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GROUP HEALTH LIENS
RIGHTS, REMEDIES AND STRATEGIES

Prepared By:

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I. Subrogation vs. Reimbursement

A. Right of Subrogation

1. The substitution of one party in the place of another with respect to a lawful claim or right.

2. Subrogation is based on equity.

a) The legal doctrine of subrogation evolved out of the equitable belief that the party that has caused a loss should bear the burden of that loss. Courts of equity reasoned that a wrongdoer should not be allowed to benefit from the fact that the injured party had the foresight to obtain insurance. "Subrogation rests on the equitable principle that one, other than a volunteer, who pays for the wrong of another should be permitted to look to the wrongdoer to the extent he has paid and be subject to the defenses of the wrongdoer." *Garrity v. Rural Mutual Insurance Co.*, 77 Wis. 2d 537, 253 N.W. 2d 512 (1977).

b) Public Policy Against Double Payment. "Another equitable premise of subrogation is that an injured person should not recover twice for the same loss. An individual whose medical expenses are paid for by his health insurer should not also be able to recover from another party sums representing those same medical expenses." *Rawlings & Associates National Subrogation Law Manual* (1999).

(1) Wisconsin recognizes that it is contrary to public policy to recover twice for the same loss. *Cunningham v.*

Metropolitan Life Insurance Co., 121 Wis. 2d 437, 360 N.W. 2d 33 (1985).

3. Two (2) types of subrogation: Contractual ("conventional subrogation") and equitable ("legal subrogation").

   a) Contractual subrogation: Based on rights conferred by contract. Example: A health insurer may include a provision in its policy or insurance contract that it will be subrogated to the rights of the insured against the person or party responsible for the loss which necessitated its payment of benefits.

   b) Equitable subrogation: Based on the principle of fairness. In the case of equitable subrogation, an insurer has subrogation rights even though the contract may not contain any express subrogation language. The very fact that an insurer makes a payment for its insured establishes the right of equitable subrogation.

      (1) Most states recognize equitable subrogation rights. Equitable subrogation allows the insurer to proceed directly against the responsible party without the health insurance policy specifically providing this right.

      (2) Wisconsin recognizes both the contractual and equitable rights of subrogation. Wisconsin courts, for purposes of subrogation, have made a distinction between policies of investment verses policies of indemnity. Insurers with policies providing indemnity will be allowed to pursue subrogation even if there is no specific contract language. If, however, the policy proves to be one of investment, an insurer will not be permitted to pursue subrogation without an express subrogation clause. *Cunningham v. Metropolitan Life Insurance Co.*, 121 Wis. 2d 437, 360 N.W. 2d 33 (1985); *Jindra v. Diederich Flooring*, 181 Wis. 2d 579, 511 N.W. 2d 855 (1994).

4. Standard subrogation provision found in group health policy:

   SUBROGATION

   If, after payments have been made under this policy, you or your covered dependents have a right to recover damages from a responsible party, we will be subrogated to your rights to recover. You or your covered dependent will do whatever is necessary to enable us to exercise our right and will do nothing after loss to prejudice it. If we are precluded from

exercising our right of subrogation, we may exercise our right of reimbursement.

B. Right of Reimbursement

1. Contractual recovery against insured. Reimbursement is the right of the insurer to make a claim against its insured after the insured has recovered funds from another party responsible, at least in part, for expenses or damages paid by the insurer.

2. The right of reimbursement arises only after the insured recovers his loss from the third party.

3. Generally triggered in a worker's compensation case. Group health policies routinely exclude payments for work-related benefits.

4. Standard Worker's Compensation exclusion in group health policy:

EXCLUSIONS

This policy does NOT provide benefits for:

Treatment of any bodily injury or sickness that is sustained by an employee or a covered dependent that arises out of, or as the result of, any work for wage or profit when coverage under any Workers Compensation Act or similar law is required for the employee or covered dependent.

