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 **JULY 2011**

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 AND ERISA SUBROGATION

WISCONSIN SUPREME COURT ISSUES MAJOR ERISA SUBROGATION DECISION

By Ryan L. Woody

On July 8, 2011, the Wisconsin Supreme Court handed ERISA subrogation practitioners a gift basket in the form of *Steffens v. BlueCross BlueShield of Illinois*, 7901 N.W.2d 543 (Wis. App. 2011). For all too many subrogation professionals out there, this will be a familiar situation. Currently, the litigation strategy of choice for plaintiff's attorneys in Wisconsin is to attempt to defeat subrogation rights. Hopefully, this decision will put a stop to that practice.

Initially, this case was a typical Wisconsin negligence case. The plaintiff, Steffens, was rear-ended by a car driven by Wesley Dishno. Dishno had liability insurance with AIG. In the lawsuit, Steffens claimed severe personal injuries and that he had to undergo a lumbrosacral fusion surgery as a result of accident-induced grade-one spondylolisthesis. Steffens joined BlueCross pursuant to Wis. Stat. § 803.03 and named it as a subrogated defendant because it had paid $67,477.57 for his medical expenses. BlueCross, which administered a self-funded ERISA Plan, filed a cross-claim against the defendants for subrogation and a counterclaim against Steffens for reimbursement. Throughout the case, Steffens answered discovery by alleging more than $130,000 in medical bills and claiming permanent injury to his back.

So far everything is fairly normal for a negligence lawsuit in Wisconsin. However, here's where things get interesting. Without providing any notice to BlueCross, Steffens settled his lawsuit with AIG and Dishno for $100,000. After settlement, Steffens amended his discovery answers such that he alleged no permanent injury and claimed only $2,000 in accident-related medical expenses. He went so far as to name the defendant's IME doctor as his new expert witness. Essentially, Steffens did a complete 180° turn and instead of arguing that he was severely injured, denied the same. He did this in an obvious attempt to avoid having to repay BlueCross' subrogation claim. Following the settlement, BlueCross filed for a declaratory judgment that it was entitled to 100% reimbursement of its subrogation claim. The trial court agreed, holding that Steffens was judicially stopped from taking inconsistent provisions. To hold otherwise, according to the trial court, would be to purport a fraud upon the court.

Steffens appealed to the Wisconsin Court of Appeals. In an unpublished decision, the Court of Appeals reversed. While the intermediate court agreed that Steffens had taken inconsistent positions, the Court concluded that the third element of judicial estoppel had not been met because Steffens had "never convinced any court to adopt his position that the surgery was related to the accident."

The Supreme Court accepted the appeal and reversed the Court of Appeals. However, instead of addressing the important question of judicial estoppel, the Supreme Court opted to go a different route. Instead, the Court asked whether BlueCross' decision that the surgery was related to the accident was a reasonable interpretation of the Plan. Despite the absence of any written decision by the Plan administrator, the Court essentially turned the Plan's subrogation claim into the enforcement of an administrative decision. In this case, the Plan granted the administrator discretion to interpret the terms of the Plan. As such, the Court noted that "[r]eview of a Plan administrator's decision is limited to the record available to the Plan administrator at the time the decision was made". *Id.* at ¶51.

Applying the deferential standard of review found under the Plan, the Court easily found that the Plan's subrogation determination was reasonable. It pointed out that Steffens' Complaint, Amended Complaint, Answers to Interrogatories, Requests to Admit, and original Witness List all alleged that the surgery was related to the accident. It was only after he settled with AIG for $100,000 that he changed his position as to the surgery. Accordingly, the Court held that "because Steffens himself averred both before and after BlueCross' counterclaim for reimbursement under the Plan that the surgery-necessitating injuries arose out of the accident, it is reasonable for the Plan administrator to have reached the same conclusion." *Id*. at ¶66.

