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MONTHLY ELECTRONIC SUBROGATION NEWSLETTER **APRIL 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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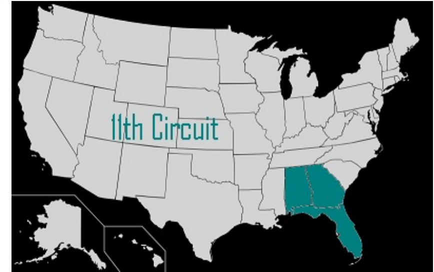
HEALTH INSURANCE SUBROGATION

11TH CIRCUIT FINALLY WEIGHS IN ON COMMON FUND DOCTRINE IN ERISA SUBROGATION

Zurich American Ins. Co. v. O'Hara, 2010 WL 1641369 (11th Cir. 2010)

Slowly but surely, like a paleontologist filling in the missing bones of a fossilized skeleton, reported decisions are slowly answering some of the unknown questions plaguing ERISA subrogation in the various federal circuits. Until recently, for example, there were no 11th Circuit decisions that specifically indicated to what extent Plan language was necessary in order to overcome the application of the Common Fund Doctrine in ERISA subrogation cases. When it comes to attorneys' fees in American litigation, the American Rule obligates each party to civil actions to pay his or her own attorney's fees unless statute, contract, or equity allows otherwise. The Common Fund Doctrine is an equitable exception to the American Rule. The Common Fund Doctrine is "rooted in the equitable concepts of *quasi-contract*, restitutions and recapture of unjust enrichment," and aimed at properly compensating active litigants and their counsel whose efforts result in correcting an injustice and creating a fund in which other non-participating beneficiaries maintain an interest. In ERISA subrogation settings, this means that if the Plan beneficiary's attorney is successful in recovering a pool of money for his client against which an ERISA Plan is

asserting a subrogation lien or interest, the attorney may reduce the Plan's subrogation interest by a pro rata percentage to require the Plan to bear part of the burden of the beneficiary's attorney's fees.



For years, the various federal circuits had slowly chimed in on their approach to whether a Plan could, within its terms, contract around this common fund obligation. The 11th Circuit, for some reason, had not had the opportunity to weigh in on this important area of ERISA subrogation. In 2001, an 11th Circuit Federal District Court indicated that the Common Fund Doctrine is not applicable in an ERISA case because it only applies where specific statutory guidelines underlying the award of attorneys' fees are not available. *HCA v. Clemmons*, 162 F. Supp.2d 1374 (M.D. Ga. 2001). The court in *Clemmons* held that because the statutory language of ERISA provided for specific statutory authorization of attorneys' fees, the Common Fund Doctrine will not be applicable in most cases because Congress intended that the offending party bears the costs of the award, rather than non-culpable, non-party Plan participants. *Id.*; 29 U.S.C. § 1332(g). In addition, the court in *Clemmons* held that the Plan in that case specifically stated that Clemmons would be responsible for any legal fees incurred pursuing the damage claim against the third-party tortfeasor. Before the 11th Circuit had opined on the applicability of the Common Fund Doctrine to ERISA Plans, a 2006 Federal District Court in Alabama noted that although every circuit to address the question has upheld an ERISA Plan's ability to preclude attorneys' fee deductions from any subrogation reimbursements, the express language in an ERISA Plan can preclude the operation of the Common Fund Doctrine. *Culp, Inc. v. Cain*, 2006 WL 335807 (M.D. Ala. 2006).

In 2010, however, the 11th Circuit finally weighed in on the issue. *Zurich American Ins. Co. v. O'Hara,* 2010 WL 1641369 (11th Cir. 2010). In *O'Hara,* the 11th Circuit evaluated the subrogation rights of a Plan which contained the following language:

> *"That no court costs or attorneys' fees may be deducted from the Plan's recovery without the Plan's express written consent; any so-called 'Fund Doctrine' or 'Common Fund Doctrine' or 'Attorney's Fund Doctrine' shall not defeat this right...."* Id.