5. It is not uncommon for claims to be submitted by a provider to the health insurer even if the injuries are work-related and should be paid by the worker's compensation carrier. Many times, the health insurer will pay such claims because the health insurer did not know that the accident was work-related. Because most health insurance policies exclude payments of medical expenses covered by the worker's compensation carrier, the health insurer has the right to recoup the payments if they were made by mistake.

6. Many times claims will be paid by the health insurer because the worker's compensation carrier disputes that the injury was work-related. The health insurer has the right to seek reimbursement or recoup the payments if a disputed claim is later determined to be work-related.

7. Wisconsin: Section 102.30(7)(a), Wis. Stats.

The Department may order direct reimbursement out of the proceeds, payable under this Chapter for payments made under a non-industrial insurance policy, covering the same disability and expenses compensable

under Sec. 102.42 when the claimant consents or when it is established that the payments under the non-industrial insurance policy were improper. No attorney fee is due with respect to that reimbursement.

8. In a few states, health carriers are required by law to pay medical bills if the worker's compensation carrier denies the claim. For example, in Michigan and Minnesota, the group health carrier must pay the outstanding medical bills. The group carriers are then entitled to intervene in the worker's compensation proceeding.

9. In most states, the decision by the group health carrier to pay medical bills in a disputed worker's compensation case is purely voluntary. If payments are made, however, the group health carrier will likely seek to enforce its right to reimbursement.

10. In Couch on Insurance 3d, the author indicated that the preference was to allow group health insurers the right to obtain reimbursement:

"In any case of doubtful liability, the safest course for the insurer is to immediately pay benefits on the assumption that the sickness or injury was covered by the policy, and later seek reimbursement if there is a successful Worker's Compensation proceeding." *Couch on Insurance 3d* § 180:23 at 180-38.

11. Sample provision providing group health carrier with a right of reimbursement in a worker's compensation case:

WORKER'S COMPENSATION

If benefits are paid by us and we determine you received Worker's Compensation for the same incident, we have the right to recover as described under the "Recovery Rights" provision. We will exercise our right to recover against you.

The Recovery Rights will be applied even though:

1. The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise;

2. No final determination is made that bodily injury or sickness was sustained in the course of or resulted from employment;

3. The amount of Worker's Compensation due to medical or health care is not agreed upon or defined by you or the Workers' Compensation carrier; or

4. The medical or health care benefits are specifically excluded from the Workers' Compensation settlement or compromise.

You hereby agree that, in consideration for the coverage provided by this policy, you will notify us of any Workers Compensation claim you make, and that you agree to reimburse us as described above.

RIGHT OF REIMBURSEMENT

If benefits are paid under this Policy and you or your covered dependent recovers from a responsible party by settlement, judgment or otherwise, we have a right to recover from you or your covered dependent an amount equal to the amount we paid.

12. In a worker's compensation proceeding, the group health carrier is likely to argue that it has a contractual right of recovery. Since it is not subrogation, common law subrogation rules (i.e. made whole) will not apply.

II. Group Health Carrier's Participation in Worker's Compensation Proceeding

A. Is group health carrier required to give notice of its lien? Lack of notice may bar group health carrier from enforcing reimbursement interest. If claimant is aware that benefits have been paid, then group health carrier may assert that claimant is required to notify carrier of existence of pending worker's compensation claim.

B. In some states, a group health carrier is entitled to intervene in a worker's compensation proceeding. Example: Indiana

C. A few states allow a group health carrier a right of subrogation to proceed directly against the employer. Example: Kentucky

D. The majority of states do not allow a group health carrier to directly participate in worker's compensation claims. Their only remedy is to litigate against the claimant under a general breach of contract theory. Example: Illinois and Wisconsin.

1. Wisconsin: Wis. Stats. § 102.30(7)(a) prohibits a group health carrier from intervening in proceedings under the Worker's Compensation Act, but provides the commission with the power to order reimbursement.

E. Effect of compromise on health care provider's claim against employer/insurance carrier.

In *LaCrosse Lutheran Hospital v. Oldenbeurg*, 73 Wis. 2d 71 (1975), the employer and employee had compromised the case. The court dismissed

the health care provider's claim for reimbursement against the employer because payment by the compromise agreement, which specifically denied liability on the part of the employer, satisfied any obligation the employer may have had under the Worker's Compensation Act. The compromise agreement is the same as far as third parties are concerned, as would be a finding by the commission that the employer had no liability.

