The Different Worlds of Litigation in Property and Casualty Subro v. Healthcare Subro

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LITIGATING ANY CASE IS OFTEN A MATTER OF WEIGHING RISK AND ANALYZING COST AGAINST BENEFIT. IN THE PROPERTY & CASUALTY (P&C) WORLD OF SUBROGATION, THE ANALYSIS IS OFTEN A "HARDER" OBJECTIVE ONE, DRIVEN BY CALCULATIONS OF THE COSTS INVOLVED PREDICATED ON SPECIFIC FACTS AND DOLLARS PAID. IN THE HEALTHCARE WORLD, DECIDING WHETHER TO LITIGATE INVOLVES MANY "SOFTER" CONSIDERATIONS, ESPECIALLY SINCE IT OFTEN INVOLVES AN EMPLOYER SUING ITS OWN EMPLOYEE, OR VICE VERSA. BUT SO WHAT? THE POINT OF THIS ARTICLE IS TO COMPARE AND CONTRAST P&C AND HEALTHCARE SUBROGATION LITIGATION AND, IN THE PROCESS, TAKE A CLOSER LOOK AT THE LITIGATION CONSIDERATIONS INVOLVED IN HEALTHCARE LIENS THAT SOMETIMES HAVE NOTHING TO DO WITH THE CASES THEMSELVES.

Property and Casualty Subro vs. Healthcare Subro

Property and casualty subrogation is a process that allows an insurer, after covering their insured's property, automobile damage, and/or No Fault or Medical Payments loss, to assume the rights of their insured and seek indemnity from the wrongdoer. While the innocent insured could pursue the tortfeasor on his or her own and not file a claim with their own insurance carrier, that rarely happens. Submitting a covered claim and allowing the carrier to subrogate becomes the usual choice. The clearest example of this is a car accident in which one car collides with another non-moving vehicle at a stop sign. In most cases, the innocent insured will file a claim with his or her own insurance company under the collision portion of their policy. The carrier will appraise the vehicle, pay the damages less the insured's deduct-

ible, and pursue the negligent driver through subrogation. If an insured chooses not to carry automobile physical damage coverage and decides to pursue such cases on their own, they would bear the cost and risks of doing so including those associated with any litigation. One of the reasons people buy insurance is so they do not have to deal with that hassle. Instead, they can leave it up to their insurance company.

Health insurance subrogation is a different matter altogether. First, a bodily injury claim from a car accident involves many different forms of damages, not just property damage as described above. A subrogee health plan cannot simply pay to fix a broken leg and then stand in the member's shoes against the third party to demand and receive full reimbursement. How nice that would be, but it is more complicated than that. Lost wages, uncovered medical expenses and of course the Holy Grail of personal injury litigation, pain and suffering, all get thrown into the mix. And often, there is a limited amount of money to go around. Consider further that automobile accidents make up eighty percent of healthcare subrogation cases. In the past fifteen years, the average healthcare lien has nearly quadrupled while auto liability minimums have stayed the same, making the fight even more intense.

Second, as opposed to property and casualty, the rights of a health plan to subrogate or seek reimbursement have been the subject of endless common law decisions and legislative changes in the last twenty years. In a typical car accident case, the third party may have $100,000 in liability coverage. The victim may have damages, including the health plan's claim payments that exceed the available $100,000. When this occurs, which is often, the health plan member and his or her attorney will find themselves fighting with the subrogating health plan. It is no wonder that hundreds of cases, including three at the U.S. Supreme Court level, have been litigated in which injured health plan members have sought to limit or eliminate the health plan as a claimant (i.e. competitor) for the third party funds. And complicating matters even further is the ability of a health plan to require the accident victim to repay the health plan from the tort settlement.

Finally, in contrast to P & C insurers who are governed by state law, health insurers come in many different forms and a combination of state and/or federal law can apply. There have always been traditional indemnity policies that cover certain medical expenses for a fixed premium. HMOs are popular too of course, but for our purposes they have no significant legal distinction from an indemnity plan. For both, state law applies in most instances. Employers not wishing to pay large premiums for a policy that could be under-utilized choose instead to bear the risk themselves and self-insure. These employer plans fund a trust, which essentially takes the form of a checking account managed by a third party administrator (TPA) who processes the claims according to the employers' plan design. Here, ERISA and other federal law controls unless, of course, the self-funded plan is a municipality, church, or school. While self-funded, those plans are not covered by federal law, but rather by state law. So, the laws for health insurance subrogation are different by state, and federal circuit, and vary depending upon whether the plan is insured or self-funded. No matter how you do the math, there are many different sets of rules to play by.

To litigate or not to litigate?