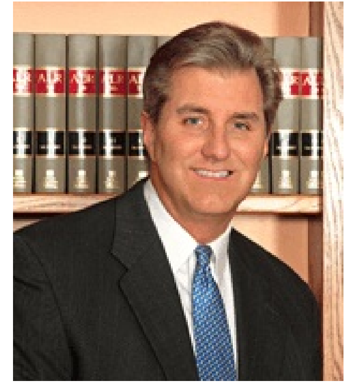
Although, the decision centered around the applicability of the Made Whole Doctrine to Zurich's subrogation rights under ERISA and *O'Hara* did not specifically challenge the Federal Trial Court's order that the Common Fund Doctrine was disclaimed by the above language, the Court did set forth the following in a footnote:

> *FN4. O'Hara does not explicitly challenge that aspect of the district court's order finding that the Plan precludes deduction of attorneys' fees from Zurich's total recovery. However, to the extent his argument necessarily encompasses such a challenge, we note that because the Plan clearly and unambiguously disclaimed the "common fund doctrine," the district court correctly found that Zurich was owed the entire amount it paid on O'Hara's behalf without a deduction of attorneys' fees.* Id.

Therefore, it should be safe to assume that the 11th Circuit has now officially weighed in on the issue and declared, at a minimum, that if a Plan "clearly and unambiguously" disclaims the Common Fund Doctrine in its terms, the Common Fund Doctrine will not be applicable. The extent and strength of language sufficient to overcome the doctrine will undoubtedly be the subject of future litigation and appellate opinion.

If you should have any questions regarding this article or the Common Fund Doctrine, please contact Gary Wickert at gwickert@mwl-law.com.

HEALTH INSURANCE SUBROGATION



EQUITY INVADES HOSPITAL LIEN LAW

Common Fund Doctrine Held Applicable To Hospital Liens

Howell v. Dunaway, 2010 WL 763918 (Ill. App. 2010)

By Gary L. Wickert

Subrogation professionals are by now quite used to the tortured and twisted application of equitable doctrine such as the "Made Whole Doctrine" or the "Common Fund Doctrine" to contractual and statutory subrogation and reimbursement rights. However, a new Illinois 5th District Court of Appeals decision completely rewrites the laws of equity by invading the province of a legislature to grant hospitals an absolute right to be reimbursed when a patient who hasn't paid his hospital bill recovers from a third-party tortfeasor.

The Illinois Health Care Services Lien Act creates a lien on behalf of every health care professional and health care provider that renders any service on behalf of an injured person upon all the claims and causes of action of that injured person. 770 I.L.C.S. 23/10. The lien is in the amount of the reasonable charges and attaches to any verdict, judgment, award, settlement, or compromise secured by or on behalf of the injured person on his claim or cause of action. 770 I.L.C.S. 23/20. On the petition of any interested party, the circuit court must adjudicate the rights of all the interested parties and enforce the lien. 770 I.L.C.S. 23/30. The Act further provides that it shall not be construed as limiting the right of the health care professional or provider to pursue collection, through all the available means, of its reasonable charges or of the amount of its reasonable charges that remain unpaid after the satisfaction of its lien under the Act. 770 I.L.C.S. 23/45.

In *Howell v. Dunaway*, consolidated with another case and decided on March 4, 2010, the plaintiffs were injured in car accidents and treated in Illinois' Herrin Hospital and St. Joseph Hospital, respectively. They filed personal injury lawsuits against the drivers of the motor vehicles that injured them. The hospitals filed liens against any recovery in these personal injury actions pursuant to the Act. Both of the personal injury suits were settled, with the plaintiffs recovering damages. The plaintiffs then filed petitions under § 30 of the Act to adjudicate these liens, seeking to apply the Common Fund Doctrine to reduce the amount of the liens by one-third for attorneys' fees incurred by the plaintiffs in their personal injury lawsuits. The Circuit Court granted the petitions, applying the Common Fund Doctrine for the first time to a lien filed pursuant to the Act and the hospitals appealed.