F. Effect of compromise on health care provider's claim against employee.

However, group health insurers can attempt to recover payments indirectly through the use of a reimbursement clause in the policy that requires the claimant to reimburse the group health carrier for payments made that should have been made by the worker's compensation insurer. *Employers Health Ins. Co. v. Tesmer,* 161 Wis. 2d 733, 469 N.W. 2d 203 (Wis. App. 1991).

In *Udelhoefen v. John Hancock Mutual Ins. Co.,* 128 Wis. 2d 216, 381 N.W. 2d 579 (Ct. App. 1985), the employee compromised the case with the employer disputing liability. The employee later made a claim under the group health policy, and the insurer refused medical expenses relying upon its policy exclusion for work-related injuries. The court noted the marked differences between its case and *LaCrosse Lutheran* since there was no claim asserted in *Udelhoefen* against the employer.

"The liability of the employer for worker's compensation will be unaffected by the grant or denial of the claim against John Hancock on its group health policy. The compromise will be unaffected. The only effect will be on the third party's liability to the employee. The LaCrosse Lutheran Hospital holding is not pertinent to the liability of the third party. We hold that the compromise agreement does not deprive John Hancock of the right to litigate whether Udelhoefen's injuries or disease came within the policy exclusion." Id. at 738-739.

G. In *Employers Health Ins. Co. v. Tesmer,* 161 Wis. 2d 733, 469 N.W. 2d 203, the court held that, constitutionally, a group health carrier is not precluded from a remedy merely because it is not entitled to intervention. The court explained that several remedies exist for the group health carrier.

"If Employers believes it has improperly paid Tesmer's expenses, it may proceed against Tesmer directly for reimbursement. Second, sec. 102.30(7)(a) permits DILHR to order reimbursement for payments improperly made under a nonindustrial insurance policy covering the same disability and expenses. Thus, if Tesmer should succeed in his worker's compensation claim, Employers may petition DILHR for reimbursement under sec. 102.30(7)(a)." *Id*. At 205-06.

H. Therefore, from the employer's/insurance carrier's perspective, the compromise is valid as to third parties, but from the employee's perspective, the compromise is not valid in considering the insurance carrier policy exclusion.

I. If group health carrier is denied, a non-industrial carrier can deny payment of post-compromise medical expenses to the injured employee.

III. Negotiating with the Health Insurer.

A. Force the health insurer to prove its lien.

1. Ask for copies of the medical bills.

2. Ask for copy of policy to examine pertinent contractual language. Look for policy provisions that limit group health carrier's right to reimbursement.

3. Lay seeds at an early stage regarding difficulties inherent in worker's compensation process.

4. Provide group health carrier with medical documentation establishing difficulty in proving worker's compensation claim.

IV. Creative Compromises that Attempt to Freeze Out the Group Health Carrier

A. Limited Compromises Leaving Past Meds Open

B. Settle Primary Compensation and Try Meds

C. Have Language Include an Order that Payment of Meds by Group Health Carrier Not Improper

D. Hold Harmless Agreements

1. Shifts the burden of reimbursing group health carrier to the Worker's Compensation carrier, who agrees to indemnify and hold the applicant harmless against claim by group carrier for payment of medical expenses. Group health carrier will file suit against its insured, but the defense will be provided by Worker's Compensation carrier.

2. Problems with Hold Harmless Agreements

a) Worker's compensation carriers generally want a full and final compromise agreement.

b) If worker's compensation carrier does not resolve group health lien, group health carrier may file a lawsuit against claimant.

E. Reimbursement Agreements

1. Examine reimbursement agreement provisions. If provisions are narrowly defined (i.e., reimbursement required only if applicant receives benefits pursuant to an award) then bypassing lien more likely. If reimbursement provisions are broadly defined (i.e., reimbursement required for any worker's compensation recovery) then bypassing lien less likely.

