "advance", and consequently, the Plan's obligation to make future benefit payments ceased. The settlement with the third-party tortfeasor satisfied the Plan's lien and released the manufacturer from liability, which resulted in the Plan having no further obligation to provide future benefits. *Id*. In effect, the Plan achieved the credit through an exclusionary clause in the Plan language.

Determining whether or not a health Plan is entitled to a future credit when its Plan beneficiary makes a third-party recovery may be much more complicated than simply looking for a clause which provides the Plan with such a right. Rarely does the table of plan contents have an entry which reads "Right to Future Credit Upon Third-Party Recovery." They should – but they don't. Other language within the Plan, combined with judgments, settlement agreements, and releases executed in connection with a third-party recovery, can create the right to a future credit. Sometimes, all of these documents must be reviewed in conjunction with the Plan's subrogation or reimbursement provisions, in order to formulate an argument or a basis on which the Plan can take a vacation from paying future benefits under the Plan as a result of a credit. Unfortunately, documenting and laying the foundation for a future credit is often an afterthought, and this is considered in the flurry of activity surrounding a large third-party settlement and a significant recovery for a health Plan based on past medical benefits it has paid. *Ruhnke v. Pipe Fitters' Welfare Fund*, 2005 WL 1869740 (N.D. Ill. 2005) (*unreported decision*). Getting subrogation counsel involved immediately upon realization that a third-party lawsuit is or will be pending, is essential.

Case law with regard to a Plan's obligations to pay future benefits after a third-party settlement is sparse. A federal district court in the 7th Circuit decided a case in which the Plan refused to make future benefit payments after the Plan beneficiary had received a large third-party recovery. *Id*. The beneficiary was

involved in an automobile accident for which the Plan paid $225,132.99. The terms of the Plan required that the beneficiary provide the fund with a *Subrogation and Reimbursement Agreement*, which they did. The *Subrogation and Reimbursement Agreement* read as follows:

> *Should Participant and his/her representative receive any money or other assets from a responsible Third Party, the Participant does hereby agree to repay the TRUST FUND 100% of the benefits paid on account of the accident by the TRUST FUND, [sic] shall not however, be entitled to receive reimbursement in excess of the amount which the Participant receives from all responsible Third Parties.*

The beneficiary's third-party case settled for $1,100,000.00, and the Plan denied medical benefits submitted to the Plan for payment after the settlement based on the language of this agreement. The federal court granted the Plan's motion to dismiss the beneficiary's subsequent lawsuit, based on the language of the subrogation agreement. The court reasoned as follows:

> *With respect to the more recent request for $12,800.00 in medical expenses arising from the car accident, the analysis is very similar. These expenses, like the expenses already paid, are expenses arising from the car accident - an accident which resulted in a claim against the third party. If the Plan had paid these expenses, it would immediately have triggered Mrs. Ruhnke's obligation to reimburse the Plan for the same amount. The Plan language explicitly requires reimbursement of "a sum sufficient to fully reimburse the Fund Office for all (100%) benefits advanced" but "the Fund is not entitled to receive reimbursement in excess of the amount [the beneficiary] receive[s] from all responsible parties."*

A reasonable explanation for the Plan's decision is that if it paid Mrs. Ruhnke would immediately owe the Plan $12,800.00 and thus, the Plan owed Mrs. Ruhnke $0 for those medical benefits. This is true, because Mrs. Ruhnke's medical expenses have yet to exceed the amount she collected from the responsible third party. *Ruhnke v. Pipe Fitters' Welfare Fund*, 2005 WL 1869740 (N.D. Ill. 2005) (*unreported decision*). The court held that because there was a reasoned explanation for the Plan's decision, the Plan administrator's decision was not arbitrary or capricious, and the court dismissed the beneficiary's lawsuit.

