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 **SEPTEMBER 2010**

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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HEALTH INSURANCE SUBROGATION

CLIENT SUES OWN SUBROGATION VENDOR

County of Bergen Emp. Benefit Plan v. Horizon Blue Cross Blue Shield of New Jersey, 2010 WL 624021 (N.J. Super. 2010)

By Gary L. Wickert

These are indeed strange times. Judges and legislators, ignorant to the societal benefits of subrogation, curtail or eliminate those rights in the name of "tort reform." Many insurers are drawn to the "lowest bidder" when it comes to subrogation services, only to discover after the fact that you get what you pay for. Large corporations are waking up to the many benefits of aggressively pursuing third-party recoveries and rights of contribution, while some large insurance companies are still fast asleep. But who would expect to see a subrogation client suing its own subrogation vendor to aggressively pursue subrogation? That is what happened in *County of Bergen Emp. Benefit Plan v. Horizon Blue Cross Blue Shield of New Jersey*, 2010 WL 624021 (N.J. Super. 2010). There are lessons to be learned here for everybody.

Bergen County is a public entity which had in place a self-insured employee welfare benefits plan for its employees. Horizon Blue Cross Blue Shield of New Jersey (Horizon) and the County entered into an

Administrative Services Agreement (ASA) pursuant to which Horizon became the Plan's Administrator. In this role, Horizon provided claims processing, adjudication, and other services related to the Plan. Although Horizon was the Plan's Administrator, it subcontracted subrogation issues to defendants, Affiliated Computer Services, Inc. (ACS) and Primax Recoveries, Inc. (Primax).

The instant lawsuit arose out of Bergen County's efforts to seek reimbursement for medical expenses it paid under the Plan on behalf of an employee, Andres Tineos. In August 2002, Tineos' wife, Wanda, became pregnant and advised her physician that she was predisposed to bear a child inflicted with Myotubular Myopathy (MTM), "a congenital muscular disease which causes severe physical disability." Wanda underwent an amniocentesis procedure to detect MTM and other abnormalities. Justin was born on April 7, 2003, with MTM. In 2004, Tineos filed a medical malpractice lawsuit, alleging that due to the negligence of physicians, laboratory workers, and possibly others, the test samples were either not tested or reported to be false-negative for MTM. In February 2007, a jury returned a verdict for $28,000,000, and the case was settled, post-judgment, for $18,000,000.

The County's Plan paid approximately $575,701.91 in net benefits associated with Justin Tineos' care. In December 2003, the Tineos' inquired of Horizon and a former Plan Administrator (Insurance Design Administrators) as to any lien they intended to pursue on plaintiffs' behalf, on the Tineos' recovery. Horizon forwarded counsel's request to its subrogation consultant, ACS/Primax. In February and May 2006, ACS/Primax advised the Tineos' counsel that it would not seek subrogation against any recovery from the medical malpractice litigation.

In October 2007, when plaintiffs first learned about the Tineos' settlement and defendants' decision not to seek subrogation, plaintiffs filed an action against defendants, alleging breach of contract, breach of fiduciary duty, and negligence in failing to pursue plaintiffs' claimed right of subrogation to recover from third-party tortfeasors funds which the Plan paid for Justin Tineo's healthcare and which, they allege, are recoverable by participants under the Plan. The main issue in the case was not whether the subrogation vendors *should* have pursued subrogation, but whether they *could* have.

At the heart of the case is whether New Jersey's subrogation-unfriendly version of the collateral source rule bars plaintiffs, who expend funds on behalf of their insured, to recoup those payments through subrogation or contract reimbursement when the insured recovers against a tortfeasor in a post-verdict settlement.