2. Claimants sometimes argue unconscionability of repayment agreement. These agreements are signed at a time when employee requires medical care. Obviously, they are inclined to sign anything. It would be against public policy. The argument can be made that the group health carrier has a duty to make payments.

3. In response, carrier will argue that reimbursement agreements are enforceable because the parties would enter into the agreement with full knowledge of facts regarding the accident, and also presumably the applicable law.

F. State in the settlement agreement that the injury is not work-related. In some states, an ALJ may assist the parties in freezing out a health carrier by rendering findings of fact in the settlement that appear to close the door on the group health carrier by indicating that the injury is not work-related.

G. If group carrier will not agree to a reasonable pro-rata resolution, then consider a limited compromise on all issues other than medical expenses and simply try the issue of medical expenses.

H. Ignore group health carrier. The applicant will accept the potential risk of suit by group health carrier.

V. Settlement of Group Health Lien.

A. Argue merits of worker's compensation claim. Ask group health carrier to take pennies on the dollar.

B. How to value the health insurer's recovery.

1. Made whole

a) When a fixed and limited sum of money must be divided between claimant and its health insurer, the health insurer is not entitled to recover until insured has been "made whole," which does not

occur unless claimant has been completely compensated for all elements of its damages.

b) Example – A claimant has total damages of $50,000. That is the made whole number. The insurer has paid $30,000 in medical expenses on behalf of the claimant. The claimant settles for $30,000. Thus, the claimant has received, or received the benefit of, $60,000, or $10,000 over his or her made whole number. That excess $10,000 is available to reimburse the group health carrier. If the claimant recovers less than $20,000 by way of settlement, then he or she has not been made whole, and the group health carrier is not entitled to recover.

c) The made whole argument will generally not be successful in resolving group health lien in worker's compensation proceedings. Remember that reimbursement rights are not akin to subrogation, so state common law subrogation rules do not apply. The group health carrier will take the position that if applicant receives even $1 through settlement of worker's compensation claim, the contract provides the group health carrier with a right to full recovery.

2. Pro-rata reimbursement – best way to resolve group health liens

a) Prove to the group health carrier that claimant's case has settled for pennies on the dollar. Ask the group health carrier to proportionally adjust its lien.

b) Enter into a pro-rata repayment agreement whereby the group health carrier agrees to accept a proportion of its lien as the applicant receives relative to the maximum value of the case. For example, if the claimant's case is worth $50,000, the settlement is for $25,000 and the group health carrier's lien is $20,000, the group health carrier receives 50%, or $10,000.

VI. Self-funded ERISA Plans.

A. Self-funded employee benefits plans are governed by ERISA, which preempts state laws that "relate to any employee benefit plan." *FMC Corp. v. Holliday*, 498 U.S. 52, 57-58 (1990).

B. The ERISA preemption argument may no longer be persuasive following the U.S. Supreme Court's decision in *Great West Life and Annuity Insurance Company v. Knudson*, 534 U.S. 204, 122 S. Ct. 708, 151 L.Ed.2d 635 (2002). Knudson was injured in a car accident. Great West Life and Annuity paid approximately $400,000 pursuant to an ERISA self-funded plan. Plaintiff settled this case and

earmarked $13,000 to satisfy Great West's reimbursement claim. Great West filed a federal action to enforce the plan's reimbursement provision. The court held that because Great West sought legal relief on a contractual obligation, ERISA did not apply. The court basically held that the type of monetary relief sought in a reimbursement action was not the type of equitable relief allowed by ERISA. The court expressed no opinion as to whether the plan could have intervened in the state court tort action or whether the plan could have taken direct action against the Plaintiff asserting state law claims such as breach of contract. The Supreme Court never criticized the merits of Great West's reimbursement claim. The court basically stated that you need to bring the right claim, which presumably would be a breach of contract action.

C. It will be interesting to see how courts interpret *Knudson*. Will claims for reimbursement still be subject to ERISA? Will they still be filed in federal court? Will state subrogation or reimbursement law apply?

