

To Lien or Not to Lien: Handling Subrogation Rights of Third-Party Health Care Plans

by Steven B. Goolnick, Esq.

Due to a technical error, Steven B. Goolnick's article 'To Lien, or Not to Lien: Handling Subrogation Rights of Third-Party Health Care Plans' was printed without its accompanying footnotes in the Spring issue. The following is a full copy of the article with footnotes.

As we all know, New York's Insurance Law provides for mandatory No-Fault coverage for persons injured in auto accidents, including reimbursement of medical expenses, lost earnings and other reasonable and necessary expenses.¹ This coverage is generally referred to as personal injury protection or PIP coverage.

Often the No-Fault carrier will deny further payments for medical treatment based upon a purportedly "independent medical examination" performed by one of a coterie of "practitioners" on an approved list of insurance carrier examiners. Should the claimant need further medical treatment (notwithstanding the opinion of the carrier's examiner) and have private health insurance coverage, he/she may then go to their own private health care carrier and request continued treatment upon presentment of a copy of the Denial of Claim form from the No-Fault carrier.

Afterwards – some time during the course of the personal injury action – counsel will receive a letter, typically from The Rawlings Company or another agent of a health insurance plan, claiming a lien or right of repayment out of the proceeds of the case. What this claim really is, and how to handle it, has been a vexatious issue within the P.I. field.

Benefits afforded by a private health care carrier can be subject to equitable subrogation rights as against the third party claim made by your client. Though technically not a lien at law, "(a)n insurer has the right to recover, by way of subrogation, for damages that it has been called to pay to an insured under its policy. The subrogation of an indemnity insurer arises by operation of law when it makes payment to the insured..."²

There has been a great deal of controversy regarding the type of language that has to appear in the private health care contract to afford equitable subrogation rights. Case law indicates that if there is no specific language contained in the health insurer's policy, then the claimant (and his/her attorney) need not protect these subrogation rights. The

Court of Appeals has held that, "(a)n equitable lien is dependent upon some agreement express or implied that there shall be a lien on specific property. The agreement must deal with some particular property either by identifying it or by so describing it so that it can be identified and must indicate with sufficient clearness an intent that the property so described or rendered capable of identification is to be held, given or transferred as security for the obligation."³

Based upon this language from this state's highest court, it becomes paramount that the able practitioner reads the client's health care policy – especially those portions that pertain to subrogation rights. (Clients not in possession of the policy can request it from their health care provider directly.) Once placed on notice that the health care provider is claiming a subrogation right, counsel can then request a copy of the policy from the entity that sent notification. The burden is on the incoming health care insurer (after No-Fault has been denied) to prove that they have viable subrogation rights. However, the practitioner should be aware that there are lower court decisions that indicate, "(t)he policy provision creates an equitable lien by subrogation against any recovery by the insured from a third-party by reason of medical expenses paid to the insured."⁴

Many practitioners have tried to either extinguish or reduce the health insurer's subrogation rights by claiming that CPLR section 4545 is applicable. This is a very unwise tactic – courts have consistently rejected this argument. Section 4545 only applies to reduce verdicts after trial in the amount paid by a collateral source: It does not apply to pre-verdict settlements, as it is an evidentiary provision.⁵

Once aware that the health insurer is claiming a subrogation right, counsel must not give the tortfeasor a General Release in settlement of the tort action: Doing so without securing the health insurer's subrogation rights is in breach of the Contract of health insurance⁶. Once the claimant executes a General Release (which by reference includes the health insurer's derivative claim for subrogation), this release destroys any rights that the health insurer may have against the tortfeasor, provided that the health insurer was not timely notified of the equitable subrogation lien.

Therefore, a good practice tip is to notify the tortfeasor's carrier that the claimant's health insurer is claiming a subrogation right. There is case law that suggests that a General Release can be used if the tortfeasor has been given actual notice of the health insurer's subrogation rights at the time of the settlement.⁷ However, this is a bit risky and, on balance, not advisable. A determination should be made regarding the subrogation rights held by the health insurer before a General Release is given to the tortfeasor.

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Thirdly, to settle the issue with the health insurer prior to direct action or arbitration, counsel can attempt to negotiate with the health insurer's representative. Since the health insurer cannot assert this right directly against the tortfeasor prior to settlement absent a showing of any real prejudice, the subrogee must deal directly with plaintiff's counsel - you." The easiest way to negotiate with the health insurer's representative is to claim at least one-third off the amount allegedly owed, on the theory that any monies being repaid to the subrogee are recovered only based upon counsel's efforts as the attorney for the subrogor (similar to reducing a worker's compensation lien without the statutory language).