New Jersey is an anti-subrogation state. New Jersey prohibits subrogating health insurance policies, not as a result of an anti-subrogation statute, but through statutory abrogation of the common law collateral source rule. Section 2A:15-97 (known as "§ 97") of the New Jersey Statutes provides as follows:

> *In any civil action brought for personal injury or death, except actions brought pursuant to the [New Jersey Automobile No-Fault Act], if a plaintiff receives or is entitled to receive benefits for the injuries allegedly incurred from any other source other than a joint tortfeasor, the benefits, other than workers' compensation benefits or the proceeds from the life insurance policy, shall be disclosed to the court in the amount thereof which duplicates any benefit contained in the award shall be deducted from any award recovered by the plaintiff, less any premium paid to an insurer directly by the plaintiff or by any member of the plaintiff's family on behalf of the plaintiff for the policy period during which the benefits are payable. Any party to the action shall be permitted to introduce evidence regarding any of the matters described in this Act.* N.J.S.A. § 2A:15-97 (1987).

This anti-subrogation statute reduces a tort judgment or settlement by the amount of collateral source benefits, prohibits health insurers and health Plans from recovering subrogation or reimbursement out of any

tort judgment or settlement in favor of the Plan beneficiary. *Perreira v. Rediger*, 778 A.2d 429 (N.J. 2001); *County of Bergen Emp. Benefit Plan v. Horizon Blue Cross Blue Shield of New Jersey*, supra. Its purpose is twofold: (1) to eliminate the double recovery to plaintiffs that flowed from the common law collateral source rule and to allocate the benefit of that change to liability carriers, and (2) to contain spiraling liability insurance costs. *County of Bergen Emp. Benefit Plan*, supra. By reducing a plaintiff's tort judgment by the amount of benefits already received (with limited statutory exceptions), the Legislature intended to reduce the burden to liability carriers, rather than health insurers. As the legislative history reveals, the choice was made to favor liability carriers. *Kiss v. Jacob,* 650 *A.*2d 336 (N.J. 1994). Therefore, in enacting § 97, New Jersey eliminated a double recovery to plaintiffs, allegedly reduced the burden on the tortfeasors' liability carrier, and erroneously claims to have left health insurers in the same position as they were prior to the enactment of § 97. Prior to the 1987 passage of § 2A:15-97, New Jersey followed the common law collateral source rule, which prohibited a tortfeasor from reducing payment of a tort judgment by the amount of money received by an injured party from other sources. In effect, the common law collateral source rule allowed an injured party to recover the value of medical treatment from a culpable party, irrespective of payment of actual medical expenses by the injured party's insurance carrier.

The New Jersey Supreme Court declared that "subrogation," which substitutes a health insurer in place of a Plan beneficiary, and "reimbursement," a contractual undertaking which allows the insurer or Plan to recover payments directly from its own Plan beneficiary after the Plan beneficiary recovers from a third party, are both prohibited as a result of this anti-subrogation statute. Id. Because the County was a government plan, it could not avail itself of the benefits of ERISA preemption. Section 2A:15-97 of the New Jersey Statutes is not "saved" from preemption under ERISA because it does not regulate insurance. *Levine v. United Healthcare*, 402 F.3d 156 (3rd Cir. 2005).

Aside from being a sober reminder of the sad anti-subrogation atmosphere existing in New Jersey as a result of this questionable statute, the facts of this case should also reinforce in us all the realization that we want our subrogation vendors and counsel to aggressively recognize and pursue all subrogation potential which can be cost-effectively realized. In addition, good communication between subrogation professionals and their clients is of the utmost importance. Poor communication can run both ways – from client to subrogation counsel, and vice-versa. Either way, without good, constant and substantive communication, the ultimate result is subrogation inefficiency and lost subrogation opportunities. In this particular case, the subrogation opportunity was foreclosed because of bad New Jersey law. The next time, however, it might not be.

If you should have any questions regarding this article or subrogation in general, do not hesitate to contact Gary Wickert at gwickert@mwl-law.com.

HEALTH INSURANCE SUBROGATION

MWL SUCCESSFULLY WINS SUMMARY JUDGMENT IN ERISA REIMBURSEMENT ACTION

By Ryan L. Woody

Matthiesen, Wickert & Lehrer ("MWL") Attorney Ryan Woody successfully won summary judgment in an ERISA reimbursement action in the Western District of Arkansas. The case, *Manzey v. Department of Veterans Affairs,* 06-CV-06082 (W.D. Ark. Aug. 4, 2010), involved a personal injury claim sustained in the

parking lot of a local V.A. Hospital. The plaintiff eventually went on to recover $185,000.00 in a settlement with the hospital. The plaintiff had been covered under an ERISA policy from her husband's employer, Munro & Company, a local Arkansas manufacturer of fine shoes. The Plan paid out more than $76,195.03 in medical bills on behalf of Ms. Manzey and sought reimbursement in that amount. More than two years transpired with the Plan and Ms. Manzey unable to reach an agreement on the subrogation claim. The plaintiff's attorney refused to consider even the most reasonable offers. Instead, he now took the position that very few of the bills paid by the Plan were actually related to Ms. Manzey's injuries. He invited the Plan to prove up its lien, while offering only minimal offers to resolve the lien.