By way of background, as a general rule, the right of an attorney to recover for professional services must rest on the terms of a contract of employment with the person sought to be charged and cannot be based on a benefit derived by a third party from the services rendered by the attorney. *Maynard v. Parker,* 54 Ill. App.3d 141, 143 (1977), aff'd, 75 Ill.2d 73 (Ill. 1979). Further, the client who engaged the attorney and paid his fees is not entitled to recover a proportionate share of the attorneys' fees from those who receive a benefit from the services. *Maynard,* 54 Ill. App.3d at 143. The Common Fund Doctrine is an exception to these general rules. *Id*.

The Common Fund Doctrine is based on the equitable concept that an attorney who performs services in creating a fund should in equity and good conscience be allowed compensation out of the whole fund from all of those who seek to benefit from it. The doctrine rests upon the perception that persons who obtain the

benefit of a lawsuit without contributing to its costs are unjustly enriched. *Bishop v. Burgard,* 198 Ill.2d 495, 509 (Ill. 2002). The policy behind the Common Fund Doctrine is to prevent those who benefit from a fund without contributing to the cost of its creation from "freeloading." However, there is no discussion about the fact that but for the third-party settlement, it would have been the injured plaintiffs who were freeloading on the backs of the hospitals which treated them. Accordingly, the Common Fund Doctrine permits a party who creates, preserves, or increases the value of a fund in which others have an ownership interest to be reimbursed from that fund for litigation expenses incurred, including counsel fees. *Scholtens v. Schneider,* 173 Ill.2d 375, 385 (Ill. 1996). It is now well established that a litigant or a lawyer who recovers a common fund for the benefit of persons other than himself or his client is entitled to a reasonable attorney's fee from the fund as a whole.

To sustain a claim under the Common Fund Doctrine in Illinois, the attorney must show that (1) the fund was created as the result of legal services performed by the attorney, (2) the claimant did not participate in the creation of the fund, and (3) the claimant benefitted or will benefit from the fund that was created. For the first time ever, the *Howell* decision applies the common fund doctrine to the statutory right of hospitals to be reimbursed from uninsured individuals. Practically, it works this way:

(1) Hospital bills patient $10,000.
(2) Case settles for, say, $100,000.
(3) Client pays $33,333.33 (or so) in attorney's fees out of the settlement proceeds.
(4) Hospital would normally be entitled to its entire $10,000. Yet this case notes that the hospital is only getting repaid by virtue of the attorney's work, and would reduce the hospital's recovery to $6,666.66 (representing two-thirds of the total).

There is a risk here for plaintiffs and their attorneys. Trial lawyers are jumping up and down at this landmark decision, and other states will undoubtedly now be faced with copycat claims and efforts at applying the Common Fund Doctrine to the hospital lien statutes of those states. However, trial lawyers should probably stop jumping long enough to read the last paragraph of the opinion. If the Common Fund Doctrine is applied to a hospital's reimbursement right under the Illinois Health Care Services Lien Act, it creates a conflict of interest between the plaintiffs and their attorneys which will result in the plaintiffs owing more money to the lien holders. This is because any amounts paid to the attorneys out of the lien holders' recovery will have to be paid at a later date by the plaintiffs, who still will not have paid their full hospital bill. So if lawyers try to apply this new, questionable decision to cases involving hospital liens, their selfish claim for a fee will expose their own clients to significant liability to the hospital which would otherwise have been extinguished if the lien had simply been paid off without reduction for the Common Fund Doctrine.

The Illinois Court of Appeals expressed no opinion over whether the hospital is still entitled to the remaining one-third of its billed amount. Paying two-thirds of the lien to the hospital would reduce the lien but not reduce the amount of the bill. Expect trial lawyers to work hard to negotiate a final settlement of the hospital providers' bills rather than simply taking their common fund attorney's fees out of the lien and closing their file. If they don't, their clients could be billed for the remainder, sometimes weeks or months later after all of the settlement money has been spent.