Additionally, the Court noted that both parties agreed that the Plan language trumped Wisconsin's Made Whole Doctrine. More importantly, the Supreme Court clarified that under ERISA the subrogated Plan has no obligation to prove medical causation. In what will prove to be a pivotal footnote, it wrote:

> *Steffens, erroneously, argues that BlueCross must prove causation, namely, that the accident caused the surgery-necessitating injuries. Steffens grounds this argument in the law of negligence under which causation is an element. However, the subrogation issue here arises under contract law, not tort law. See Herzberger, 205 F.3d at 330 ("An ERISA Plan is a contract."). Therefore, we look to the terms of the contract, i.e., the terms of the Plan. Pursuant to the terms, the question is whether the administrator's determination that the surgery-necessitating injuries arose from the accident was arbitrary and capricious, not whether BlueCross must prove the accident caused the injuries.*
>
> *An example provided by Steffens illustrates his error in grounding his argument in tort law. In an attempt to argue that BlueCross must prove causation, he contends: "For instance, if an insured injures his arm in a car accident and subsequently has an unrelated surgery on*

his toe, the insurer would be able to take money out of a settlement regarding the arm for bills the insurer paid on the toe surgery, if not required to prove causation." Under the law set out above, and assuming the Plan in this example is identical to BlueCross' Plan, this example reaches an erroneous conclusion. Under the Plan, the insurer would not be capable of reimbursement from the settlement money unless the Plan administrator reasonably determined that the toe surgery arose from the car accident. Such a determination would be arbitrary and capricious since the example explicitly states that the two events were unrelated. Id. at n.22.

Because the Court used this administrative review deference to hold that the Plan was entitled to 100% reimbursement, it refused to reach the question of judicial estoppel.

In a dissent, Justice Abrahamson criticized the majority's treatment of the subrogation claim as an administrative decision. She notes that there was no written decision from which the Court could review. In addition, she points out that the record did not even include a copy of the Plan. She wrote:

> *I searched the record to find the answers to many questions: When did the Plan administrator interpret the Plan? What was that interpretation? What decision was made? On what facts was decision based? And what was the Plan administrator's reasoning in reaching the decision? I can't find answers in the record to any of these questions.*

Justice Abrahamson

> *No copy of the Plan administrator's decision is in the record. No affidavit of the Plan administrator is in the record. Nevertheless, the majority opinion declares that it is evaluating the Plan administrator's decision on the basis of the information the administrator had when it made its decision. A court cannot evaluate an interpretation and decision of a Plan administrator and determine whether that decision is arbitrary and capricious without knowing what the interpretation and decision is, and on what it is based. Id. at ¶¶79-81.*
>
> *I am not convinced that the Plan's counterclaim can be read to constitute an administrative decision. Further, I am also disinclined to accept the majorities errant conclusion that "this is an action brought by the Plan administrator under § 1132(a)(3)(B)" Id. at ¶44. As that statute clearly provides, "the district courts of the United States shall have exclusive jurisdiction" over actions brought under § 1132(a)(3).*

In the end, the Court reached the right decision, albeit likely on shaky grounds. Instead, the Court should have simply addressed this, as many other courts have, under judicial estoppel and found that the plaintiff's settlement of the action constituted the requisite element of convincing a court of its position. Regardless, though, this is an exciting decision for ERISA subrogation in Wisconsin. It will hopefully end the deplorable practice of plaintiff's attorneys who change their position only after settlement in a blatant attempt to defeat a valid ERISA lien.

A copy of this decision can be viewed by clicking **HERE**. Should you have any questions about this decision or what it means for ERISA subrogation in Wisconsin, please feel free to contact Ryan Woody at rwoody@mwl-law.com.

WORKERS' COMPENSATION SUBROGATION: A FINGER IN THE DIKE

By Gary L. Wickert

Last year, a *Wall Street Journal* article quoted the CEO of a leading U.S. carrier describing workers' compensation as a "time bomb". Liberty Mutual, the largest workers' compensation insurer in the United States by premium volume, has indicated its plans to reduce exposure to workers' compensation claims because of rising costs and dwindling profits. AIG, the nation's second-largest workers' compensation insurer, has also undertaken to reduce its exposure in this line of insurance. As the future face of workers' compensation in America remains blurred, we should keep in focus and be diligent about one of the few variables affecting the profitability of workers' compensation over which we have control – subrogation.