This summer the plaintiff's attorney sought the district court's assistance in settling the matter with the ERISA Plan. He filed a motion with the court and the court invited the Plan to stake its claim to the settlement funds. In the interim, the plaintiff's attorney, apparently confident in his position, deposited only $65,000 of the disputed funds in the court's registry. The Plan retained the services of MWL attorney, Ryan Woody, to represent them in the case. At the hearing we argued that the Plan had first priority reimbursement rights and that the plaintiff could not simply change his position with respect to whether the medical bills were related to the accident only after settling the case. The plaintiff's attorney told the court that he had actual evidence that only a fraction of the bills were related to her injuries from the fall and that many were from her pre-existing conditions. The Court took things under advisement but reserved any ruling on the matter, instead instructing the plaintiff's counsel to submit his counter-evidence within 14 days.

Nearly six weeks went by and the Plan heard nothing from the plaintiff's counsel. He never presented any evidence or filed any responsive briefs. At that time, we began working on a motion for summary judgment with supporting affidavits, which was filed shortly thereafter. In addition, per the Federal Rules of Civil Procedure, we sent the plaintiff's attorney a Rule 11 letter with a draft of our motion for sanctions seeking that he withdraw his opposition to the lien in absence of any counter-evidence. The plaintiff responded to the motion for summary judgment with no additional evidence and argued that the amount of medical bills was in dispute and could only be decided at trial. In our reply brief we argued that the plaintiff had utterly failed to rebut our *prima facie* case for summary judgment. The district court agreed, writing:

> *Plaintiff has not submitted any countervailing evidence. (Doc. Nos. 54-55). Plaintiff has not submitted an affidavit or other type of evidence supporting her allegation that the submitted charges did not result from the May 2, 2005 accident. Without any evidence, Plaintiff has not met her burden of showing, through specific evidence, that a triable issue of fact remains. See FED. R. CIV. P. 56(e)(2). Thus, this Court finds, based upon the evidence submitted, there is no genuine issue of material fact as to whether Munro & Company is entitled to $76,195.03.*

In addition, the court also found objectionable the plaintiff's inconsistent positions with respect to the medical bills and applied the doctrine of judicial estoppels to preclude the argument. It held:

> *This Court finds it worth noting, however, that Plaintiff herself even represented that these medical bills resulted from the May 2, 2005 accident. Such an admission is evidence in this case, and this Court is not inclined to allow Plaintiff to take a position inconsistent with her position in the underlying action. See Total Petroleum, Inc. v. Davis, 822 F.2d 734, 737-38 n.6 (8th Cir. 1987) (noting that judicial estoppel is "to protect the integrity of the judicial process"). See also Murrey v. U.S., 73 F.3d 1488, 1455 (8th Cir. 1996) (recognizing that "extrajudicial admissions" by a party opponent are admissible as evidence under FED. R. EVID. 801(d)(2)).*

In total, the Court went on to award the Plan its full lien amount of $76,195.03, plus interest. The court implied that it would consider awarding attorneys' fees upon a proper motion. As such, the Plan has filed a motion for attorneys' fees under both ERISA 502(g) and sought Rule 11 sanctions. These motions are

pending and the Plan is hopeful of a complete recovery inclusive of all attorneys' fees, costs, and two years worth of pre-judgment interest.