D. No matter how the courts interpret *Knudson*, the following standard rules apply for practitioners dealing with a self-funded claim.

1. Obtain and review the summary plan description and all the plan's documents. Compare the summary plan description with the actual plan's documents. If the plan documents are more favorable, you can elect to enforce them against the plan.

2. Review the plan language. Some ERISA plans contain made whole provisions, or provide that state law controls questions of interpretation. The applicable language will determine whether state common law rules apply. Of course, following *Knudson*, it is possible that state law will apply anyway, so there will be an issue as to whether established subrogation law or simple breach of contract principles will apply.

STATE OF ILLINOIS
IN THE CIRCUIT COURT OF THE TWENTIETH JUDICIAL CIRCUIT
ST. CLAIR COUNTY

AMERICAN MEDICAL SECURITY INSURANCE COMPANY, 3100 AMS Boulevard Green Bay, WI 54307 Plaintiff, -vs- **JOHN CORBETT,** 655 Wicks Well Road Madisonville, Kentucky Defendant.	)	Case No._____

COMPLAINT

The above named plaintiff, American Medical Security Insurance Company, by its attorneys, Lindner & Marsack, S.C., by Douglas M. Feldman, and Timothy J. Schumann, complains of the above named defendant and alleges and shows to the Court as follows:

1. Plaintiff, American Medical Security Incorporated [hereinafter "American Medical Security"], is a foreign corporation with its principal place of business located at 3100 AMS Boulevard, in the City of Green Bay, County of Brown, State of Wisconsin.

2. Defendant, John Corbett, is an adult resident of the State of Illinois, with his principal place of residence at, 655 Wicks Well Road, City of Madisonville, State of Kentucky.

3. Attached as Exhibit A, and incorporated herein by reference, is a copy of a health insurance policy issued to American Medical Security sponsored by Coal Miners, Inc. That as of June 1, 1999, Defendant John Corbett was insured under Exhibit A.

4. John Corbett was involved in a work-related accident on September 25, 1999 that occurred while he was hanging curtains and cables in the course of his employment at Coal Miners, Inc.

5. On June 26, 2000, Defendant filed an application for adjustment of his Worker's Compensation claim with the State of Illinois Industrial Commission.

6. The Defendant filed a request for hearing in the County of St. Clair, State of Illinois, case number 00-WC-35807. In his request for hearing, Defendant requested worker's compensation benefits for the injury that occurred at Coal Miner Inc on September 25, 1999.

7. In June 7, 2001, Defendant entered into a contractual settlement of his Worker's Compensation claim with Coal Miners Inc regarding injuries that he sustained on September 25, 1999. A copy of the settlement contract is attached to this complaint and incorporated by reference as Exhibit C.

8. As a result of medical treatment that Defendant incurred for injuries caused by the September 25, 1999 accident, Plaintiff American Medical Security paid $18,156.38 in medical benefits on behalf of Mr. Corbett pursuant to the Health Insurance policies attached as Exhibit A. A total of $18,156.38 was paid on behalf of Mr. Corbett pursuant to Exhibit A

9. Exhibit A contains a provision entitled "Exclusions" which provides in part:

> The Plan does not cover expenses for:
> . . .
>
> 6. Charges for injury or sickness occurring during or arising from your course of employment (unless this Plan provides around-the clock coverage (for the employee only); or payable under Worker's Compensation or an Occupational Disease Act or Law.

10. Exhibit A contains a reimbursement clause regarding Worker's Compensation benefits. The insurance contract provides in part:

WORKER'S COMPENSATION

This Plan is not issued in lieu of, nor does it affect any requirement of, coverage under any Act or Law which provides benefits for any injury or sickness occurring during, or arising from, your course of employment.

This Plan will apply the Right of Reimbursement provision for work related injuries or sickness even though benefits are in dispute or are made by means of settlement or compromise, no final determination is made that injury or sickness was sustained in the course of or resulted from your employment, the amount due for health case is not agreed upon or defined by you or the carrier, or the health care benefits are specifically excluded from settlement or compromise.