The National Council on Compensation Insurance (NCCI) - the statistical and rating organization for a majority of states - recently described the workers' compensation market as "precarious" and said just this past spring that this market was "deteriorating." Its 2011 Annual Issues Report, which rates the profitability of it, reported a combined ratio of 110 for workers' compensation in 2009, a 5-point increase from 2009 and a 9-point increase from 2008, can be read by clicking **HERE**. The 110 combined ratio means that for every $1.10 in claims and expenses the carrier receives $1.00 in premiums. Exacerbating the number recently are the low interest rates which prevent carriers from successfully investing these premiums until they are needed to pay claims. NCCI reports that in 2009, carriers' return on equity was a paltry 1.6%.

While it is true that the disappointing numbers from 2009 to 2010 were the primary result of one carrier (unnamed by NCCI) adding more than $800 million to excess workers' compensation reserves, the trend is not positive during a time in which property and casualty carriers were having a reasonable year. Obviously, returning us to a good economy and a reasonable investment environment is beyond the capability of the insurance industry alone. Our deep economic recession - exacerbated by a Congress unwilling to tackle the spending cuts needed to right our listing economic ship – and significant changes in the regulatory environment, are both contributing factors which are beyond our ability to change. Cyclical issues are clearly at play. But there are still things we can do right now to improve the profitability of a workers' compensation market which has been hit by the triple challenges of decreasing policy prices, a deterioration of reserves, and an increase in claim frequency. Subrogation is at the top of the list.

Workers' compensation subrogation is much different from other forms of subrogation, and should be treated as such. Workers' compensation legislation first came into being in 1911 when Wisconsin became the first state to adopt workers' compensation legislation. By 1948, every state had some form of "workman's compensation." Such legislation had its roots in socialism and is a social contract in which employers are mandated by law to pay unlimited medical expenses and lost wages when employees are injured while working – even if the employer is absolutely without fault. In exchange for this social safety net, workers' compensation becomes a worker's exclusive remedy against their employer, and the employer is given immunity from liability. As part of the contract, the employer (or its insurance carrier) are also entitled to be reimbursed for any benefits paid whenever a third-party tortfeasor (somebody other than the employer or employee) is responsible for the injury or death. Unfortunately, courts and legislatures have begun eroding away the employers' end of the bargain, rendering them liable both when they are at fault, and when they are not. At the same time, their rights of reimbursement have also been assailed.

The term "subrogation" might be a misnomer when it comes to workers' compensation, because the carrier's right is more appropriately one of "statutory reimbursement." The Wisconsin Court of Appeals has correctly observed that "the rights granted by the statute are distinct from subrogation." *Campion v. Montgomery Elevator Co.,* 493 N.W.2d 244 (Wis. App. 1992). Rather, they are a defined set of rules for honoring our social contract with employers by safeguarding reimbursement, placing the responsibility for the loss on the backs of the wrongdoers, and holding down employers' insurance premiums. Unlike traditional subrogation, the carrier here is not subrogated to the rights of its insured – but rather, is statutorily given the right to press the claim of or receive reimbursement from the injured worker, a stranger to the insurance contract.