This is yet another great result we've been able to achieve for our national clients. This case is a great example of an ERISA Plan who refused to back down to empty threats by a plaintiff's attorney. Not only did the court find no merit to the plaintiff's position, but it precluded him from using one of the oldest tricks in the book. Too many times we have encountered attorneys who argue throughout the case that their client's injuries are all related to the accident, but when it comes time to honoring subrogation, they turn around and tell the Plan that nothing is related. Well, feel free to use this case as a prime example of a court that refused to buy into such legal gamesmanship.

By using the national ERISA attorneys of MWL, you can be sure that we will fight for every dime that was paid by the Plan and on special occasions end up getting you back every penny you paid, plus more in attorneys' fees, costs and interest. Should you have any questions or comments, please do not hesitate to contact Attorney Ryan Woody at rwoody@mwl-law.com.

HEALTH INSURANCE SUBROGATION

HOSPITAL LIEN NEGATED BY TERMS OF HEALTH INSURANCE PROGRAM

MCG Health, Inc. v. Owners Ins. Co., 2010 WL 852009 (Ga. App. 2010)

This significant hospital lien decision arose from the dismissal of a complaint filed by MCG Health, Inc. ("MCG"), against Owners Insurance Company ("Owners"), against which MCG had filed a hospital lien for services provided to Braxton Morgan at the Medical College of Georgia after he was injured in an automobile accident caused by an individual insured by Owners. The trial court granted third-party defendant Morgan's cross-motion for summary judgment, dismissing MCG's complaint. The Court affirmed for the following reasons.

At the time he received treatment at the Medical College of Georgia, Morgan was an active-duty member of the United States Army covered by the U.S. Department of Defense TRICARE health insurance program. MCG had a contract to provide certain services to beneficiaries of the TRICARE program, and the contract provided limitations on MCG's recovery of payment for medical services provided to TRICARE beneficiaries. The total cost of the services provided to Morgan at the Medical College of Georgia was $18,259.61. After Morgan was discharged from the hospital, MCG filed a hospital lien for the full cost of services provided to Morgan pursuant to O.C.G.A. § 44-14-470, *et seq*., against all causes of action against unknown persons liable for Morgan's injuries; MCG did not bill TRICARE at any time before or after filing the hospital lien. After MCG filed the hospital lien, Morgan entered into a release and settlement agreement with Owners for $50,000; however, Owners and its insured did not admit liability for the accident as part of the settlement. In exchange for the sum, Morgan agreed to release all his claims against Owners, to indemnify Owners and its insured, and to settle all valid liens incurred based on the accident from the settlement proceeds, $18,259.61 of which was placed into an escrow account in the event that the hospital lien was determined to be valid.

MCG instituted a lawsuit against Owners in order to collect on its hospital lien. Owners then filed a third-party complaint against Morgan, who then filed an answer and cross-claim against MCG, and a motion to dismiss MCG's complaint for failure to state a claim, arguing that the hospital lien was invalid. MCG also filed a motion for summary judgment.

The trial court granted Morgan's motion to dismiss MCG's complaint, stating that the contract between MCG and TRICARE precluded MCG from recovering the cost of Morgan's services from Owners (1) because the section of the contract relied upon by MCG to establish its right to file the hospital lien conflicted with other parts of the contract and with federal statutes and regulations governing TRICARE, which were made part of the contract; (2) because the contract required MCG to submit a bill to TRICARE for reimbursement prior to taking other steps for reimbursement; and (3) because balance billing a TRICARE beneficiary, which the court determined would effectively occur if MCG was able to collect under its hospital lien, was prohibited by the contract and by federal statute.

Generally, a hospital has the right to file a lien for reasonable charges against any cause of action accruing to an injured person to whom the hospital provided care. *See* O.C.G.A. § 44-14-470(b).This Georgia statute makes clear that the lien is not against the treated individual and only attaches to the individual's available causes of action. Moreover, the court said that no release of the cause or causes of action or of any judgment thereon or any covenant not to bring an action thereon is valid or effectual against the lien ... unless the holder thereof shall join therein or execute a release of the lien." See O.C.G.A. § 44-14-473(a). For instance, the settlement between Owners and Morgan did not destroy MCG's right to file and foreclose on a hospital lien against Owners. See *Dawson v. Hosp. Auth. of Augusta*, 98 Ga.App. 792, 793-794(1) (106 S.E.2d 807) (1958). Nevertheless, a contract between the treated individual's health insurer and the health care provider may preclude a hospital from seeking recovery through the statutory lien process. See *Constantine v. MCG Health, Inc.*, 275 Ga. App. 128, 129-131(1) (619 S.E.2d 718) (2005) (hospital lien could not be maintained because balance billing was prohibited by contract between the individual's insurer and the health care provider, and the health care provider had already accepted contractual payment from individual's insurer).