A P&C insurer considers litigation by weighing cost, potential return, and underlying liability. In P&C subrogation cases that are litigated, the actual insured has no part other than perhaps to testify that the third party caused the accident. Anticipated costs involve attorneys and expert witnesses who typically testify on the issues of liability and damages. As property subrogation

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involves one form of damages and the same set of litigants, there are few if any laws restricting the practice. For all of these reasons, the decision to litigate a P&C subro case is not an emotional one.

On the other hand, deciding to litigate a health care subrogation claim may carry with it much greater risk and expense in the form of damage to carrier reputation and/or company culture. When a health plan or self-insured company decides to file suit, it ultimately means bringing suit against the health plan member or employee. The goal of a health insurance subrogation lawsuit, when there are limited funds, is to reduce the portion of the settlement going to the injured party so the health plan can be reimbursed. True subrogation in the health care context is largely a textbook creature because no liability insurer is going to pay back a health plan for its economic loss knowing the injured plaintiff will be seeking additional damages for the same loss. As a result, health plans have wisely added contractual provisions requiring the injured plan participant to reimburse the health plan from any tort settlement. To many plan members who have contributed to their health insurance coverage in one way or another, this concept of having to repay their health plan is quite shocking.

Litigation Factors

What factors should be considered by a health insurer or self-funded employer? The obvious answers involve cost and applicable law. The not-so-obvious involves business relationships and publicity and the ever present chance of a hollow victory.

COST: Ultimately, consideration must be given to whether the amount being pursued is worth what it will cost to collect it. If the health plan is to file a lawsuit in federal court, then it ought to figure on retaining counsel on a one-third contingency fee. If an hourly arrangement is made, a plan should expect to pay $3,000 to initiate the lawsuit. If negotiations reach an impasse and the matter ultimately goes to trial, the bill could easily tally $10,000 or more, plus costs, and all of this with no guarantee of a victory. Along purely financial lines, the decision should be an easy one; the lawsuit should only commence for liens of at least $25,000. However, in the past few years, with the economy tightening, companies are pursuing litigation against their employees for as little as $6,000.

APPLICABLE LAW: Will state or federal law control? Beyond the general rules of state law for insured plans and federal law for self-funded plans, jurisdictional battles still take place adding even more cost and time before reaching the merits. Depending on the issues in the case, this consideration can be especially dicey for self-funded plans.

PUBLICITY: What message is sent when a health plan or company sues its member or employee? Conduct a search of subrogation lawsuits and Wal-Mart will appear in your results more than any other single employer. An aggressive pursuer of subrogation, Wal-Mart learned a hard lesson in *Administrative Committee of Wal-Mart Stores, Inc. Associates' Health and Welfare Plan v. Shank*, 500 F.3d 834 (August 31, 2007), where the company pursued Ms. Shank through the federal court system right up to the point where the U.S. Supreme Court declined to hear her appeal. Despite the member's severe injury and a host of sympathetic and mitigating factors, Wal-Mart prevailed and was awarded $417,000 from her settlement, which after court costs and attorney fees left her with nothing. Along the way Wal-Mart pointed out that they hold all

employees to the same standards. Yet in the end, in a surprising turn under immense public pressure, Wal-Mart retreated and allowed Ms. Shank to keep all of her settlement funds. In the other direction, in an unpublished opinion, a self-funded plan decided to file suit against, ironically, their own human resources employee who refused to cooperate or reimburse the plan. There were multiple conference calls during which the company's management anguished over the decision. The plan had the resources to file suit and the lien was over $100,000, so the economics made sense. That company pushed on because it thought it needed to send a message through this particular employee that they were serious about the provisions in the plan.

HOLLOW VICTORIES: A plan should be aware of hollow victories in which it pursues and even succeeds

in a lawsuit without recovering any funds. A clear example of this is from recent case of *Rizzo v. Mosley*, 2010 NY Slip Op 20524 in which the Court allowed an insured health plan to intervene in the plaintiff's lawsuit in an effort to protect its lien. At issue was a New York statute that prohibits subrogation for insured plans and self-funded municipalities, yet the statute seemingly inadvertently only applied when cases settled. One wonders why state lawmakers would cut off their counties' rights, but that is a question for another day. What makes this a hollow victory is that the plan can only recover if the case goes to a verdict. But we know that most cases do not. So what if the parties in the underlying tort case "settled?" Certainly this case would motivate the parties to do so. Not long after, lawmakers in New York proposed an amendment (Senate Bill 4576) which would prevent plans from recovering in settlements AND verdicts. The result is that while the *Rizzo* case allows a health plan to intervene, the result will encourage a settlement or new legislation, or both, and the plan will get nothing under either scenario.

P&C subrogation certainly involves cases more sophisticated than the examples presented here, but the litigation landscape is more complicated in the healthcare subrogation world. It is not only the prevailing law and financial considerations that make litigating healthcare subrogation cases difficult. By definition, the defendants are physically injured and often in an employer-employee relationship with the plaintiff.