The 8th Circuit denied a Plan the right to stop making future benefits where the Plan had effectively waived its subrogation rights in an earlier malpractice suit which produced a third-party settlement for the beneficiary. *Janssen v. Minneapolis Auto Dealers' Beneficiaries' Fund,* 447 F.3d 1109 (8th Cir. 2006). A complicating factor in this case, however, was that the Plan failed to respond to a motion in the district court to dismiss the Plan's subrogation claim.

In one Connecticut federal district court decision, where a health Plan denied paying future benefits after a third-party settlement, the court held that the trustee of the Plan reasonably interpreted the Plan's provisions as barring benefits for future benefits, even though the Plan had previously advanced pre-settlement benefits (subject to a reimbursement agreement). *Sargeant v. International Union of Operating Engineers, Local 478,* 746 F.Supp. 241 (D.C. Conn. 1990). The reimbursement provision at issue in the Plan read, *"[t]he Fund is not liable for any health expenses caused by the negligence of third parties."* The court held that the trustee reasonably interpreted this clause as limiting past and future liabilities extending to the future.

Effective future credit language can be found in roughly half of all health Plans. Even when language is less than clear, or the Plan is less than committed to claiming such a credit due to "Debbie Shanks-type" facts surrounding the injury and third-party recovery, a well-advocated argument by subrogation counsel indicating such intent can result in increased recoveries of past benefits. Carriers interested in effectively claiming future credits can include clearer language in their Plans and should engage subrogation counsel immediately upon recognition that the beneficiary has hired a lawyer and plans to sue – if not sooner.

AUTO SUBROGATION

Michael R. Sinnen

ONTARIO COURT UPHOLDS CARRIER'S RIGHT TO SUBROGATE FOR DAMAGE TO TRAILER

***G.L. Gibbons Delivery Service, Ltd. v. Norman Jenkins and Team Logistics Systems, Inc.*, [2008] O.J. No. 1790, Ontario Superior Court of Justice**

By Michael R. Sinnen

In a victory for carriers whose insureds transport trailers and other cargo, the Ontario Superior Court of Justice recently ruled that an insurer may retain subrogation rights in cases in which items extraneous to an insured's automobile are damaged.

In *Gibbons*, the Ontario Superior Court dealt with a situation in which Markel Insurance Company's insured, a towing company, was hauling a trailer to the premises of its customer, when the trailer was struck by an at-fault third-party. The issue the Court needed to resolve was whether Ontario's Direct Compensation Statute barred Markel's subrogation case. Ontario's Direct Compensation Statute, which is found in Section 263 of Ontario's Insurance Act, prohibits automobile subrogation when an accident occurs through the use and operation of a motor vehicle, and the vehicles involved in the accident had liability coverage from a carrier that is licensed to provide coverage in Ontario.

Ontario Superior Court
Toronto, Ontario

In *Gibbons*, Markel provided liability insurance for the tow truck. In turn, the defense argued that the loss fell within Ontario's direct compensation scheme. However, Markel's policy with its insured expressly provided that direct compensation coverage did not apply to trailers, save situations when the trailers were less than a certain weight and were not designed or used for living quarters. The Court ruled that Markel was able to avert the Direct Compensation Statute via the policy language, and, since the exception provided in the policy did not apply to the present case, Markel was able to pursue its subrogation case against the third party.

Another noteworthy facet of *Gibbons* was the Court's interpretation of Section 263(7) of Ontario's Insurance Act. Section 263(7) is an exception to the Direct Compensation Statute, as it permits subrogation when damage is incurred to "contents" of an automobile, when those "contents" are being transported "for a reward". The defense asserted that the trailer, which was being transported on its own wheels, was not part of the "contents" of the tow truck. However, the Court focused on the overall purpose of the Section 263(7), which, the Court stated, is to exclude items that are being "carried for reward". Since the trailer was being transported, the Court found that it was within the meaning of the word "contents", and, therefore, the exception to the Direct Compensation Statute was also applicable.

If you should have any questions regarding this article or auto subrogation, please contact Michael Sinnen at msinnen@mwl-law.com.