Section 17 of the contract between MCG and TRICARE, labeled "No Liability to Beneficiaries for Charges," stated that:

> *[MCG] hereby agrees that in no event, including, but not limited to nonpayment by HMHS or the Government, HMHS insolvency or breach of this Agreement, shall [MCG] bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against Beneficiaries, or persons other than HMHS acting on their behalf, for Covered Services provided pursuant to this Agreement. See 10 USC § 1079(j)(3); 32 CFR §§ 199.16(d)(5) (stating that participating hospitals may not bill TRICARE beneficiaries for balances in excess of TRICARE payments). This provision shall not prohibit collection of fees for any non-covered service and/or Copayments in accordance with the terms of the Beneficiary's coverage and this Agreement.*
>
> *Nothing in this Agreement shall be construed to limit [MCG]'s rights under O.C.G.A. § 44-14-470 et seq. [MCG] shall have the right to seek to recover its charges, to the extent that said charges exceed what Health Plan or Payor pays [MCG] pursuant to this Agreement, incurred as a result of Hospital's providing Hospital Services to Members and which charges are the liability of a third party. The parties further agree that payment by Health Plan or Payor to [MCG] does not extinguish [MCG]'s lien or in any way limit [MCG]'s rights under O.C.G.A. § 44-14-470, et seq., except that the amount of the [MCG]'s lien shall not include the amount of any payment(s) by Health Plan or Payor to [MCG] on behalf of a Member.*
>
> *[MCG] further agrees that (I) this provision shall survive termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of the Beneficiary, (II) this provision supersedes any oral or written contrary Agreement now existing or hereafter entered into between [MCG] and Beneficiary or persons acting on their behalf, and (III) this provision shall apply to all employees and subcontractors of [MCG]. [Emphasis Supplied].*

The contract also specifically made part of the agreement "[t]he Provider Handbook and the statutes, regulations[,] and manuals applicable to the TRICARE program...." The TRICARE manual stated that prior to submission of a claim, the hospital could seek recovery from a third party, including auto or homeowners

insurance, no-fault auto or uninsured motorist coverage. Once a claim was filed, however, the hospital could seek recovery from the beneficiary or the liability insurer only the deductible and cost-share.

O.C.G.A. § 44-14-470(b) gives hospitals, such as MCG, a *lien* for reasonable *charges* for an injured person's hospital care and treatment on *any and all causes of action accruing to the person* on account of injuries giving rise to the cause of action which necessitated the hospital care. The statute specifically states that the lien is only against the cause of action and cannot be a lien against the injured person or their property and is not evidence of the person's failure to pay a debt.

The statute does not state whether or not it requires the existence of a debt to support enforcement. However, the statute expressly creates a "lien." Lien is defined as "[a] legal right or interest that a creditor has in another's property, lasting [usually] until a debt or duty that it secures is satisfied." Black's Law Dictionary 1006 (9th Ed. 2009); see *Waldroup v. State*, 198 Ga. 144, 148-149 (30 S.E.2d 896) (1944) (Bouvier's Law Dictionary defines lien as a hold or claim which one person has on the property of another as security for some debt or charge).