In consideration for coverage under this Plan, you agree to notify American Medical Security of any claim you make. You agree to reimburse this based on the information above.

11. Exhibit A provides American Medical Security with a right to recover directly from Mr. Corbett for his failure to reimburse American Medical Security pursuant to the terms of the contract. The contract provides in part:

RECOVERY RIGHTS

SUBROGATION

You agree this Plan is subrogated to your right to damages, to the extent of benefits provided, for injury or sickness, for which a third party is liable or causes. You assign your claim against a liable party to the extent of this Plan's payment, and do not prejudice it subrogation rights. American Medical Security shall recover on a pro-rata basis. If you enter into a settlement or compromise arrangement with a third party without this plan's prior written consent, that settlement or compromise arrangement is deemed to prejudice this Plan's rights. You must promptly advise American Medical Security in writing whenever a claim against another party is made, provide additional information reasonably requested, and agree to fully cooperate in protecting this Plan's rights against a third party.

RIGHT OF REIMBURSEMENT

You may receive benefits under this plan and may also recover losses from another source, including Worker's Compensation, uninsured, no-fault or

> personal injury protection coverage. The recovery may be in the form of a settlement, judgement, or other payment. You must reimburse the Plan from these recoveries in an amount up the benefits paid under this Plan. This Plan will have an automatic lien on any recovery, if allowed by law.

12. To date, Defendant has failed to reimburse Plaintiff, as required pursuant to Exhibit A, out of his Worker's Compensation contractual settlement with Coal Miners Inc. Defendant's failure to reimburse Plaintiff $18,156.38 in medical benefits pursuant to Exhibit A constitutes a breach of said contracts.

13. As a result of the breach of contract by Defendant John Corbett, Defendant owes Plaintiff, American Medical Security, an amount proper to compensate Plaintiff for all damages naturally flowing from the breach.

14. Wherefore Plaintiff, American Medical Security, prays for judgment against the Defendant, John Corbett, in a sum of $18,156.38, plus interest, plus costs of this suit, and such other and further relief, as the Court may deem just and equitable.

Respectfully submitted this _____ day of April, 2003.

LINDNER & MARSACK, S.C.
Attorneys for Plaintiff

By: _____
Timothy J. Schumann
Wisconsin State Bar No. 1024947

_____
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HOLD HARMLESS AGREEMENT

_____ alleges to have sustained an injury on or about _____, while in the course of his/her employment with _____. _____ and _____ worker's compensation carrier, _____ , have agreed to resolve this disputed claim and the terms and conditions of the settlement are set forth in a separate worker's compensation settlement agreement. The Employer and carrier continue to deny that the claimant's condition was work related and that he/she is entitled to any worker's compensation benefits.

Nonetheless, in order to help facilitate the settlement of this claim, the carrier has agreed to hold _____ harmless and indemnify him/her for any claim made against _____ by _____ for any payment of medical expenses that _____ may have made on behalf of _____ for medical expenses incurred by _____ between the date of injury through _____. _____ agrees to defend _____ in any court action maintained by _____ and to indemnify him/her should a judgement be taken.

_____ has the obligation under this agreement to immediately notify the Company, the insurance carrier or their attorney, Douglas M. Feldman, in the event that any action is taken by the _____ against him/her. The failure of _____ to notify any of the above parties of a pending action nullifies and voids this entire agreement if said lack of notice prejudices their ability to defend the case. _____ also agrees to cooperate fully with the carrier and Employer in defending any action maintained by _____.

This agreement to hold the Applicant harmless has a monetary cap of $_____ and _____ liability under this agreement shall not exceed that amount.

Dated this _____day of _____, 2003.

By: _____
**
Employee-Applicant

Dated this _____day of _____, 2003.

_____ LAW OFFICES, S.C.

By: _____
**
Attorney for the Employee/Applicant

Dated this _____day of _____, 2003.

LINDNER & MARSACK, S.C.

By: _____
Douglas M. Feldman
Attorney for the Employer and Insurer