Judges and legal scholars agree that subrogation recoveries are an important component in calculating premiums, and clearly address and affect the bottom line. An insurance company sets its rates based on historical net costs. One legal scholar at the University of Chicago explained how subrogation impacts insurance premiums. See Jeffrey A. Greenblatt*, Insurance and Subrogation: Where the Pie Isn't Big Enough, Who Eats Last?* An insurance company sets its rates based on historical net costs. Thus, if the insurer had 100 policyholders in the experience period, and experienced a total of $20,000 in claim costs, it will set its actuarial premiums at $200 per policy holder. If, on the other hand, the insurance company experienced $20,000 in claim costs and received $5,000 in subrogation, it will set its actuarial premiums at $150 per policy holder." *Id*. at 1355. Similarly, another writer explained how subrogation recoveries figure into an insurer's premium calculations:

> *Revenue gained by the insurer, whether through subrogation collection or otherwise, is applied toward responding to the actual risk that is required to be paid by the insurer under the terms of the contract or policy…As a source of revenue, subrogation operates to reduce the actual past cost total used in the calculation of probable future insurable risk or loss on which future premiums will be based.* F. Joseph Du Bray, *A Response to the Anti-Subrogation Argument: What Really Emerged From Pandora's Box,* 41 S.D.L. Rev. 264 (1996).

Courts throughout the country agree that subrogation benefits society by lowering insurance costs and preventing double recoveries. See *Brooks v. A.M.F., Inc.*, 278 N.W.2d 310, 313 (Minn. 1979). Subrogation along all lines of insurance serves the vital function of helping to keep premiums low for billions of insureds worldwide, and should be protected at all costs. This is especially true with workers' compensation insurance where the laws of some states require reimbursements to be considered in calculating premiums.

The complicated calculation of workers' compensation premiums necessarily involves the concept known as the Experience Modification Factor. The Experience Modification Factor (also known as an Experience Modification Rating, EMR, Experience Modifier, or just the Mod) is an adjustment that is made to the workers' compensation insurance premium of American employers. This means that the calculation of insurance premiums for an employer takes into consideration a number of factors, including prior years' payroll, loss history, and subrogation recoveries.

According to the Workers' Compensation Subcommittee of the American Academy of Actuaries, as reported to the U.S. Senate Judiciary Committee on the dangers and economic harm associated with efforts to limit subrogation rights in the workers' compensation arena, the role subrogation plays in holding down workers' compensation premiums is even much more pronounced than in some lines of insurance because when the employee makes a successful third-party recovery, the workers' compensation carrier not only has a right to recover past benefits it has paid, but, in most states, it has the right to take a credit in the amount of the worker's net recovery toward any future benefit payments it might owe. This combination of subrogation and future credit plays a large role in erasing negative loss histories,

positively affecting risk modifiers, and helping workers' compensation carriers to operate profitably in an unprofitable economic environment.

Subrogation not only benefits American businesses, it helps U.S. insurers struggling in a challenging and temporarily unprofitable market make ends meet until the cyclical nature of things helps turn the workers' compensation world right side up again. A carrier's pursuit of and squeezing every subrogation dollar possible reflects an excellence in business and a virtue every carrier should strive for. It was Aristotle who said, "We do not act rightly because we have virtue or excellence, but rather, we have those because we have acted rightly."

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

INSURANCE SUBROGATION

BANKRUPTCY FOR SUBROGATION PROFESSIONALS

A Primer

By Timothy S. Mentkowski

Few words or phrases – other than perhaps "made whole" – create more terror in the minds and files of subrogation professionals, than the word "Bankruptcy." All too often, a defendant's filing of bankruptcy spells the end of recovery efforts in a file, leaving the subrogation claims handler scratching his or her head as to what it all means and what recourse is available to them. This primer on bankruptcy is intended to answer those questions and provide direction when the subrogation killer known as bankruptcy raises its ugly head.

Bankruptcy stems from federal, as opposed to state law. While there are several types of bankruptcy, the three we need to be familiar with are the following:

Chapter 7. This is also known as a "straight liquidation", because the debtor's non-exempt assets are sold and the proceeds applied to pay administrative expenses, with the small amount remaining used to pay debts. Chapter 7 bankruptcies necessitate the involvement of a bankruptcy trustee, who determines if there are any assets or money available to pay debts. The trustee uses his powers to set aside fraudulent transfers of property and money – known as a "preferential transfer" – made to an unsecured creditor within 90 days before the filing of the bankruptcy petition, as well as "fraudulent conveyances" – the transfer of anything the debtor has for less than fair market value – made within two years of the filing of the Chapter 7 bankruptcy. In this type of bankruptcy, there are almost always no assets other than those which the debtor can protect and keep because they are exempt. The result of a Chapter 7 bankruptcy is usually the discharge of the debtor's personal liability on debts which are dischargeable. Most debts are dischargeable, but debts such as taxes or debts procured by fraud are not. A creditor must usually file an objection to the discharge of a specific debt, and the debt will survive bankruptcy. An objection to discharge must usually be filed within 60 days of the first meeting of creditors. Even after a discharge is granted, an adversary proceeding may be filed by a creditor within one year after the discharge, challenging the discharge.

Chapter 11. This is known as a "reorganization" bankruptcy, and is filed by corporations who plan to emerge from bankruptcy as an ongoing entity with less debt. The corporate debtor tries to reorganize its affairs and remain in business. The idea is that a rehabilitated business is worth more to creditors than one which simply

goes out of business. The Chapter 11 debtor continues to control its own affairs during the bankruptcy process – known as a Debtor-in-Possession. A group of creditors may petition the court to have a trustee appointed to control the company if they feel it is necessary.

Chapter 13. This type of bankruptcy is similar to a Chapter 7, except that the debtor must file a plan which governs the payment of existing debts. The plan can be for three to five years, and all disposable income of the debtor must be applied to the payment of unsecured debts. Creditors have an opportunity to object to the plan if they don't think it is fair, but ultimately the court approves what it thinks is fair under the circumstances.

In all bankruptcies, the debtor files a schedule – a list of assets and liabilities. When a bankruptcy is filed, it is usually accompanied by an automatic stay – an injunction against the continuance of any lawsuits or legal action against the debtor or the debtor's property. The defendant/debtor will file a Suggestion of Bankruptcy in a pending lawsuit, to put all parties and the court on notice that the automatic stay is now in place. This stay is automatic and is in place the moment the debtor files a bankruptcy complaint. It ends all subrogation lawsuits, interventions, or collection efforts until the stay is lifted or the bankruptcy ends. There are severe penalties for violating the stay, such as fines and award of attorney's fees. If there is liability insurance covering the debtor, a creditor such as a subrogated insurance carrier can ask the bankruptcy court to lift the stay to allow proceeding against the liability limits of the insurance policy only. It must be shown that the liability insurance company will pay any damages as well as attorney's fees for defense of the debtor. If only one of several defendants in a subrogation lawsuit files for bankruptcy, the action against all defendants is also stayed, because of the possible effect it could have on the defendant who did file for bankruptcy.

Creditors looking to collect from a debtor must file a Proof of Claim in order to receive money from the bankruptcy estate. This claim allows the court or trustee to verify the legitimacy of the debt and provide for its payment or partial-payment. Deadlines for filing a Proof of Claim are dictated within each bankruptcy case in order to allow finality and discharge of the debtor's debts. It puts the court and all parties on notice of your claim and allows you to participate in the bankruptcy process. The Proof of Claim must set forth the amount of your claim, basis for the claim (*e.g.*, product liability, contract, negligence lawsuit, etc.), date it accrued, and other information. If you do not file a Proof of Claim, you are out of luck.

Subrogation professionals who are not represented by subrogation counsel and are confronted with a bankruptcy should immediately take the following action:

(1) Obtain a copy of the bankruptcy petition and all schedules;
(2) File a Proof of Claim with the bankruptcy court as soon as possible;
(3) If the debtor/defendant has liability insurance, you should file a Motion for Relief from Stay seeking a lift of the stay in order to proceed against this insurance to the extent of its limits.
(4) Appear at the 341A hearing if there are questions the subrogated carrier wants to ask the debtor, including possibly asking the debtor's attorney if he or she will agree to reaffirm the subrogation debt; and
(5) Monitor the bankruptcy proceedings regularly, to determine if the bankruptcy is dismissed for failing to comply with procedures or other requirements.