Section 13 of the contract states that MCG "shall [accept] as payment in full for all Covered Services" the payment amounts contained in the contract, plus "the amounts owed by Beneficiaries pursuant to the terms of their coverage, including ... any co-payments, coinsurance, deductibles[,] and/or cost-share amounts." Emphasis supplied; see also 32 CFR § 199.16(d)(1) (stating that participating hospitals must accept TRICARE payment as payment in full for services). Section 17 states:

> *[MCG] hereby agrees that in no event, including, but not limited to nonpayment by HMHS or the Government, HMHS insolvency or breach of this Agreement, shall [MCG] bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against Beneficiaries, or persons other than HMHS acting on their behalf, for Covered Services provided pursuant to this Agreement. This provision shall not prohibit collection of fees for any non-covered service and/or Copayments in accordance with the terms of the Beneficiary's coverage and this Agreement. [Emphasis Supplied].*

The Wisconsin Court of Appeals has determined that a similarly worded contract provision precludes recovery under that state's hospital lien statute because such recovery would effectively be from the beneficiary of the health plan even though Wisconsin's hospital lien statute (like Georgia's) limits attachment of the lien to the cause of action of the beneficiary. See *Dorr*, 228 Wis.2d at 442-444(I).

These two contractual provisions which required the hospital to hold harmless the patient to whom services are rendered when the patient is insured through TRICARE unambiguously negated the existence of Morgan's obligation to pay MCG, and MCG conceded that Morgan owed it no debt. The court held that while the contract provisions may allow the filing of the lien under § 44-14-470(b), the lien is invalid because other provisions of the contract negate any debt that could support it. Thus, the court said that MCG's argument that the inclusion of the second paragraph of § 17 allows it to file a lien irrespective of the hold harmless provision is without merit. Further, the act of filing a lien attaching Morgan's claim to the settlement proceeds violated the contract because pursuing the insurance proceeds was an attempt to seek recourse against Morgan as the claim and any proceeds resulting from that claim belong solely to Morgan.

The field of health care liens is filled with confusion, urban legends, and broadly-held misunderstandings. Gradually, positive case law clarifying some of these issues is slowly, but surely being made. If you have any health care lien subrogation or collection needs, please contact Gary Wickert at gwickert@mwl-law.com.

WASHINGTON SUPREME COURT LEGISLATES AGAINST WORKERS' COMPENSATION SUBROGATION

Tobin v. Dep't of Labor & Indus., 2010 WL 3170295 (Wash. 2010)

Usually, state legislatures pass laws and state courts interpret those laws. In an overzealous effort to inhibit the right of workers' compensation carriers and the Washington Department of Labor and Industries ("Department") from effectively subrogating in third-party cases, the Washington Supreme Court has essentially exchanged roles with the Washington legislature, and "rewritten" the Washington workers' compensation statute in a way it was never intended to be written.

On August 12, 2010, in an extremely unsound and questionable decision, the Washington Supreme Court held for the first time that the reimbursement rights of a subrogated workers' compensation carrier, self-insured employer, or the Department, does not extend to damages for pain and suffering recovered by the injured worker in a third-party action. *Tobin v. Dep't of Labor & Indus.*, 2010 WL 3170295 (Wash. 2010). In *Tobin,* Jim Tobin was permanently disabled after being hit by a crane and sued the crane operator, settling for $1.4 million in damages. The majority of the damages were for pain and suffering. Under § 51.24.060, an injured worker is required to distribute a portion of a third-party recovery to the Department to reimburse the agency for workers' compensation benefits. The Department claimed that this includes a percentage of pain and suffering damages, since the statute says that "recovery includes all damages except loss of consortium." Tobin argued that the statute was designed to reimburse the Department for benefits paid, and the Department does not pay benefits for pain and suffering. In a seriously flawed opinion, the Supreme Court ignored the clear language of the statute passed by the legislature and held that subrogation rights extend to all damages *except* to those for pain and suffering.

In Washington, if a worker elects not to proceed against a third party, this operates as an automatic assignment of the cause of action to the Department or self-insurer, which may then prosecute or settle the third-party action in its discretion in the injured worker's name. R.C.W.A. § 51.24.050(1) (1995). If a worker's injury results in the worker's death, the Department may petition the court for appointment of a special personal representative for limited purposes of maintaining an action under § 51.24.050 and Chapter 4.20 of the Washington statutes. If the beneficiary is a minor child, an election not to proceed against a third person on the action may be exercised by the beneficiary's legal custodian or guardian. Any recovery made by the Department on an assigned cause of action is distributed as follows:

(1) The Department is paid the expenses incurred in making the recovery including reasonable attorneys' fees;
(2) The injured worker is paid 25% of the recovery's balance which shall not be subject to a credit;
(3) The Department or self-insurer is paid its lien; and
(4) The injured worker receives the remaining balance. R.C.W.A. § 51.24.050(4)(a-d) (1995).