However, more than hospitals are affected here. There are numerous Illinois statutes which grant liens to various health care providers:

- Hospital Lien Act, 770 I.L.C.S. 35/1, *et seq.*
- Physicians Lien Act, 770 I.L.C.S. 80/1, *et seq.*
- Clinical Psychologists Lien Act, 770 I.L.C.S. 10/1, *et seq.*
- Dentists Lien Act, 770 I.L.C.S. 20/1, *et seq.*
- Emergency Medical Services Personnel Lien Act, 770 I.L.C.S. 22/1, *et seq.*

- Home Health Agency Lien Act, 770 I.L.C.S. 25/1, *et seq.*
- Optometrists Lien Act, 770 I.L.C.S. 72/1, *et seq.*
- Physical Therapist Lien Act, 770 I.L.C.S. 75/1, *et seq.*

It is important to remember that recipients of personal injury settlements are entitled to an evidentiary hearing to determine the reasonableness of health care provider liens and the court can reduce the amount of health care provider liens based on the unreasonableness of the charges. *Phillips v. DeCarlo*, 301 Ill. App.3d 680 (Ill. 1998). Also, as in other states, the lien holder has the burden of proving that the treatment provided is causally connected to the tortfeasor's conduct. *Anderson v. Dept. of Mental Health and Developmental Disabilities*, 305 Ill. App.3d 262 (Ill. 1999). Subrogation vendors and purchasers of liens should be reminded that in Illinois, at least, such liens are not assignable. *In re Petry*, 224 B.R. 899 (Bankr. C.D. Ill. 1998). In interpreting the Hospital Lien Act, the Court held that rights under the Act are not assignable. Also to be remembered is that under the health care provider liens in Illinois the provider's lien is limited to one-third of the plaintiff's recovery. *Burrell v. Southern Truss*, 176 Ill.2d 171 (Ill. 1997). This means the aggregate liens of ALL providers is limited to one-third of the plaintiff's recovery.

The Common Fund Doctrine is not applicable to contractual medical lien holders in most states, nor should it be. See *Lovett v. Carrasco*, 63 Cal. App.4th 48, 73 Cal. Rptr.2d 496 (Cal. App. 4th Dist. 1998); *Trevino v. HHL Financial Services, Inc.*, 945 P.2d 1345 (Colo. 1997). However, this unusual and questionable Illinois decision is a reminder to hospitals and health care providers that subrogation counsel is advisable in larger health care lien cases.

Matthiesen, Wickert & Lehrer represents the subrogation and reimbursement rights of hospitals and health care professionals under the hospital lien laws of all 50 states. We recommend that Illinois hospitals simply do not negotiate away one-third of their lien so that the plaintiffs' attorneys can pocket it. You have the advantage at this point and gain nothing by giving up your one-third. The pressure will be on the attorney to negotiate something more advantageous to you.

The *Howell* decision illustrates the need for competent and aggressive subrogation counsel even with regard to something as seemingly "automatic" as hospital and health care liens. Most hospital lien laws provide that a hospital lien attaches when an injured person enters the hospital, but is only perfected by timely filing the lien and zealously advocating to protect your statutory rights. If you don't, they will be chipped away at just like they were in this decision. If you need help in collecting or enforcing hospital liens anywhere within the U.S., please contact Gary Wickert at gwickert@mwl-law.com.

HEALTH INSURANCE SUBROGATION

ALASKA HOSPITAL LIEN PROCEDURE IS EXCLUSIVE

Supreme Court Says Statutory Procedure Must Be Followed

Mat-Su Regional Medical Center, LLC v. Burkhead, 2010 WL 572522 (Alaska 2010)

On February 19, 2010, the Alaska Supreme Court issued a decision with broad ramifications for health care providers wishing to attach and perfect their health care liens under Alaska law. Mat-Su Regional Medical Center tried to assert a direct claim against a motor vehicle driver who allegedly injured Brandi Burkhead, to whom Mat-Su then provided medical services. At Mat-Su's request, Burkhead assigned to Mat-Su all her rights and claims against Meg Voss, the tortfeasor. The trial court denied Mat-Su's motion to intervene in Burkhead's personal injury lawsuit against Voss. In S-13326, we consider whether Mat-Su may bring a direct

action, based on Burkhead's assignment of her personal injury claim, against Voss. The Alaska Supreme Court held that the hospital could not intervene into the patient's personal injury suit and that Mat-Su's only remedy was provided by the Medical Lien Statute, § 34.35.475, which provides:

> ***Alaska Stat. § 34.35.450. Hospital's, physician's, and nurse's lien.*** *(a) An operator of a hospital in the state, a licensed special nurse in a hospital in the state, or a physician who furnishes service to a person who has a traumatic injury has a lien upon any sum awarded to the injured person or the personal representative of the injured person by judgment or obtained by a settlement or compromise to the extent of the amount due the hospital, nurse, or physician for the reasonable value of the service furnished before the date of judgment, settlement, or compromise, together with costs and reasonable attorney fees that the court allows, incurred in the enforcement of the lien. Alaska Stat. §§ 34.35.450-34.35.480 do not apply to a claim, right of action, or money accruing under Alaska Stat. § 23.30 (Workers' Compensation Act).*

> *(b) When the person receiving hospitalization has a contract providing for indemnity or compensation for the sum incurred for hospitalization, the hospital has a lien upon the amount payable under the contract. The party obligated to make reimbursement under the contract may pay the sum due under it directly to the hospital, and this payment is a full release of the party making the payment under the contract in the amount of the payment.*

Alaska Stat. § 34.35.460 deals with notice and the procedures needed to perfect a lien:

> ***Alaska Stat. § 34.35.460. Notice of lien.*** *(a) To perfect the lien described in Alaska Stat. §§ 34.35.450-34.35.480, the hospital or the owner or operator of the hospital, or the physician or licensed special nurse, shall, not later than 90 days after the date of injury, or in no event later than 90 days after the discharge of the injured person from the hospital or the provision of the physician's services, file a notice of lien substantially in the form prescribed in Alaska Stat. § 34.35.465, containing a general description of the services rendered and a statement of the amount claimed, with a recorder's office, and shall, after the 90-day period, before the date of judgment, settlement, or compromise, serve a copy of the notice of lien by registered mail, at the last known address, upon the person alleged to be responsible for causing the injury and from whom damages are claimed, and upon the insurance carrier that has insured against the liability, if the insurance carrier is known.*

> *(b) A hospital or the owner or operator of a hospital, or a physician or licensed special nurse who files a notice of lien under (a) of this section for hospitalization or services provided to a recipient of medical assistance under Alaska Stat. § 47 shall mail a copy of the notice of lien to the unit of the Department of Health and Social Services that administers medical assistance for needy persons under Alaska Stat. § 47. The copy must be sent by certified mail no later than 30 days after the filing of the notice of lien under (a) of this section.*

Mat-Su argues that the statutory lien procedure set out in Alaska Stat. § 34.35.475(b) was not its exclusive remedy for recovering its medical lien, especially considering the assignment it received. Mat-Su contended that it does not need statutory authorization to obtain common law contract-based assignment rights, but that the "relevant statutory framework" nevertheless permits it to proceed directly against Voss. According to Mat-Su, the "relevant statutory framework" includes a federal bankruptcy statute, the Alaska Exemptions Act, the Employee Retirement Income Security Act (ERISA), Alaska's treatment of insurance companies' subrogation rights, state Medicaid law, and federal Medicare law. It argued that those bodies of law provide instructive, analogous

examples in which creditors, providers of governmental services, or possessors of subrogation rights may pursue claims directly against third-party tortfeasors, and argued it had a right to intervene in the patient's personal injury action and wasn't bound by the strict procedures set forth in the statute above for attaching and perfecting its statutory lien. The Supreme Court disagreed.

The Supreme Court pronounced that the hospital lien enforcement procedure set out in the statute provides Mat-Su's exclusive remedy against Voss and that permitting Mat-Su to proceed directly against Voss would "eviscerate the careful tripartite balance" the Alaska legislature established between the "patient/plaintiff, health care provider, and tortfeasor/insurer." This decision underscores the importance of having subrogation counsel promptly take efforts to comply with the statutory framework of hospital lien laws in all 50 states, thereby attaching and perfecting its lien to avoid its defeat later in third-party litigation.