Naturally, one should use one's best efforts to try and reduce the lien even further, since most clients won't understand why they have to repay any monies to the health insurer in the first place after paying premiums (or working) for those benefits. The easy answer for the client is that the language in their health insurance contract compels them to do so.

There is also another, public policy, reason why this payment should be made. Without subrogation, the cost of the claimant's medical expenses is not saved but merely shifted from the tortfeasor's insurer to the claimant and his insurer, netting the public no overall insurance benefit. Granting these subrogation rights to the paying insurance carrier is

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supposed to alleviate the problem of lack of affordability, and hence availability, of insurance to the New York State consumer, as well as to prevent a double recovery by claimants. To circumvent a health insurer's subrogation rights would allow a third-party tortfeasor to escape all liability for medical costs beyond No-Fault whenever the injured party is sufficiently insured, resulting in all health care recipients sharing the tortfeasor's burden. Hence, subrogation can, at times, serve the oft-praised purpose of placing the burden upon the insurer for the one who caused the harm.

In conclusion, one cannot ignore a claim for subrogation rights from the claimant's health insurer, even though it may come disguised as a lien of dubious worth. Not recognizing or properly addressing such a claim places one's client in jeopardy of being responsible for repayment of the subrogation rights claimed by the health insurer. Though counsel will not be responsible to the subrogee (since counsel is not in privity with the insurer), counsel remains answerable to the client for failure to handle this situation appropriately.¹²

The foregoing is the result of a Research Project undertaken by NYSTLA's Automobile Litigation and No-Fault Insurance Committee, with principal authorship by Steven B. Goolnick, Esq., a partner with Blank Goolnick & Dittenhoefer.

Notes

- 1 See Insurance Law sections 5102,5103.
- 2 See *Government Employees Insurance Company v. Halfpenny*, 103 Misc.2d 128, 425 N.Y.S.2d 212 (Sup. Ct., New York County, 1980).
- 3 See *Winkelmann v. Excelsior Insurance Company*, 85N.Y. 2d577, 626 N.Y.S.2d 994 (1995).
- 4 See *Miller v. Liberty Mut. Fire Ins. Co.*, 48 Misc.2d 102, 264 N.Y.S.2d 319 (Supreme Court, Kings County, 1965).
- 5 See *Teichman v. Community Hospital of Western Suffolk*, 87 N.Y.2d 514, 640 N.Y.S. 2d 472, (1996); *Nossoughi v. Federated Dept. Stores*, 175 Misc. 2d 585, 669 N.Y.S.2d 479 (Supreme Court, New York County, 1998); *Niemann v. Luca*, 168 Misc. 2d 1023, 645 N.Y.S. 2d 401 (Supreme Court, Suffolk County, 1996).
- 6 See *Weinberg v. Transamerica Insurance Company*, 62 N.Y. 2d 379, 477 N.Y.S.2d 99 (1984).
- 7 See *Nationwide Ins. Co., v. Mocchi*, 243 A.D. 2d 692, 663 N.Y.S. 2d 640 (2nd Dept., 1997); *Blacharsh v. Hartford Ins. Co.*, 104 A.D.2d 839, 480 N.Y.S. 2d 241 (2nd Dept., 1984); *Scavone v. Kings Craft Corp.*, 55 A.D.2d 807, 390 N.Y.S. 2d 20 (4th Dept., 1976).
- 8 See *Independent Health Association, Inc. v. Grabenstatter*, 254 A.D.2d 722, 678 N.Y.S. 2d 220 (4th Dept., 1998)
- 9 See *Kozlowski v. Briggs Leasing Corp*, 96 Misc.2d 337, 408

N.Y.S.2d 1001 (Supreme Court, Kings County, 1978).

- 10 See *Record v. Royal Globe Insurance Co.*, 83 A.D.2d 154, 443 N.Y.S.2d 755 (2nd Dept., 1981).
- 11 See: *Pell v. Malibu Resorts Int'l., Ltd.*, 249 A.D. 2d 605, 669 N.Y.S.2d 939 (2nd Dept., 1998); *Warner v. University Hospital @ Stonybrook*, 246 A.D.2d 535, 666 N.Y.S.2d 931 (2nd Dept., 1998); *Philip Morris Companies, Inc., v. Federal Ins. Co.*, 244 A.D.2d 223, 664 N.Y.S. 2d 45 (1st Dept., 1997).
- 12 See *Provident Life & Accident Ins. Co., v. LaRose*, 1/15/91 N.Y.L.J. 27 (col. 1).

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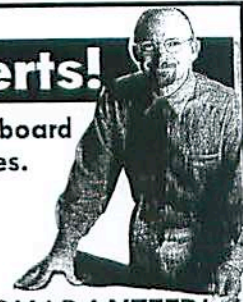
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