When a cause of action has been assigned a self-insurer, and compensation benefits have been paid or are payable from state funds for the injury, prosecution of the cause of action is for the benefit of the Department to the extent of benefits paid or to be payable by the Department. R.C.W.A. § 51.24.050(6)(a)(1995). In addition, any compromise or settlement of such cause of action which results in less than the recovery owing to the Department under Washington law is void unless made with the Department's express written approval. R.C.W.A. § 51.24.060(6)(b)(2001). In such a situation, the Department is entitled to be reimbursed for benefits paid, but will also bear its proportionate share of costs and reasonable attorneys' fees incurred by the self-insurer in obtaining a recovery. R.C.W.A. § 51.24.060(6)(c-d) (2001). Any remaining balance after distribution constitutes a credit to reduce the Department's obligation to pay future benefits and the self-insurer, in proportion to the obligations each bear to the remaining entitlement of the worker or beneficiary to such benefits. R.C.W.A. § 51.24.060(6)(e) (2001).

The issue of which damages constitute the "recovery" from which the Department is to be reimbursed has received legal attention over the years. The Washington Court of Appeals had previously held that a workers' compensation carrier may not assert a right of reimbursement for any portion of an award or judgment against a third-party tortfeasor on an individual's claim for loss of consortium. *Flanigan v. Wash. State Dep't of Labor & Indus.*, 827 P.2d 1082 (Wash. App. 1992).

The *Tobin* decision represents the absolute worst in judicial activism and appears to completely ignore the language of the statute, the intent of the legislature, and clear precedent. The history of § 51.24.030(5) confirms that the legislature intended to include damages for pain and suffering in the statute's distribution formula. This subsection was adopted immediately after the Supreme Court held that a spouse's loss of consortium was not subject to distribution. *Flanigan,* supra. The decision also ignores the definition of "recovery" found in § 51.24.030(5) which describes it as "all damages except loss of consortium." The subrogation statute itself also broadly states that "any recovery" must be distributed in accordance with the statute. After the *Flanigan* decision excepting loss of consortium damages from the definition of "recovery", the Washington legislature took steps to clarify what "recovery" meant, so it is not inconceivable that the legislature will step in to fix this clearly erroneous Supreme Court decision in *Tobin*.

Washington is a monopolistic state which means employers must purchase workers' compensation insurance directly from the state's Department of Labor and Industries. Employers have two options: purchase workers' compensation insurance from the state fund or self insure. This means that most private workers' compensation carriers do not have to deal with the Washington workers' compensation laws. However, private carriers will face situations where they are subrogating in Washington and are potentially subject to the Washington workers' compensation laws.

UPCOMING EVENTS.....

November 8-9, 2010 - Ryan Woody will be presenting *"A Review of Longaberger v. Kolt And Other Potential ERISA Game-Changers"* on Novermber 9th at 12:30 p.m. at the NASP 2010 Annual Conference in Grapevine, Texas. For information on this conference, please go to www.subrogation.org**.**

November 10-11, 2010 - MWL will be exhibiting at the19th Annual National Workers' Compensation and Disability Conference Expo in Las Vegas, Nevada. Jamie Breen will be at our exhibit booth so stop by if you plan on attending this conference. For information on this conference, please go to www.wcconference.com.

November 30, 2010 - Gary Wickert will be presenting a live webinar entitled *"Subrogating Against God: Creative Ways of Circumventing The Act of God Defensive"* from 10:00 - 11:00 a.m. (CST). The webinar is approved for 1.0 hours of Texas CE credit and is free to clients and friends of MWL. A registration link is on our website homepage but you can register now by clicking on the "Register Now" button to the right.

PLEASE NOTE.....

We are providing webinars and, as we do, we're putting recorded versions of the webinars on our Seminars/Webinars page on our website at www.mwl-law.com, which can be viewed at no cost. The most recent webinars to be added are *State of Washington: PIP and Med Pay Subrogation* and *Construction Defect Subrogation*.