Once your Proof of Claim is filed, the order of priority for paying claims is as follows: secured claims (claims connected to property that acts as collateral, such as a mortgage on a house or a loan for the purchase of a car), administrative expenses of the bankruptcy estate, general unsecured claims, and finally, certain specified types of unsecured claims.

Unsecured subrogation claims are usually not afforded preferential status in bankruptcies, and it is not uncommon for subrogated carriers to receive pennies on the dollar when all is said and done. However,

there are exceptions, and due diligence requires subrogation professionals to properly document their claims and comply with procedures within the bankruptcy court, if they are to have any chance of recovery at all. We sometimes laugh at the futility and foolishness of the person who routinely buys lottery tickets – until they win.

If you should have any questions regarding this article or subrogation in general, please contact Tim Mentkowski at tmentkowski@mwl-law.com.

INSURANCE SUBROGATION

UNDERWRITING CREDIT SCORING APPROVED IN TEXAS

In a world sometimes run amok with political correctness and a complete abdication of common sense in the application of risk management and sound business practices, the Texas Supreme Court has approved the use by insurance underwriters of credit scoring using completely race-neutral factors, even if it has an unintended impact on minorities. The 8-0 decision was issued last month in the case of *Ojo v. Farmers Group, Inc.,* 10-0245, 2011 WL 2112778 (Tex., May 27, 2011). It announced that the state's law "does not prohibit an insurer from using race-neutral factors in credit-scoring to price insurance, even if doing so creates a racially disparate impact."

Patrick Ojo, an African-American, received a renewal on his homeowner's insurance with a 9% increase despite the fact he never had a claim. Ojo sued the company, claiming that the increase was the result "of unfavorable credit information acquired through its automated credit-scoring system." The suit was brought on behalf of himself and other minorities who experienced the same increases because of credit-scoring, claiming that several undisclosed factors resulted in "disparate impacts for minorities and violate the federal Fair Housing Act."

The Court stated that the state's insurance code "is void of any language" that creates "a cause of action for a racially disparate impact." David Snyder, vice president and associate general counsel of the American Insurance Association, says: "The vast majority of states (46) permit insurance scoring subject to such regulation as is the case in Texas. Credit-based insurance scoring continues to play a major role in creating a positive and competitive personal lines market. Its use allows insurance companies to give more favorable rates to consumers who are less likely to have costly losses."

Joe Woods, vice president for the Property Casualty Insurers Association of America, comments, "This decision will help add clarity regarding the use of insurance scores and the inappropriateness of disparate impact tests for property casualty insurance. For insurers, the issue has always been one of risk, not race. Insurance scoring is an objective process."

Underwriting is subrogation's cousin, and credit-based scoring is a very widely-used method of determining risk. The fact that the Texas Supreme Court came out in support of the practice is good news for an industry which has been unfairly accused of everything from discrimination to red lining, when it comes to underwriting practices. This practice has been one of the most controversial and highly-regulated and highly-legislated insurance practices in recent memory, and has been upheld as legitimate in almost every jurisdiction as beneficial to consumers.

UPCOMING EVENTS……

September 20, 2011 - Ryan Woody will be presenting a live webinar entitled *"Avoiding The Made Whole And Common Fund Doctrines*" from 10:30 a.m. - 11:30 a.m. (CST). This webinar is approved for 1.0 Texas CE credits and is free to clients and friends of MWL. 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.

October 26-28, 2011 - MWL will be exhibiting at the *Self Funding Employer Healthcare and Workers' Compensation Conference* in Chicago, Illinois. Jamie Breen will be at Exhibit Booth 105 so stop by our booth if you plan on attending this conference and introduce yourself. For more information on this conference, please go to www.selffundingconference.com.

May 9-12, 2012 - MWL will be exhibiting at the *7th Annual Claims Education Conference* in Napa Valley, California. Jamie Breen will be at Exhibit Booth 12 so stop by our booth if you plan on attending this conference and introduce yourself. For more information on this conference, please go to www.claimseducationconference.com.