HEALTH INSURANCE SUBROGATION

RYAN L. WOODY WINS SUMMARY JUDGMENT IN WRONGFUL DEATH CASE

Court Finds Estate Misallocated Funds in an Attempt to Avoid Health Plan's Lien

By Ryan L. Woody

They say good things come to those who wait. After two published decisions and several years of litigation, Chief Judge Jack Camp of the Northern District of Georgia ruled in favor of the ERISA plan in *Diamond Crystal Brands, Inc. v. Wallis, et. al.*, 2010 WL 1525536 (Ga. 2010). The case was originally filed in 2007 and includes a long history that began with a Temporary Restraining Order ("TRO") and featured published decisions on the Court's entry of a preliminary injunction and on its subsequent order on a motion for reconsideration. The facts are rather straightforward. The case arose after Deborah Hayes went into the hospital for routine back surgery. Tragically, however, she died as a result of the hospital's negligence. Her employer's ERISA-covered health Plan paid significant benefits related to the hospital's attempts to resuscitate and save her life following the medical negligence. After Ms. Hayes's death, her surviving daughter, Tamara Hayes, brought a wrongful death and survival action on behalf of herself and the estate against the physicians. The case resulted in a settlement of $900,000, of which Tamara Hayes' attorney allocated the maximum allowable under Georgia law to her wrongful death claim. The little that remained was allocated to the estate's claim for medical bills. Unfortunately, this is a quite common allocation scenario in wrongful death cases around the country. Predictably, the plaintiffs' attorney told the Plan that it was not entitled to reimbursement from anything allocated to the wrongful death beneficiary.

It is important to note that the plaintiffs' settlement occurred secretly despite the Plan administrator's request to be involved in any settlement negotiations. After finding out about the settlement, the health Plan objected to the proposed allocation and insisted that it had a right to full reimbursement from the total settlement proceeds. The plaintiffs' attorney refused and offered the Plan only a fraction of the amount allocated to the estate as reduced by his 40% attorneys' fees and costs. After it was clear that the estate's attorney had no intention of offering the Plan any of the funds that he unilaterally allocated to the wrongful death claim, the Plan filed suit to prevent dissipation of the funds and seeking reimbursement of its full lien amount. The Court entered an ex-parte TRO on the Plan's behalf in order to preserve the funds.

The Court then ordered a preliminary injunction hearing be held at which testimony would be heard. At the hearing the plaintiffs' attorney testified as to how he allocated the maximum amount allowed to the wrongful death claim and that whatever remained was allocated to the estate's claim. The plaintiffs' attorney defended his decision arguing that he offered the Plan the opportunity to intervene into the state court action and pay his costs associated with the case, but the Plan refused his offer. He argued that the Plan had the opportunity to intervene but refused and therefore could not now challenge the allocation. In addition, the plaintiffs' attorney informed the Court that he no longer had the settlement funds because he had returned the check to the insurance company which, therefore, meant the Court had no subject matter jurisdiction under ERISA.

The Trial Court was not pleased by the plaintiffs' tactics. The Court ruled that it had jurisdiction over the case despite the fact that the plaintiffs' attorney returned the settlement check to the insurance company even while under the Court's TRO. It held that:

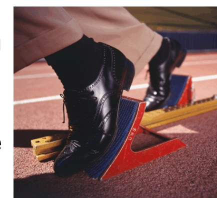
> *The fact that funds are held by a third party, such as Hudson, rather than the beneficiary, does not defeat a claim under Section 502(a)93). Horton, 513 F.3d at 1229 ("[T]he most important consideration is not the identity of the defendant, but rather that the settlement proceeds are still intact, and thus constitute an identifiable res that can be restored to its rightful recipient.").*

After finding that the Court had jurisdiction because the claim was, in fact, equitable in nature, the Court turned to the merits. The issue was whether the Plan could recover its lien from portions of the settlement that had been unilaterally allocated to Tamara Hayes' wrongful death claim. The Plan argued that the estate of Deborah Hayes was bound by the Plan and that there had been a misallocation of funds away from the estate's claim and to the wrongful death claim. Conversely, Tamara Hayes argued that she was not bound by the Plan and that the funds belonged to her individually. However, the Court recognized that Tamara Hayes was not only acting in her individual capacity when she made the settlement allocation, but that she was also acting as the administrator of her mother's estate. As such, the moment the $900,000 settlement fund was identified and before the purported allocation, the Plan was entitled to a first lien. The court wrote:

> *Moreover, after agreeing to settle the state court action for $900,000.00, Tamara Hayes in her capacity as Temporary Administrator of the Estate may not avoid the subrogation provision contained in the plan document and the equitable lien it creates by structuring the Settlement Agreement and Release to allocate the maximum amount allowable under the law to her and then seeking to appoint a new Administrator of the Estate to execute the Settlement Agreement and Release on behalf of the Estate. See generally Wright v. Aetna Life Ins. Co., 110 F.3d 762, 765, n.3 (11th Cir. 1997) ("Since Aetna was not a party to the settlement agreement, that agreement's purported allocation of damages does not govern the district court's determination. To hold otherwise would allow [the covered individual] and the [tortfeasor] to control Aetna's reimbursement rights.")*
>
> …
>
> *Finally, the plan document also prohibits the Estate from doing "anything which may have the effect of prejudicing any of the foregoing rights, including but not limited to…arranging for others to receive proceeds of any judgment, award, settlement, covenant, release or other payment: or releasing any claim in whole or part without reasonable compensation therefore." (Plan Document at p.44.) Defendant Tamara Hayes, while acting as the Temporary Administrator of the Estate, and in conjunction with the attorneys representing the Estate, structured the settlement with the third party tortfeasor by arranging for her to recover the vast majority of the settlement funds, $836,536.00 of the total $900,000.00 settlement. As her attorney acknowledged, he allocated the full amount allowable under Georgia law to her individual claim and then allocated whatever amount was left to the Estate. (Prelim. Inj. Hr'g Tr. 38-40.) The Estate's actions in structuring the*

settlement to minimize its reimbursement to the Plan for the medical expenses of Deborah Hayes while maximizing the recovery to Defendant Tamara Hayes violates the express terms of Plan 501.

The Court went on to hold that the Plan was entitled to full reimbursement and rejected the defendant's argument that the Make-Whole Doctrine applied. This is a major victory for ERISA Plans subrogating wrongful death cases in Georgia and throughout the country. The decision recognizes the inherent conflict of interest when a wrongful death beneficiary also represents the estate's claim for medical bills. It opens up a new avenue for recovery in those cases involving both wrongful death and an estate's claim for medical bills. By arguing that there was a prior misallocation, ERISA Plans can avoid the thorny issue of preemption of state wrongful death statutes. Instead, the Plans can simply request that the federal court properly allocate the settlement proceeds subject to the Plan's lien.



There is one caveat, however. Subrogating ERISA Plans MUST have proper language in order to challenge this allocation. In this case, the Plan had language that prevented misallocations by the estate to other parties. This language made a critical difference in this case and allowed the federal judge to find that a violation had occurred such that the court could properly reallocate the settlement funds.

As a note to our readers, this case has been appealed by the defendants to the 11th Circuit Court of Appeals in Atlanta. Briefing has been scheduled and MWL will update this story once an appellate decision is issued.

UPCOMING EVENTS.......

Upcoming Events

May 11-14, 2010 - MWL will be exhibiting at the 5th Annual Claims Education Conference being held in New Orleans, Louisiana. 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 http://www.claimseducationconference.com.

June 1, 2010 - Ryan Woody will present a live webinar entitled *"Subrogating Occupational Accident Plans"* from 10:00 - 11:15 a.m. (CST). A registration link will soon be on our website homepage but you can register now by clicking on the "Register Now" button to the right.

November 10-11, 2011 - 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.

We are pleased to say that our April 20, 2010 webinar on *Introduction to Property and Casualty Subrogation* was a huge success. We had more than 400 people in attendance and received excellent reviews and numerous questions following the webinar. The webinar certainly exceeded our expectations and we want to thank all of those people who attended. The recorded version of this webinar, along with our first webinar on *Workers' Compensation Subrogation 101*, can be viewed on the Seminars/Webinars page of our website at www.mwl-law.com.

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